STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225357	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winchester Rehabilitation and Nursing Center	223 Swanton Street, #1968 Winchester, MA 01890

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. 15024 Based on interviews and records reviewed, for one of three sampled residents (Resident #1), whose Health Care Proxy had been activated in July of 2022, the Facility failed to ensure it honored a request for copies of medical record information within two working days, when his/her Health Care Agent (HCA) requested copies of documentation from his/her medical record verbally and through email correspondence, but was not provided with copies in accordance with federal regulations. Findings include: Review of the Facility Release of Medical Records Policy, dated May 2022, indicated medical records will be released with a valid request in accordance with state and federal laws. The Policy indicated upon request to access or obtain copies of the medical record, the Facility should review the authorization to ascertain access rights of that person. Authority to access or release records is only granted by the resident or the resident's legal representative. A valid request for medical information concerning a resident, by a party other than the resident, included the following: name of resident, name and address of individual or organization requesting information, specific information and reports requested, period of stay for which information is to be released, date of request and signature of the resident or legally appointed representative authorizing release of information. The corporate office/risk manager should be notified of the request for records. The Policy indicated that records should not be released prior to discussion with corporate office/risk manager in order to further validate authenticity of the request. The Policy indicated access rights to medical information state the resident or his/her legal representative may receive a copy of his/her medical record within two working days after the request has been made. Review of the Facility's Authorization For Release of Information form, dated as revised in December 2010, indicated it included a request for the Patient/Legal Representatives Signature, and that he/she had carefully read and understood the above and do herein expressly and voluntarily consent to disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above. The form also included this statement I further release physicians, nursing home, and its employees from any liability arising from the said release of information. Resident #1's clinical record contained a Health Care Proxy form which indicated Family Member #1 was his/her Health Care Agent (HCA) and the Health Care Proxy was activated in July 2022, due to moderate to severe dementia. (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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Progress Note, dated 06/14/24 at 4:36 P.M., written by the Assistant Director of Nurses indicated his/her HCA requested a copy of lab results that were in the medical record from a staff nurse, the medical record release form was left at the nurses station to be completed by the HCA and oncoming staff were made aware. Review of Grievance Form, dated 09/10/24, indicated Resident #1's HCA has requested laboratory result multiple times in writing. The Grievance Form follow-up indicated the HCA has been informed that the Facility will review and release any record with a signed consent for release form for the medical record. Review of an Email, dated 09/10/24 at 3:15 P.M., sent from the HCA to the Director of Nurses indicated as the HCA, she repeatedly requested in writing Resident #1's test results of lab work performed early last week. The Email indicated the results have not been provided. Review of an Email, dated 09/11/24 at 9:02 A.M., sent from the HCA to the Director of Nurses indicated Resident #1's Health Care Proxy was activated and as his/her HCA, she wanted a copy of Resident #1's medical record lab results immediately. The Email indicated that she (HCA) had written over 20 requests asking for these documents, that were refused to be provided. The Email indicated that the HCA would not sign a liability release indicating that she would not sue. During a telephone interview on 10/02/24 at 10:25 A.M., Resident #1's HCA said that she has requested copies of documentation from Resident #1's clinical record verbally and through emails since January 2024 and has not received the documentation requested. The HCA said requests were made to the Medical Records Coordinator, the Director of Nurses and Nursing Supervisor. The HCA said since May 2024, she had made approximately 10 requests for copies of tests results and medical record information and her requests were denied. The HCA said she has not received the documentation to date because she refused to sign the Authorization For Release of Information form. The HCA said although she had signed this form in the past, said she decided not to sign the form on these occasions as it indicated that by signing it, it would release the Facility from any liability. During an interview on 10/02/24 at 2:10 P.M., the Medical Records Coordinator said the former Administrator told her not to release medical record information unless the Authorization For Release Of Information form was signed. The Medical Records Coordinator said over the past year, on at least three occasions (exact dates unknown), the HCA asked her for a copy of Resident #1's medical record. The Medical Records Coordinator said the HCA did not want to sign the release form and therefore the information was not provided. The Medical Records Coordinator said she told the HCA she was unable to provide her with copies of Resident #1's medical record unless she signed the Authorization For Release Of Information form. The Medical Records Coordinator said she suggested as an alternative that the HCA's attorney could document something indicating there was a request for a copy of Resident #1's medical records, however neither were provided. During a telephone interview on 10/03/24 at 1:40 P.M., the Nursing Supervisor said during the end of August 2024 (exact dates unknown), the HCA asked for a copy of Resident #1's laboratory results. The Nursing Supervisor said she showed the HCA the results, but said, however a copy was not provided as requested since the HCA refused to sign the Authorization For Release Of Information form. (continued on next page)

