STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225184	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Webster Park Rehabilitation and Healthcare Center	56 Webster Street Rockland, MA 02370

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. 34145 Based on record review and interviews, the facility failed to ensure for one Resident (#15), out of a total sample of 21 residents, that the Resident's legal guardian (a person who has been appointed by a court or otherwise has the legal authority to care for the personal and property interests of another person who is deemed incapacitated) was informed of a change in skin condition by the physician or other practitioner or professional, informed of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options, and to choose the alternative or option he/she preferred. Specifically, the facility failed to inform the legal guardian when Resident #15 developed wounds on his/her left heel and the second and third toes of the right foot, failed to inform of the risks and benefits of treatment and obtain consent for surgical debridement (surgically cleaning a wound by removing non-viable tissue with a scalpel or other surgical tools) and skin substitute grafting of wounds to the Resident's left heel and/or second and third toes of the right foot on 16 occasions. Findings include: Resident #15 was admitted to the facility in February 2019 and had diagnoses including dementia. Review of the Minimum Data Set (MDS) assessment, dated 12/4/24, indicated Resident #15 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 7 out of 15, and had a legal guardian. Review of the medical record indicated Resident #15 was adjudicated incapacitated by the court and was appointed a legal guardian on 4/10/15. Further review of the medical record indicated the consultant wound physician's evaluations and progress notes included but was not limited to: (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: 225184	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-10/10/24 (initial visit): Patient has wounds on the left heel (unstageable deep tissue injury), right third toe and right second toe. Treatments performed included sharp selective debridement procedure (a medical technique where a healthcare professional uses sharp instruments like a scalpel, scissors, or forceps to carefully remove only dead or necrotic tissue from a wound, leaving healthy tissue unharmed) to the left heel, surgical excisional debridement procedure to the right, third toe and cauterization for abnormal granulation to the right, second toe. Treatment options-risks-benefits and the possible need for subsequent additional procedures on the wounds were explained on 10/10/24 to the patient who indicated agreement to proceed with the procedure(s). Further review of the note failed to indicate the legal guardian was informed of the wounds, risks and benefits of treatment options, and provided consent for surgical debridement and cauterization to be performed. -10/17/24: The patient has a wound on the left heel and left second toe. The wounds on the right third toe and right second toe have resolved. Treatment performed included sharp selective debridement procedure to remove devitalized tissue at margins of a wound on the left heel. Treatment options-risks-benefits and the possible need for subsequent additional procedures on this wound were explained on 10/10/24 to the patient who indicated agreement to proceed with the procedure(s). Further review of the note failed to indicate the legal guardian was informed of the wounds, risks and benefits of treatment options, and provided consent for surgical debridement to be performed. -10/24/24: The patient has wounds on the left heel and left second toe. Treatment included sharp selective debridement procedure to remove devitalized tissue at margins of a wound on the left heel and non-contact, non-thermal, low frequency ultrasound, which was indicated to promote healing based on debridement attempt but aborted due to pain in the left second toe. Treatment options-risks-benefits and the possible need for subsequent additional procedures on this wound were explained on 10/24/24 to the patient who indicated agreement to proceed with the procedure(s). Further review of the note failed to indicate the legal guardian was informed of the wounds, risks and benefits of treatment options, and provided consent for surgical debridement and ultrasound to be performed. -10/31/24: The patient has a wound on the left heel; left second toe wound resolved. Treatment performed included sharp selective debridement procedure to remove devitalized tissue at margins of a wound on the left heel. Treatment options-risks-benefits and the possible need for subsequent additional procedures on this wound were explained on 10/24/24 to the patient who indicated agreement to proceed with the procedure. Further review of the note failed to indicate the legal guardian was informed of