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	06/14/2024

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

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44337 Based on record review and interview, the facility failed to notify the Office of the State Long-Term Care Ombudsman in writing, of a transfer or discharge for four Residents (#66, #43, #73, #51) out of a total sample of 23 residents. Specifically: 1. For Resident #66, the facility failed to notify the Office of the State Long-Term Care Ombudsman when the Resident was transferred out of the facility to the hospital on 11/11/23, 12/22/23, 3/11/24 and 5/15/24. 2. For Resident #43, the facility failed to notify the Office of the State Long-Term Care Ombudsman when the Resident was transferred to the hospital on 3/3/24. 3. For Resident #73, the facility failed to notify the Office of the State Long-Term Care Ombudsman when the Resident was transferred out of the facility to the hospital on 11/4/23, 2/4/24, and 2/15/24. 4. For Resident #51, the facility failed to notify the Office of the State Long-Term Care Ombudsman when the Resident was transferred out of the facility to the hospital on 3/3/24. Findings include: 1. Resident #66 was admitted to the Facility in June 2023 with diagnoses including Congestive Heart Failure (CHF- caused when the heart is unable to pump blood effectively resulting in fluid build-up in the lungs, arms, feet and other organs), Atrial Fibrillation (A-fib: irregular, rapid heartbeat that can lead to blood clots and other heart related complications) and Dementia (a group of conditions that impair brain functions such as memory and judgment). Review of Resident #66's clinical record indicated the following: -Resident #66 was transferred to the hospital on 11/11/23 and returned to the facility 11/12/23. -Resident #66 was transferred to the hospital on 12/22/23 and returned to the facility 12/23/23. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225586	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/14/2024
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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #66 was transferred to the hospital on 3/11/24 and returned to the facility 3/13/24. -Resident #66 was transferred to the hospital 5/15/24 and returned to the facility 5/16/24. Further review of Resident #66's clinical record did not indicate any evidence that the Office of the State Long-Term Care Ombudsman had been notified in writing of any of the hospital transfers for Resident #66. During an interview on 6/13/24 at 11:16 A.M., the Social Worker (SW) said that she had worked in the facility since October 2023 and is responsible for providing bed hold and transfer notices to Residents and/or their Representatives upon transfer or discharge from the facility. The SW said that she could not provide any evidence the Office of the State Long-Term Care Ombudsman had been notified in writing when Resident #66 was transferred to the hospital on 11/11/23, 12/22/23, 3/11/24, and 5/15/24. The SW also said that she was unaware that the facility was required to notify the Office of the State Long-Term Care Ombudsman when residents were transferred or discharged from the facility. 2. Resident #43 was admitted to the facility July 2023 with diagnoses including Peripheral Vascular Disease (a circulatory condition in which blood vessels narrow causing reduced blood flow to the limbs) and Diabetes Mellitus 2 (DM - disease in which the body's ability to produce or respond to the hormone insulin is impaired resulting in elevated blood glucose [sugar] levels in the blood). Review of Resident #43's clinical record indicated that Resident #43 was transferred to the hospital on 3/3/24 and returned from the hospital to the facility on [DATE]. Further review of Resident #43's clinical record did not indicate any evidence that the Office of the State Long-Term Care Ombudsman had been notified in writing when Resident #43 was transferred to the hospital on 3/3/24. During an interview on 6/13/24 at 11:16 A.M., the SW said that she could not provide any evidence that the Office of the State Long-Term Care Ombudsman had been notified in writing when Resident #43 was transferred to the hospital on 3/3/24. The SW said that she was unaware that the facility was required to notify the Office of the State Long-Term Care Ombudsman when residents were transferred or discharged from the facility. 47901 3. Resident #73 was admitted to the facility in February 2023 with diagnoses including Cerebral Infarction (stroke: damage to tissues in the brain caused by blood clots, disrupted blood supply and restricted oxygen supply to the specific area), Atherosclerotic Heart Disease (build up of fats, cholesterol and other substances in the artery causing decreased blood flow to the heart) and Pulmonary Embolism (blood clot in the lungs). Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #73 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a total score of 15. Review of Resident #73's clinical record indicated the following: (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #73 was transferred to the hospital on 11/4/23 and returned to the facility on [DATE] -Resident #73 was transferred to the hospital on 2/4/24 and returned to the facility on [DATE] -Resident #73 was transferred to the hospital on 2/15/24 and returned to the facility on [DATE] Further review of Resident #73's clinical record did not indicate any evidence that the Office of the State Long-Term Care Ombudsman had been notified in writing of any of the hospital transfers for Resident #73. During an interview on 6/13/24 at 1:14 P.M., the SW said notification to the Office of the State Long-Term Care Ombudsman had not been done as required. 42761 4. Resident #51 was admitted to the facility in February 2024 with diagnoses including severe protein calorie malnutrition (condition where the body lacks enough protein and energy to function properly) and gastrostomy (G tube: tube inserted through the abdominal wall into the stomach, used to deliver nutrition) status. Review of Resident #51's Minimum Data Set (MDS) assessment dated [DATE], indicated the following: -The Resident was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of 15 total points. -The Resident was transferred to the hospital on 3/3/24 and his/her return to the facility was anticipated. Review of Resident #51's Transfer to Hospital Form dated 3/3/24, indicated the Resident was transferred from the facility to the hospital due to the Resident having removed his/her G tube. Review of Resident #51's clinical record indicated the following: -The Resident did not return from the hospital to the facility. -No evidence that the facility notified the Office of the State Long-Term Care Ombudsman in writing of the Resident's hospital transfer. During an interview on 6/14/24 at 10:30 A.M., the Director of Nursing (DON) said the facility could not provide any evidence that the Office of the State Long-Term Care Ombudsman was notified in writing of Resident #51's hospital transfer which occurred on 3/3/24.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident’s assessment is updated at least once every 3 months. 