STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225383	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westfield Rehabilitation and Health Center	37 Feeding Hills Road Westfield, MA 01085

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, and interviews, the facility failed to ensure that food was prepared, distributed, and served in accordance with professional standards for food service safety in the facility's main kitchen.Specifically, the facility failed to ensure:1. that a fan in use in the main kitchen was clean and free from dust and debris.2. that an open window in the main kitchen had a screen to prevent outside elements including dust and insects from getting into the kitchen and contaminating food and food preparation surfaces.Findings include:On 4/1/26 at 7:20 A.M., the surveyor observed the following in the facility's main kitchen:-Uncovered muffins on the counter across from a fan in use that was blowing in the direction of the muffins.-The fan in use was covered in dust and debris build-up.-An open window (approximately 18-24 inches) had no screen to protect from outside elements.-The fan in use was located directly in front of the open window with no screen.During an interview directly following the kitchen observations, Directory Aide #1 said the facility was aware of the missing window screen. He said because the kitchen would get unbearably hot, the kitchen staff utilized a combination of fans, open windows and one air-conditioner. Dietary Aide #1 said the running fan was covered in dust and needed to be cleaned. When the surveyor indicated that the fan was blowing in the direction of the muffins on the counter, Dietary Aide #1 nodded in agreement that the fan was blowing in the direction of the food, however, did not remove the muffins or turn the fan off. Dietary Aide #1 said if he turned the fan off the room would become too hot.During an interview on 4/1/26 at 9:44 A.M., with the Food Service Director (FSD) and the Corporate Food Service Manager, the FSD said maintenance was responsible for cleaning the fans. The Corporate Food Service Manager said the facility was also trying to find a screen to put in the window. The FSD said the kitchen staff could close the window and turn the fan off until a screen was put in place and the fan was cleaned. The FSD said the issue of having a window open with no screen was that small animals, bugs or birds could make their way into the kitchen. The FSD said the running fan that was covered in dust and debris could potentially push debris into the kitchen and onto the food. On 4/1/26 at 9:51 A.M., the surveyor observed the following in the main kitchen:-the fan remained in use and was still covered in dust and debris build up.-the open window (approximately 18-24 inches) was still missing a window screen to prevent outside elements from contaminating the food and food preparation areas.-The fan in use remained directly in front of the open window.During an interview on 4/1/26 at 12:00 P.M., the Maintenance Director said he was new, however it was his understanding that the housekeeping staff was responsible for cleaning the fans.During an interview on 4/1/26 at 12:14 P.M., the Housekeeping Director said she had nothing to do with cleaning the kitchen fans and that it was the responsibility of the kitchen and maintenance staff to maintain the cleaning schedule for the kitchen.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that the comprehensive care plan was reviewed and revised by an interdisciplinary team and changes implemented as required for one Resident (#22), out of a total sample of 16 residents. Specifically, for Resident #22, the facility failed to ensure the plan of care was revised to reflect the updated recommendations from the Speech Language Pathologist (SLP) and Occupational Therapy (OT) relative to:-changes in the level of supervision by staff during the Resident's meals from Physician ordered supervision (staff present while the Resident was eating) to Rehabilitation Therapy recommended intermittent supervision (staff would occasionally observe Resident during meals).-straws were able to be utilized by the Resident when there were current Physician orders for no use of straws.-addition of adaptive equipment including two handled mugs for meals which was not implemented. Findings include:Review of the facility policy titled Comprehensive Person-Centered Care Plans, revised March 2022, indicated the following:-A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident-The Interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.-Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. -Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change.