the wounds, risks and benefits of treatment options, and provided consent for surgical debridement to be performed. -11/7/24: The patient has a wound on the left heel. Treatment performed included sharp selective debridement procedure to remove devitalized tissue at margins of a wound on the left heel. Treatment options-risks-benefits and the possible need for subsequent additional procedures on this wound were explained on 10/24/24 to the patient who indicated agreement to proceed with the procedure. Further review of the note failed to indicate the legal guardian was informed of the wounds, risks and benefits of treatment options, and provided consent for surgical debridement to be performed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Webster Park Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 56 Webster Street Rockland, MA 02370	

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-11/14/24: The patient has a wound on the left heel. Treatment performed included sharp selective debridement procedure to remove devitalized tissue at margins of a wound on the left heel. Treatment options-risks-benefits and the possible need for subsequent additional procedures on this wound were explained on 10/24/24 to the patient who indicated agreement to proceed with the procedure. Further review of the note failed to indicate the legal guardian was informed of the wounds, risks and benefits of treatment options, and provided consent for surgical debridement to be performed. -11/21/24: The patient has a wound on the left heel. Debridement attempted but aborted due to pain. Today this wound underwent treatment with non-contact, non-thermal, low frequency ultrasound. Further review of the note failed to indicate the legal guardian was informed of the wounds, risks and benefits of treatment options, and provided consent for surgical debridement and ultrasound to be performed. -11/27/24: The patient has a wound on the left heel that has been present for greater than 46 days and has failed to respond appropriately for over 30 days despite standard management. The wound was evaluated as a candidate for wound treatment using a skin substitute. The anticipated amount of skin substitute material that is being considered for use on this wound is 12 cm2 (centimeters squared). Discussion of the potential risks and benefits of using this human tissue-based skin substitute graft treatment was held with the patient who expressed that all questions and concerns were addressed. It was agreed upon by all parties to proceed with the placement during the subsequent wound care visit. Today this wound underwent treatment with non-contact, non-thermal, low frequency ultrasound. Further review of the note failed to indicate the legal guardian was informed of the wounds, risks and benefits of treatment options, and provided consent for ultrasound and that the Resident was evaluated for a skin substitute graft. -12/5/24: The patient has a wound on the left heel. During today's visit this full thickness, chronic arterial wound of the left heel underwent the placement of a skin substitute graft. Further review of the note failed to indicate the legal guardian was informed of the risks and benefits of treatment options and provided consent for any procedure to be performed. -12/12/14: The patient has a wound on the left heel. Application of skin substitute graft material was performed today on this wound. Further review of the note failed to indicate the legal guardian was informed of the wound, risks and benefits of treatment options, and provided consent for application of a skin substitute graft to the left heel. -12/19/24: The patient has a wound on the left heel. During today's visit this full thickness, chronic arterial wound of the left heel underwent the placement of a skin substitute graft. In preparation of the wound bed, surgical excisional debridement was performed to remove visible necrosis just prior to skin substitute application. Further review of the note failed to indicate the legal guardian was informed of the wound, risks and benefits of treatment options, and provided consent for surgical debridement and application of a skin substitute graft to the left heel. -12/27/24: The patient has a wound on the left heel. During today's visit this full thickness, chronic arterial wound of the left heel underwent the placement of a skin substitute graft. Further review of the note failed to indicate the legal guardian was informed of the wound, risks and benefits of treatment options, and provided consent for the application of a skin substitute graft to the left heel. