STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225394	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woburn Rehabilitation and Nursing Center	18 Frances Street, #3095 Woburn, MA 01801

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 43963 Based on records reviewed and interviews for one of ten sampled residents (Resident #3), who had experienced a significant change with a decline in medical status, the Facility failed to ensure Resident #3's physician was notified of the change which included the development of a new pressure injury and need for change in treatment. Findings include: Review of the Facility Policy titled, Notification of Changes, dated as last revised 02/2023, indicated that the facility will promptly notify the resident, consult the resident's physician, and notifies, consistent with his/her authority, the resident's representative when there is a change requiring notification. Resident #3 was admitted to the Facility in February 2024, diagnoses included Alzheimer's type dementia, peripheral vascular disease (PVD), congestive heart failure (CHF), chronic kidney disease, and amyloidosis (ATTR, a rare disease that occurs when a protein called amyloid builds up in organs and can make organs not work properly). Review of Resident #3's Nurse Progress Note, dated 05/17/24, indicated he/she had become lethargic and had been complaining of left leg pain and sent out to the Hospital Emergency Department for evaluation. Review of Resident #3's Nurse Progress Note, dated 05/20/24, indicated that upon readmission to the facility he/she had a suspected deep tissue injury (DTI, purple or maroon area of discolored intact skin due to damage of underlying soft tissue) to his/her intergluteal cleft, as well as to his/her right buttocks. The Progress Note further indicated that there were no new orders. Review of Resident #3's Weekly Skin Assessment, dated 05/21/24, indicated that an open area had been identified on his/her left buttocks and coccyx areas, treatment applied. However, review of Resident #3's Physicians orders and Treatment Administration Record (TAR) indicated there was no documentation to support that the Physician was notified that Resident #3 had a DTI, and that treatment orders were obtained by nursing upon readmission to the facility. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3's Weekly Skin Assessment, dated 06/07/24, indicated he/she had sacral and coccyx areas with ongoing wounds and treatments were in place. However, review of Resident #3's TAR indicated there were no physician's orders written for treatments to his/her buttocks/coccyx in place. Review of an additional Skin Assessment completed on Resident #3, dated 06/09/24, indicated his/her right buttock had a necrotic peri wound and his/her sacrum had an open wound without drainage. Review of Resident #3's Nurse Progress Note, dated 06/09/24, indicated he/she had a Stage 3 (full thickness tissue loss) to his/her right buttocks measuring 4 centimeters (cm) by 5 cm with small scattered small areas to his/her coccyx. Review of Resident #3's Medical Record, including but not limited to Physician Progress Notes, Physician Orders and Nurse Progress Notes, indicated there was no documentation to support nursing staff had notified or updated his/her providers of the development of his/her new sacral pressure injury (that was documented by nursing upon his/her readmission on 5/20/24, to the facility). During a telephone interview on 08/01/24 at 2:33 P.M., Nurse #1 said that she had not known that Resident #3's Physician was unaware of his/her new area to his/her sacrum and said if a nurse documents that a resident has a fragile coccyx, the nurse should inform the physician so they can provide an order for treatment. During a telephone interview on 08/01/24 at 12:39 P.M., the Nurse Supervisor said that she was aware that Resident #3 had multiple skin issues. The Nurse Supervisor said she does not remember calling the Resident #3's physician for any treatment orders and said that once a new skin area is discovered on a resident, the physician must be notified immediately to ensure that the nurse obtains an order for treatment. During an interview on 07/24/24 at 2:18 P.M., the Director of Nurses (DON) said that she was not aware of the new pressure area found on Resident #3's sacrum. The DON said that it is the Facility's expectation that once any abnormal skin area is identified on any resident the nurse is to notify their physician immediately to ensure that they are made aware of the new area, and so the physician can provide an intervention or treatment order for the area in a timely manner.

