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	01/09/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on observation, record review and interview, the facility failed to provide a dignified existence and self determination. Specifically, the facility failed to: 1. Ensure staff did not utilize resident rooms for personal storage for one Resident (#32) out of a total of 29 sampled residents. 2. Attempt to accommodate one Resident (#16)'s, who is his/her own person, desire to attend the senior center, out of a total of 29 sampled Residents. 3. Provide a dignified dining experience in one unit dining room. Findings include: Review of the facility's policy Promoting/Maintaining Resident Dignity, dated May 2022 indicted: It is the practice of this facility to protect and promote resident weights and treat each resident with respect and dignity as well as care for reach resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. 1. Resident #32 was admitted to the facility in January 2017 with diagnoses including Alzheimer's disease and vascular dementia. Review of the Minimum Data Set Assessment, dated 11/21/24, indicated Resident #32 is severely cognitively impaired evidenced by a score of 6 out of a possible 15 on the Brief Interview for Mental Status Exam (BIMS). On 1/6/25 at 7:36 A.M., the surveyor observed Resident #32 asleep in his/her bed. There was a black backpack on a towel on chair next to the bed. On 1/6/25 at 12:07 P.M., the surveyor observed the black backpack on a towel on the chair next to the bed. On 1/6/25 at 1:18 P.M., the surveyor observed there was no backpack on the chair. (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

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	01/09/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/7/25 at 7:11 A.M. the surveyor observed Resident #32 resting in bed. There was a black backpack on a towel on the chair next to the bed. Resident #32 said he/she was not sure who the backpack belonged to. During an interview on 1/7/25 at 8:48 A.M., Unit Manager #1 and the surveyor observed the backpack on the chair in Resident #32's room. Unit Manager #1 said she did not know who it belonged to and that staff should not be leaving their personal items in resident rooms. During an interview on 1/8/25 at approximately 2:20 P.M., the Administrator said that she learned the backpack belonged to an employee and he should not have stored his personal effects in a resident room. 41019 2. Resident #16 was admitted in May 2024 with diagnoses including depression and anxiety. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #16 scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. Review of the medical record failed to indicate Resident #16 had an activated health care proxy (a form used to designate and individual to make choices on behalf of the resident). Review of the care plan for Resident #16 indicated Resident #16 is at risk for an altered psychosocial well-being related to adjustment to admission and grieving the loss of his/her independence in the community (initiated 5/17/24). Intervention: Follow up with responses to concerns brought up (initiated 5/17/24). During a record review of the grievance log, a grievance filed on 7/26/24 indicated the following: - A staff member submitted a grievance because Resident #16 told her that staff did not change his/her wound dressing. - Review of the investigation indicated Resident #16 was refusing care and food because he/she cannot go out for social leave to the Senior Center. - Further review of the investigation indicated that Resident #16's brother and sister in law did not want him/her to attend the senior center out of fear that Resident #16 would drink and not come back to the facility. Review of the record failed to indicate that Resident #16's wish to attend the senior center was ever accommodated or any plan was put in place to allow Resident #16 to attend the senior center. During an interview on 1/9/25 at 7:35 A.M., Resident #16 said he/she would like to go to the senior center, but he/she has been told no by staff. (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	01/09/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/9/25 at 9:03 A.M., the Administrator said Resident #16 is his/her own person and can make his/her own decisions, but does not understand why his/her health care proxy is not activated. The Administrator said the family is afraid that Resident #16 is a safety risk due to his/her drinking and potential elopement, but does acknowledge Resident #16 is his/her own person. The Administrator said Resident #16's brother offered to take him/her to the senior center and sit with Resident #16 while he/she was there, but Resident #16 did not want his/her brother to be there with him/her. The Administrator said she has not spoken with the physician about activation of Resident #16's health care proxy. During an interview on 1/9/25 at 9:46 A.M., the Social Worker said Resident #16 could not attend the senior center at the beginning of his/her admission because he/she was on their skilled benefit and could not leave the facility to remain covered. The Social Worker said after the 100 days were exhausted then family told the facility that Resident #16 is not safe to leave the building, but agreed to take Resident #16 to the senior center. The Social Worker said that this was the agreed plan, but Resident #16 did not want to go with family. The review of the record failed to indicate that any alternative plan was discussed or agreed to. During an interview on 1/9/25 at 10:05 A.M., Resident #16 said his/her mood has been down and that he/she has only gone out of the facility one time to get his/her toenails cut, but has never gone to the senior center. 3. During a lunch time observation in the C and D unit dining room on 1/8/25 at 12:36 P.M., the following was observed: - A table of six residents with only one resident eating in front of the other five residents. - A table of three residents with only one eating in front of the others. - A table with four residents with three of the residents eating while one sat waiting for their tray. The resident waiting for his/her tray asked a staff member where his/her tray was at 12:41 P.M. - At 12:40 P.M., a resident sitting at a table, with one resident eating in front of him/her, asked the surveyor where his/her tray was. - At 12:45 P.M., a staff member went to serve a juice box to one Resident and opened and touched the mouth of the straw with ungloved hands. Hand hygiene was not observed prior to touching the straw. During a breakfast service observation on 1/9/25 at 8:11 A.M. on the C and D unit dining room, the following was observed: - A table of three residents with only one eating breakfast. One of the residents asked a staff member where his/her tray was while waiting. - A table of four residents with only two eating breakfast. - A table of three residents with two eating while one sat and waiting for his/her breakfast. (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	01/09/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/9/25 at 9:20 A.M., the Administrator acknowledged that the meal time trays come at different times for each unit and because it is a shared dining room and residents sit where they would like, it is difficult to deliver the trays to residents at the same table. The Administrator said that she is bringing back a point of service dining room where the meals are served directly to the residents when ordered.

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	01/09/2025

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 41456 Based on review of the grievance log, resident group response and interviews, the facility 1) failed to ensure residents of the facility were aware of the grievance process, had access to grievance forms and 2) failed to resolve a grievance for one Resident (#35) out of a total sample of 29 residents. Findings include: 1. Resident group was held on 1/7/25 at 1:37 P.M. with 20 residents actively participating in the meeting. During the meeting, 15 out of the 20 residents said they did not know how to file a grievance, did not feel the facility resolved concerns of the residents and felt fear of retaliation from the staff if they were to complain/file a grievance at the facility. During all days of survey, the surveyor was unable to locate grievance forms on any nursing unit. During an interview on 1/8/25 at 2:46 P.M., the Administrator said she is responsible for all grievances. The Administrator said she was unaware the residents in the facility felt they did not know how to file a grievance or feared retaliation from the staff. The Administrator said the grievance forms must have been taken down off the wall when construction started, however said the forms should still be made available to the residents. During an interview on 1/9/25 at 7:11 A.M., the Director of Nursing (DON) observed the A Unit with the surveyor and noted there were no grievance forms available for the residents. The DON said the grievance forms must have been removed when construction began months ago, however said the grievance forms need to be available to the residents regardless of the construction. 2. Review of the grievance book indicated a grievance dated 1/19/24, which indicated the following grievance from Resident #35: -Detail of complaint/grievance: Resident reported to receptionist that on (his/her) was (sic) to appointment that the staff member hurt (him/her) by squeezing (his/her) hand. The tall one. I want to report her. Cannot close my hand. -Date occurred 1/19/24. -The grievance follow-up section was blank, indicating there was no follow-up or resolution to the grievance. During an interview on 1/8/25 at 2:46 P.M., the Administrator said she is responsible for all grievances and all grievances should be resolved within two days. The Administrator reviewed Resident #35's grievance and said she was not working at the time this grievance was filed; however, the grievance did not have a resolution and it should have had one.