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-1/3/25: The patient has a wound on the left heel. During today's visit this full thickness, chronic arterial wound of the left heel underwent the placement of a skin substitute graft. Further review of the note failed to indicate the legal guardian was informed of the wound, risks and benefits of treatment options, and provided consent for the application of a skin substitute graft to the left heel. -1/9/25: The patient has a wound on the left heel. During today's visit this full thickness, chronic arterial wound of the left heel underwent the placement of a skin substitute graft. Further review of the note failed to indicate the legal guardian was informed of the wound, risks and benefits of treatment options, and provided consent for the application of a skin substitute graft to the left heel. -1/16/25: The patient has a wound on the left heel. During today's visit this full thickness, chronic arterial wound of the left heel underwent the placement of a skin substitute graft. Further review of the note failed to indicate the legal guardian was informed of the wound, risks and benefits of treatment options, and provided consent for the application of a skin substitute graft to the left heel. -1/23/25: The patient has a wound on the left heel. During today's visit this full thickness, chronic arterial wound of the left heel underwent the placement of a skin substitute graft. Further review of the note failed to indicate the legal guardian was informed of the wound, risks and benefits of treatment options, and provided consent for the application of a skin substitute graft to the left heel. Review of the nursing progress notes from 10/10/24 through 1/28/25 failed to indicate Resident #15's legal guardian was informed of the wounds, informed in advance of the risks and benefits of proposed treatment and gave consent for treatments administered from 10/10/24 through 1/23/25 including surgical debridement of wounds, low frequency ultrasound and weekly application of a substitute skin graft. During a telephonic interview on 1/27/25 at 12:22 P.M., Resident #15's legal guardian reviewed her documentation and said her last communication with the facility was on 9/17/24 for a care plan meeting and she has not heard from them since that time. She said she assumes the Resident's status is stable and has had no changes in condition. The surveyor read the consultant wound physician's notes from 10/10/24 to 1/23/25 to the legal guardian. She reviewed her notes again and said she was not informed of the wounds by telephone or email, was not provided with any information about treatments and did not give consent for the treatments. She said she should have been informed of the changes and proposed treatment because she is the Resident's legal guardian and must give consent. During a telephonic interview on 1/27/25 at 2:55 P.M., the consultant wound physician (MD #1) said he sees Resident #15 weekly for assessment and treatment of the Resident's wounds. The surveyor read aloud his wound evaluation and summary note, dated 10/10/24. He said he obtained consent from Resident #15 to perform surgical debridement of the left heel wound and the right, third toe and also cauterization for the wound on the right, second toe. MD #1 said he was not aware, and facility staff did not tell him, that Resident #15 had a legal guardian and was unable to give consent for any of the procedures. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interviews on 1/27/25 at 3:20 P.M. and 1/28/25 at 7:40 A.M., the Director of Nursing (DON) said that she spoke to Resident #15's legal guardian following surveyor inquiry and said the legal guardian did not give consent for any of the treatment procedures performed by MD #1 from 10/10/24 to 1/23/25. She said the procedures should not have been performed without consent from the Resident's legal guardian. She said she reviewed the Resident's medical record and said nursing documented that the guardian was aware. During an interview on 1/28/25 at 9:10 A.M., Unit Manager #3 said she documented that the guardian was aware of Resident #15's wounds but was not able to confirm that she spoke to the legal guardian or left a message for her regarding Resident #15's wounds and proposed treatment. During a subsequent telephonic interview on 1/29/25 at 12:00 P.M., Resident #15's legal guardian said the facility has both her cell phone number and landline number to use to contact her. She said she reviewed her cell phone records back to October 2024 and did not receive a call, voice or text message from the facility during that timeframe. She said she has had difficulty with her landline since the end of August 2024 and even with the assistance of her telephone provider, has been unable to retrieve any phone records to confirm the facility called her or left a voice message to inform her of the Resident's wounds, proposed treatment, and to obtain consent for surgical debridement and other treatments.