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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. 43963 Based on records reviewed and interviews for five of ten sampled residents' (Resident #1, #2, #3, #4, and #5) who were all assessed as being a high risk for developing a pressure injury or had an existing pressure injury upon admission, the Facility failed to ensure nursing staff provided care and services that met professional standards of practice related to timely follow up on recommendations, regarding preventative skin care, and obtaining medication and/or treatment orders. Findings include: Review of the Facility Policy titled, Pressure Injury Prevention and Management, dated as last revised 02/2023, indicated that the facility is committed to the prevention of avoidable pressure injuries and to provide treatment and services to heal the pressure injury, prevent infection, and the development of additional pressure injuries. The Policy also indicated the following; -Basic or routine care interventions could include, but not limited to redistribute pressure (repositioning, protecting and/or offloading heels etc.); minimize exposure to moisture and keep skin clean, especially of fecal contamination; provide appropriate, pressure redistributing support surfaces; provide non-irritating surfaces; and maintain or improve nutrition and hydration status. -The Unit Manager/designee will review all relevant documentation regarding skin assessments, risks, progression towards healing and compliance at least weekly, and document findings in the medical record; and -The attending physician will be notified of the presence of a new pressure injury upon identification, the progression towards healing, or lack of healing, of any pressure injuries weekly, and any complications as needed. 1) Resident #1 was admitted to the Facility in May 2024, diagnoses included Parkinson's Disease, Multiple System Atrophy (MSA, a rare degenerative neurological disorder affecting your body's involuntary functions), respiratory failure, diabetes mellitus, and an unstageable (slough or eschar covering the wound bed and unable to determine stage) pressure injury to his/her sacrum (base of the lumbar vertebrae and connected to the pelvis). Review of Resident #1's Admission Skin Assessment, dated 05/05/24, a stage three (full thickness tissue loss) pressure injuries had been identified to his/her sacrum and to his/her gluteal fold. Review of Resident #1's Norton Scale for Predicting Risk of Pressure Ulcer, dated 05/05/24, indicated he/she had a score of 11, placing him/her at moderate risk for developing pressure injuries (Low Risk 16-20, Moderate Risk 11-15, and High Risk 0-10). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's Nutrition Assessment, dated 05/09/24, indicated that the Registered Dietician (RD) recommended he/she be administered Vitamin C 500 milligrams (mg) by mouth daily, Zinc Sulfate 220 mg by mouth daily, and Liquid Protein 30 milliliters (ml) by mouth daily, to assist with the healing of his/her skin. Review of Resident #1's Physician's Order, dated 05/14/24, indicated to administer; - Liquid protein Oral Liquid, give 30 ml by mouth one time daily for wound healing; -Vitamin C Tablet, give 500 mg by mouth one time a day; and -Zinc Sulfate 220 mg, give one tablet by mouth one time a day. However Physician's Orders were not obtained until five (5) days after the RD recommended the additional vitamins and supplements for Resident #1 to help promote healing of his/her pressure injuries. During a telephone interview on 08/01/24 at 2:08 P.M., the Registered Dietician said that she puts any recommendations for residents that she makes directly into Point Click Care (PCC, the Facility's electronic medical record). The RD said that once her recommendations for a resident are entered into PCC a Nurse must notify the Physician and review the recommendations for approval, obtain an order, and then enter the order into PCC for whichever recommendations had been approved. The RD said she was unaware that Resident #1 dietary recommendations went un-addressed 5 days before being clarified with his/her Physician. Review of Resident #1's Wound Care Progress Note (written by the Wound Physician Assistant, PA), dated 05/13/24, indicated to apply Calcium Alginate (highly absorbent dressing made of calcium alginate creating a comfortable gel when in contact with drainage and keeps a moist wound environment) dressing to sacral wound, cover with bordered foam dressing, change twice daily and as needed. Review of Resident #1's Medical Record, for May 2024, including but not limited to, Medication Administration Records (MAR), Treatment Administration Records (TAR), Physician's Orders, and Nurse Progress Notes, indicated there was no documentation to support Nursing staff obtained a physician's order to change the dressing order as recommended by the Wound PA. During an interview on 07/24/24 at 11:46 A.M., the Unit Manager said she was unaware that there were any dietary or wound care recommendations that had been missed for Resident #1. The Unit Manager said if she had been aware of the recommendations, she would have followed through and would have called the Physician to review the recommendations and obtained new orders needed. During a telephone interview on 08/01/24 at 4:51 P.M., the Director of Nurses said that she was unaware that Resident #1's dietary or wound recommendation went un-addressed for several days prior to being confirmed with his/her Physician. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) Resident #2 was admitted to the Facility in May 2024, diagnoses included diabetes mellitus, congestive heart failure, status post fall suffering a subdural hematoma (a pool of blood between the brain and the outermost covering) and subarachnoid hemorrhage (bleeding in the space between the brain and the tissues covering the brain), and an unstageable pressure injury to his/her right heel. Review of Resident #2's Admission Skin Assessment, dated 05/02/24, indicated his/her coccyx was discolored and pink, right heel was blanchable, boggy (an indication of tissue injury), with a scab noted; and left heel was boggy. Review of Resident #2's Norton Scale for Predicting Risk of Pressure Ulcer, dated 05/02/ 24, indicated he/she had a score of 7, placing him/her at high risk for developing pressure injuries (Low Risk 16-20, Moderate Risk 11-15, and High Risk 0-10). Review of Resident #2's Wound Care Progress Note (written by the Wound PA), dated 05/13/24, indicated he/she had a diabetic foot ulcer (full thickness wound) to his/her right heel and Moisture Associated Skin Damage (MASD, caused by prolonged exposure to various sources of moisture) to his/her right buttocks. The PA's Wound Note also indicated there was a recommendation to elevate his/her lower extremities. Review of Resident #2's Physician's Orders, dated 05/24/24, indicated to offload his/her right foot when in bed or chair. However, this order was not obtained or implemented until eleven (11) days after the recommendation had been made by the Wound PA. During an interview on 07/24/24 at 11:46 A.M., the Unit Manager said she was unaware that wound care recommendations were missed for Resident #2 and said if she had been aware of the recommendations she would have followed through. The Unit Manager said she would have called the Physician to review the recommendations and obtained new orders, as needed. 3)Resident #3 was admitted to the Facility in February 2024, diagnoses included Alzheimer's type dementia, peripheral vascular disease (PVD), congestive heart failure (CHF), chronic kidney disease, and amyloidosis (ATTR, a rare disease that occurs when a protein called amyloid builds up in organs and can make organs not work properly). Review of Resident #3's Wound Care Progress Note, dated 03/25/24 (written by the Wound Physician's Assistant, PA), indicated that there were only neuropathic ulcers to his/her left second toe and arterial ulcers to bilateral heels. The Wound Noted further indicated to provide soft heel boots to both heels to improve heel offloading. However, this order was not obtained until 07/03/24, more than three months after the original recommendation was made by the Wound PA. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/24/24 at 11:46 A.M., the Unit Manager said she was unaware that wound care recommendations were missed for Resident #3 and said if she had been aware of the recommendations she would have followed through. The Unit Manager said she would have called the Physician to review the recommendations and obtained new orders, as needed. 4) Resident #4 was admitted to the Facility in April 2024, diagnoses include status post fall with a right hip fracture, anemia, malnutrition, and anxiety. Review of Resident #4's Norton Scale for Predicting Risk of Pressure Ulcer, dated 04/30/ 24, indicated he/she had a score of 6, placing him/her at high risk for developing pressure ulcers (Low Risk 16-20, Moderate Risk 11-15, and High Risk 0-10). Review of Resident #4's Hospital Discharge Summary, dated 04/22/24, indicated to apply offloading booties to both heels and that his/her coccyx was slow to blanch (normal blood flow to a given area does not return promptly). Review of Resident #4's Wound Care Progress Note (written by the Wound PA), dated 05/13/24, indicated he/she had a Stage 2 (partial thickness loss of dermis) pressure injury to his/her right heel, with a recommendation to apply soft heel boots to improve offloading. Review of Resident #4's Nutrition Progress Note, dated 05/15/24, indicated he/she MASD