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	01/09/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 41456 Based on record review and interviews, the facility failed to investigate allegations of potential abuse for six Residents (#35, #39, #253, #254, #255, and #256) out of a total sample of 29 residents. Findings include: Review of the facility policy titled, Abuse, Neglect and Exploitation, dated 2/203, indicated the following: -An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. -Written procedures for investigations include: -identifying staff responsible for the investigation; -exercising caution and handling evidence that could be used in a criminal investigation; -investigating different types of alleged violations; -identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; -focusing the investigation on determining if abuse, neglect, exploitation, and or mistreatment has occurred, the extent, and cause; and -providing complete and thorough documentation of the investigation. 1. Resident #35 was admitted to the facility in January 2022 with diagnoses including Alzheimer's Disease. Review of the grievance log indicated Resident #35 submitted the following grievance: -Detail of complaint/grievance: Resident reported to receptionist that on (his/her) was (sic) to appointment that the staff member hurt (him/her) by squeezing (his/her) hand [sic]. The tall one. I want to report her. Cannot close my hand. -Date occurred 1/19/24. -The grievance follow-up section was blank, indicating there was no follow-up or resolution to the grievance. The facility failed to provide an investigation for Resident #35's allegation. (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	01/09/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #39 was admitted to the facility in August 2021 with diagnoses including congested heart failure. Review of the grievance log indicated Resident #39 submitted the following grievance: -Details of Complaint/Grievance: unsatisfactory care by CNA (Certified Nursing Assistant). Changing for bed at 3 pm to [sic] early. CNA put hand on left shoulder which has been dislocated is sensitive. Asked her not to lean on shoulder and did not answer. Put me on bed pan and left privacy curtain open. Embarrassed people going by room. -The grievance follow-up indicated education on customer service was completed. The facility failed to provide an investigation for Resident #39's allegation. 3. Resident #253 was admitted to the facility in April 2024 and was discharged in July 2024. Resident #253's diagnoses included heart failure. Review of the grievance log indicated Resident #253's nephew submitted the following grievance for him/her: -Details of Complaint/Grievance: His (aunt/uncle) complained that they are rough on (him/her) when are dressing (him/her). (The Resident) said they are always rushing so they move fast and (his/her) body hurts. -The grievance follow-up indicated staff was educated on the issue. The facility failed to provide an investigation for Resident #253's allegation. 4. Resident #254 was admitted and discharged from the facility in July 2024. Resident #254's diagnoses included diabetes. Review of the grievance from indicated Resident #254 submitted the following grievance: -Complaint/Grievance: When I had to use the bathroom, I had to go, but the nurse pulled my johnny off before I go. -The grievance follow-up indicated staff was educated on kindness and compassion. The facility failed to provide an investigation for Resident #254's allegation. 5. Resident #255 was admitted to the facility in June 2024 with diagnoses including heart failure and was discharged in June 2024. Review of the grievance from indicated Resident #255 submitted the following grievance: -Complaint/Grievance: (CNA) told patient that (he/she) is here because God is punishing (him/her). (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	01/09/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The grievance follow-up indicated the Administrator met with the Resident, however, did not indicate she spoke with the Resident about the specific statement made by the CNA. It also showed the Administrator did not interview the CNA directly regarding the incident. The facility failed to provide an investigation for Resident #255's allegation. 6. Resident #256 was admitted and discharged from the facility in October 2024 with diagnoses including stroke. Review of the grievance from indicated Resident #256 submitted the following grievance: -Complaint/Grievance: The aid went in (to room) without saying a word, started to take of (his/her) clothes which made (him/her) uncomfortable. -The grievance follow-up indicated staff were educated on customer service. The facility failed to provide an investigation for Resident #256's allegation. During an interview on 1/8/25 at 2:46 P.M., the Administrator said all grievances go to her and she is responsible for the resolutions. The Administrator said she would like all grievances to be resolved within two days and does her best to keep notes on all follow-ups to the grievances. The Administrator said she makes sure to investigate any grievance that may rise to a level more serious than a grievance and may be possible abuse and a full investigation would include interviewing the resident, the staff involved and all other residents and staff that may have knowledge of the situation or were also taken care of by that staff member. The Administrator and surveyor reviewed the above grievances and the Administrator said all of these instances could potentially be instances of abuse and would need to be investigated. The Administrator said she spoke to all of these residents and staff members, however did not do full investigations that included interviewing other staff and residents to ensure abuse did not occur.

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	01/09/2025

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 48671 Based on record review and interview, the facility failed to develop and implement baseline care plans within 48 hours from admission to the facility for one Resident (#360) out of a total sample of 29 residents. Findings include: Resident #360 was admitted to the facility in January 2024 with the following diagnoses: unspecified displaced fracture of fifth cervical vertebra, diabetes mellitus with diabetic polyneuropathy, and muscle weakness. Review of the most recent Minimum Data Set (MDS) assessment was not available as of the date of the survey. Review of the medical record indicated Resident #360 scored three out of 15 on the Brief Interview for Mental Status exam indicating he/she has severe cognitive impairment. Review of Resident #360's baseline care plans indicated the following: -Resident is at risk for pressure injury R/T (related to) Diabetes Mellitus, Neuropathy. This resident will not develop avoidable pressure injuries. Dated 1/6/25. -Resident has actual non-pressure skin impairment/s present R/T trauma (skin tear L (left) calf). The non pressure skin impairment will heal. Dated 1/7/25. -Resident has an actual skin impairment. 1. Pressure injury (coccyx) Stage II. There will be no s/s (signs or symptoms) of infection. Dated 1/7/25. Resident #360's baseline care plans indicated they were developed on 1/6/25 and on 1/7/25; over 48 hours after admission to the facility. Further review of Resident #360's baseline care plan indicated interventions related to the coccyx pressure wound, left calf skin tear, and use of Aspen neck collar were not implemented on admission. During an interview on 1/9/25 at 10:05 A.M., the Director of Nursing the baseline care plan must be created upon admission to the facility in order to care for the Resident safely and appropriately.