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 34145 Based on observation, interviews, and document review, the facility failed to ensure that residents were fully aware of the grievance process. Specifically, for 14 of 14 residents attending the resident group meeting during the facility survey, the facility failed to ensure residents were aware they could formulate grievances anonymously, should they choose not to alert a staff member of their concern(s). Findings include: Review of the facility's policy titled Grievance and Complaint Procedure, dated January 2022, indicated but was not limited to: -Upon admission, residents are provided with written information on how to file a grievance or complaint within the facility. Such information will also be posted on the resident bulletin board. -Grievances and complaints may be submitted orally or in writing without threat or fear of retaliation. They may also be filed anonymously. On 1/24/25 at 10:30 A.M., the surveyor held a resident group meeting with 14 residents, representing each of the facility's three units, in attendance. The residents said they don't always want to identify who they are when they have a complaint, so they don't fill out a grievance form or say anything to staff. Fourteen of 14 residents in attendance were not aware that they have the right to file a grievance anonymously. During an interview on 1/28/25 at 9:46 A.M., the Activity Director said she coordinates the monthly Resident Council Meeting and records the meeting minutes. She said she is aware that residents don't want to say who they are when they have a complaint, and this is an obstacle to them bringing issues forward. On 1/28/25 at 10:32 A.M. on the second-floor unit and at 11:36 A.M. on the third-floor unit, the surveyor observed a wall mounted file holder with blank grievance forms in a folder at the elevator. A sign was posted alongside the folder and indicated the following: -What is grievance? A grievance is a dispute resolution process that you may use when you have a complaint or concern. -You have the right to: -You may voice grievances without discrimination or reprisal; -Know of a timely resolution of your grievances including those with respect to the behavior of other residents; (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-You may recommend changes in policies and services to facility staff and/or outside representatives, free from interference, coercion, discrimination, restraint, or reprisal from the facility; -You may voice grievances concerning your care without fear of discrimination; -Be ensured that a method is in place to respond promptly to your complaints or grievances and recommendations. -You may write a grievance on the form located on your neighborhood or express your concern with staff who will then write a grievance form out for you. The posted grievance information failed to indicate residents could file a complaint or grievance anonymously. During an interview on 1/28/25 at 10:50 A.M., the Administrator said he is the Grievance Officer and grievance forms are available on each of the units. He said he was not aware that residents did not know they could file a grievance anonymously. On 1/28/25 at 11:45 A.M., the surveyor and Social Worker toured the first-floor unit and were unable to locate any posting about the grievance process.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 34145 Based on interview and record review, the facility failed to provide care and services consistent with professional standards of practice for three Residents (#85, #15, and #23), out of a total sample of 21 residents. Specifically, the facility failed to ensure: 1. For Resident #85, staff implemented a taper and discontinuation of a Nicotine patch (smoking cessation treatment) recommended by the consultant pharmacist and agreed upon by the Resident's physician; 2. For Resident #15, the consultant wound physician did not perform treatments including invasive surgical procedures, cauterization, ultrasound therapy and substitute skin grafts to the Resident's wounds without obtaining informed consent to do so from the Resident's legal guardian; and 3. For Resident #23, to ensure a left upper extremity (LUE) hand carrot (device designed to position fingers away from the palm protecting the skin from moisture, pressure and other injury) was donned/doffed (put on/ taken off) as prescribed in physician's orders. Findings include: 1. Resident #85 was admitted to the facility in January 2024 with diagnoses including chronic pulmonary embolism and chronic obstructive pulmonary disease. Review of the Minimum Data Set (MDS) assessment, dated 12/4/24, indicated Resident #85 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score 13 out of 15 and did not use tobacco. Review of a three-ringed binder labeled with Resident #15's attending physician's name on it indicated Consultant Pharmacist Recommendations to Prescriber, dated 7/20/24, to consider the manufacturer recommended taper schedule: -Nicotine Patch 14 milligrams (mg)/24-hour (hr) everyday x 2 weeks; then -Nicotine Patch 7 mg/24-hr everyday x 2 weeks, then discontinue Nicotine Patch The physician/prescriber response section indicated the physician agreed and signed the recommendation on 7/25/24. Review of the January 2025 Physician's Orders indicated but was not limited to: - Nicotine Patch 24 Hour 14 mg/24 hr Apply 1 patch transdermally one time a day for Smoking Cessation. Remove the old one and remove per schedule (1/15/24) Review of January 2024 through January 2025 Medication Administration Records (MAR) indicated the Nicotine Patch 14 mg/24 hr was applied at 9:00 A.M. and the previous patch removed at 8:59 A.M. daily as ordered. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the entire medical record failed to indicate the Nicotine Patch taper was implemented as agreed upon by the physician on 7/25/24. During an interview on 1/27/25 at 11:00 A.M., Unit Manager #3 said the process for pharmacy recommendations is that the recommendation forms are placed in the physician's three-ringed binder on the unit, the physician reviews them and indicates if they agree or disagree with the recommendation and then signs the form. She said nursing retrieves the signed recommendations from the binder, makes sure they get done, then files the forms in the resident's medical record. She said she doesn't know why Resident #15's signed and approved recommendation from July 2024 was still in the three-ringed binder. She said it should have been implemented when it was signed by the physician. During an interview on 1/28/25 at 1:15 P.M., the Director of Nursing (DON) reviewed Resident #15's entire medical record and said she was unable to find any evidence that nursing followed through with the physician's authorization to initiate the taper or that the Resident refused. 2. Resident #15 was admitted to the facility in February 2019 and had diagnoses including dementia. Review of the MDS assessment, dated 12/4/24, indicated Resident #15 had moderate cognitive impairment as evidenced by a BIMS score of 7 out of 15, and had a legal guardian. Review of the medical record indicated Resident #15 was adjudicated incapacitated by the court and was appointed a legal guardian on 4/10/15. Review of the medical record indicated consultant wound physician (MD #1) performed an initial evaluation on 10/10/24 and identified an unstageable deep tissue injury (a pressure injury where the stage is unclear because the wound is covered by dead tissue) to Resident #15's left heel, a non-pressure wound of the third right toe, and a wound of the right second toe. The note indicated MD #1 performed a sharp selective debridement procedure (a medical technique where a healthcare professional uses sharp instruments like a scalpel, scissors, or forceps to carefully remove only dead or necrotic tissue from a wound, leaving healthy tissue unharmed) to the left heel, surgical excisional debridement procedure to the right, third toe and cauterization (a medical procedure that uses heat to destroy or seal off tissue) for abnormal granulation to the right, second toe. Further review of the note indicated MD #1 performed surgical debridement and wound cauterization without obtaining consent from the legal guardian. Further review of the medical record indicated MD #1 performed 15 additional treatments to the Resident's wounds without obtaining consent from the legal guardian as follows: -10/17/24: sharp selective debridement procedure to the left heel. -10/24/24: sharp selective debridement procedure to the left heel and left second toe; non-contact, non-thermal, low frequency ultrasound. -10/31/24: sharp selective debridement procedure to the left heel. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-11/7/24: sharp selective debridement procedure to the left heel. -11/14/24: sharp selective debridement procedure to the left heel. -11/21/24: sharp selective debridement procedure to the left heel and non-contact, non-thermal, low frequency ultrasound. -11/27/24: non-contact, non-thermal, low frequency ultrasound. -12/5/24: the left heel wound underwent the placement of a skin substitute graft (a material used to replace skin that has been damaged or removed). -12/12/24: application of skin substitute graft material was applied to the left heel wound. -12/19/24: sharp selective debridement procedure to the left heel and application of skin substitute graft material was applied to the left heel wound. -12/27/24: application of skin substitute graft material was applied to the left heel wound. -1/3/25: application of skin substitute graft material was applied to the left heel wound. -1/9/25: application of skin substitute graft material was applied to the left heel wound. -1/16/25: application of skin substitute graft material was applied to the left heel wound. -1/23/25: application of skin substitute graft material was applied to the left heel wound. Review of the entire medical record, including nursing progress notes from 10/10/24 through 1/28/25, failed to indicate Resident #15's legal guardian was informed and gave consent for any treatments administered to Resident #15 from 10/10/24 through 1/23/25. During a telephonic interview