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	07/16/2025

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition (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

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to identify and complete a Significant Change in Status (SCSA) Minimum Data Set assessment (MDS) for one Resident (#13), when he/she changed hospice providers and remained in the facility, out of a total sample of 22 residents.Findings include: Review of the MDS 3.0 Resident Assessment Instrument (RAI) Manual, dated October 2024, indicated a SCSA comprehensive assessment must be completed by the end of the 14th calendar day following determination that a significant change has occurred. The RAI Manual further indicated a SCSA is required to be performed when a terminally ill resident changes hospice providers and remains a resident at the nursing home. Resident #13 was admitted to the facility in April 2025 with diagnoses including malnutrition and chronic obstructive pulmonary disease (a lung disease that causes difficulty breathing). Review of Resident #13's readmission practitioner note, dated 5/14/25, indicated:- Patient has been readmitted to the facility with previous hospice services (Hospice Vendor #1) however it was noted that patient did not wish to continue with these hospice services.- Patient endorsing wish to transfer services to different hospice group. - Consult Hospice Vendor #2 for further hospice evaluation. Review of Resident #13's Hospice Vendor #2 form titled 'Facility Notification of Hospice Admission', dated 5/15/25, indicated:- Date of hospice admission: [DATE]. Review of Resident #13's physician's order, dated 6/16/25, indicated:- Resident admitted to Hospice Vendor #2 on 5/15/25. Review of the Significant Change in Status (SCSA) MDS assessment, dated 6/26/25, indicated Resident #13 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. This MDS also indicated Resident #13 received hospice services. Review of this SCSA indicated it was completed on 7/11/25, which was 57 days after he/she was admitted to new hospice provider. During an interview on 7/15/25 at 10:48 A.M., Resident #13 said he/she was on hospice and was concerned with the communication between the facility staff and Hospice Vendor #2. Resident #13 said he/she's not sure who is responsible for different parts of his/her care but would like to know what's going on regarding his/her current health status. During a follow-up interview on 7/16/25 at 10:03 A.M., Resident #13 said he/she had not been offered or had a care plan meeting since being admitted to Hospice Vendor #2 but would have liked to have one and would like to be more involved in his/her plan of care. Review of Resident #13's progress notes, dated 5/15/25 to 7/16/25, failed to indicate any care plan meeting had been offered to the Resident/Resident Representative. During an interview on 7/16/25 at 10:11 A.M., Unit Manager #1 said she attends all resident care plan meetings. Unit Manager #1 said she did not recall attending any care plan meetings for Resident #13 and that Social Worker #1 is responsible for scheduling care plan meetings. During an interview on 7/16/25 at 10:15 A.M., Social Worker #1 said Resident #13 had not had any care plan meetings since shortly after he/she was first admitted to the facility in April 2025. Social Worker #1 said all residents/resident representatives should be invited to participate in a care plan meeting within seven days after the completion of an MDS assessment, including a SCSA. Social Worker #1 said there is no MDS Coordinator in house and it was expected that the facility staff communicate any need to schedule a SCSA with the Regional MDS Coordinator. Social Worker #1 was unaware that a change in hospice providers required a SCSA. Social Worker #1 said Resident #13 has had many concerns since his/her admission and would have benefitted from the team going over his/her entire plan of care together during a care plan meeting after his/her change in hospice providers, but one was not scheduled. During an interview on 7/16/25 at 10:28 A.M., the Regional MDS Coordinator said there is not an MDS Coordinator physically in the facility, and the expectation is that the facility staff communicate the need for any SCSA to her in order for them to be scheduled. The Regional MDS Coordinator said a SCSA is required to be completed when a resident changes hospice provider and remains in the facility. The Regional MDS Coordinator said Resident #13 should have had a SCSA completed within 14 days of 5/15/25 when he/she changed hospice providers, but it was never scheduled because she was not notified. The Regional MDS Coordinator said a care plan meeting with the Resident/Resident Representative is required within seven days of the MDS completion. The Regional MDS Coordinator said it wasn't identified as missed until the end of June, which resulted in no care plan meeting invitation being offered to Resident #13. During an interview on 7/16/25 at 11:05 A.M., the Director of Nursing (DON) said she expects the facility to follow the RAI manual guidelines for MDS assessment completion. The DON said a SCSA should have been completed for Resident #13 within 14 days of the change in hospice provider, but it was not