42761 Based on record review and interview, the facility failed to reassess one Resident (#99) out of a total sample of 23 residents, using the quarterly review instrument specified by the State and approved by Centers for Medicare and Medicaid Services (CMS) at least once every three months. Specifically, the facility staff failed to complete a Quarterly Minimum Data Set (MDS) Assessment for Resident #99 when the MDS Assessment was due, which increased the Resident's risk for an unidentified change in status between assessments. Findings include: Resident #99 was admitted to the facility in October 2023 with a diagnosis of Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory and loss of judgment). Review of Resident #99's clinical record indicated the following: -A Quarterly MDS Assessment, completed 1/30/24. -No evidence that any other Quarterly MDS Assessments had been completed after 1/30/24. During an interview on 6/13/24 at 2:19 P.M., the MDS Coordinator said the last MDS Assessment that had been completed for Resident #99 was done on 1/30/24, and the Resident should have had another Quarterly MDS Assessment since 1/30/24. The MDS Coordinator said that Quarterly MDS assessments were important because completing the assessments helped to identify changes in the residents' status between comprehensive assessments. The MDS Coordinator said a Quarterly MDS Assessment should have been completed for Resident #99 in April 2024, but the Quarterly MDS Assessment was not completed.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42761 Based on observation, interview, and record review, the facility failed to complete assessments that accurately reflected the status of two Residents (#103 and #95) out of a total sample of 23 residents. Specifically, facility staff failed to complete: 1. an accurate assessment relative to wandering (aimless walking, getting lost, repetitive pacing) for Resident #103 2. an accurate assessment relative to cognition on the facility's Smoking Assessment for Resident #95. Findings include: 1. Resident #103 was admitted to the facility in February 2024 with diagnoses including Dementia (group of symptoms that affects memory, thinking and interferes with daily life) with Behavioral Disturbance. Review of Resident #103's Minimum Data Set (MDS) assessment dated [DATE], indicated the following: -The Resident was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of four out of 15 total points. -The Resident had exhibited wandering daily during the assessment period with the risk for getting into a potentially dangerous place. Review of Resident #103's Behavior Care Plan, initiated 2/18/24 and revised 6/11/24, indicated: -Resident #103 . wanders . intrusive at times . related to Dementia. Review of Resident #103's MDS Assessment, dated 5/21/24, indicated the following: -The Resident was severely cognitively impaired as evidenced by a BIMS score of four out of 15 total points. -The Resident exhibited no wandering behavior. Review of Resident #103's Certified Nurses Aide (CNA) Behavior Record for May 2024, indicated the Resident wandered with intrusive behavior during the observation assessment period for the MDS Assessment, dated 5/21/24, on six out of seven days as follows: 5/15/24 - 5/17/24 and 5/19/24 - 5/21/24. Review of Resident #103's Quarterly Nursing Assessment, dated 5/21/24, indicated the following: -The Resident was ambulatory. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Resident had a history of elopement. -The Resident walked independently on the Unit. -The Resident wandered daily, and the wandering was not new. -The Resident had inattention and disorganized thinking. Further review of Resident #103's Quarterly Nursing Assessment did not indicate the Resident as being at risk for wandering and the section to identify interventions implemented for wandering was blank. During an interview on 6/13/24 at 11:30 A.M., CNA #1 said Resident #103 wandered daily and when the Resident wandered, staff were to provide the Resident with redirection and document the wandering behavior on the CNA Behavior Record. During an interview on 6/13/24 at 11:34 A.M., with Unit Manager (UM) #3 and the MDS Coordinator, UM #3 said Resident #103 wandered often and required redirection from staff when wandering occurred. The surveyor and UM #3 reviewed Resident #103's Quarterly Nursing assessment dated [DATE], and the May 2024 CNA Behavior Record. UM #3 said Resident #103 exhibited wandering behaviors at the time the Quarterly Nursing Assessment was completed, but she was not sure whether the Assessment should have indicated the Resident as being at risk for wandering or whether the interventions provided should have been included in the assessment. The MDS Coordinator said she would review Resident #103's clinical record and get back to the surveyor on whether wandering should have been coded under behaviors on the Resident's MDS Assessment, dated 5/21/24. During an interview on 6/13/24 at 12:10 P.M., the surveyor and the Director of Nursing (DON) reviewed Resident #103's Quarterly Nursing Assessment. The DON said the Assessment indicated the Resident wandered daily, and the Assessment should have indicated the Resident was at risk for wandering and should have included the interventions provided to Resident #103 for wandering. During a follow-up interview on 6/13/24 at 2:19 P.M., the MDS Coordinator said she reviewed Resident #103's clinical record and that the Resident did exhibit wandering behaviors during the observation assessment period for the MDS assessment dated [DATE]. The MDS Coordinator said wandering should have been coded on Resident #103's MDS Assessment, but it was not. 44337 2. Review of the facility policy titled Smoking-Residents last revised July 2017, indicated the following: -The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. If a smoker, the evaluation will include current level of tobacco consumption, method of tobacco consumption, desire to quit smoking, and ability to smoke safely with or without supervision (per completed safe smoking evaluation). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #95 was admitted to the facility in May 2024, with a diagnosis of Wernicke's Encephalopathy (a degenerative brain disorder caused by the lack of thiamine [vitamin B1] that causes mental confusion, vision problems, and lack of muscle coordination). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #95 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of four out of a total score of 15. Review of Resident #95's current Smoking assessment dated [DATE], indicated the Resident smoked cigarettes and had no cognitive impairment. During an interview on 6/12/24 at 12:28 P.M., Unit Manager (UM) #1 said she performed smoking assessments on residents who smoked to determine if the residents were safe to smoke independently or if they required supervision to smoke. UM#1 said that she had completed a facility Smoking Assessment when Resident #95 was first admitted to the facility by observing him/her smoke in the designated smoking area and determined that Resident #95 could smoke independently. UM #1 also said that all residents who resided in the facility who smoke were independent smokers. During an interview on 6/12/24 at 12:47 P.M., the Administrator said that an MDS assessment dated [DATE], indicated Resident #95 scored a four on the BIMS assessment and a facility Smoking Assessment completed 5/28/24, indicated Resident #95 had no cognitive loss/impairment. The Administrator said that Resident #95 had cognitive loss because he/she had a BIMS score of four and that the Smoking Assessment done on 5/28/24 was inaccurate. The Administrator further said that a Resident with a BIMS score of four would most likely not be an independent smoker.