to his/her sacrum and he/she had a right heel pressure injury. Review of Resident #4's Physician's Orders, dated 06/07/24, indicated to apply soft heel booties while resident is in bed, remove and check skin integrity during care. However this order was not obtained by nursing staff until twenty-five (25) days after wound care recommendation was originally made by the Wound Care PA. The Hospital Discharge Summary recommendation to apply offloading booties was not implemented until 46 days after Resident #4's admission. During a telephone interview on 08/01/24 at 12:04 P.M., the Former DON said that all impaired skin (including boggy heels) should be reported to the resident's physician immediately so that they are aware of any skin areas and for orders for preventative skin interventions as needed, to help prevent additional breakdown. During a telephone interview on 08/01/24 at 4:51 P.M., the Former Assistant Director of Nurses (ADON) said that upon admission if any abnormal areas are found during the resident's skin assessment, the nurse is to inform the resident's physician, obtain any orders until other disciplines such as dietary and Wound Team could assess the resident and make their own recommendations. During a telephone interview on 08/01/24 at 4:51 P.M., the Director of Nurses said that she was unaware that Resident #4's Hospital Discharge Summary (4/22/24) recommended to provide offloading booties to both heels and that the Wound PA had recommended the offloading booties (05/13/24). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON said that she was unaware that Resident #4's Admission Skin Assessment had indicated that he/she had boggy heels and at that time. The DON said that the nurse who identified the areas should have informed his/her physician upon admission and obtained preventative orders at that time. 5) Resident #5 was admitted to the Facility in April 2024, diagnoses include cerebral vascular accident (CVA), Parkinson's Disease, aphasia (language disorder that affects a person's ability to communicate), and dementia. Review of Resident #5's Norton Scale for Predicting Risk of Pressure Ulcer, dated 04/19/ 24, indicated he/she had a score of 3, which placed him/her at high risk for developing pressure injuries (Low Risk 16-20, Moderate Risk 11-15, and High Risk 0-10). Review of Resident #5's Initial Wound Care Progress Note, (written by the Wound PA), dated 04/22/24, indicated he/she had MASD to his/her right buttocks, left buttocks, and sacrum. The PA's Wound Note indicated to apply Calcium Alginate and foam to the right buttocks, left buttocks, and sacrum wounds to be changed daily and as needed. Review of Resident #5's Physician's Order, dated 04/22/24, indicated to apply Calcium Alginate and foam to the right buttocks, left buttocks, and sacrum wounds to be changed daily and as needed. Review of Resident #5's PA Wound Care Progress Note, dated 05/06/24, indicated he/she had MASD to his/her right buttocks and an unstageable deep tissues injury to his/her sacrum. The PA's Wound Note indicated to apply Calcium Alginate and foam to the right buttocks and sacral wounds, to be changed twice daily and as needed. Review of Resident #5's PA's Wound Care Progress Note, dated 05/13/24, indicated he/she had MASD to his/her right buttocks and a Stage 3 (full thickness tissue loss) pressure injury to his/her sacrum. The PA's Wound Note indicated to apply Calcium Alginate and foam to the right buttocks and sacral wounds, to be changed twice daily and as needed. Review of Resident#5's Nurse Progress Note, dated 05/13/24, indicated he/she had been seen by the Wound PA and to continue the current dressing treatment orders to both wounds. Review of Resident #5's Physician's Order, dated 05/14/24, indicated to apply Calcium Alginate and foam to the right buttocks, left buttocks, and sacrum wounds, change twice a day and as needed. However this was nine (9) days after the Wound PA recommended to change the treatment order from a daily dressing, to the dressing being changed twice a day. During an interview on 07/24/24 at 11:46 A.M., the Unit Manager said she was unaware that any of the PA's wound care recommendations were missed for Resident #5. The Unit Manager said if she had been aware of the recommendations she would have followed through and said she would have called the Physician to review the recommendations and obtained any orders as needed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 08/01/24, the Former ADON said that she had been responsible to accompany the Wound PA on wound rounds weekly and said that if she was unable to inform the resident's physician's, she would review recommendations and provide them to the Unit Manager or Staff Nurse so they could notify the physician and obtain any orders needed. During a telephone interview on 08/01/24 at 4:51 P.M., the Director of Nurses said that she was unaware that Resident #5's wound recommendation went days prior to being confirmed with his/her Physician. The DON said it is the Facility's expectation that all recommendations given by any provider be reviewed with the resident's attending physician as soon as they are received and all abnormal skin, including but not limited pressure injuries, be reported to the resident physician immediately.