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	01/09/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456 Based on observations, record review and interviews, the facility failed to provide assistance with Activities of Daily Living (ADLs) for one Resident (#4) out of a total sample of 29 residents. Findings include: Review of the facility policy titled, Activities of Daily Living (ADLs), dated 9/2024, indicated the following: -The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless unavoidable. -Care and services will be provided for the following activities of daily living: bathing, dressing, grooming and oral care. Resident #4 was admitted to the facility in November 2024 with diagnoses including dementia. Review of Resident #4's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 13 out of a possible 15, which indicated he/she is cognitively intact. The MDS also indicated Resident #4 required physical assistance from staff for all self-care activities. During an interview on 1/6/25 at 8:04 A.M., Resident #4 was observed to have significant long, chin hair. When asked, Resident #4 said he/she would like to have this chin hair removed and would be willing to have staff assist in removing it. During an observation on 1/9/25 at 7:38 A.M., Resident #4 was observed to have significant long, chin hair. Review of Resident #4's ADL care plan created on 11/27/24, failed to indicate the level of assistance Resident #4 requires for grooming tasks, the Resident's grooming preferences, or that the Resident refuses ADL care. During an interview on 1/9/25 at 8:03 A.M., Certified Nursing Assistant (CNA) #5 said facial hair is removed as part of daily care. CNA #5 said Resident #4 requires moderate assistance from staff for grooming tasks. During an interview on 1/9/25 at 8:25 A.M., CNA #6 said all facial hair should be removed from residents if the resident would prefer that. CNA #6 said she had not removed Resident #4's facial hair and the Resident refuses care at times. CNA #6 said refusals of care are documented in the medical record. Review of Resident #4's medical record failed to indicate any refusal of care or displayed behaviors. (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	01/09/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/9/25 at 9:06 A.M., the Director of Nursing said the expectation is that facial hair is removed during care if desired.

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	01/09/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456 Based on observations, record review and interviews, the facility failed to 1) provide edema management for one Resident (#39) and 2) failed to identify a new skin wound on Resident (#360) left calf and document it on a skin assessment, out of a total sample 29 residents. Findings include: Resident #39 was admitted to the facility in August 2021 with diagnoses including congestive heart failure. Review of Resident #39's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15, indicating he/she is cognitively intact. The MDS also indicated Resident #39 requires substantial assistance from staff for activities of daily living and mobility. During an interview on 1/6/25 at 8:19 A.M., Resident #39 said his/her legs are often swollen. Review of Resident #39's physician orders indicated the following order: -Weekly weights every evening shift every Monday related to chronic congested heart failure. Notify MD/NP (medical doctor/nurse practitioner) if greater or less than 5 pounds/week. Review of Resident #39's potential nutritional risk d/t (due to) PMH (past medical history): heart failure, LE (lower extremity) edema, hyponatremia on diuretics includes the following interventions: -monitor PO (by mouth), wts (weights), labs, na+ (sodium) level and skin. Review of Resident #39's weight log indicated the facility had not been obtaining weekly weights as ordered and the Resident had two instances of a five pound weight change on 10/21/24 and 11/27/24. The medical record failed to indicate Resident #39 had refused having his/her weight taken. Review of Resident #39's nursing and medical provider notes failed to indicate the nursing staff notified the medical provider when these two significant weight changes occurred. During an interview on 1/7/25 at 11:15 A.M., Certified Nursing Assistant #6 said Resident #39 will have swollen feet at times. During an interview in 1/7/25 at approximately 11:20 A.M., Nurse #6 said any residents who have edema are typically managed with diuretics, non-pharmalogical interventions and are weighed more frequently. Nurse #6 said there needs to be communication with the medial provider if the resident were to gain a significant amount of weight or were to have increased edema/swelling. Nurse #6 said Resident #39 has an order to weigh weekly and Nurse #6 was unaware that the order had not been followed. Nurse #6 said the Resident may have refused to have his/her weight taken but without documentation of that she could not say that the Resident did in fact refuse. Nurse #6 the reviewed the Resident's weight log and confirmed there were two instances where the medical provider should have been notified of a significant weight change and said there is no documentation that this occurred. (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	01/09/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/7/25 at 11:30 A.M., the Staff Educator said she is familiar with Resident #39 as she often covers the floor as a Unit Manager. The Staff Educator said residents with edema usually have their weights more closely monitored and typically have parameters to notify the medical provider if a significant weight change occurs. The Staff Educator said nurses are expected to write a note if a resident refuses to be weighed and should write a note every time they contact the medical provider regarding care or a change in status. The Staff Educator said she is aware Resident #39's weight fluctuates. She then reviewed Resident #39's weight log and said the weights are not being taken as ordered and she would have expected the medical provider to be notified on the two instances of weight change. The Staff Educator said that if there is no note of notification to the medical provider, she cannot say that the notification occurred. The medical provider was on vacation during survey and was not able to be contacted. 48671 2. Resident #360 was admitted to the facility in January 2025 with the following diagnoses: unspecified displaced fracture of fifth cervical vertebra, diabetes mellitus with diabetic polyneuropathy, alzheimer's disease, and muscle weakness. Review of the most recent Minimum Data Set (MDS) assessment was not available as of the date of the survey. Review of the medical record indicated Resident #360 scored three out of 15 on the Brief Interview for Mental Status exam indicating he/she has severe cognitive impairment. During an interview on 1/8/25 at 1:25 P.M., Nurse #5 said Resident #360 has a skin tear to the left lower calf that is covered so it does not get worse because he/she is in bed all the time. Review of Resident #360's hospital discharge summary dated 1/3/25, indicated: Integumentary- Skin tear to posterior left calf. Review of the Patient Admission Assessment, dated 1/3/25, indicated the following: -Skin Impairment -Yes -Non- pressure injury site: *Left Lower leg (rear) two wounds, serosanguinous drainage. Review of the nurse progress note, dated 1/3/25, indicated: Two wounds measuring 1x1/2 (inches) on left leg cleansed and dressing done per TAR (treatment administration record), patient has several bruises left lower back, left lower abdomen, left ankle. Further review of the medical record failed to include documentation including assessment data of the two left lower leg wounds. Resident #360's care plan dated 1/7/25 (four days after he/she was admitted), indicated the following: (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	01/09/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Focus: This resident has actual non-pressure skin impairment/s present R/T trauma (skin tear L (left) calf). Goal: The non pressure skin impairment will heal. Interventions Included: -Monitor and treat for pain before during and after wound treatment. -Monitor document and report s/s of infection including but not limited to: purulent drainage from the wound, foul odor from the wound, redness & warmth around the wound, increased pain at the wound site. -Notify the physician of a worsening skin impairment. -Treatment as ordered to the wound. -Weekly skin checks by licensed nurse. During an observation and interview on 1/8/25 at 1:39 P.M., the surveyor along with Nurse #5 observed Resident #360 lying in bed with his/her legs flat on the bed. One foam dressing was observed on the Residents' left calf; part of a wound could be seen partially covered by the edge of the dressing. Nurse #5 removed the dressing and part of the dressing boarder containing adhesive was placed directly over one of the wounds. The surveyor and Nurse #5 observed three open skin ulcers, the size of quarters with white and pale tissue throughout each ulcer, surrounding skin tissue to each ulcer was pink and red, and dark red, pink and yellow drainage was observed on the old dressing. Resident #360 said his/her calf was sore and reported pain when touched. Nurse #5 proceeded to cleanse each wound and applied a cut layer of Xeroform gauze (sterile wound dressing to help with healing), and proceeded to cover the calf with two boarder gauze dressings measuring 4 inches by 4 inches each. Nurse #5 placed the two boarder gauze dressings directly over part of the wound bed, leaving the Xeroform gauze exposed on one of the wound ulcers leaving it uncovered. The adhesive part of the gauze dressing was placed directly over one of the wounds. Review of Resident #360's physician orders indicated the following: Order dated 1/4/25: Skin tear to left calf wash with normal saline apply Xeroform cover with bordered dressing every shift. Every evening shift for wound. Dated 1/4/25. Review of Resident #360's physician orders, physician notes, nurse practitioner notes, care plans and clinical notes did not indicate he/she had three open skin wounds to the left calf. Further review of the medical record failed to indicate a physician's order for weekly skin checks was entered. Review of Resident #360's medical record on 1/9/25 at approximately 10:00 A.M., indicated there was no documentation to indicate Nurse #5, or any other staff notified the physician about his/her three left calf wounds. (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	01/09/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/9/25 at 8:43 A.M., Certified Nurse Aide (CNA) #4 said she was unaware the Resident had open wounds on his/her calf because she does not touch the bandage. The surveyor observed the Xeroform dressing that was applied on 1/8/25 was still visible over one of the wounds and had not been removed and re-applied. During an interview on 1/9/25 at 10:03 A.M., the Director of Nurses (DON) said she was not aware of the wounds to Resident #360's left calf and said skin assessments must include location, size, measurements, and descriptions of any skin areas identified on admission. The DON reviewed the medical record with the surveyor and said there was no documentation in the record of any of the areas identified on admission, and said there was no documentation to indicate staff notified the physician about Resident #360's calf wounds or obtained new physician's treatment order for each wound. The DON said she has had issues with staff documenting and reporting skin issues and said Resident #360 should have been seen by the wound doctor who comes in every Thursday. The DON said Nurses are expected to follow the physician orders and call the physician if the orders do not match the treatment necessary to care for the resident. During a follow up interview on 1/9/25 at 11:30 A.M., the DON said she observed Resident #360's left calf identified three open wound ulcers and one new small open ulcer and said she notified the medical director of the four wound ulcers and obtained new orders for calcium alginate to be applied and said the wound doctor will be in today to assess the new wounds.