on 1/27/25 at 12:22 P.M., Resident #15's legal guardian reviewed her documentation and said her last communication with the facility was on 9/17/24 for a care plan meeting and she has not heard from them since that time. The surveyor read the consultant wound physician's notes from 10/10/24 to 1/23/25 to the legal guardian. She reviewed her notes again and she said she was not informed of the wounds by telephone or email, was not provided with any information about treatments and did not give consent for the treatments. She said she should have been informed of the changes and proposed treatment because she is the Resident's legal guardian and must give consent. During a telephonic interview on 1/27/25 at 2:55 P.M., MD #1 said he performed treatments to Resident #15's left heel and toe wounds including surgical debridement, cauterization, ultrasound and skin grafts. He said he was not aware, and facility staff did not tell him that Resident #15 had a legal guardian and was unable to give consent for any of the procedures. He said he obtained consent for the procedures from the Resident. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interviews on 1/27/25 at 3:20 P.M. and 1/28/25 at 7:40 A.M., the DON said that she spoke to Resident #15's legal guardian following surveyor inquiry and said the legal guardian did not give consent for any of the treatment procedures performed by MD #1 from 10/10/24 to 1/23/25. She said the procedures should not have been performed without consent from the Resident's legal guardian. 48362 3. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated: Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber's that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. Resident #23 was admitted to the facility in October 2022 with diagnoses including Parkinson's disease, dementia, and muscle weakness. Review of the MDS assessment, dated 12/31/24, indicated Resident #23 was severely cognitively impaired as evidenced by a BIMS score of 4 out of 15; he/she had a left upper extremity range of motion (ROM) impairment and required extensive assistance for activities of daily living. Review of Resident #23's Physician's Orders included but were not limited to the following: - 1/23/25: LUE carrot daily as tolerated; apply with A.M. care and doff with P.M. care; may remove for skin checks and hygiene; two times a day for skin integrity. - 7/9/24 to 1/23/25: LUE carrot for up to 8 hours; remove for skin checks and hygiene; two times a day for skin integrity. The surveyor observed Resident #23 in bed with no LUE carrot in his/her hand as follows: - On 1/23/25 at 9:45 A.M. - On 1/23/25 at 4:15 P.M. - On 1/27/25 at 8:59 A.M. - On 1/27/25 at 2:58 P.M. - On 1/27/25 at 4:24 P.M. Review of Resident #23's Treatment Administration Record (TAR) for January 2025 indicated Resident #23's LUE carrot was donned and doffed with A.M./P.M. care since 1/23/25 twice daily. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225184	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER Webster Park Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 56 Webster Street Rockland, MA 02370	

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #23's medical record failed to indicate refusal to wear the LUE carrot and/or inability to tolerate wearing the LUE carrot. The medical record also failed to indicate any attempts by the Resident to self-remove the LUE carrot. During an interview on 1/28/25 at 8:43 A.M., Certified Nurse Aide (CNA) #7 said Resident #23 only sometimes wears the LUE carrot in his/her hand. CNA #7 said they are able to don/doff the LUE carrot to his/her hand during care. CNA #7 said she was not aware of when or how often the LUE carrot was supposed to be worn or removed. During an interview on 1/28/25 at 8:57 A.M., Occupational Therapist (OT) #1 said she recently did an Occupational Therapy evaluation on 1/24/25 to assess the LUE carrot for Resident #23's hand contracture. OT #1 said she did not initially issue the LUE carrot to the Resident, but she believed it was an appropriate device for their contracture management. OT #1 said she spoke the Unit Manager (UM) about the Resident's wearing schedule and tolerance to the device. OT #1 said she would expect communication back to the Rehabilitation Department if the Resident was refusing to wear the LUE carrot, having difficulty tolerating the LUE carrot or had a change in condition. OT #1 said she had not received any communication about the Resident not being able to wear the LUE carrot since the reassessment on 1/24/25. During an interview on 1/28/25 at 9:17 A.M., Nurse #3 said Resident #23 wears a LUE carrot in his/her hand. Nurse #3 said either nursing staff or OT staff place the LUE carrot on the Resident in the morning. Nurse #3 said the Resident was supposed to wear the LUE carrot for eight hours a day. Nurse #3 said she would let the UM or the therapy department if the Resident was refusing to wear the device or there were