-The IDT reviews and updates the care plan at least quarterly, in conjunction with the required quarterly Minimum Data Set (MDS) assessment. Resident #22 was admitted to the facility in January 2024 with diagnoses including Dementia with behavioral disturbance, adult failure to thrive, feeding difficulties, and oropharyngeal dysphagia. Review of the SLP Discharge summary, dated [DATE], indicated Resident #22:-could safely feed him/herself using the mechanical soft diet/ground textures.-required the following interventions: upright for meals, small bites, clear between bites, alternate liquids and solids to clear if needed, no talking with meals.-was upgraded to intermittent supervision at this time. Review of the Comprehensive Care Plan included the following:-Nutrition Care Plan, initiated 10/7/25, indicated Resident #22 was at increased nutritional risk related to variable intake and included the following interventions:>Refer to Registered Dietitian (RD), OT or SLP as needed.>Resident uses a two handled cup with lid to encourage increased fluids, initiated 1/7/25>provide and serve a NAS (No Added Salt) mechanical soft diet with ground meat and gravy, two handle spout cup for (hot) liquids, initiated 2/11/25>NO STRAWS, intermittent supervision with meals, small bites and single sips, double swallow or alternate liquids and solids, initiated 3/10/25-Activities of Daily Living (ADL) Care Plan, initiated 11/17/22, indicated the Resident had a performance deficit and included the following interventions:>Resident was issued a two handled spout cup for all liquids, revised on 12/2/25>Resident requires set up with meals, may require increased assistance at times, provide cues for initiation and completion of meals as needed to eat, revised 12/2/25 Review of the MDS assessment dated [DATE] indicated the following relative to Resident #22:-exhibited severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of four out of a possible 15 points.-required set up with meals-was on a therapeutic and mechanically altered diet. Review of the April 2026 Physician's orders indicated the following relative to Resident #22:-NAS, Mechanical Soft texture, thin consistency, with ground meat and gravy, supervision by staff and NO STRAWS, initiated 3/10/25.-two handled mug with cover for hot liquids, initiated 1/10/24. Review of the Certified Nurse Aide (CNA) Care Card as of 4/2/26 at 4:15 P.M., indicated the following under Eating/Nutrition:-Resident requires set up of meals, may require increased assistance at times, (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provide cues for initiation and completion of meals as needed to eat. -Resident uses a two handled cup with lid to encourage increased fluids.-Provide and serve NAS mechanical soft diet with ground meats and gravy, encourage milk and juice with meals, two handled soup cup for hot liquids . -3/10/25: no straws, intermittent supervision at meals, small bites and single sips, double swallow or alternate liquids and solids. On 4/2/26 at 11:58 A.M. through 12:30 P.M., the surveyor observed the following during the lunch meal:-Resident #22 was seated at the edge of the bed in his/her room with the lunch tray positioned in front of him/her on the over the bed table. -The Resident had a pink pitcher with a straw on his/her over the bed table.-A lunch tray consisted of chicken with gravy, mashed potatoes with gravy, zucchini, and two regular glasses which contained milk and juice. -No two handled cups with lids were observed with the Resident's meal tray.-Resident #22 was consuming the meal in his/her room with no staff present for supervision. On 4/2/26 at 5:19 P.M., the surveyor observed the dinner meal and observed the following:-Resident #22 was seated at the edge of his/her bed with the overbed table positioned in front of him/her.-The dinner tray consisted of pork, egg noodles, and two regular glasses containing milk and juice. -The Resident's meal ticket indicated NAS, mechanical soft, gravy, no straws and lip plate. The meal ticket did not indicate that two handled mugs were to be provided.-The pink pitcher with a straw remained on the Resident's over the bed table.-No two handled cups with lids were provided with the Resident's dinner meal.-Resident #22 was observed to consume the meal in his/her room with no staff present for supervision. On 4/3/26 at 7:53 A.M. through 8:22 A.M., the surveyor observed the following during breakfast:-Resident #22 was lying in bed with his/her eyes closed.-A breakfast meal tray was on the over the bed table positioned next to the Resident's bed and contained two covered bowls of hot cereal, a small, covered bowl of fruit, two regular glasses containing milk and juice, and a covered mug with a hot beverage.-No two handled mugs were provided.-A pink pitcher with a straw was observed on the over the bed table.