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 43963 Based on records reviewed and interviews for five of ten sampled residents (Resident #1,#2, #3, #4, and #5), who all required physical assistance of one to two staff members with Activities of Daily Living (ADL) and positioning, and (Resident #3, who also required new treatment orders for newly diagnosed pressure injury) the facility failed to ensure they maintained complete and accurate medical records, related to Certified Nurse Aide (CNA) ADL Flow Sheets and Positioning Sheets and when daily documentation by CNA's (for all three shifts) were not consistently completed, with flow sheets often left blank and for Resident #3, although nursing noted treatments were in place for his/her buttock/coccyx wound, there were no physician's orders on his/her Treatment Administration Record (TAR) in place, or nursing documenation specifically related to wound care for these areas. Findings include: Based on the Facility Policy titled, Documentation in Medical Record, dated as last revised 02/2023, indicated that the resident's medical record shall contain an accurate representation of the actual experiences of the resident and progress through complete, accurate, and timely documentation. The Policy indicated the following; -Licensed staff shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy; -Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred; and -Documentation is performed manually or as per the facility's specific electronic medical record software program. 1) Resident #1 was admitted to the Facility in May 2024, diagnoses included Parkinson's Disease, Multiple System Atrophy (MSA, a rare degenerative neurological disorder affecting your body's involuntary functions), respiratory failure, diabetes mellitus, and an unstageable (slough or eschar covering the wound bed and unable to determine stage) pressure injury. Review of Resident #1's Admission Minimum Data Set (MDS) Assessment, dated 05/12/24, indicated he/she requires various levels of assistance with his/her ADL's, including but not limited to bathing, dressing, grooming, transfers, bed mobility, toileting and positioning every two hours. Review of Resident #1's Care Plan, titled ADL-Self-Care Deficit, dated 05/06/24, indicated he/she required varying levels of physical assistance with his/her care needs. Review of Resident #1's Documentation Survey Report (ADL Flow Sheets), dated from 05/05/24 through 05/31/24, indicated that for the following shifts, documentation on the flow sheets was incomplete; -7:00 A.M. to 3:00 P.M.-14 days (out of 27) all ADL care areas were left blank. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-3:00 P.M. to 11:00 P.M.-8 days (out of 27) all ADL care areas were left blank. -11:00 P.M. to 7:00 A.M.-21 days (out of 27) all ADL care areas were left blank. Review of Resident #1's Documentation Survey Report (ADL Flow Sheets), dated from 06/01/24 through 06/07/24, indicated that for the following shifts, documentation on the flow sheets was incomplete; -7:00 A.M. to 3:00 P.M.-2 days (out of 7) all ADL care areas were left blank. -3:00 P.M. to 11:00 P.M.-4 days (out of 7) all ADL care areas were left blank. -11:00 P.M. to 7:00 A.M.-5 days (out of 6) all ADL care areas were left blank. 2) Resident #2 was admitted to the Facility in May 2024, diagnoses included diabetes mellitus, congestive heart failure, status post fall suffering a subdural hematoma (a pool of blood between the brain and the outermost covering) and subarachnoid hemorrhage (bleeding in the space between the brain and the tissues covering the brain), and an unstageable pressure injury to his/her right heel. Review of Resident #2's Admission Minimum Data Set (MDS) Assessment, dated 05/08/24, indicated he/she requires various levels of assistance with his/her ADL's, including but not limited to bathing, dressing, grooming, transfers, bed mobility, toileting and turning and positioning every two hours. Review of Resident #2's Care Plan, titled ADL-Self-Care Deficit, dated 05/13/24, indicated he/she required varying levels of physical assistance with his/her care needs. Review of Resident #2's ADL Flow Sheets, dated from 05/02/24 through 05/31/24, indicated that for the following shifts, documentation on the flow sheets was incomplete; -7:00 A.M. to 3:00 P.M.