complications related to the use of the LUE carrot. During an interview on 1/28/25 at 9:30 A.M., UM #2 said Resident #23 had been wearing a LUE carrot for a while. UM #2 said nursing dons the LUE carrot every morning and it should be worn for eight hours daily. UM #2 said nursing documents on the TAR when the LUE carrot is donned/doffed. UM #2 and the surveyor reviewed the observations made during the survey process. UM #2 said nursing should identify on the TAR if they were unable to don the LUE carrot for the Resident. During an interview on 1/28/25 at 10:52 A.M., Resident Representative (RR) #1 said she visits the Resident several times per week. RR #1 said the Resident does not always have the LUE carrot on when they visit. RR #1 said the LUE carrot is not consistently donned. RR #1 said the Resident had never complained the LUE carrot was uncomfortable or needed to be taken off when they were visiting. During an interview on 1/28/25 at 12:11 P.M., the DON said the Resident often requires multiple attempts to don the LUE carrot. The DON said the expectation would be for the CNA staff to notify the Nurse or UM if the resident was refusing the LUE carrot or taking it off by themselves. The DON said it should be identified and documented if the Resident refused or if multiple attempts were required to don the LUE carrot.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Webster Park Rehabilitation and Healthcare Center	56 Webster Street Rockland, MA 02370

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 42742 Based on observation, record review, and interview, the facility failed to ensure it was free from a medication error rate of greater than 5% when two of five nurses observed made two errors out of 28 opportunities, resulting in a medication error rate of 7.14%. Those errors impacted two Residents (#22 and #64). Findings include: Review of the facility's policy titled Administering Medications, revised April 2019, indicated but was not limited to the following: -Medications are administered in accordance with prescriber orders, including any required time frame. -Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and/or the need for additional staff training. -The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. 1. Resident #22 was admitted to the facility in July 2022 and had diagnoses including atrial fibrillation, osteoarthritis, benign intracranial hypertension, and lymphedema (swelling most often in the leg or arm caused by lymphatic system blockage). On 1/27/25 at 8:51 A.M., the surveyor observed Nurse #4 prepare Resident #22's medications and observed the following: 8:51 A.M. - Nurse #4 opened an over-the-counter bottle of generic One-Daily Multi-vitamin with Minerals (includes a combination of various vitamins alongside essential minerals like calcium, iron, and magnesium, while a multivitamin without minerals contains only a blend of vitamins) from the top drawer of the medication cart and added one whole tablet into a medication cup along with five other various whole tablets. 9:06 A.M. - Nurse #4 administered the medications to Resident #22. Review of current Physician's Orders on 1/27/25 at 11:13 A.M., indicated the following: -Multivitamin Tablet (Multiple Vitamin), Give 1 tablet by mouth in the morning for vitamin deficiency, 7/27/22 During an interview on 1/27/25 at 1:28 P.M., the surveyor reviewed the medical record with Nurse #4 who said the order was for a multivitamin tablet, without minerals. She said all medications should be given per physician's orders. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #64 was admitted to the facility in January 2021 and had diagnoses including thrombocytopenia (low number of platelets in the blood) and hypercholesterolemia. On 1/27/25 at 9:17 A.M., the surveyor observed Nurse #5 prepare Resident #64's medications and observed the following: 9:17 A.M. - Nurse #5 opened an over-the-counter bottle of generic One-Daily Multi-vitamin with Minerals from the top drawer of the medication cart and added one whole tablet into a medication cup along with another whole tablet. 9:21 A.M. - Nurse #5 administered the medications to Resident #64. Review of current Physician's Orders on 1/27/25 at 11:24 A.M., indicated the following: -Multiple Vitamin Tablet, Give 1 tablet by mouth one time a day for supplementation, 3/18/24 During an interview on 1/27/25 at 1:22 P.M., the surveyor reviewed the medical record with Nurse #5 who said the order was for a multivitamin tablet daily, not a multivitamin tablet with minerals. She said one has just vitamins and the other has minerals added to it. She said medications should be administered per physician's orders. During an interview with the Assistant Director of Nurses and the Director of Nurses (DON) on 1/27/25 at 4:49 P.M., the DON said she was already made aware of the medication errors and both said nursing staff should follow physician's orders for medication administration.