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	01/09/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on observation, record review and interview, the facility failed to address documented significant weight losses for two Residents (#30 and #12) out of a total of 29 sampled residents. Findings include: Review of the facility policy titled Weight Monitoring, dated as revised 11/26/23, indicated: Policy: Each resident's weight will be monitored to ensure interventions are offered and implemented ensuring the resident's needs are met. Procedure: Monthly weights are to be obtained by the 10th of the month. Residents who have had a five pound weight difference since the previous weight obtained regardless as to when that was should be re-weighed within 24 hours of this most recent weight. If a significant weight change (suggested parameters for evaluating significance of unplanned and undesired weight loss are 5% in 30 days and 10% in 180 days) the physician, Registered Dietitian resident and/or resident representative are to be notified. The care plan will be reviewed and revised to reflect the current weight/nutritional status of the resident. The Registered Dietitian will recommend frequency of weights to be increased based on the dietary evaluation or as the physician ordered. If the resident consistently refuses to be weighed or circumstances prevent weighing the resident the physician will be notified. 1. Resident #30 was admitted to the facility in April 2019 with diagnoses including Alzheimer's and peripheral vascular disease. A diagnosis of adult failure to thrive was added to Resident #30's medical record on 9/5/23 and a diagnosis of nutritional deficiency unspecified was also added to his/her medical record on 2/28/24. Review of the Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #30 is severely cognitively impaired and requires assistance with eating. On 1/7/25 at 9:00 A.M., the surveyor observed Resident #30 resting in bed with his/her lunch meal on the tray table in front of him/her. Resident #30 had eaten a few bites of his/her hot cereal, but the remainder of the items were untouched. Resident #30 was unable to participate in the interview process due to his/her cognition. (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	01/09/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #30's Nutritional Care Plan, Focus: Resident #30 is at potential nutritional problem due to history of Alzheimer's dementia, with decline in meal intake, history of altered labs (dated 9/17/24). Goal: Resident will maintain adequate nutritional status, as evidenced by stable weight (dated 11/17/24). Interventions: Consult with speech therapy as needed (dated 8/14/29), monitor meal preferences (dated 4/15/24), monitor intake, weights, labs, skin (dated 10/2/23), provide diet as ordered (dated 8/6/20), provide supplement as ordered (dated 10/2/23.) Review of the physician's orders indicated: - House supplement, two times a day (initiated 10/24/23). - Nutritional fruit drink, one time a day (initiated 10/3/23). Review of Resident #30's weights indicated: - 8/12/24: 164.2 lbs (pounds) - No weight documented September 2024 - No weight documented October 2024 - 11/19/24: 151.6 lbs (a significant loss of 7.6% of his/her total body weight since August 2024.) - 12/6/24: 151.5 lbs Review of the clinical record failed to indicate Resident #30 refused his/her weight to be obtained in September 2024. The clinical record indicated Resident #30 refused his/her weight to be obtained in October 2024 on one occasion, but did not indicate staff re-visited or requested he/she be weighed. A re-weight was not completed per policy after Resident #30's weight was obtained on 11/19/24. Review of the Nutrition note, dated 11/30/24, indicated: Follow up weight loss. Diet: Reduced sodium. Supplements: nutritional juice drink, house supplement. Intake: 50% at best. Labs none new for review. We reviewed with IDT at risk meeting. Intake remains variable; supplements in place. Resident is on monthly weights. Would re-check weight and re-eval need for weekly weights. Continue supplements as ordered. Preferences noted. A re-weigh was not completed as recommended in the nutrition note. Review of the Nutritional Assessment, dated 12/3/24, indicated the Resident is at risk for malnutrition due to variable intake 50/75%. House supplement and nutritional juice warranted No new recommendations. (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	01/09/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/7/25 11:39 A.M., CNA #2 said that Resident #30 has had some weight loss. During an interview on 1/7/25 at 11:44 A.M., Unit Manager #1 said that residents are usually weighed monthly and if a weight change is noted, a re-weigh is completed and the nurse practitioner and Dietitian become involved. Unit Manager #1 said that Resident #30 was behavioral and often refused being weighed. Unit Manager #1 said that staff should be documenting if a Resident is refusing to be weighed and re-approach at another time to obtain weights. On 1/7/25 at 12:07 P.M., the surveyor observed Nurse #1 speak with Dietitian regarding Resident #30's weight loss. The Dietitian said that they could introduce a magic cup (a nutritional supplement) at meals for Resident #30. During an interview on 1/7/25 at 1:25 P.M., the Dietitian said that the facility had been working on obtaining accurate weights and putting them in the system. The Dietitian said that she was aware Resident #30 had a documented significant weight loss and that interventions had not been implemented until today, (1/7/25). 2. Resident #12 was admitted to the facility in June 2019 with diagnoses including Alzheimer's and dysphagia. Review of the Minimum Data Set Assessment, dated 11/7/24, indicated Resident #12 is severely cognitively impaired and requires assistance with bathing and dressing. On 1/6/25 at 9:09 A.M., the surveyor observed Resident #12 asleep in bed. His/her breakfast tray was uncovered and untouched in front of him/her. Review of Resident #12's care plans indicated: Focus: Resident is at potential nutritional risk, (dated 6/19/19.) Interventions: Monitor intake, weights, labs, skin (dated 6/19/19). Monitor preferences and offer alternates as needed, (dated 7/8/2024). Provide diet as ordered, (dated 6/9/19), Review of Resident #12's weights indicated: - 11/25/2024 158.0 Lbs (pounds) - 12/9/2024 154.0 Lbs - 12/23/2024 149.0 Lbs (A loss of 5.7% of his/her total body weight since 11/25/24). - 1/6/2025 144.4 Lbs - 1/6/2025 145.5 Lbs (A loss of 7.91% of his/her total body weight since 11/25/24). A re-weigh had not been completed after Resident #12's initial documented weight loss on 12/23/24. (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	01/09/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record indicated that the Dietitian had not evaluated or assessed Resident #12 or possible interventions related to the weight loss. Review of Resident #12's physicians orders failed to indicate any supplements or appetite stimulants were ordered. During an interview on 1/7/25 at 11:32 A.M., Certified Nursing Aide #3 said that he believed that Resident #12 had lost around three pounds. During an interview on 1/7/25 at 11:50 A.M., Unit Manager #1 said that Resident #12 had recently had a change of his/her appetite and had a weight loss about a month ago. Unit Manager #1 said that the Nurse Practitioner and Dietitian were aware but did not know if interventions were implemented related to the weight loss. Unit Manager #1 could not say why a re-weigh was not completed. On 1/7/25 at 12:07 P.M., the surveyor observed Nurse #1 speak with Dietitian regarding Resident #12's weight loss. The Dietitian said that they could introduce supplements in response to Resident #12's weight loss. During an interview on 1/7/25 1:33 P.M., the Dietitian said that the facility had been working on obtaining weights and re-weighs to confirm weight loss. The Dietitian said that after Resident #12's initial weight loss was documented on 12/23/24, she had asked for a re-weigh. The Dietitian said that she initiated supplements for Resident #12 today (1/7/25), in response to his/her weight loss.