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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** 42761 Based on interview, record and policy review, the facility failed to provide interdisciplinary team (IDT: professionals from various disciplines who work in collaboration to address a patient with multiple physical and psychological needs. An interdisciplinary team is not just a group of experts implementing separate treatments on a patient. They complement one another's expertise and actively coordinate to work toward shared treatment goals) review and revision of care plans after each Minimum Data Set (MDS) assessment for three Residents (#103, #55, and #61) out of a total sample of 23 residents. Specifically, the facility staff failed to provide IDT review and revision of: 1. Resident #103's care plan following an MDS Assessment completed for the Resident on 3/13/24. 2. Resident #55's care plan following MDS Assessments completed for the Resident on 8/10/23, 2/6/24, and 5/7/24. 3. Resident #61's care plan following MDS Assessments completed for the Resident on 1/12/24 and 4/10/24. Findings include: Review of the facility's policy, titled Care Planning - Interdisciplinary Team, dated March 2022, indicated the following: -Comprehensive, person-centered care plans are based on resident assessments and developed by an IDT. -Care plan meetings are scheduled at the best time of day for the residents and family when possible. 1. Resident #103 was admitted to the facility in January 2024 with a diagnosis of Dementia (group of symptoms that affects memory, thinking and interferes with daily life) with Behavioral Disturbance (progressive disease with impairment in memory and functioning that includes symptoms such as depression, anxiety, psychosis, agitation, aggression, disinhibition, and sleep disturbances). Review of Resident #103's clinical record indicated the following relative to MDS assessments: -One MDS Assessment, with an assessment reference date (ARD: the last date of the observation period which serves as the reference point for determining care and services captured on the MDS Assessment) of 2/22/24, was completed on 3/13/24. -One MDS Assessment, with an ARD of 5/21/24, was completed on 6/4/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #103's clinical record indicated no evidence that the facility's IDT reviewed and revised the Resident's care plan after the MDS Assessments were completed on 3/13/24 and 6/4/24. 2. Resident #55 was admitted to the facility in May 2019 with a diagnosis of Dementia with Behavioral Disturbance. Review of Resident #55's clinical record indicated the following relative to MDS assessments: -One MDS Assessment, with an ARD of 8/1/23, was completed on 8/10/23 -One MDS Assessment, with an ARD of 1/30/24, was completed on 2/6/24 -One MDS Assessment, with an ARD of 4/30/24, was completed on 5/7/24 Further review of Resident #55's clinical record indicated no evidence that the facility's IDT reviewed and revised the Resident's care plan after the MDS Assessments were completed on 8/10/23, 2/6/24, and 5/7/24. 50320 3. Resident #61 was admitted to the facility January 2022 with diagnosis of Dementia. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating the Resident had severe cognitive impairment. Review of the Resident's clinical record indicated the following relative to MDS assessments: -One MDS Assessment, with an ARD of 12/26/23, was completed on 1/12/24 -One MDS Assessment, with an ARD of 3/26/24, was completed on 4/10/24 Further review of Resident #61's clinical record indicated no evidence that the facility's IDT reviewed and revised the Resident's care plan after the MDS Assessments were completed on 1/12/24 and 4/10/24. During an interview on 6/12/24 at 11:15 A.M., the Social Worker (SW) said she was responsible for setting up and inviting Residents and their Representatives to care plan meetings based on the calendar of MDS Assessments due for Residents each month. The SW said she would contact Residents and their Representatives to inquire whether they wanted to have an IDT meeting to review the care plan, and if no IDT meeting was desired, the IDT did not meet collaboratively to review and revise the care plan, but would individually complete their specified sections of the care plan. The SW also said she did not realize that the IDT review of Residents' care plans was required to occur following completion of the MDS Assessments and that she thought the reviews could occur anytime during the month the MDS Assessments were scheduled to be completed. The SW further said she could not provide evidence that IDT care plan reviews and revisions occurred following MDS Assessment completions for Residents #103, #55, and #61 for the dates indicated.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44337 Based on observation, interview, and policy review, the facility failed to provide an environment that was as free of accidents and hazards as possible for two Residents (#95, #44), out of a total sample of 23 residents. Specifically, the facility staff failed to: 1. For Resident #95, secure a disposable lighter from the Resident after he/she returned from a smoking activity. 