STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225283	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Webster Manor Rehabilitation & Health Care Center	745 School Street Webster, MA 01570

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on records reviewed and interviews, for one of three sampled residents (Resident #1) who was found to have an injury (new bruise), the Facility failed to ensure he/she was provided with quality of care and services in accordance with his/her comprehensive person-centered plan of care, when although the facility was unable to determine exactly when or how the injury occurred, as a result of their investigation it was determined that gait belts were not consistently being used by staff during transfers, in accordance with facility policy, therefore placing Resident #1 and other residents at risk for potential injury. Findings include:Review of the Facility Policy titled, Gait Belt Use, dated April 2025, indicated gait belts must be used when physically transferring or ambulating residents.Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 01/23/26, indicated Resident #1 had sustained a fracture. The Report indicated the fracture was likely sustained during a transfer from chair to bed.Resident #1 was admitted to the Facility February 2022, with diagnoses including vascular dementia, hypertension (high blood pressure), hypothyroidism (low thyroid hormone) repeated falls and difficulty walking.Review of Resident #1's Minimum Data Set (MDS) Assessment, dated 01/09/26, indicated he/she had short-term and long-term memory problems, and was dependent on staff for activities of daily living (eating, dressing, bathing, toileting, and transferring).Review of Resident #1's Certified Nurse Aide (CNA) Care Card (used by CNAs to determine individual resident care needs), indicated he/she was dependent on staff assistance for transfers from chair to bed and bed-to chair.Review of Resident #1's Impaired Functional Mobility care plan, reviewed and renewed with his/her 01/09/26 MDS, indicated he/she required assistance of one staff, or two staff when fatigued, to move from a lying position to sitting on the edge of the bed, to be positioned in the chair, to be positioned in bed, and to ambulate with a walker.Review of Nurse Progress Note, dated 01/17/26, indicated Resident #1 had a fracture of the distal right femoral metaphysis (lower end of the thigh bone).Review Resident #1's Mobile X-ray report, dated 01/17/26, indicated an acute distal right femoral metaphysis fracture.During an interview on 02/10/26 at 1:45 P.M., the Assistant Director of Nurses said that on the morning of 01/16/26, nursing staff requested that she look at a bruise on Resident #1's right knee. The Assistant Director of Nurses said she assessed Resident #1, found his/her knee to be bruised and swollen, notified the Nurse Practitioner and obtained an order for an x-ray. The Assistant Director of Nurses said she had been responsible for investigating Resident #1's injury and determined that the injury most likely occurred during a transfer.During an interview on 02/10/26 at 3:00 P.M., CNA #3 said that he had noticed the bruise on Resident #1's leg while he was dressing him/her on the morning of 01/16/26. CNA #3 said he did not transfer Resident #1 that day but said that he had transferred Resident #1's on previous days by lifting him/her from the bed with another CNA without using a gait belt.During a telephone interview on 02/11/26 at 3:00 P.M., CNA #5 said that she had assisted CNA #3 to stand-pivot transfer Resident #1 on previous days, and that they had transferred him/her without the use of a gait belt. During an (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 02/10/26 at 2:30 P.M., CNA #2 said she and another CNA (could not provide name or identify) had transferred Resident #1 from his/her wheelchair to bed in the afternoon on 01/15/26. CNA #2 said that they had lifted Resident #1 from the wheelchair and pivoted him/her to the bed and did so without using a gait belt. CNA #2 said nothing unusual had occurred during the transfer and that Resident #1 showed no changes in behavior or signs of pain during the transfer or afterwards while she was providing care. CNA #2 said they should have used a gait belt to transfer Resident #1 but that they had not.The Assistant Director of Nurses said she had determined that the last time Resident #1 was transferred, prior to staff noticing a bruise on his/her knee, was on 01/15/26 when he/she was transferred from his/her wheelchair back into bed in the afternoon. The Assistant Director of Nurses said during her investigation she had spoken with staff who had told her that a gait belt had not been used during Resident #1's transfer from wheelchair to bed in the afternoon on 01/15/26. The Assistant Director of Nurses said it was the Facility policy to use a gait belt when physically transferring or ambulating residents and that staff should have used a gait belt for Resident #1's transfer to bed in the afternoon on 01/15/26, but that they had not.On 02/10/26, the Facility was found to be in Past Non-Compliance and presented the Surveyor with a plan of correction, with an effective date of 02/04/26, which addressed the area of concern as evidenced by:A. Resident #1 no longer resides at the Facility.B. On 1/19/26, Administrative staff ensured that gait belts were available and accessible on all nursing units.C. On 1/26/26 the Assistant Director of Nurses and/or designee completed a house wide audit of residents who required assistance with transfers and ambulation to determine if staff were using gait belts according to Facility policy.D. On 02/2/26 the Director of Nurses and/or designee initiated ongoing audits (which included observations) of gait belt use by staff during resident transfers and ambulation. Audits (random observations) will continue weekly for four weeks, then monthly for three months.E. On 02/04/25, the Director of Nurses, Assistant Director of Nurses and Staff Development Coordinator (SDC) completed training for Nurses and CNAs on the use of gait belts for resident transfer and ambulation, which included a review of Facility policy.F. The concern for gait belt use during resident transfers and ambulation was discussed by the Quality Assurance Performance Improvement Committee (QAPI) on 01/28/26, ongoing audit result will be submitted to QAPI committee monthly for three months to ensure compliance.G. The Director of Nurses and/or designee are responsible for overall compliance.