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	01/09/2025

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on record review and interview, the facility failed to provide behavioral health services for one Resident (#16) out of a total sample of 29 residents. Specifically, Resident #16 verbalized he/she was not happy and had an increased Patient Health Questionnaire (PHQ-9) score, indicating worsening mood. Findings include: Review of the Behavioral Health Services policy, dated 10/2024, indicated the following: - Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders, psychosocial adjustment difficulty, and trauma or post-traumatic stress disorders. - Behavioral health care and services shall be provided in an environment that is conducive to mental and psychosocial well-being. - Facility staff will implement person-centered care approaches designed to meet the individual goals and needs of each resident, which includes non-pharmalogical interventions. Resident #16 was admitted in May 2024 with diagnoses including depression and anxiety. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #16 scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. Review of the medical record failed to indicate Resident #16 had an activated health care proxy (a form used to designate and individual to make choices on behalf of the resident). Review of the care plan for Resident #16 indicated Resident #16 is at risk for an altered psychosocial well-being related to adjustment to admission and grieving the loss of his/her independence in the community (initiated 5/17/24). Intervention: Behavioral health services as ordered and needed (initiated 5/17/24). Review of the PHQ-9, dated 8/14/24, indicated Resident #16 scored a 0 out of 27, indicating no presence of depression. Review of the Psychological Services progress note, dated 10/22/24, indicated the psychologist spoke with Resident #16, but Resident #16 was recovering from an illness and seemed withdrawn. The psychologist documented they would re-attempt and provide support when resident is receptive. Review of the record failed to indicate any follow up was completed after 10/22/24. Review of the Resident #16's PHQ-9, dated 11/11/24, indicated Resident #16 scored a 9 out of 27, indicating mild depression and worsening mood. (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	01/09/2025

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the psych services note that was completed by the psych nurse practitioner, dated 11/11/24, indicated Resident #16 told the psych nurse practitioner I am not happy. The psych nurse practitioner documented that they will continue to monitor client for changes in mood/mental status. Review of the clinical record failed to indicate that any other behavioral interventions were attempted to help Resident #16's worsening mood. Review of the record failed to indicate that social services met with the Resident. During an interview on 1/9/25 at 11:21 A.M., the Social Worker said the facility has a psychologist and a psych nurse practitioner in house to provide behavioral health services. The Social Worker said if a psych nurse practitioner is responsible for the PHQ-9 test and if a Resident scores higher than their previous baseline, then she would expect to be notified of that so they can meet as a team and see if there is anything that can be done for the Resident. The Social Worker said she does not remember if she was ever notified of that change in mood that occurred on 11/11/24 for Resident #16. During an interview on 1/9/25 at 10:05 A.M., Resident #16 said that he/she feels down and feels like he/she cannot say anything to anyone for fear of retaliation. Resident #16 said he/she feels like he/she cannot do anything right. Resident #16 said that he/she only met with a talk therapist one time, but would like to have one to meet with regularly.