-At 8:18 A.M.: CNA #2 entered Resident #22's room and prompted the Resident to wake up to eat breakfast and exited the room shortly after. The Resident remained sleeping and did not eat. -At 8:22 A.M.: CNA #1 entered the Resident's room and encouraged him/her to eat breakfast. Resident #22 declined the meal and CNA #1 removed the breakfast tray from the room but left the mug of hot beverage and the pink pitcher with a straw in the Resident's room. During an interview on 4/3/26 at 9:00 A.M., the Director of Rehabilitation (DOR) said Resident #22 was previously followed by Speech Therapy and had been discharged from services. The DOR said there had been no changes in the Resident's plan of care from when the SLP made recommendations at discharge (in March 2025). The DOR said the recommendations from the SLP should be in the Physician's orders located in the electronic medical record. The DOR said OT completed a quarterly review for Resident #22 and there have been no changes to his/her plan of care. During an interview on 4/3/26 at 10:00 A.M., with the Director of Nursing (DON), Consulting Staff #1 and the DOR, the surveyor relayed observations from 4/2/26 and 4/3/26 about Resident #22's meals and the DOR said there were no changes to Resident #22's plan of care since the SLP discharged him/her in March 2025. Consulting Staff #1 said the Resident's current Physician's orders indicated he/she was to have supervision with meals, mechanical soft diet, two handled mug and no straws. The DOR said the Resident's ADL care plan indicated the Resident required set up with meals with assistance as needed. The DOR also said that adaptive equipment should be indicated on the Resident's meal ticket. During an interview on 4/3/26 at 10:11 A.M., CNA #2 said Resident #22 was very independent but required supervision and assistance at times from staff. CNA #2 said if the Resident was sleeping during breakfast, the staff were to leave the meal in his/her room and continue to encourage him/her to eat. CNA #2 said Resident #22 was independent with eating after staff set up the meal for him/her, and that the Resident eats in his/her room for meals, except occasionally he/she will eat in the dining room for lunch. CNA #2 said the Resident was on a mechanical soft diet with ground meats and did not have any adaptive equipment with meals. On 4/3/26 at 10:21 A.M., the surveyor and the DON observed Resident #22 lying in bed with his/her eyes closed. The over the bed table was positioned next to the (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident's bed and contained a covered mug and a pink pitcher with a straw. The DON knocked, entered the room and removed the covered mug which contained coffee and the straw from the pink pitcher located on the over the bed table in the Resident's room. During an interview on 4/3/26 at 10:23 A.M., Nurse #3 said Resident #22 was supposed to be supervised during meals and was not supposed to have straws. Nurse #3 said supervision meant that staff should be in the room when the Resident was eating. Nurse #3 said Resident #22 was previously on a regular diet and had a choking episode in the past, SLP was consulted and the Resident was now on a mechanical soft diet with supervision and was to have no straws. Nurse #3 said the Resident's meal ticket should include the diet consistency and any recommended adaptive equipment. Nurse #3 said Resident #22 had improved with his/her eating/drinking but continued to occasionally have some coughing episodes during meals. During an interview on 4/3/26 at 10:38 A.M., Nurse #1 said there was a bed board in the unit kitchenette which instructs the CNAs on the residents' level of care. At this time, Nurse #1 showed the surveyor the bed board which indicated Resident #22 required set up for meals. During an interview on 4/3/26 at 11:42 A.M., the SLP said she completed an evaluation today on Resident #22 and that the Resident remains stable from where he/she was when previously discharged from SLP services in March 2025. The SLP said Resident #22 should remain on the mechanical soft diet with ground meats, intermittent supervision from staff and can have straws. The SLP said intermittent supervision meant that staff were to walk by the Resident's room to ensure that he/she did not go back to bed or lay down when provided the meal. The SLP said the Resident was able to follow the safe swallow strategies independently and did not require staff to continuously supervise him/her. The SLP said the Resident had been cleared to utilize straws when he/she was discharged from SLP services on 3/20/25, but the SLP forgot to update the plan of care. The SLP said OT had recommended the two handled cups with hot beverages and that this intervention should have been included on the Resident's meal tickets. During a follow-up interview on 4/3/26 at 12:28 P.M., the DON said the Resident's plan of care should be reviewed and revised at a minimum of every three months. The DON said the IDT was responsible for reviewing the Resident's plan of care to ensure it was accurate and up to date.