

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225412	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/05/2025
NAME OF PROVIDER OR SUPPLIER  Medway Country Manor Skilled Nursing & Rehabilitat		STREET ADDRESS, CITY, STATE, ZIP CODE  115 Holliston Street Medway, MA 02053	

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)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41107</b></p> <p>Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had moderate cognitive impairment and was dependent on staff to meet his/her care needs, the Facility failed to ensure staff implemented and followed their Abuse Policy when on 01/18/25, after being notified of an allegation of verbal abuse by staff, the Activity's Director did not immediately report the allegation of verbal abuse to Administration, and did not do so until two days later.</p> <p>Findings include:</p> <p>Review of the Facility's Abuse Policy, untitled and undated, indicated the following:</p> <ul style="list-style-type: none"> <li>- verbal abuse includes, but is not limited to, threats of harm and/or making statements to frighten a resident, and</li> <li>- upon receiving an allegation of abuse, covered individuals will take necessary steps to protect all residents and then immediately notify the Administrator.</li> </ul> <p>Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 01/23/25, indicated that on 1/18/25 at approximately 11:30 A.M., Activity Assistant (AA) #1 was pushing her activity cart down the hallway when Resident #1 moved in front of the activity cart. The Report indicated that a CNA (later identified as CNA #1) was beside Activity Assistant #1 and told her (AA #1) to run Resident #1 over with the activity cart and kill him/her because she (CNA #1) hated him/her (Resident #1).</p> <p>Review of the Facility's Internal Investigation Summary Report, undated, indicated that on 01/18/25 at approximately 11:30 A.M., Activity Assistant #1 had stopped the activity cart she was pushing because Resident #1 had moved in front of it with his/her wheelchair. The Report indicated that CNA #1 was standing next to Activity Assistant #1 when she (CNA #1) told her to run Resident #1 over with the activity cart and kill him/her because she (CNA #1) hated him/her (Resident #1).</p> <p>During an interview on 02/05/25 at 10:01 A.M., Activity Assistant #1 said that on 01/18/25 at approximately 11:20 A.M., she was wheeling her cart down the hall and stopped because Resident #1 had moved his/her wheelchair in front of the cart. Activity Assistant #1 said that when she stopped and waited for Resident #1 to move, CNA #1 told her to just run Resident #1 over with the cart, murder him/her, and [NAME] him/her somewhere because she (CNA #1) could not stand him/her. Activity Assistant #1 said she immediately called the Activity Director and reported the incident.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/05/25 at 10:21 A.M., the Activity's Director said that Activity Assistant #1 called her on 01/18/25 to report that while she had been waiting for Resident #1 to move out of her way, CNA #1 told her to get him/her (Resident #1) out of there, kill him/her, and get rid of him/her because she (CNA #1) did not like him/her (Resident #1). The Activity's Director said she did not report the allegation of verbal abuse to Administration until 01/20/25 (two days later), but said she should have reported it immediately.</p> <p>During an interview on 02/05/25 at 2:17 P.M., the Director of Nurses (DON) said she was not notified of the allegation of verbal abuse by staff that occurred on 01/18/25 involving Resident #1, until 01/20/25. The DON said that the allegation should have been reported to her immediately, but it was not.</p> <p>During an interview on 02/05/25 at 2:40 P.M., the Administrator said she was not notified of the allegation of verbal abuse by staff that occurred on 01/18/24 involving Resident #1 until 01/20/25. The Administrator said the Activity's Director should have reported the allegation of verbal abuse to her immediately, but she had not.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>41107</p> <p>Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had moderate cognitive impairment and was dependent on staff to meet his/her care needs, the Facility failed to ensure that on 01/20/25, after Facility Administration was made aware of an allegation of verbal abuse of a resident (Resident #1) by a staff member (Certified Nurse Aide #1), that they reported the allegation to the Department of Public Health (DPH) within two hours as required, when it was not reported to DPH until 01/23/25, (three days later).</p> <p>Findings include:</p> <p>Review of the Facility's Abuse Policy, untitled and undated, indicated the following:</p> <ul style="list-style-type: none"> <li>-verbal abuse includes, but is not limited to, threats of harm and/or making statements to frighten a resident, and</li> <li>-the Facility must report an allegation of abuse to the Department of Public Health within two hours of becoming aware of the allegation.</li> </ul> <p>Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated as submitted on 01/23/25, indicated that on 1/18/25 at approximately 11:30 A.M., Activity Assistant (AA) #1 was pushing her activity cart down the hallway when Resident #1 moved in front of the activity cart. The Report indicated that a CNA (later identified as CNA #1) was beside Activity Assistant #1 and told her (AA #1) to run Resident #1 over with the activity cart and kill him/her because she (CNA #1) hated him/her (Resident #1).</p> <p>Review of the Facility's Internal Investigation Summary Report, undated, indicated that on 01/18/25 at approximately 11:30 A.M., Activity Assistant #1 had stopped the activity cart she was pushing because Resident #1 had moved in front of it with his/her wheelchair. The Report indicated that CNA #1 was standing next to Activity Assistant #1 when she (CNA #1) told her to run Resident #1 over with the activity cart and kill him/her because she (CNA #1) hated him/her (Resident #1).</p> <p>During an interview on 02/05/25 at 10:21 A.M., the Activity's Director said that Activity Assistant #1 called her on 01/18/25 to report that while she had been waiting for Resident #1 to move out of her way, CNA #1 told her to get him/her (Resident #1) out of there, kill him/her, and get rid of him/her because she (CNA #1) did not like him/her (Resident #1). The Activity's Director said she did not report the allegation of verbal abuse to Administration until 01/20/25, but said she should have reported it immediately.</p> <p>During an interview on 02/13/25 at 1:23 P.M., the Administrator said that sometime in the morning, on 01/20/25, she was notified of an allegation of verbal abuse by a staff member (CNA #1) that occurred on 01/18/25 and involved Resident #1. The Administrator said she thought the allegation had been reported timely, but said she had misunderstood the timing and the process of reporting to DPH via the HCFRS. The Administrator said after being made aware of an allegation of abuse, it should be reported to DPH within two hours, but for alleged incident it had not been.</p>		