2. For Resident # 44, implement monitoring of the Resident during a smoking activity when the Resident had a diagnosis of Seizure Disorder (also known as Epilepsy, a brain condition that causes recurring seizures [sudden, uncontrolled burst of electrical activity in the brain that causes changes in behavior, movements, feelings and level of consciousness]) and was known to have seizures occur while smoking independently. Findings include: Review of the facility policy titled Smoking-Residents last revised July 2017 indicated the following: -The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. If a smoker, the evaluation will include current level of tobacco consumption, method of tobacco consumption, desire to quit smoking, and ability to smoke safely with or without supervision (per completed safe smoking evaluation). -The staff shall consult with the attending Physician and the Director of Nursing (DON) to determine if safety restrictions need to be placed on a resident's smoking privileges based on the Safe Smoking Evaluation. -A resident's ability to smoke safely will be re-evaluated quarterly, upon significant change (physical or cognitive) as determined by staff. 1. Resident #95 was admitted to the facility in May 2024 with a diagnosis of Wernicke's Encephalopathy (a degenerative brain disorder caused by the lack of Vitamin B1 that causes mental confusion, vision problems, and lack of muscle coordination). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #95 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of four out of a total score of 15. Review of Resident #95's facility Smoking Policy Contract, signed by the Resident on 5/17/24, indicated that independent smokers are prohibited to have any lighters in their possession at any time except while smoking in the facility designated smoking area. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/24 at 9:21 A.M., the surveyor observed Resident #95 remove a red disposable lighter from his/her front pants pocket. During an interview at the time, Resident #95 said that he/she smoked and kept the lighter to light his/her cigarettes. Resident #95 said he/she went outside whenever he/she wanted to smoke. During an interview and observation on 6/11/24 at 9:46 A.M., Nurse #1 said residents are not permitted to keep disposable lighters in their possession because it was unsafe. Nurse #1 said that disposable lighters are supposed to be kept in a drawer at the nurse's station. The surveyor observed Nurse #1 asking Resident #95 if he/she had a disposable lighter in his/her pocket. Resident #95 was observed to remove the disposable lighter from his/her front pocket and gave it to Nurse #1. During an interview on 6/11/24 at 4:04 P.M., the Administrator said that all residents who smoked signed a facility Smoking Policy Contract which included a statement that smokers were prohibited to have disposable lighters in their possession. The Administrator said that residents who smoke are required to return disposable lighters to the nurse's station immediately after they attended a smoking activity, and that Resident #95 should not have had a disposable lighter in his/her pocket. 47901 2. Resident #44 was admitted to the facility in June 2023 with diagnoses including Seizure Disorder and Cerebrovascular Accident with left sided hemiparesis (stroke [interruption of blood flow to part of the brain] with left sided weakness). Review of a Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #44: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a total score of 15. -with left upper and left lower extremities (a limb of the body, such as the arm or leg) impaired. -was wheelchair dependent. During an interview on 6/11/24 at 9:05 A.M., Resident #44 said that he/she had a seizure while he/she was smoking, slid out of the wheelchair to the floor and was sent out to the hospital. Resident #44 further said upon his/her return from the hospital the facility staff noted that he/she had obtained three skin tears on his/her left hand from the fall. Review of the Smoking Assessment completed on 12/23/23, indicated that Resident #44 was an independent smoker. Review of Resident #44's Care Plan indicated that during seizure activity, staff should document the type of seizure, duration, level of consciousness, any incontinence, whether the Resident slept or was dazed after seizure activity. Further review of the Resident's Care Plan indicated not to leave the Resident alone during seizure activity. The Resident's Care Plan also indicated to protect the Resident from onlookers but did not include any precautions for when the Resident was outside smoking by himself/herself. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225586	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/14/2024