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	01/09/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 48990 Based on observations, interviews, and record review for two Residents (#72 and #37) out of three residents observed, the facility failed to ensure it was free from a medication error rate of greater than 5%. One out of two nurses observed made 13 errors out of 25 opportunities resulting in a medication error rate of 56%. Specifically, 1.) Nurse #2 attempted to administer 13 medications to the incorrect Resident (#72), which were meant for Resident #37. 2.) Nurse #2 administered the incorrect dose of aspirin to Resident #37. Findings include: Review of the facility policy titled 'Medication Administration', dated as reviewed September 2024, indicated: - Identify resident by photo in the MAR (medication administration record). - Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time. 1.) Resident #72 was admitted to the facility in December 2024 with diagnoses including chronic heart failure, acute kidney injury, and allergies to penicillin and aspirin. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/19/24, indicated Resident #72 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. On 1/7/25 at 8:14 A.M., the surveyor observed Nurse #2 tell Resident #72's roommate that he would bring his/her morning medication in right away. On 1/7/25 at 8:19 A.M., the surveyor observed Nurse #2 prepare the following medications: - Amoxicillin-Potassium Clavulanate (a penicillin-based antibiotic) 875-125 mg (milligrams), 1 tablet. - Aspirin 81 mg, 1 tablet - Flecainide Acetate (a medication used to prevent or treat irregular heartbeats) 100 mg, 1 tablet. - Escitalopram oxalate (an antidepressant) 20 mg, 1 tablet. - Ferrous sulfate (iron) 325 mg, one tablet. - Multivitamin with minerals, one tablet. (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	01/09/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Proheal liquid protein, 30 ml (milliliters). - Cholecalciferol Oral Tablet (vitamin d) 25 mcg (micrograms), 2 tablets. - Docusate sodium (a stool softener) 100 mg, 1 capsule. - Famotidine 20 mg, 1 tablet. - Fexofenadine HCl (hydrochloride) (an antihistamine)180 mg, 1 tablet. - Folic acid (vitamin b) 1000 mcg, 1 tablet. - Polyethylene glycol (a laxative) 3350 powder, 17 g (grams). On 1/7/25 at 8:37 A.M., Nurse #2 placed the prepared medications on Resident #72's (who was Resident #37's roommate) bedside table and told Resident #72 it was his/her medications. Nurse #2 did not request the Resident to verify their name, date of birth, or any identifying information. Nurse #2 did not check the Resident's identification bracelet. Resident #72 asked what these medications were and Nurse #2 repeated that it was his/her medications and to take them. The surveyor intervened and asked if these medications were supposed to be for the roommate (Resident #37). Nurse #2 said they were not, and they were for Resident #72. Nurse #2 moved the 13 medications closer to Resident and again said to take the medications. Resident #72 presented as confused and stared from the medications to the nurse multiple times. After a short time, Nurse #2 picked up the medication and left Resident #72's bedside. At this point, Nurse #2 said he was glad the surveyor intervened because he thought he had prepared Resident #72's medication but should have checked that it was the correct Resident's medication before attempting to administer them. During an interview on 1/7/25 at 11:14 A.M., the Director of Nursing (DON) said Nurse #2 should have verified Resident #72 was the same Resident that the medications were ordered for prior to attempting to administer the medications. The DON said the resident's identity should be verified in two ways before every medication administration, including ways such as checking the photograph in the medical record, checking identification bracelet, or asking the resident to identify themselves. The DON said Resident #72 is on a busy rehabilitation floor that is a revolving door making it especially important to verify identification prior to administering medications. 2.) Resident #37 was admitted to the facility in December 2024 with diagnoses including atrial fibrillation (a condition which causes an irregular heartbeat), hypertension, and a history of a myocardial infarction (heart attack). Review of the most recent Minimum Data Set (MDS) assessment, dated 12/19/24, indicated Resident #37 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. On 1/7/25 at 8:19 A.M., the surveyor observed Nurse #2 prepare the following medications: - Aspirin 81 mg, 1 tablet Review of Resident #37's active physician's order, initiated 12/15/24, indicated: (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	01/09/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Aspirin 81 Oral Tablet Delayed Release 81 mg, give 2 tablets by mouth one time a day. During a follow-up interview on 1/7/25 at 1:15 P.M., Nurse #2 verified Resident #37's physician's order for aspirin. Nurse #2 said he administered one tablet but should have administered two tablets. During an interview on 1/7/25 at 11:14 A.M., the Director of Nursing (DON) said Nurse #2 should have followed the physician's order to administer the correct dose. Refer to F760.

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	01/09/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 48990 Based on observation, interviews, and record review, the facility failed to ensure one Resident (#72) was free from significant medication errors, out of a total sample of 29 residents. Specifically, Nurse #2 attempted to administer medications to the incorrect Resident (#72), including medications that the Resident was allergic to and medications that could jeopardize his or her health and safety. Findings include: According to the U.S. Food and Drug Administration prescribing information for amoxicillin/clavulanate potassium (a penicillin-based antibiotic), dated December 2006, indicated: - Amoxicillin/clavulanate potassium should be used by prescription only. - Amoxicillin/clavulanate potassium is contraindicated in patients with a history of allergic reactions to any penicillin. - Serious and occasionally fatal hypersensitivity (anaphylactic) reactions have been reported in patients on penicillin therapy. These reactions are more likely to occur in individuals with a history of penicillin-hypersensitivity. Before initiating therapy with amoxicillin/clavulanate potassium, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins. If an allergic reaction occurs, amoxicillin/clavulanate potassium should be discontinued and the appropriate therapy instituted. Serious anaphylactic reactions require immediate emergency treatment with epinephrine, oxygen, intravenous steroids, and airway management, including intubation should also be administered as indicated. According to the U.S. Food and Drug Administration prescribing information for flecainide acetate (an antiarrhythmic medication used to prevent or treat irregular heartbeats), dated December 2024, indicated: - Flecainide acetate should be used by prescription only. - Flecainide acetate, like other antiarrhythmic agents, can cause new or worsened supraventricular or ventricular arrhythmias. Ventricular proarrhythmic effects range from an increase in frequency of PVCs to the development of more severe ventricular tachycardia, e.g., tachycardia that is more sustained or more resistant to conversion to sinus rhythm, with potentially fatal consequences. According to the U.S. Food and Drug Administration prescribing information for escitalopram oxalate (an antidepressant medication), dated August 2023, indicated: - Escitalopram oxalate should be used by prescription only. (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	01/09/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Increased risk of suicidal thoughts and behavior in pediatric and young adult patients taking antidepressants. Closely monitor all antidepressant-treated patients for clinical worsening and emergence of suicidal thoughts and behaviors Review of the facility policy titled 'Medication Administration', dated as reviewed September 2024, indicated: - Identify resident by photo in the MAR (medication administration record). - Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time. Resident #72 was admitted to the facility in December 2024 with diagnoses including chronic heart failure, acute kidney injury, and allergies to penicillin and aspirin. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/19/24, indicated Resident #72 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. On 1/7/25 at 8:14 A.M., the surveyor observed Nurse #2 tell Resident #72's roommate that he would bring his/her morning medication in right away. On 1/7/25 at 8:19 A.M., the surveyor observed Nurse #2 prepare medications including: - Amoxicillin-Potassium Clavulanate (a penicillin-based antibiotic) 875-125 mg, 1 tablet. - Aspirin 81 mg, 1 tablet - Flecainide Acetate (used to prevent or treat irregular heartbeats) 100 mg, 1 tablet. - Escitalopram oxalate (an antidepressant) 20 mg, 1 tablet. On 1/7/25 at 8:37 A.M., Nurse #2 placed the prepared medications on Resident #72's bedside table and told Resident #72 it was his/her medications. Nurse #2 did not request the Resident to verify their name, date of birth, or any identifying information. Nurse #2 did not check the Resident's identification bracelet. Resident #72 asked what these medications were and Nurse #2 repeated that it was his/her medications and to take them. The surveyor intervened and asked if these medications were supposed to be for the roommate (Resident #37). Nurse #2 said they were not, and they were for Resident #72. Nurse #2 moved the medications closer to the Resident and again said to take the medications. Resident #72 presented as confused and stared from the medications to the nurse multiple times. After a short time, Nurse #2 picked up the medication and left Resident #72's bedside. At this point, Nurse #2 said he was glad the surveyor intervened because he thought he had prepared Resident #72's medication but should have checked that it was the correct Resident's medication before attempting to administer them because there were some medications that could have jeopardized the Resident's health and safety. (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	01/09/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/7/25 at 11:14 A.M., the Director of Nursing (DON) said Nurse #2 should have verified Resident #72 was the same Resident that the medications were ordered for prior to attempting to administer the medications. The DON said the resident's identity should be verified in two ways before every medication administration, including ways such as checking the photograph in the medical record, checking identification bracelet, or asking the resident to identify themselves. The DON said Resident #72 is on a busy rehabilitation floor that is a revolving door making it especially important to verify identification prior to administering medications. The DON said residents should not be administered medications that they are allergic to but declined to answer any further questions about the significance of the other medications attempted to be administered.