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, record review and interview, the facility failed to ensure nursing implemented physician's orders and the recommendations made by therapy services for one Resident (#10) out of a total sample of 22 residents. Specifically, the facility failed to ensure Resident #10 was wearing a soft hand splint as ordered by the physician and as recommended by the therapy department.Findings include: Review of the facility policy titled Specialized Rehabilitation Services, dated and revised December 2009, indicated the following:- Policy Interpretation and Implementation: Once a resident has met his/her care plan goals, a licensed professional can either discontinue treatment or initiate a maintenance program which either nursing or restorative aides will implement to assure that the resident maintains his/her functional and physical status. Resident #10 was admitted to the facility in December 2024 with diagnoses including multiple sclerosis, hemiplegia and hemiparesis affecting right dominant side.Review of Resident #10's most recent Minimum Data Set Assessment, dated 5/20/25, indicated a Brief Interview Status for Mental Status score of 12 out of 15 indicating moderate cognitive impairment. Further review of the MDS indicated that the Resident is dependent on staff for activities of daily living, does not reject care, and has impairment on one side. The surveyor made the following observations:- On 7/15/25 at 9:54 A.M., Resident #10 was lying awake in his/her bed. His/her right hand was in a fisted position. Resident #10 said he/she used to wear something on his/her hand, but has not in a long time.- On 7/15/25 at 2:10 P.M., Resident #10 was lying awake in his/her bed. His/her right hand was in a fisted position. No hand device was being worn on his/her right hand.- On 7/16/25 at 9:27 A.M., Resident #10 was lying awake in his/her bed. His/her right hand was in a fisted position. No hand device was being worn on his/her right hand. Resident #10 said he/she has not worn a hand splint in a long time and would like to if staff asked him/her to put it on. Resident #10 said he/she thinks he/she can move his/her hand better when a splint is on. The Resident asked the surveyor to look in his/her room for the splint but one was not located.Review of Resident #10's physician's order dated 3/3/24 indicated the following:- Soft splint to RUE (right upper extremity) as tolerated. On in AM (morning) and remove at HS (bedtime). Assess skin integrity on 3-11 shift. Remove as needed for careReview of Resident #10's care plans indicated the following:- Focus: ADLS (activities of daily living): Resident is at risk for decreased ability to perform ADLS in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion and toileting - dated 5/13/22Intervention: Soft Splint to RUE as tolerated. On in AM and remove at HS (at night) - dated 3/3/24.- Focus: The Resident has limited physical mobility r/t (related to) contractures, MS (multiple sclerosis), weakness - dated 8/25/24Goal: The resident will demonstrate the appropriate use of soft hand splint to right hand contracture as tolerated- revised 2/11/25Review of Resident #10's Kardex (a form indicating the level of care a resident needs) indicated the following:- Other Devices: Soft splint to RUE as tolerated. On in AM and remove at HS- Dressing/Grooming/Bathing: PERSONAL HYGIENE:Provide Resident #10 with EXTENSIVE TO TOTAL assist of ONE for personal hygiene (grooming). Review of the Certified Nursing Assistant (CNA) documentation for the month of July 2025, indicated that CNAs provided grooming care to Resident #10 daily. Review of Resident #10's Occupational Therapy Evaluation and Plan of Treatment dated 12/31/24 indicated the following: Musculoskeletal System Assessment: Functional Limitations present d/t contracture = yes. Functional limitations as result of Contracture: self-care, ROM (range of motion) ROM; is skilled therapy needed to address impairment? = No (patient has splint which staff has been educated on donning/doffing). During an interview on 7/16/25 at 11:19 A.M., CNA #2 said Resident #10 is totally dependent on staff for ADLs. CNA #2 said Resident #10 has had a right-hand contracture for a long time and that he/she always used to wear a splint, but she does not know what happened to it as she has not seen it in a long time.During an interview on 7/16/25 at 11:22 A.M., CNA #1 said she performs ADL care on Resident #10 since he/she is dependent on care. CNA #1 said Resident #10's right hand has always been in a fisted position and she does not remember seeing a hand splint on his/her hand.During an interview 7/16/25 at 11:34 A.M., Nurse #1 said Resident #10's right hand is contracted, and he/she wears a splint. Nurse #1 said the three o'clock shift is in charge of putting the splint on. The surveyor and Nurse #1 observed Resident #10 lying in his/her bed and he/she was not wearing a splint. Nurse #1 located the splint in the corner of the Resident's room on a chair under a pile of clothes. Nurse #1 and the surveyor reviewed Resident #10's physician's orders and she said the morning shift should be putting the splint on. Nurse #1 said all physician's orders should be followed as written.During an interview on 7/16/25 at 11:41 A.M., the Director of Rehab (DOR) said Resident #10 has had a right-hand