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

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/12/24 at 2:21 P.M., Unit Manager (UM) #1 said Resident #44 fell out of the wheelchair during seizure activity while the Resident was outside smoking. UM #1 said he was unsure of the seizure precautions in place for Resident #44 while he/she was outside smoking independently. During an interview on 6/12/24 at 4:43 P.M., the Nurse Evening Supervisor said she was informed by another Resident who was outside smoking that Resident #44 had fallen out of his/her wheelchair and on the ground while smoking. The Nurse said she was unsure how long Resident #44 had been on the floor but when she was notified, a staff member went to the smoking area to stay with the Resident until the Emergency Medical Services (EMS) arrived and Resident #44 was transferred to the hospital. During an interview on 6/12/24 at 4:53 P.M., the Social Worker (SW) said she had been assigned to supervise the smoking area as of 6/12/24 and that the facility had initiated a rotation schedule to supervise the Residents during smoking. During an interview on 6/13/24 at 10:15 A.M., Resident #44 said that he/she had to wait to be accompanied by a facility staff member when he/she was outside smoking moving forward.

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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 0693

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47901

Based on observation, interview, policy and record review, the facility failed to provide appropriate care, services, and monitoring of a gastrostomy tube (G-tube- a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medication, also referred to as a feeding tube) for two Residents (#57 and #80), for two applicable residents, out of a total sample of 23 residents.

Specifically, the facility staff failed to:

1. For Resident #57, provide appropriate care and services to facilitate restoring oral eating skills as possible for the Resident.

2. For Resident #80, verify proper placement of a G-tube every shift to identify and prevent potential complications associated with enteral (passing through the gastrointestinal [GI] tract) feeding.

Findings include:

1. Resident #57 was admitted to the facility in March 2024, with diagnoses including Gastrostomy, Dementia (loss of memory, language, problem-solving and other thinking abilities) and Dysphagia (difficulty swallowing).

Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #57:

-was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 9 out of a total score of 15

-was dependent for all activities of daily living (ADL - bathing, grooming and dressing)

-and had a G-tube

Review of the GI Follow-up Progress Note dated 4/15/24, indicated that Resident #57's G-tube was placed on 3/7/24 during an inpatient admission after the Resident had failed multiple swallow evaluations. The GI Progress Note also indicated that the Resident had a repeat video swallow evaluation that had gone well, and his/her diet was advanced to mildly thick nectar liquids and pureed solids, and the Resident was to follow-up with Speech Therapy at the facility.

Review of Resident #57's Care Plan for Tube Feedings, dated 3/14/24, indicated an intervention for Speech Therapy evaluation and treatment as ordered.