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	01/09/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48990 Based on observations and interviews, the facility failed to ensure staff stored drugs and biologicals in accordance with State and Federal requirements. Specifically, 1.) The facility failed to ensure medications were stored in secured areas and not left unsecured in residents' rooms. 2.) The facility failed to properly secure treatment carts on two of four units. 3.) The facility failed to ensure medications were dated once opened, according to manufacturer's guidelines, in two out of four medication carts observed. Review of the facility policy titled 'Medication Storage', dated as reviewed September 2024, indicated: - It is the policy of this facility to ensure all medications housed on our premises will be stored according to manufacturer's recommendations. - All drugs and biologicals will be stored in locked compartments. - Only authorized personnel will have access to the keys to locked compartments. Review of the facility policy 'Resident Self-Administration of Medication, dated as reviewed September 2024, indicated: - Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the other resident's rooms or to confused roommates of the resident who self-administers medication. The following conditions are met for bedside storage to occur: the manner of storage prevents access by other residents. 1.) During an observation of the B Unit on 1/6/25 at 8:07 A.M., the surveyor observed the following medications clearly visible and unsecured in resident rooms: - One bottle of glycerin suppositories (a laxative administered rectally). - One tube of diclofenac gel (a topical pain reliever) on a dresser. - One bottle of metamucil (a fiber supplement with laxative properties) on a windowsill. - Two unopened lidocaine patch (a topical pain reliever) packets on a nightstand. - One bottle of artificial tears eye drops on a bedside table. (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	01/09/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observations of the B Unit on 1/6/25 at 1:23 P.M., the surveyor observed the following medications clearly visible and unsecured in resident rooms: - One bottle of glycerin suppositories. - One tube of diclofenac gel on a dresser. - One bottle of metamucil on a windowsill. - Two unopened lidocaine patch packets on a nightstand. - One bottle of artificial tears eye drops on a bedside table. During a follow up tour of the B Unit on 1/7/25 at 8:09 A.M., - One bottle of glycerin suppositories. - Two unopened lidocaine patch packets on a nightstand. - One bottle of artificial tears eye drops on a bedside table. During an initial tour of the D Unit on 1/6/25 at 9:24 A.M., the surveyor observed the following medication clearly visible and unsecured in a resident room. - One container of nicotine mini mouth/throat lozenge 4 mg (milligram) container on the bedside table with about 7-8 lozenges were on the table surface next to the container. During an interview on 1/9/25 at 8:18 A.M., Unit Manager #2 said that medications cannot be stored at bedside unless they have a self-administration of medication assessment completed to assess the resident's ability to ensure that medications are stored safely and securely. Unit Manager #2 said there are no residents on the B Unit who have had this assessment completed and there should be no medications stored at bedside. The surveyor reviewed to medications observed at bedside and Unit Manager #2 said glycerin suppositories, diclofenac gel, metamucil, lidocaine patches, and artificial tears eye drops should not be have been stored unsecured in resident's rooms. During an interview on 1/9/25 at 8:28 A.M., Nurse #4 said nicotine lozenges are a medication. Nurse #4 said nicotine lozenges should not be stored in any resident rooms without having a self-administration of medication assessment completed to assess the resident's ability to ensure that medications are stored safely and securely. Nurse #4 said this had not been completed and the nicotine lozenges should not have been stored in the resident's room. During an interview on 1/9/25 at 8:40 A.M., the Director of Nursing (DON) said that medications cannot be stored at bedside unless the resident had a self-administration of medication assessment completed to assess the resident's ability to ensure that medications are stored safely and securely. The DON said she was not aware of any residents in the building who currently are able to have any medications stored at bedside. The DON said there should be no medications stored unsecured at bedside in the facility, including glycerin suppositories, diclofenac gel, metamucil, lidocaine patches, artificial tears eye drops, and nicotine lozenges. (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	01/09/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.) On 1/7/25 at 1:14 P.M., the surveyor observed C Unit treatment cart unlocked in the hallway. The nurse was not within sight line of the medication cart. The surveyor observed multiple prescription topical medications within this treatment cart. During an interview on 1/7/25 at 1:16 P.M., Nurse #1 returned to the C Unit treatment cart and said the treatment cart should have been locked when not within her view. On 1/7/25 at 11:40 A.M., the surveyor observed the D Unit treatment cart unlocked and unattended in the hallway. On 1/7/25 at 1:22 P.M., the surveyor observed the D Unit treatment cart unlocked and unattended in the hallway. The nurse was not within sight line of the medication cart. The surveyor observed multiple prescription topical medications within this treatment cart. During an interview on 1/7/25 at 1:32 P.M., Nurse #3 said she should have locked her D Unit treatment cart because it was not within her view. During an interview on 1/9/25 at 8:40 A.M., the Director of Nursing (DON) said treatment carts should be looked when unattended and not within the nurse's view. 3a.) On 1/7/25 at 1:32 P.M., the surveyor and Nurse #3 observed the following in the Unit D right medication cart: - One bottle of proheal (liquid protein), open and undated. The proheal bottle label indicated to discard 60 days after opening date. - One vial of insulin lantus 100 units/ml (u/ml), open and undated. - One insulin lispro kwik pen (a disposable pen containing insulin) 100 u/ml, open with two different dates on it. The first date was 11/29/24 (which is 40 days after the opening date), and the second date was 12/29/24. During an interview on 1/7/25 at 1:34 P.M., Nurse #3 said the proheal was not dated, but should have been since it should be discarded 60 days after opening. Nurse #3 said insulin should be dated when opened because it must be discarded 28 days after opening. Nurse #3 said the insulin pen should only be dated upon opening, and it should have been discarded since the opening date was unclear. Nurse #3 said all these open and undated medications were currently being used by residents in the facility. During an interview on 1/9/25 at 11:23 P.M., the Director of Nursing (DON) said insulin and proheal should be dated when opened because it has a shortened expiry date once opened. The DON said the insulin pen with two dates should have been discarded and not used because the open date was unclear. 3b.) On 1/7/25 at 1:48 P.M., the surveyor and Nurse #2 observed the following in the B Unit left medication cart: One bottle of timolol maleate eye drops, open and undated. During an interview on 1/7/25 at 1:50 P.M., Nurse #2 said the timolol maleate eye drops were not dated but should have been because it has a shortened expiry date once opened. (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	01/09/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/9/25 at 11:23 P.M., the DON said timolol maleate eye drops should be dated when opened because it has a shortened expiry date once opened.