-16 days (out of 29) all ADL care areas were left blank. -3:00 P.M. to 11:00 P.M.-9 days (out of 30) all ADL care areas were left blank. -11:00 P.M. to 7:00 A.M.-22 days (out of 30) all ADL care areas were left blank. 3) A. Resident #3 was admitted to the Facility in February 2024, diagnoses included Alzheimer's type dementia, peripheral vascular disease (PVD), congestive heart failure (CHF), chronic kidney disease, and amyloidosis (ATTR, a rare disease that occurs when a protein called amyloid builds up in organs and can make organs not work properly). Review of Resident #3's Quarterly Minimum Data Set (MDS) Assessment, dated 05/26/24, indicated he/she requires various levels of assistance with his/her ADL's, including but not limited to bathing, dressing, grooming, transfers, bed mobility, toileting and positioning every two hours. Review of Resident #3's Care Plan, titled ADL-Self-Care Deficit, dated 04/08/24, indicated he/she required varying levels of physical assistance with his/her care needs. Review of Resident #3's ADL Flow Sheets, dated 05/01/24 through 05/31/24, indicated that for the following shifts, documentation on the flow sheets was incomplete; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-7:00 A.M. to 3:00 P.M.-14 days (out of 31) all ADL care areas were left blank. -3:00 P.M. to 11:00 P.M.-11 days (out of 31) all ADL care areas were left blank. -11:00 P.M. to 7:00 A.M.-24 days (out of 31) all ADL care areas were left blank. B) Review of Resident #3's Nurse Progress Note, dated 05/20/24, indicated that upon readmission to the facility he/she had a suspected deep tissue injury (DTI, purple or maroon area of discolored intact skin due to damage of underlying soft tissue) to his/her intergluteal cleft, as well as to his/her right buttocks. The Progress Note further indicated that there were no new orders. Review of Resident #3's Weekly Skin Assessment, dated 05/21/24, indicated he/she had an open area to his/her left buttocks/coccyx area, and that the nurse applied a treatment. Review of Resident #3's Weekly Skin Assessment, dated 06/07/24, indicated he/she had sacral and coccyx areas (of skin breakdown) with ongoing wounds and indicated treatments were in place. Review of an additional Skin Assessment completed on Resident #3, dated 06/09/24, indicated his/her right buttock had a necrotic peri-wound and his/her sacrum had an open wound without drainage. Review of Resident #3's Nurse Progress Note, dated 06/09/24, indicated he/she had a Stage 3 (full thickness tissue loss, subcutaneous fat may be visible) pressure injury to his/her right buttocks measuring 4 centimeters (cm) by 5 cm, with several scattered small open areas to his/her coccyx. Review of Resident #3's Medical Record, from 5/20/24 through 6/10/24, including but not limited to Physician's Orders, Physician's Progress Notes, Medication Administration Record (MAR), Treatment Administration Record (TAR), and Nurse Progress Notes, indicated that although he/she returned to the facility after a hospitalization with a noted DTI, there was no documentation to support nursing obtained new physician's orders for treatments or documented wound care that was provided to the new wound areas. During a telephone interview on 08/01/24 at 2:33 P.M., Nurse #1 said that she had not known that Resident #3's provider was unaware of his/her new area of skin breakdown on his/her sacrum. Nurse #1 said if a nurse documented that a resident has a DTI, that the nurse should have also informed the provider so they can provide an order to treat the newly identified area. During a telephone interview on 08/01/24 at 12:39 P.M., the Nurse Supervisor said that she was aware that Resident #3 had multiple skin issues and recalled he/she had a stage one (observable, pressure-related alteration of intact skin with non-blanchable redness of a localized area, usually over a bony prominence) pressure injury to his/her bottom. The Nurse Supervisor said she does not remember calling the provider for an order for a treatment and said that once a new area is discovered on a resident the provider must be notified by nursing immediately to ensure that they obtain an order to treat the new area. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225394	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woburn Rehabilitation and Nursing Center	18 Frances Street, #3095 Woburn, MA 01801