Review of Resident #57's June 2024 Physician's orders indicated:

-3/12/24 Speech evaluation and treat as needed

-3/12/24 Nothing by mouth (NPO)

(continued on next page)

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-3/15/24 Enteral Feed Order every shift for nutrition: Glucerna 1.5 (nutritional liquid supplement low in calories and sugar, high in protein) at 50 milliliters per hour (ml/hr) continuous -3/25/24 Recommended Skilled Speech Therapy services: 12 visits x 30 days for Dysphagia management. Review of the Speech Therapist Notes, dated 4/5/24, indicated the following: -Resident demonstrated adequate oropharyngeal performance (a voluntary process that uses motor and sensory pathways to move food from the mouth to the oropharynx [middle section of the throat] triggering a series of reflexive movements). -With trials of soft sandwich requests adequate breakdown and timely appearing swallow, no to limited sign and symptom with trials, however Resident continued with significant GI concern with vomiting occurring post completion of small amounts of intake. -Was compliant with trials with Speech Therapy. During an interview on 6/11/24 at 10:01 A.M., Resident #57 said he/she has been asking to eat orally but was informed by the facility staff that he/she had to wait for the Speech Therapist. During an interview on 6/13/24 at 10:14 A.M., the Director of Rehabilitation Services said Resident #57 was discharged from Speech Therapy services on 4/24/24. During an interview on 6/13/24 at 4:59 P.M., the Speech Therapist (ST) said Resident #57 had been discharged from speech therapy sessions since 4/24/24, because the Resident had episodes of vomiting during the therapy sessions and needed to be evaluated by the Physician. The ST said she treated the Resident on three occasions and had brought the concerns about the Resident vomiting to the nursing staff and the Registered Dietitian (RD). During an interview on 6/13/24 at 5:15 P.M., the RD said she knew that Resident #57 had been discharged from speech therapy services. The RD said that she had spoken with the ST regarding concerns for Resident #57 having vomiting episodes after eating. The RD said if there were concerns for a Resident having vomiting relative to eating, the RD would alert the Director of Nursing (DON), and the DON would then notify the Physician or Nurse Practitioner (NP) so that the Resident could be assessed. The RD could not say whether she had informed the DON of Resident #57's vomiting after eating. During an interview on 6/14/24 at 7:59 A.M., the Infection Preventionist (IP) said Resident #57 would ask for food all the time but the IP knew that the Resident was working with Speech Therapy before his/her diet could be advanced. During an interview on 6/14/24 at 8:09 A.M., Resident #57's Health Care Proxy (HCP- the person chosen as the healthcare decision maker when the individual is unable to do so for themself)) said Resident #57 was expected to be followed by Speech Therapy and that the G-tube was not supposed to be permanent. During an interview on 6/14/24 at 8:20 A.M., Nurse #1 said Resident #57 was working with Speech Therapy and that other staff could not provide oral feedings to the Resident until the Speech Therapist said that it was safe to do so. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/16/24 at 9:13 A.M., the Nurse Practitioner (NP) said the facility staff had not informed her that Resident #57 had been discharged from Speech Therapy sessions, that the Resident was expected to continue with oral feeding trials, and that the G-tube was not permanent. The NP said if she had been made aware of the Resident's vomiting, she would have made changes to the Resident's medications to ensure he/she tolerated the oral feedings. The NP further said she could have reached out to the GI Physician if a trial of medications to manage the vomiting had failed. The NP said that these interventions had not occurred because she was not made aware of the Speech Therapist's concern. During an interview on 6/14/24 at 10:38 A.M., the DON said she was not aware until the surveyor's inquiry that Resident #57 had been discharged from speech therapy sessions and that the discharge from speech therapy was due to vomiting. The DON said since she was not aware she had not informed the Physician or NP of any concerns that needed to be addressed for the Resident. 2. Resident #80 was admitted to the facility in February 2024 with diagnoses including Adult Failure to Thrive (a syndrome of global decline in older adults as a worsening of physical frailty that is frequently compounded by cognitive impairment), Gastrostomy and Dysphagia. Review of the facility policy titled Enteral Tube Feeding via Gravity Bag, last revised March 2024, indicated: -Verify placement of feeding tube. -When correct tube placement has been verified, flush tubing with at least 30 ml of warm water. Review of the MDS assessment dated [DATE], indicated that Resident #80: -was severely cognitively impaired as evidenced by a BIMS score of 2 out of a total score of 15 -was dependent with ADL care -and had a G-tube Review of Resident #80's June 2024 Physician's orders included the following: -3/3/24 Enteral Feed Order: five times a day for hydration, water flush - 90 mls of warm water before and after every bolus (a method of tube feeding that involves delivering a large amount of formula or liquid food through a feeding tube in several doses throughout the day). -2/12/24 NPO -2/15/24 Enteral Feed Order: [NAME] times a day related to moderate protein-calories malnutrition, Jevity 1.5 (source of nutrition) Cal, administer 240 mls bolus (slowly administering large amounts of formula multiple times a day) via gravity five times a day. On 6/13/24 at 9:47 A.M., the surveyor observed Nurse #1 administer a bolus feeding to Resident #80. Nurse #1 did not check to verify proper placement of the G-tube prior to administering the bolus feeding. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/13/24 at 11:15 A.M., Unit Manager (UM) #1 said he was unsure whether the facility staff were required to check for placement of Resident #80's G-tube. During an interview on 6/13/24 at 11:30 A.M., Nurse #1 said she should have checked for G-tube placement, but she did not. During an interview on 6/13/24 at 11:45 A.M., the DON said there should have been a Physician's order to check for placement of Resident #80's G-tube when he/she was admitted to the facility. The DON also said that Nurse #1 should have checked to verify placement of the Resident's G-tube prior to administering the bolus feeding as required.

