STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225586	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westford Nursing and Rehabilitation Center	3 Park Drive Westford, MA 01886

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 37086 Based on records reviewed and interviews for one of three sampled residents (Resident #1), who had diagnoses of paraplegia (paralysis of legs and lower body) and Stage IV (wound that has lost full thickness tissue, exposing bone, muscle, or tendon) pressure injury to sacral (lower back) region and required physical assistance from staff for Activities of Daily Living (ADL-bathing, dressing, grooming), the Facility failed to ensure they developed a baseline Care Plan which included minimal healthcare information related to the level of assistance he/she required to complete ADLs within forty-eight hours of admission as required, and per facility policy. Findings Include: The Facility Policy titled Care Plans-Baseline, with a revision dated of March 2022, indicated a baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. The Policy indicated a baseline Care Plan included instructions needed to provide effective, person-centered care of the resident that meets professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident. Resident #1 was admitted to the Facility in November 2023, diagnoses included Paraplegia (paralysis of the legs and lower body), Multiple Sclerosis, and Stage IV pressure injury of sacral region. Review of Resident #1's Medical Record indicated there was no documentation to support that a baseline Care Plan was developed related to his/her ADL care needs within forty-eight hours of his/her admission. During an interview on 05/07/24 at 2:48 P.M., the Director of Nurses (DON) said that there was no baseline ADL Care Plan developed for Resident #1 and said it should have been developed within twenty-four hours of his/her admission to the Facility. On 05/07/24, the Facility was found to be in Past Non-Compliance and presented the Surveyor with a plan of correction which addresses the areas of concern as evidenced by: A) 01/19/24 through 01/31/24, the Director of Nurses educated all licensed staff on the admission process, including baseline care plans. (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B) 01/19/24, the Director of Nurses educated all Unit Managers to bring resident charts to morning meeting to review New Admission Charts, Consents, Care Plans, and Physician's orders for accuracy. C) 01/19/24, daily audits were initiated related to the New Admission/Readmission resident charts, to verify Physician's orders for accuracy and to ensure care plans were in place. D) Daily audit results were reviewed daily at morning meetings by the Director of Nurses or designee. E) 01/19/24, weekly audits were initiated related to the New Admission/Readmission resident charts, to verify Physician's orders for accuracy and to ensure care plans were in place. F) Weekly audit results were reviewed on Mondays following the completion of the previous week by the Director of Nurses or designee. G) 02/01/24, initial results of the audits for New Admissions and Readmissions were brought to Quality Assurance Performance Improvement (QAPI) meeting. H) Monthly audits to be reviewed at QAPI meetings by QAPI committee and Director of Nurses or designee. I)The Director of Nurses and or designee are responsible for overall compliance.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 37086 Based on records reviewed and interviews for one of three sampled residents (Resident #1), who had diagnoses of paraplegia (paralysis of the legs and lower body) and Stage IV (wound that has lost full thickness tissue, exposing bone, muscle, or tendon) pressure injury to sacral (lower back) region, and required physical assistance from staff for mobility and positioning, the Facility failed to ensure they maintained a complete and accurate medical record, related to Certified Nurse Aide (CNA) Activity of Daily Living (ADL) Flow Sheets and Positioning Sheets, when daily documentation by CNAs was not consistently completed. Findings include: Review of the Facility's policy titled Charting and Documentation, with a revision date of July 2017, indicated that all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. Resident #1 was admitted to the Facility in November 2023, diagnoses included Paraplegia (paralysis of the legs and lower body), Multiple Sclerosis, and Stage IV pressure injury of sacral region. Review of Resident #1's Admission Minimum Data Set (MDS) Assessment, dated 11/27/23, indicated that Resident #1 had impaired functional range of motion on both sides of his/her lower extremities and that he/she was dependent on staff for bathing, dressing, personal hygiene and to roll from lying on his/her back to his/her left/right side in bed. Review of Resident #1's Documentation Survey Report v2 (ADL Flow Sheets), completed by CNAs, dated 11/21/23 through 11/30/23, indicated that on the following shifts, documentation on the flow sheets were incomplete: -3:00 P.M. to 11:00 P.M.- 6 days (out of 9) all care areas were left blank -11:00 P.M. to 7:00 A.M.- 3 days (out of 9) all care areas were left blank Review of Resident #1's ADL Flow Sheets, completed by CNAs, dated 12/01/23 through 12/21/23, indicated that on the following shifts, documentation on the flow sheets were incomplete: -7:00 A.M. to 3:00 P.M.- 3 days (out of 19) all care areas were left blank -3:00 P.M. to 11:00 P.M. - 6 days (out of 19) all care areas were left blank -11:00 P.M. to 7:00 A.M.- 4 days (out of 19) all care areas were left blank Review of Resident #1's Positioning Sheet, completed by CNA's, dated 12/01/23 through 12/21/23, indicated for the following shifts, documentation on the positioning sheets were incomplete. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-7:00 A.M. to 3:00 P.M.- 3 days (out of 19) positioning every two hours was left blank -3:00 P.M. to 11:00 P.M.- 8 days (out of 19) positioning every two hours was left blank -11:00 P.M. to 7:00 A.M.- 3 days (out of 19) positioning every two hours was left blank During an interview on 05/07/24 at 2:25 P.M., Certified Nurse Aide (CNA) #2 said all care provided to residents is documented electronically and should be completed at the end of their shift. During an interview on 05/07/24 at 2:48 P.M., the Director of Nurses (DON) said documentation had been a problem and the CNA ADL Flow Sheets and Positioning Sheets should not be incomplete, she said that the CNAs should be documenting all care provided to each resident. On 05/07/24, the Facility was found to be in Past Non-Compliance and presented the Surveyor with a plan of correction which addresses the areas of concern as evidenced by: A) 04/03/24 through 04/15/24, the Director of Nurses educated all Certified Nurse Aides (CNAs) to accurately document Activities of Daily Living care and behaviors in the Plan of Care (electronic) system. B) 04/03/24, the Director of Nurses completed an initial 30-day look-back audit of all CNA documentation. C) Weekly audits to be completed by the Director of Nurses or designee weekly for four weeks, then monthly for three months, or until substantial compliance is achieved. D) Quality Assurance Performance Improvement (QAPI) committee will assess results of audits to determine effectiveness of improvement plan. E) The Director of Nurses and or designee are responsible for overall compliance.