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	01/09/2025

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456 Based on observations, record review and interviews, the facility failed to provide dental services for one Resident (#8) out of a total sample of 29 residents. Findings include: Review of the facility policy titled, Dental Services, indicated the following: -It is the policy of this facility to assist residents in obtaining routine (to the extent covered under the state plan) and emergency dental care. -Routine dental services means an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings (new and repairs), minor partial or full denture adjustments, smoothing of broken teeth, and limited prosthodontic procedures, e.g., taking impressions for dentures and fitting dentures. -The dental needs of each resident are identified through the physical assessment and MDS assessment processes, and are addressed in each resident's plan of care. -The facility will, if necessary or requested, assist the resident with making dental appointments and arranging transportation to and from the dental services location. Resident #8 was admitted to the facility in January 2023 with diagnoses including pleural effusion. Review of Resident #8's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she had a Brief Interview for Mental Status (BIMS) score of 13 out of a possible 15 which indicated the Resident was cognitively intact. The MDS also indicated Resident #8 required supervision for oral care tasks. During an interview on 1/6/25 at 8:08 A.M., Resident #8 said he/she had recently broken his/her left upper tooth and had not yet seen a dentist. The Resident said he/she believed that staff were aware. Resident #8 said he/she had not seen a dentist in a very long time. The Resident's teeth were observed to be discolored. Review of Resident #8's medical record indicated the following: -A consent to be treated by the dentist on 4/14/23. -A physician order, initiated on 4/14/23, May be seen and treated by (dental services provider) as needed. -Resident #8 was last seen by the dentist on 5/16/23 with a request for an annual exam for May 2024. The medical record failed to indicate this annual exam was completed. (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	01/09/2025

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an oral assessment dated [DATE] indicated Resident #8 had broken of carious teeth. Review of the previous oral assessment dated [DATE] failed to indicate any broken teeth were observed. Review of Resident #8's care plans, indicated an oral health care plan developed on 12/20/24 which indicated the following interventions: -Have this resident seen by a dentist routinely and as needed. During an interview on 1/7/25 at 10:55 A.M., Nurse #6 said all residents in the facility are offered dental services and are scheduled for routine dental appointments if requested. Nurse #XX said the dentist typically sees residents every six months but if there is an emergent situation, such as a broken or painful tooth, the resident can be seen immediately. Nurse #6 said she was unaware Resident #8 had a broken tooth and did not know the last time the Resident was seen by the dentist. During an interview on 1/9/25 at 10:19 A.M., the Unit Coordinator said she is responsible for scheduling dental appointments for the residents in the facility. The Unit Coordinator showed the surveyor the list of residents recently seen by the dentist and Resident #8 was not on this list. The Unit Coordinator said she was unaware Resident #8 had a broken tooth or was signed up to be seen by the dentist. During an interview on 1/9/25 at 10:14 A.M., the MDS Nurse said she had completed an oral assessment on Resident #8 in December 2024 and had observed the Resident to have a broken tooth and documented it on the assessment. The MDS Nurse said this prompted her to create an oral risk care plan for the Resident. Review of the medical record failed to indicate the nurses or medical providers were notified of the broken tooth found on the oral assessment. During an interview on 1/9/25 at 10:49 A.M., the Director of Nursing said she was unsure of how often residents should be seen by the dentist. The Director of Nursing said she was unaware Resident #8 had a broken tooth and was unaware the Resident had not seen by the dentist since May of 2023.

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	01/09/2025

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 41019 Based on observation and interview, the facility failed to provide meals at an appetizing, palatable, and safe temperature. Findings include: During the Resident Group Interview on 1/7/24 at 1:30 P.M., all participating Residents reported that the food at the facility is consistently cold and does not taste good. During a test tray on 1/7/25 at 12:17 P.M., the following was observed: - The turkey in gravy was 101 degrees Fahrenheit and tasted lukewarm and bland. During a test tray on 1/9/25 at 8:15 A.M., the following was observed: - Milk was 52 degrees Fahrenheit. - Eggs were 118 degrees Fahrenheit and lukewarm. During a test tray on 1/9/25 at 8:16 A.M., the following was observed: - Eggs were 89 degrees Fahreneheit and cold. During a test tray on 1/9/25 at 8:45 A.M., the following was observed: - Eggs were 95 degrees Fahrenheit and lukewarm. - Oatmeal was 115 degrees Fahrenheit and lukewarm. During an interview on 1/9/25 at 9:20 A.M., the Administrator said she is aware of the issues in the food service department and is planning on doing point of service steam tables to resolve the issue.

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	01/09/2025

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019 Based on observation and interview, the facility failed to provide the appropriate diet texture for one Resident (#91) out of a total sample of 29 residents. Findings include: Resident #91 was admitted in April 2024 with diagnoses including adult failure to thrive and dementia. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #91 scored a 2 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. Review of the MDS and certified nursing aide documentation, indicates Resident #91 varies from independence to dependence with eating. Review of the physician's orders for Resident #91 indicated Resident #91 was to receive a pureed diet texture with nectar thickened liquids. During an observation on 1/9/25 at 8:45 A.M., Resident #91 had a tray at his/her bedside table. The Resident had scrambled eggs on his/her tray that were not pureed. During an interview on 1/9/25 at 8:46 A.M., Nurse #7 said that he checks the trays, but Resident #91 was served eggs that were not pureed.

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	01/09/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41019 Based on observation and interview, the facility failed to follow and maintain foodservice sanitation practices. Specifically, the facility failed to ensure there were thermometers in two refrigerators and failed to accurately record temperatures of the service line, failed to label and date dry products in the kitchen, and failed to ensure there is safe and properly working equipment in the kitchen. Findings include: During an observation on 1/7/25 at 8:08 A.M., the kitchenette on the C and D unit contained opened meat and cheese package and a package of pepperoni that was not labeled and dated. During an observation on 1/7/25 at 12:02 P.M., the temperature log for 1/7/25 indicated that the temperatures for the dinner meal were already recorded. During an observation on 1/7/25 at 12:15 P.M., walk in refrigerator and the milk chest refrigerator both were missing thermometers. During an observation on 1/7/25 at 12:17 P.M., a container of bread crumbs, container of flour, and container of white rice were all not labeled or dated. During an observation and interview on 1/7/25 at 12:17 P.M., a lighter was sitting next to the gas stovetop burner. The cook said that sometimes he needs to use the lighter to light the middle cooktop burner. During an interview on 1/7/25 at 12:20 P.M., the Food Service Director replaced the fridge thermometers and said that the food log should not have been filled out ahead of time.