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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 0698

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide safe, appropriate dialysis care/services for a resident who requires such services.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47901

Based on observation, interview, and record review, the facility failed to provide care and services consistent with professional standards for one Resident (#101) out of one applicable resident, out of a total sample of 23 residents, who required dialysis (procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly) treatment.

Specifically, the facility staff failed to provide the delivery of meals in coordination with Resident #101's dialysis treatment schedule to ensure that the Resident received meals and/or snacks on dialysis treatment days.

Findings include:

According to the National Institute of Diabetes and Digestive and Kidney Disease, revised September 2016: (https://www.niddk.nih.gov/health-information/kidney-disease/kidney-failure/hemodialysis/eating-nutrition), a person's choices on nutrition and hydration while on hemodialysis can make a difference in how the person feels and can make the treatment work better.

Resident #101 was admitted to the facility in May 2024, with diagnoses including End Stage Renal Disease (ESRD: the final and permanent stage of chronic kidney disease, kidneys are no longer able to function properly and meet the body's needs), Type 1 Diabetes (a lifelong condition where the pancreas makes little or no insulin, which leads to high blood sugar levels), Nutritional Anemia (a condition where the body's hemoglobin concentration drops due to a deficiency in one or more nutrients), and Protein-Calorie Malnutrition (nutritional state that occurs when someone does not get enough food, calories, protein or other essential nutrients).

Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #101 was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of a total score of 15.

On 6/11/24 at 10:47 A.M., the surveyor observed an untouched breakfast tray in Resident #101's room with the breakfast meal intact. The surveyor also observed that the Resident was not in the room. At 11:05 A.M., the surveyor observed a staff member enter the Resident's room and remove the breakfast tray. During an interview at the time, the staff member said Resident #101 was out of the facility for dialysis treatment.

During an interview on 6/11/24 at 11:25 A.M., Resident #101 said he/she had just returned to the facility from his/her dialysis treatment. The Resident said his/her only concern was not eating breakfast before or after dialysis on dialysis treatment days. Resident #101 further said that he/she went to dialysis treatment four days a week.

Review of the Physician's orders for May 2024 and June 2024 indicated that Resident #101 attended dialysis treatments on Mondays, Tuesdays, Thursdays, and Fridays and is picked up by 5:30 A.M. on treatment days.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/12/24 at 10:25 A.M., Unit Manager (UM) #1 said Resident #101 would leave the facility for dialysis treatments at 5:30 A.M UM #1 was unsure whether the Resident received breakfast or snacks before he/she left for dialysis treatments or upon returning from dialysis. During an interview on 6/12/24 at 5:14 P.M., the surveyor and the Director of Nursing (DON) reviewed the meal percentage intake and the DON said there was no indication that Resident #101 had received breakfast or snacks on the mornings of dialysis treatment days. During an observation on 6/13/24 at 8:43 A.M., the surveyor observed Resident #101's room and noted that there was a breakfast meal tray and the breakfast had been eaten. During a follow-up interview on 6/13/24 at 9:09 A.M., the DON said Resident #101 should have received breakfast and/or snacks on the mornings of the dialysis treatment days, but he/she had not. During an interview on 6/13/24 at 11:30 A.M., Resident #101 said the dialysis treatment went better today than any other day because he/she was given breakfast at 5:15 A.M., and that he/she finished eating the breakfast meal before he/she was picked up for his/her dialysis treatment.

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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 0755

Level of Harm - Potential for minimal harm

Residents Affected - Some

Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47901

Based on observation, record review and interview, the facility failed to ensure that nursing staff implemented and established systems to accurately reconcile controlled medications using acceptable standards of practice on two Units (Edgewood and [NAME]) of three units observed.

Specifically, the facility failed to:

1. Maintain documentation of prescription numbers with the date of receipt of controlled substance medications and transfers.

2. Maintain professional standards of practice for discharging and transferring controlled medications within the narcotic book.

Findings include:

Review of the facility policy tiled Controlled Substances, revised April 2019, indicated the following:

-The Nurse receiving the medication and the individual delivering the medication verify the name, dose and quantity of each medication.