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 48695 Based on observation, record review, and interviews, the facility failed to ensure the call light was accessible and within reach for one Resident (#37), out of a total of 21 sampled residents. Specifically, the facility failed to ensure the call light switch above Resident #37's bed had a string attached to it to enable the Resident to independently call for assistance. Findings include: Review of the facility's policy titled Answering the Call Light, dated April 2016, indicated but was not limited to: - Purpose: The purpose of this procedure is to respond to the resident's requests and needs. - General Guidelines: 4. Be sure that the call light is plugged in at all times. 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. Resident #37 was admitted to the facility in January 2018 with diagnoses including chronic obstructive pulmonary disease and need for assistance with personal care. Review of the Minimum Data Set (MDS) assessment, dated 12/10/24, indicated Resident #37 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 15 out 15. Further review of Resident #37's MDS indicated he/she required assistance with toileting, bathing, and dressing and was supervised for ambulation. Review of the Facility Assessment, undated, indicated but was not limed to: - Physical Environment -Equipment utilized to care for our resident population includes but is not limited to: - General Facility Equipment: Nurse call system Review of Resident #91's (roommate to Resident #37) MDS assessment, dated 12/19/24, indicated Resident #91 was cognitively intact as evidenced by a BIMS assessment score of 15 out 15. On 1/23/25 at 8:45 A.M., 12:24 P.M., and 3:39 P.M., and on 1/24/25 at 10:32 A.M., the surveyor observed Resident #37 in bed with a call light switch above his/her bed with the call light string attached to Resident #91's bedrail, the call light switch above Resident #37's bed did not have a string attached to the switch and therefore could not be used or reached to call for assistance. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/23/25 at 8:56 A.M., Resident #37 said he/she does not have a call light or any means to independently call for assistance. Resident #37 said he/she would ask his/her roommate to pull the call light string if they needed assistance. During an interview on 1/23/25 at 8:46 A.M., Resident #91 said they share a call light with Resident #37. Resident #91 said when Resident #37 needed assistance he/she would ask Resident #91 to pull the call light string for them to request assistance from the staff. Resident #91 said he/she was the keeper of the call light string because they required more assistance. Resident #91 said when staff would respond to the call light, he/she would tell them they had called for Resident #37. During an interview on 1/27/25 at 12:28 P.M., Resident #91 said on Friday (1/24/25) a maintenance person had come in and fixed Resident #37's call light by adding a pull string to the switch above their bed, after the surveyor had left his/her room. During an interview on 1/28/25 at 8:46 A.M., Nurse #2 said all residents should have their own call light. Nurse #2 said if Resident #37 needed anything he/she would have to walk down to the nurses' station and request it. During an interview on 1/28/25 at 8:48 A.M., Certified Nursing Assistant (CNA) #1 said if a resident needed assistance they would pull their call light string to request assistance. CNA #1 said all residents should have their own call light to request assistance. During an interview on 1/28/25 at 8:53 A.M., CNA #2 said both Resident #37 and Resident #91 are alert and oriented. She said when she would answer the call light in Resident #37's room she would go into the room and ask both Resident #37 and Resident #91 which one of them needed help and then shut off the shared call light. CNA #2 said both Residents should have had their own call light to request assistance. During an interview on 1/28/25 at 8:57 A.M., Unit Manager (UM) #3 said each resident should have their own call light. UM #3 said the strings attached to the call light switches in the wall are cheap and would break easily. UM #3 said she was not sure how long Resident #37 and his/her roommate had been sharing a call light. UM #3 said a new string was attached to the call light switch on Friday (1/24/25) to ensure both Residents had their own access to request assistance using the call light system. During an interview on 1/28/25 at 9:55 A.M., the Director of Maintenance (DOM) said on Friday (1/24/25) he had repaired Resident #37's call light, adding a pull string to the switch so it could be activated, but he was not aware of how long it had been without a string attached to the call light switch. During an interview on 1/28/25 at 1:51 P.M., the Assistant Director of Nursing (ADON) said the expectation was for each resident to have their own call light within their reach to be able to call for assistance.