| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225283 | A. Building<br>B. Wing | 05/12/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Webster Manor Rehabilitation & Health Care Center | 745 School Street<br>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 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who required medication to treat hypotension (low blood pressure) and had a Physician's order to hold (not administer) the medication for a systolic blood pressure (SBP-top number, represents the pressure in arteries when the heart contracts) greater than 120, the Facility failed to ensure the resident was free from significant medication errors when he/she was administered the medication outside of the prescribed parameter, placing him/her at risk for high blood pressure.Findings include:Review of the Facility policy titled, Oral Medication Administration, revised 2024, indicated Facility staff should:-Review and confirm medication orders for each individual resident on the Medication Administration Record (MAR) prior to administering medications to each resident.-Review the MAR for any tests or vital signs that need to be determined prior to preparing the medication.-Obtain and record any vital signs or other monitoring parameters ordered or deemed necessary prior to mediation administration.Resident #1 was admitted to the Facility in March 2026, diagnoses included acute and chronic respiratory failure with hypoxia (low oxygen), urinary tract infection, pneumonia, and orthostatic hypotension (sudden drop in blood pressure when standing up).Review of Resident #1's Physicians' Orders for April 2026, indicated it included an order for, but not limited to the following:Midodrine HCL (medication used to treat low blood pressure) oral tablet 10 milligrams (mg), give one tablet by mouth in the morning and one tablet by mouth in the afternoon related to orthostatic hypotension (low blood pressure). Hold (do not give) for SBP (systolic blood pressure) greater than 120, start date 04/03/26. Review of Resident #1's Medication Administration Record (MAR) for April 2026, indicated he/she was administered Midodrine HCL 10 mg by nursing, despite having (per nursing documentation) a systolic blood pressure reading that was greater than 120, (and therefore per MD orders it should have been held) on the following dates/times:04/11/26 morning dose (between 8A.M. and 10A.M.)-BP 128/72 04/11/26 afternoon dose (scheduled between 12P.M. and 2 P.M.)-BP 129/69During an interview on 05/12/26 at 4:00 P.M., Nurse #3 said that she had administered Midodrine to Resident #1 on 04/11/26 in the morning (between the hours of 8:00 A.M. and 10:00 A.M.), and again the same day in the afternoon (between the hours of 12:00 P.M. and 2:00P.M.). The surveyor and Nurse #3 reviewed Resident #1's blood pressure documentation for 04/11/26 (morning-128/72 and afternoon-129/69) and Nurse #3 said she should not have administered Midodrine to Resident #1 because Resident #1's SBP's were greater than 120, both in the morning and in the afternoon.During a telephone interview on 05/13/26 at 9:50 A.M., the Nurse Practitioner said that she expected the facility nurses to check Resident #1's blood pressure each time prior to administering Midodrine and to hold the Midodrine if his/her SBP was greater than 120. The NP said Resident #1 should not have received Midodrine on 4/11/26, when his/her SBP was over 120.During an interview on 05/12/26 at 4:40 P.M., the Director of Nursing (DON) said her expectation for medication administration is that nurses read and follow the Physicians' orders on the Medication Administration Record. The DON said Nurse #3 should not have administered Midodrine to Resident #1 in the morning and afternoon of 04/11/26 when his/her SBP was documented above 120, and therefore resulted in medication errors. |

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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for two of three sampled residents, (Resident #1 and Resident #2), the Facility failed to ensure they maintained complete and accurate medical records, when their Certified Nurse Aide (CNA) Activities of Daily Living (ADL) Flow Sheets were incomplete.Findings include:Review of the facility policy titled, POC (point of care) Documentation Skill Sheet, dated 10/27/23, indicated:-You must chart every time you give care to a resident-You must complete all charting before leaving-If it's not documented, it means it was not doneResident #1 was admitted to the Facility in March 2026, diagnoses included acute and chronic respiratory failure with hypoxia (low oxygen), urinary tract infection, pneumonia, and orthostatic hypotension (sudden drop in blood pressure when standing up).Review of Resident #1's Minimum Data Set (MDS) Assessment, dated 04/06/26 indicated he/she required various levels of staff assistance with his/her Activities of Daily Living (ADLs) including but not limited to bathing, dressing, grooming, transfer, toileting and personal hygiene.Review of Resident #1's ADL Flow Sheets (CNA documentation) dated 04/01/26 through 04/13/26 indicated that for the following shifts, documentation on the flow sheets was incomplete:-7:00 A.M. to 3:00 P.M. 9 days (out of 13 days) all ADL care areas were left blank.-3:00 P.M. to 11:00 P.M. 3 days (out of 13) all ADL care areas were left blank.-11:00 P.M. to 7:00 A.M. 2 (out of 13) all ADL care areas were left blank. Resident #2 was admitted to the Facility in September 2023, diagnoses included vascular dementia, hypertension, and depression.Review of Resident #2's MDS assessment dated [DATE] indicated he/she required various levels of staff assistance with his/her ADLs including but not limited to bathing, dressing, grooming, transfer, toileting and personal hygiene.Review of Resident #2's CNA Flow Sheet for the Month of April 2026 indicated that for the following shifts, documentation on the flow sheet was incomplete: -7:00 A.M. to 3:00 P.M.-16 days (out of 30 days) all ADL care areas were left blank.-3:00 P.M. to 11:00 P.M.-2 (out of 30 days) all ADL care areas were left blank.-11:00 A.M., to 7:00 A.M.- 4 (out of 30 days) all ADL care areas were left blank.During an interview on 05/12/26 at 3:05 P.M., CNA #2 said CNAs are responsible for documenting care every shift.During an interview on 05/12/26 at 4:40 P.M., the Director of Nursing said CNAs should document care every shift, but she realized that there had been omissions in documentation. |