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	04/06/2026

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, and record review, the facility failed to monitor range of motion (ROM) of left knee flexion contracture and implement the care plan to maintain ROM to reduce the risk of worsening the contracture for one Resident (#13), out of a sample of 13 residents. Findings include:Review of the facility's policy titled Resident Mobility and Range of Motion, revised July 2017, indicated but was not limited to the following:-Residents with limited range of motion will receive treatment services to increase and/or prevent a further decrease in range of motion.-Residents with limited mobility will receive appropriate services, equipment, and assistance to maintain or improve mobility unless reduction in mobility is unavoidable.-As part of the resident's comprehensive assessment, the nurse will identify the resident's:Current range of motion of his or her joints;-Opportunities for improvement; and-Previous treatment and services for mobility.-The care plan will be developed by the interdisciplinary team based on the comprehensive assessment and will be revised as needed.-The care plan will include specific interventions, exercises and therapies to maintain, prevent avoidable decline in, and/or improve mobility and range of motion.-Interventions may include therapies, provisions of necessary equipment, and/or exercises and will be based on professional standards of practice to be consistent with state laws and practice acts.-The care plan will include the type, frequency, duration of interventions, as well as measurable goals and objectives. The resident and representatives will be included in determining these goals and objectives.-Documentation of the resident's progress towards the goal and objectives will include attempts to address any change or decline in resident's condition or needs. Resident #13 was originally admitted to the facility in April 2023, then transferred to a secondary facility related to fire damage (December 2025-February 2026), and readmitted to this facility in February 2026 with diagnoses which included dementia, hemiplegia (one sided weakness) affecting left dominant side, paralytic (loss of muscle function) syndrome following cerebral vascular infarction (CVA- stroke), and chronic pain. Review of the Minimum Data Set (MDS) assessment, dated 3/12/26, indicated Resident #13 scored 12 out of 15 on the Brief Interview for Mental Status (BIMS), indicating the Resident had moderate cognitive impairment. Further review of the MDS indicated:-Section GG indicated Functional Limitation in Range of Motion: - Lower extremity (hip, knee, ankle, foot) (GG0115B): Impairment on both sides.-Section O indicated special treatments, procedures, and programs: - Therapy services included speech (ST) and occupational therapy (OT). No physical therapy (PT) services, no restorative nursing programs including passive or active range of motion or splint or brace. On 4/2/26 at 1:47 P.M., the surveyor observed Resident #13 sitting in the day room in a specialized adjustable medical wheelchair. Resident #13 was sitting with the left lower extremity externally rotated and the knee flexed to 90 degrees, with the leg positioned lying on the right lower extremity. During an interview on 4/2/26 at 1:48 P.M., Resident #13 said he/she was in pain with the left leg. Resident #13 said they gave him/her pain medication but the leg still hurts; he/she can't straighten it out. During an interview on 4/3/26 at 2:55 P.M., the surveyor observed Resident #13 lying in bed with his/her left knee bent to approximately 90 degrees of knee flex. Resident #13 said he/she was not in pain. Review of Resident #13's Care Plan indicated but was not limited to the following:1. Resident #13 has (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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain and/or potential for pain status post CVA with resulting hemiplegia, and polyneuropathy (disorder of nerves outside brain).-Encourage me to try non-pharmacological interventions for pain relief as applicable. For example, positioning, relaxation therapy, bathing, heat and cold application, muscle stimulation, ultrasound (Initiated 2/18/26)2. Resident #13 had a CVA, hemiplegia related to an embolism.-Range of motion exercises: If able active range of motion exercises several times per day and assist with passive range of motion for limbs with limitations (Initiate It 2/18/26.)-Therapy consult as needed- PT, OT, and ST. Review of a Rehab Screen, dated 9/26/24, performed by the physical therapist, indicated Resident #13 remains with left lower extremity knee flexion contracture with staff performing passive range of motion daily to reduce the risk of worsening. Review of Rehab Screen, dated 2/18/26, performed by the speech therapist, indicated Resident #13 was screened for readmission to the facility and the elder has experienced a change/decline/improvement: Response was in swallowing and positioning bed/chair. Therapy evaluation section indicated occupational therapy and speech therapy were appropriate. Further review of Occupational Therapy Evaluation and Plan of Treatment, dated 2/18/26, failed to indicate-An assessment of left lower extremity range of motion or strength was performed. However, did establish a contracture was present. -Goals were established for left knee range of motion deficits, contracture management, or pain management. Review of Physical Therapy Evaluation and Plan of Treatment, dated 11/24/23, indicated but was not limited to the following:-Resident #13 was referred to rehab by nursing staff due to abnormal position while sitting in Geri chair recliner. Patient has a significant history of CVA with spastic left hemiplegia, left knee flexion contracture and increased tone in the left lower extremity. Musculoskeletal Assessment: -Left hip, left knee and left ankle. Range of motion impaired. No measured Range of motion available. -No left lower extremity strength testing available related to patient unable to participate in testing due to cognitive limitations and hypertonicity limiting movement. -Contracture functional limitations present due to contracture, yes: Functional limitations as results of contracture include transfers, sitting, bed positioning. -Neuromuscular Assessment. Left extremity tone was spastic: Lower extremity tone severity was Equal to 4 (Considerable increase).