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/02/24 at 4:45 P.M., the Assistant Director of Nursing (ADON) said approximately one month ago, the HCA asked her for a copy of Resident #1's current laboratory results. The ADON said the HCA was not provided it since she would not sign the release form. During in-person interviews on 10/02/24 at 10:45 A.M. and at 3:40 P.M. and follow-up a telephone interview on 10/03/24 at 2:35 P.M., the Director of Nurses (DON) said it was the Facility's Policy for residents, legal representative, or HCA, to sign the release form to obtain copies of a resident's medical record. The DON said if an individual is uncomfortable signing the Authorization for Release of Information due to the last sentence referring to release of liability, she would need to talk to her superiors. The DON said Resident #1's HCA has asked staff members including herself, the ADON, the Medical Records Coordinator, and the Nursing Supervisor for copies of Resident #1's medical record. The DON said the requests were made verbally and through numerous emails. The DON said although medical information had been reviewed with the HCA, she refused to sign the Authorization For Release Of Information and as a result the copies of the medical record documents were not provided. The DON said although it was a universal form used to also request releasing medical information to entities outside of the facility, said the HCA misunderstood that by signing the release form it prevented her from exercising a right to sue the Facility. The DON said the Facility owner spoke with their legal department and emailed the HCA yesterday (10/01/24) offering to send the medical records requested without referencing the need for a signed release form.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 15024 Based on interviews and records reviewed, for three of three sampled residents (Resident #1, #2, and #3), the Facility failed to ensure that at the time of their discharges, that the residents, their legal representative(s) or Health Care Agents (HCA) were provided with Notice of Intent to Discharge: that was complete, and included all pages of the notice, with necessary information to file an appeal, in accordance with federal regulations and per facility policy. Findings include: The Facility Transfer and Discharge Policy, dated as revised in February 2023, indicated that the notice will be provided to the resident and the resident's representative which will include all of the following at the time it is provided: a. The specific reason and basis for transfer or discharge. b. The effective date of transfer or discharge. c. The specific location to which the resident is to be transferred or discharged . d. An explanation of the right to appeal the transfer or discharge to the State. e. The name, address (mailing and email) and telephone number of the State entity which receives such hearing requests. f. Information on how to obtain an appeal form. g. Information on obtaining assistance in completing and submitting the appeal hearing request. h. The name, address (mailing and email), and phone number of the representative of the Office of the State Long-Term Care Ombudsman. i. For nursing facility residents with intellectual and developmental disabilities (or related disabilities) or with mental illness (or related disabilities), the notice will include the name, mailing and email addresses and phone number of the state agency responsible for the protection and advocacy of these populations. Review of the Facility's Notice of Intent to Transfer or Discharge Resident with Expedited Appeal indicated that page one contained the information noted in the Policy as section a, b and c. Page two and page three contained the remaining portions of information noted as d, e, f, g, h and i. 1) Resident #1's clinical record contained a Health Care Proxy form which indicated Family Member #1 was his/her Health Care Agent (HCA) and the Health Care Proxy was activated in July 2022 due to moderate to severe dementia. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Progress Notes, dated 09/12/24 at 1:45 P.M. and 2:51 P.M., indicated his/her Health Care Agent (HCA) initiated an emergency transfer of Resident #1 to the hospital, where he/she was sent for the assessment of his/her arm. During an interview on 10/02/24 at 4:45 P.M., the Assistant Director of Nurses (ADON) said she completed and sent Resident #1's Notice of Intent to Transfer or Discharge Resident with Expedited Appeal dated 09/12/24 to the Hospital emergency room and left a copy in Resident #1's medical record. The ADON said at that time she was unaware that the Notice contained a total of three pages, and that the remainder of the information was required and missing. The ADON said there was only one page of the Notice available on the unit, and that she did not send or provide page #2 and #3, at the time of discharge. During an interview on 10/02/24 at 3:40 P.M., the Director of Nurses (DON) said on 09/12/24 after the HCA initiated Resident #1's transfer to the Hospital, the facility held a team meeting and decided Resident #1 was to be discharged to the Hospital. The DON said the HCA was informed of the discharge by email. The DON said on 09/13/24 she (the DON) mailed the copy of the Notice of Intent to Transfer or Discharge Resident with Expedited Appeal that was completed by the ADON, to the HCA. The DON said unfortunately she (did not realize that the two additional pages (#2 and #3)were excluded until she had a conversation with the Ombudsman Program Manager on 09/16/24, and subsequently mailed the last two pages to the HCA. 2) Review of Resident #2's clinical record indicated his/her Health Care Proxy was not invoked. Review of Resident #2's Progress note, dated 09/15/24 at 7:39 A.M., indicated he/she was sent to the hospital emergency room , where he/she was admitted . Review of Resident #2's clinical record indicated the copy of the Notice of Intent to Transfer or Discharge Resident with Expedited Appeal did not contain the date and location of where Resident #1 was being transferred/discharged to on page one, and there was no record that page #2 and #3 were completed and issued. 3) Review of Resident #3's clinical record indicated on the date of transfer/discharge to the hospital, his/her Health Care Proxy was not invoked. Review of Resident #3's Progress Note, dated 09/03/24 at 11:17 A.M., indicated he/she was sent to the hospital emergency room , where he/she was admitted . Review of Resident #3's clinical record indicated although page one's copy of the Notice of Intent to Transfer or Discharge Resident with Expedited Appeal was completed, there was no record that page #2 and #3 were completed and issued. The DON said after her conversation with the Ombudsman Program Manager on 09/16/24, it was discovered that the blank copies of the Notice of Intent to Transfer or Discharge Resident with Expedited Appeal kept on the Unit for completion by nursing staff did not include all three pages, and other residents issued the notice, such as Resident #2 and Resident #3, also had not received page two and page three.