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide assistance with Activities of Daily Living (ADLs) for dependent residents for one Resident (#10) out of a total sample of 22 residents. Specifically, the facility failed to ensure Resident #10's fingernails were cut short in his/her right contracted hand.Findings include:Review of the facility policy titled Activities of Daily Living (ADL), Supporting, revised March 2018, indicated the following:- Residents who are unable to carry out activities of daily living independently will receive services necessary to maintain good nutrition, grooming, and personal and oral hygiene.- Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing, grooming, oral care)Resident #10 was admitted to the facility in December 2024 with diagnoses including multiple sclerosis, hemiplegia and hemiparesis affecting right dominant side.Review of Resident #10's most recent Minimum Data Set assessment dated [DATE] indicated a Brief Interview Status for Mental Status score of 12 out of 15, indicating moderate cognitive impairment. Further review of the MDS indicated that the Resident is dependent on staff for activities of daily living, does not reject care and has impairment on one side. - On 7/15/25 at 9:54 A.M., Resident #10 was lying awake in his/her bed. His/her right hand was in a fisted position. Resident #10's pointer, middle and ring finger nails were roughly one inch in length and pressing into his/her palm. Resident #10 said someone normally comes in and cuts his/her nails but doesn't remember the last time it happened.- On 7/15/25 at 2:10 P.M., Resident #10 was lying awake in his/her bed. His/her right hand was in a fisted position. Resident #10's pointer, middle and ring finger nails were roughly one inch in length and pressing into his/her palm.- On 7/16/25 at 9:27 A.M., Resident #10 was lying awake in his/her bed. His/her right hand was in a fisted position. Resident #10's pointer, middle and ring finger nails were roughly one inch in length and pressing into his/her palm.Review of Resident #10's care plans indicated the following:Focus: ADLS: Resident is at risk for decreased ability to perform ADLS in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion and toileting - dated 5/13/22Intervention: Personal Hygiene: Provide Resident #10 with extensive to total assist of one for personal hygiene (grooming) - dated 1/18/22. Review of Resident #10's Kardex (a form indicating the level of care a resident needs) indicated the following:- Dressing/Grooming/Bathing: PERSONAL HYGIENE: Provide Resident #10 with extensive to total assist of one for personal hygiene (grooming). Review of the Certified Nursing Assistant (CNA) documentation for the month of July 2025, indicated that CNAs provided grooming care to Resident #10 daily. During an interview on 7/16/25 at 11:19 A.M., CNA #2 said Resident #10 is totally dependent on staff for ADLs. CNA #2 said Resident #10 needs help with cutting his/her nails and we should be cutting them if they are long.During an interview on 7/16/25 at 11:22 A.M., CNA #1 said she performs ADL care on Resident #10 since he/she is dependent on care. CNA #1 said CNA's cut residents' nails every week or if she notices they are long. CNA #1 and the surveyor observed Resident #10's fingernails on his/her right contracted hand. CNA #1 had to manually extend the Resident's fingers out of a fisted position to see his/her nails. CNA #1 said they are long and need to be cut. During an interview 7/16/25 at 11:34 A.M., Nurse #1 said Resident #10's right hand is contracted and CNAs should be performing ADL care for the Resident daily. Nurse #1 and the surveyor observed Resident #10's fingernails on his/her right contracted hand, Nurse #1 had to manually extend the Resident's fingers out of a fisted position to see his/her nails. Nurse #1 said they are long and need to be cut. Nurse #1 said they are starting to press into the Resident's palm.During an interview on 7/16/25 at 11:41 A.M., the Director of Rehab (DOR) said Resident #10 has had a right hand contracture since 2023. The DOR said staff should make sure Resident #10's fingernails are clipped short on his/her right contracted hand to maintain skin integrity. The DOR said if therapy staff notice long fingernails they would notify the Resident's nurse.During an interview on 7/16/25 at 11:59 A.M., Unit Manager #2 said Resident #10 is totally dependent on staff for ADL care. Unit Manager #2 said his/her fingernails should be cut short, especially on his/her contracted hands.During an interview on 7/16/25 at 12:12 P.M., the Director of Nursing (DON) said fingernails should be checked daily and if staff notice they are long, they should be cut. The DON said if a resident refuses any care then it needs to be documented in the medical record. The DON said staff should be checking on Resident #10's fingernails since his/her right hand is contracted.