-No measurements of left knee contracture are available in evaluation. Review of Physical Therapy Evaluation and Plan of Treatment, dated 4/6/26, indicated but was not limited to the following:-Resident #13 was referred to rehab by nursing due to a presentation of left knee contracture possibly due to increased tone, left lower extremity, pain of left knee joint with movement and abnormal posture. Patients require skilled rehab interventions to prevent worsening of left knee contraction with the use of an orthotic device and a range of motion program.-Musculoskeletal Assessment indicated left lower extremity range of motion: Left hip impaired, Knee impaired (minus 86 degree of left knee flexion contracture). -Contracture functional limitations present due to contracture: Yes, functional limitations because of contracture turning, transferring, repositioning self and functional mobility. Is skilled therapy needed to address impairment? Yes. Review of Resident #13's nursing notes from 2/16/26 through 4/6/26 do not indicate range of motion or positioning for left lower extremity was performed. During an interview on 4/6/26 at 10:06 A.M., Rehab Staff #2 said he was an occupational therapy assistant and is presently seeing Resident #13 for ROM related to contractures in the left hand three times a week. Rehab staff #2 said he does not do any range of motion for the left lower extremity. During an interview on 4/6/26 at 10:14 A.M., the Rehab Director reviewed the rehab screen, which did not indicate the left lower extremity ROM. The Rehab Director believed Resident #13 had been on physical therapy previously and they had recommended his/her chair be changed to a specialized adjustable medical wheelchair. The Rehab Director reviewed the electronic medical record and said the last time Resident #13 was on rehab for PT was in 2013. During an interview on 4/6/26 at 2:15 P.M., Rehab Staff #1 said he had just completed the physical therapy evaluation and Resident #13 had minus 86 degrees of left knee extension. Rehab Staff #1 said he had some ideas that could help the Resident with the left knee contracture. Rehab Staff #1 said the last time Resident #13 was evaluated was in 2023 and he recommended a Broda chair for (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	positioning, and at the time Resident #13 was not agreeable to many of the recommendations. During an interview on 4/6/26 at 4:45 P.M., the Director of Nursing provided the surveyor with Resident #13's medical record documentation and said there was no documentation for nursing staff or certified nursing assistants performing ROM for Resident #13's left leg.

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F 0715 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the physician properly assigns and delegates tasks to a qualified dietitian (or other qualified nutrition professional); or to a qualified therapist. Based on observation, record review, and interview, the facility failed to ensure the physician signed therapeutic diet orders for total parenteral nutrition (TPN- a method of delivering complete nutrition intravenously to patients who cannot use their digestive system), written by a registered dietitian (RD) for one Resident, (#10), out of a total sample of 13 residents.Findings include:Review of 105 CMR 150 Standards for Long Term Care Facilities indicated the RD's role within long-term care facilities to be as follows: -150.009: Dietary Service (A) All facilities shall provide adequate dietary services to meet the daily dietary needs of residents in accordance with written dietary policies and procedures. (2) Dietary services shall be provided directly by the facility, or facilities may contract with an outside food company provided the facility and the food company comply with 105 CMR 150.000; provided the facility or the company has a qualified dietitian who serves, as required in 105 CMR 150.000; and provided the facility and the dietitian provide for continuing liaison with physicians and the nursing staff. -The visits of the dietitian shall be of sufficient duration and frequency to provide consultation, evaluation, and advice regarding dietary personnel, menu planning, therapeutic diets, food production and service procedures, maintenance of records, training programs, and sanitation.Further review of the state regulations failed to indicate that the attending physician could delegate the task of writing dietary orders to the RD.Review of the facility's policy titled Parenteral Nutrition, dated as last revised October 2004, indicated but was not limited to the following:-A provider's order is necessary for this treatment.