-Both individuals sign the controlled substance record of receipt.

-An individual resident-controlled substance record contains:

a) name of the resident

b) name and strength of the medication

c) quantity received

d) prescription number

e) name of issuing pharmacy

f) date and time received .

During medication storage review on 6/12/24 at 7:26 A.M., the surveyor observed the following in the Units Narcotic Books for Controlled Substance documentation logs:

Edgewood Unit, Medication Cart #1:

(continued on next page)

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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 0755 Level of Harm - Potential for minimal harm Residents Affected - Some	-On page 65, there was no prescription number documented for the Tramadol (used to treat pain) medication, no documented date of the receipt of the medications, and one Nurse had transferred the medications to page 100. -On page 69, one Nurse had transferred the Tramadol medication page to page 79, and another Nurse had signed the medication out as sent home with a patient. -On page 70, one Nurse had transferred the Clonazepam medication (used to treat anxiety disorder) for a resident to page 109, and on page 109, the surveyor found there was a different medication for a different resident documented. -On page 91, one Nurse had transferred Pregabalin medication (used to treat anxiety) to page 101. -On page 106, Clonazepam medication had no prescription number and no date as to when it was received. -On page 107, Oxycodone (used to treat pain) medication had no prescription number and no date as to when it was received. -On page 109, Tramadol medication had no prescription number and no date as to when it was received. -On page 111, Oxycodone medication had no prescription number and no date as to when it was received. Edgewood Unit, Medication Cart #2: -On page 75, Lacosamide medication (used to treat neuropathic pain/ seizures) had been transferred by one Nurse to page 94 -On page 76, Lorazepam medication (used to treat anxiety) had been transferred by one Nurse to page 98. -On page 77, Morphine Sulfate (used to treat pain) medication had no prescription number and no date as to when it was received. -On page 79, Oxycodone medication had been transferred by one Nurse to page 101. -On page 98, Tramadol medication had no prescription number and no date as to when it was received. -On page 100, Tramadol medication had no prescription number and no date as to when it was received. -On page 101, Oxycodone medication had no prescription number and no date as to when it was received. [NAME] Unit, Medication Cart #1: (continued on next page)

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F 0755 Level of Harm - Potential for minimal harm Residents Affected - Some	-On page 78, one Nurse transferred Buprenorphine medication (used to treat moderate to severe pain and opioid dependence) to page 87, there was no prescription number and no date the medication was received. -On page 92, Morphine Sulfate medication was removed from the emergency kit, there was no date or emergency kit number. -On page 93, Morphine Sulfate solution medication had no prescription number and no date as to when it was received. -On page 101, Tramadol medication had no prescription number and no date as to when it was received. -On page 102, Lorazepam medication had no prescription number and no date as to when it was received. -On page 103, Dilaudid medication (used to treat pain) had no prescription number and no date as to when it was received. -On page 105, Tramadol medication had no prescription number and no date as to when it was received. -On page 106, Tramadol medication had no prescription number and no date as to when it was received. -On page 107, Lorazepam medication had no prescription number and no date as to when it was received. -On page 108, Clonazepam medication had no prescription number and no date as to when it was received. -On page 109, Clonazepam medication had no prescription number and no date as to when it was received. -On page 110, Clonazepam medication had no prescription number and no date as to when it was received. During an interview on 6/12/24 at 10:14 A.M., the surveyor and Nurse #2 reviewed the Narcotic Book and Nurse #2 said the Nurses were expected to document prescription numbers and the date the facility received the medications in the Controlled Substance Narcotic Books, but they had not done this. During an interview on 6/12/24 at 10:27 A.M., the surveyor and Unit Manager (UM) #2 reviewed the Narcotic Book and UM #2 said the Nurses were expected to document when medications were received from the pharmacy and when the medications are transferred from one page to another, but they had not. UM #2 further said the Nurses were expected to document prescription numbers and dates received from the pharmacy on every page of the Controlled Substance Narcotic Books, but they had not. (continued on next page)

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F 0755 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 6/12/24 at 10:36 A.M., UM #1 said he was unsure about the number of Nurses that were required when documenting prescription numbers, dates, and when transferring controlled medications to different pages within the Narcotic Book. During an interview on 6/12/24 at 10:42 A.M., the Director of Nursing (DON) said every page of the Narcotic Book should have the prescription numbers for the controlled substances as well as the dates the Nurses received the medications. The surveyor and the DON reviewed the Narcotic Book, Book One on the Edgewood Unit and the DON said when controlled substance medications are sent home with a Resident upon discharge, two Nurses are expected to count the medication and sign that the medication was sent out with the Resident, but this was not done. The DON further said two Nurses are expected to witness and sign when medications are being transferred from one page to another, but this had not been done.