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/24/24 at 2:18 P.M., the Director of Nurses (DON), said that she was not aware of the new pressure areas found on Resident #3's sacrum upon readmission. The DON said that is the Facility's expectation that a full head to toe assessment be completed upon admission and readmission, the nurse is to notify the physician of any abnormal skin findings, and the nurse should obtain any new orders to treat the skin to maximize healing, reduce risk for worsening areas, and prevent additional skin areas. 4) Resident #4 was admitted to the Facility in April 2024, diagnoses included status post fall and a right hip fracture, anemia, malnutrition, and anxiety. Review of Resident #4's Admission Minimum Data Set (MDS) Assessment, dated 04/24/24, indicated he she requires various levels of assistance with his/her ADL's, including but not limited to bathing, dressing, grooming, transfers, bed mobility, toileting, and turning and positioning every two hours. Review of Resident #4's Care Plan, titled ADL-Self-Care Deficit, dated 04/23/24, indicated he/she required varying levels of physical assistance with his/her care needs. Review of Resident #4's ADL Flow Sheets, dated 05/01/24 through 05/31/24, indicated that for the following shifts, documentation on the flow sheets was incomplete; -7:00 A.M. to 3:00 P.M.-7 days (out of 31) all ADL care areas were left blank. -3:00 P.M. to 11:00 P.M.-3 days (out of 31) all ADL care areas were left blank. -11:00 P.M. to 7:00 A.M.-24 days (out of 31) all ADL care areas were left blank. Review of Resident #4's ADL Flow Sheets, dated 06/01/24 through 06/11/24, indicated that for the following shifts, documentation on the flow sheets were incomplete; -7:00 A.M. to 3:00 P.M.-1 days (out of 11) all ADL care areas were left blank. -3:00 P.M. to 11:00 P.M.-3 days (out of 11) all ADL care areas were left blank. -11:00 P.M. to 7:00 A.M.-9 days (out of 11) all ADL care areas were left blank. 5) Resident #5 was admitted to the Facility in April 2024, diagnoses included cerebral vascular accident (CVA), Parkinson's Disease, aphasia language disorder that affects a person's ability to communicate), and dementia. Review of Resident #5's Admission Minimum Data Set (MDS) Assessment, dated 04/25/24, indicated he she requires various levels of assistance with his/her ADL's, including but not limited to bathing, dressing, grooming, transfers, bed mobility, toileting and turning and positioning every two hours. Review of Resident #5's Care Plan, titled ADL-Self-Care Deficit, dated 04/19/24, indicated he/she required varying levels of physical assistance with his/her care needs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225394	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woburn Rehabilitation and Nursing Center	18 Frances Street, #3095 Woburn, MA 01801

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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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #5's ADL Flow Sheets, dated 05/01/24 through 05/31/24, 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 31) all ADL care areas were left blank. -3:00 P.M. to 11:00 P.M.-9 days (out of 31) all ADL care areas were left blank. -11:00 P.M. to 7:00 A.M.-8 days (out of 31) all ADL care areas were left blank. Review of Resident #5's ADL Flow Sheets, dated 06/01/24 through 06/30/24, indicated that for the following shifts, documentation on the flow sheets was incomplete; -7:00 A.M. to 3:00 P.M.-14 days (out of 30) all ADL care areas were left blank. -3:00 P.M. to 11:00 P.M.-7 days (out of 30) all ADL care areas were left blank. -11:00 P.M. to 7:00 A.M.-19 days (out of 30) all ADL care areas were left blank. During an interview on 07/24/24 at 10:45 A.M., Certified Nurse Aide (CNA) #5 said daily documentation for each resident is very difficult to complete, that if she completes the ADL documentation for the shift then she does not have time for a break and if she takes a break then the ADL documentation does not get completed. During a telephone interview on 07/30/24 at 1:35 P.M., CNA #6 said that daily ADL documentation had been difficult to complete and said she was not always able to complete ADL documentation daily. During a telephone interview on 08/01/24 at 1:53 P.M., the Unit Manager said incomplete ADL documentation by the CNA's is not a new issue and said there are still some agency CNA's that do not complete their ADL documentation as required. The Unit Manager said that it is the Facility's expectation for all CNA ADL documentation to be completed daily before the CNA ends their shift. During a telephone interview on 08/01/24 at 4:51 P.M., the Former Assistant Director of Nurses (ADON) said that CNA ADL daily documentation had been an issue for the four years that she had been there. The Former ADON said that it is the Facility's expectation that all CNA ADL daily documentation be completed prior to the CNA leaving after their shift. During a telephone interview on 08/01/24 at 2:28 P.M., the Director of Nurses (DON) said that CNA ADL documentation is a known issue and said that it is the Facility's expectation that all CNA documentation be completed upon the completion of their shift.