-The PN order should include the formula or a list of all individual ingredients/nutrients in the base solution, total volume and rate of administration as well as orders for monitoring laboratory results on a routine basis.Resident #10 was admitted to the facility in March 2026 with diagnoses including but not limited to: peritoneal abscess (a localized pocket of infected fluid and pus inside the abdomen) and enterocutaneous fistula (an abnormal tunnel or opening that develops between the intestines and the skin) with short gut syndrome (a condition where the small intestine is too short or damaged to absorb enough water and nutrients from food).Review of the Minimum Data Set (MDS) assessment, dated 3/26/26, indicated Resident #10 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 10 out of 15. Further review of the MDS indicated he/she received parenteral/IV (intravenous, directly into the bloodstream) feeding while a resident.During an interview on 4/2/26 at 2:04 P.M., Resident #10 said he/she had been on TPN for over a year. Review of Resident #10's electronic medical record indicated a Physician's Order, dated 3/20/26, which included but was not limited to: -TPN Electrolytes Solution (Parenteral Electrolytes) Use 120 milliliters (ml)/hour (hr) intravenously two times a day for Supplement,- TPN 1800ml runs over 16-hour cycle add __ml vitamins to the bag,- 120 ml/hr for 14 hrs 60 ml/hr for last 2 hours.Further review of the physician's order in the electronic medical record failed to include the individual ingredients/nutrients and additives. Review of the Pharmacy TPN Order Form, dated 1/23/26, indicated but was not limited to:-TPN infusion time period of 16 hours run at 60ml/hr-120ml/hr- 60ml/hr,-Amino acids - 85 grams (g),-Dextrose- 280 g,-Lipids- 50 g,-Sodium acetate- 50 milliequivalents (mEq),-Sodium chloride- 50 mEq,-Sodium phosphate- 30 mEq,-Potassium acetate- 20 mEq,-Potassium chloride- 20 mEq,-Magnesium sulfate- 20 mEq,-Calcium gluconate- 5 mEq,-Zinc- 5 milligrams (mg),-Multivitamins with potassium- 10 milliliters (mL) and,-Insulin- 10 unitsFurther review of the Pharmacy TPN Order Form indicated the section for physician signature was signed by an RD and had not been signed by a physician. On 4/6/26 at 8:20 A.M., the surveyor observed Resident #10 with his/her TPN infusing. Review of the TPN bag indicated he/she was receiving the ingredients/nutrients and additives, as ordered on the Pharmacy TPN Order Form, dated 1/23/26, which included:-Amino acids - 85 g,-Dextrose- 280 g,-Lipids- 50 g,-Sodium acetate- 50 mEq,-Sodium chloride- 50 mEq,-Sodium phosphate- 30 mEq,-Potassium acetate- 20 mEq,-Potassium chloride- 20 mEq,-Magnesium sulfate- 20 mEq,-Calcium gluconate- 5 mEq,-Zinc- 5 (continued on next page)

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F 0715 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mg,-Multivitamins with potassium- 10 mL and,-Insulin- 10 units During a telephonic interview on 4/6/26 at 12:09 P.M., the Medical Director (MD) said the RD writes the TPN orders/recommendations on the TPN Pharmacy Order Form and then when she reviews the recommendations, she approves the orders by co-signing the TPN Pharmacy Order Form. During an interview on 4/6/26 at 12:42 P.M., the RD said she was not responsible for writing TPN orders because that was beyond her scope of practice. During an interview on 4/6/26 at 3:51 P.M., the Chief Nursing Officer (CNO) said the RD should review hospital orders and then the orders were reviewed and confirmed with the attending physician. The CNO said the orders written in the electronic medical record did not include all the additives in Resident #10's TPN orders. The CNO said the MD did not sign the TPN Pharmacy Order Form that included all the ingredients/nutrients and additives in the Resident's TPN feeding.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observations and interview, the facility failed to ensure trash, garbage, and refuse were disposed of and properly contained within a receptacle constructed with a tight-fitting lid. Findings include:Review of the 2022 Food Code (a model for safeguarding public health and ensuring food is unadulterated and honestly presented when offered to the consumer) by the U.S. Food and Drug Administration (FDA) indicated outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. Proper equipment and supplies must be made available to accomplish thorough and proper cleaning of garbage storage areas and receptacles so that unsanitary conditions can be eliminated. On 4/2/26 at 1:03 P.M., the surveyor observed an enclosed area with two dumpsters. One filled with cardboard and one filled with bags of trash. The surveyor observed the dumpster filled with bags of trash to be open from the top. Between the dumpsters was a large amount of leaves with empty containers of milk, thickened liquids, juice containers, water bottles, plastic cups, and plates. Next to the dumpster were pieces of lemon and pieces of bread. Behind the dumpsters were disassembled pieces of white piping with wheels on the bottom and a power wheelchair. On 4/6/26 at 1:24 P.M., the surveyor and the Food Service Director observed the enclosed dumpster area. The surveyor and Food Service Director observed the pile of leaves with trash debris including milk cartons, thickened liquid containers and juice containers. The dumpster with trash was observed opened on the top. During an interview at this time, the Food Service Director said the pile of leaves looked as if it had been under the snow previously and now the snow had melted. The Food Service Director said his staff brought trash out to the dumpsters and should be telling him if the area needs to be cleaned. He said the lid on the dumpster was broken and unable to be closed. He said the Maintenance Director had contacted the disposal company for a new one. During an interview on 4/6/26 at 2:49 P.M., the Maintenance Director said the enclosed dumpster area usually had trash debris after the dumpster company would pick up the dumpsters on Mondays, Wednesdays and Fridays. He said he did rounds to the area on those days to check on fallen trash. He said he was not sure why the same trash observed by the surveyor on Thursday was still on the ground on Monday. He said the lid on the trash dumpster had broken during the snowstorm on 2/23/26. He said he had contacted the dumpster company about the broken lid prior to the surveyor inquiry but did not have any documentation to indicate he had notified the company of the need for repair or replacement. During an interview on 4/6/26 at 2:54 P.M., the contracted trash disposal company representative said the facility had contacted them one half hour prior to this call, letting the company know the lid on the dumpster was unable to be closed. She said the facility had not contacted the company prior to this day.