

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  225425	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/03/2025
NAME OF PROVIDER OR SUPPLIER  Watertown Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  59 Coolidge Hill Road Watertown, MA 02472	

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 0557  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.  (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on record review and interviews, for one of three sampled residents (Resident #1) who was alert, oriented and able to make his/her needs known, the Facility failed to ensure that Resident #1 was treated in a dignified and respectful manner, when during a treatment session with rehabilitation department, the Physical Therapist Assistant (PTA) approached Resident #1, leaned forward close to Resident #1's face, and loudly stated, Get off the drugs, before exiting the area. Resident #1 said that the PTA's statement was disrespectful and that he/she did not like it. Findings include: Review of the Facility's Resident Rights Policy, not dated, indicated to ensure the preservation of every resident's right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Resident #1 was admitted to the Facility in February 2023, with diagnoses that included multiple sclerosis, schizoaffective disorder bipolar type, other stimulant use, and mild cognitive impairment of uncertain. Review of Resident #1's Annual Minimum Data Set (MDS) assessment, dated 10/02/25, he/she was alert, oriented, able to make self understood and understood others. The MDS indicated that he/she required assistance with Activity Daily Living (ADL) care, and for mobility he/she used a wheelchair. The Facility's Internal Investigation, dated 09/29/25, indicated that the Director of Rehabilitation reported a resident/staff member incident involving Resident #1. The Investigation indicated that, according to the Occupational Therapist (OT), about one month prior (to 9/29/25), she discussed Resident #1's therapy progress and fatigue levels with Resident #1 in the Therapy Gym while the Physical Therapist Assistant (PTA) was present. The OT said during the discussion, the PTA interrupted the conversation and asked Resident #1 if he/she wanted advice, and after the resident responded affirmatively, the PTA approached Resident #1, leaned forward close to his/her face and loudly stated, Get off the drugs, before leaving the area. During an interview on 12/03/25 at 11:58 A.M., the Director of Rehabilitation (DOR) said that on 09/29/25, during a meeting, the Occupational Therapist (OT) reported a resident/staff member incident that had occurred around three weeks earlier during a therapy session. The DOR said that the OT reported that Resident #1 was discussing his/her therapy progress and feelings of fatigue when the Physical Therapist Assistant (PTA), who was seated next to the desk area completing documentation, interrupted the conversation, approached Resident #1, leaned forward and stated, Get off the drugs. The DOR said that the OT did not immediately report the incident to her or any other member of the management team. During an interview on 12/03/25 at 2:09 P.M., Resident #1 said that he/she recalled an incident in which the Physical Therapy Assistant (PTA) approached him/her and said, Get off the drugs. Resident #1 said that he/she did not report the incident to anyone because he/she did not want the PTA to get in trouble. Resident #1 said that the PTA was generally kind and had always treated him/her well. Resident #1 said that the PTA could have offered advice differently, rather than in a disrespectful manner, and that he/she did not like how and what the PTA had said to him/her. During a telephone interview on 12/08/25 at 11:57 A.M., the Physical Therapist Assistant (PTA) said that he did say to Resident #1, Get off the drugs, but said that he was giving Resident #1 advice. The PTA said he had a good rapport with Resident #1 and knew Resident #1 well. The PTA said that he did not believe his advice would upset Resident #1. During a telephone interview on 12/08/25 at 1:15 P.M., the Occupational Therapist (OT) said that the incident between Resident #1 and the PTA had occurred around three weeks earlier (exact date unknown) during a therapy session with Resident #1, who was asking how he/she could improve not feeling fatigued. The OT said the Physical Therapist Assistant (PTA) was not part of the conversation; however, the PTA approached and interrupted them. The OT said that the PTA leaned forward, close to Resident #1's face and loudly made the statement, Get off the drugs! The OT said the PTA left after saying that. The OT said that she did not report the incident because she thought that the PTA's behavior was unprofessional not abusive. The OT said that during a meeting on 09/29/25, she mentioned the incident to the Director of Rehabilitation (DOR). The OT said that she was a travel therapist, but aware of the Facility's abuse policy related to reporting. During an interview on 12/03/25 at 3:12 P.M., the Administrator said he was notified on 9/29/25 by the Director of Rehabilitation (DOR) of an alleged resident/staff member incident in which the Physical Therapist Assistant (PTA) made a remark to Resident #1, that was overheard by the Occupational Therapist (OT). The Administrator said the OT could not recall the exact date of the incident but reported that she felt the remark made by the PTA to Resident #1 to Get off the drugs was unprofessional.</p>		

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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>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>Based on records reviewed and interviews, for one of three sampled residents (Resident #1) who was alert, oriented and able to make his/her needs known, the Facility failed to ensure that staff implemented and followed their abuse policy, when during a rehabilitation session Occupational Therapist (OT) witnessed Physical Therapist Assistant (PTA) interact with Resident #1 in potentially abusive manner, but did not immediately report the incident as required, but instead waited several weeks to do so, which was when Administration first became aware of the incident. Findings include: Review of the Facility Policy titled Resident Right to Freedom from Abuse, Neglect, and Exploitation, not dated, indicated the Facility will develop written policies and procedures that define how staff will communicate and coordinate situations of abuse, neglect, misappropriation of resident property, and exploitation. Resident #1 was admitted to the Facility in February 2023, with diagnoses that included multiple sclerosis, schizoaffective disorder bipolar type, other stimulant use, and mild cognitive impairment of uncertain. Review of Resident #1's Annual Minimum Data Set (MDS) assessment, dated 10/02/25, he/she was alert, oriented, able to make self understood and understood others. The MDS indicated that he/she required assistance with Activity Daily Living (ADL) care, and for mobility he/she used a wheelchair. The Facility's Internal Investigation, dated 09/29/25, indicated that the Director of Rehabilitation reported a resident/staff incident involving Resident #1. The Investigation indicated that according to the Occupational Therapist (OT), approximately one month prior, she had discussed Resident #1's progress in therapy and complaint of fatigue levels with Resident #1 in the Therapy Gym while the Physical Therapist Assistant (PTA) was present. The Investigation indicated that during the discussion, the PTA interrupted the conversation and asked Resident #1 if he/she wanted advice and after the resident responded affirmatively, the PTA approached Resident #1, leaned forward, and loudly stated, Get off the drugs, before leaving the area. During an interview on 12/03/25 at 11:58 A.M., the Director of Rehabilitation (DOR) said that on 09/29/25, during a meeting, the Occupational Therapist (OT) reported an incident that had occurred approximately three weeks earlier and stated that the incident made her uncomfortable. The DOR said that the OT described the Physical Therapist Assistant's (PTA) interaction with Resident #1 and indicated that the PTA's behavior was unprofessional. The DOR said that the OT reported that the PTA leaned forward toward Resident #1 and stated, Get off the drugs. The DOR said that she informed the OT that the incident should have been reported to the Administrator or the Director of Nursing (DON) at the time it occurred. The DOR said that Resident #1 was not receiving physical therapy at the time of the incident and was only receiving occupational therapy, which was nearing completion. During a telephone interview on 12/08/25 at 1:15 P.M., the Occupational Therapist (OT) said on 9/29/25, when she told the DOR about the incident that had occurred between Resident #1 and the PTA, that the incident had occurred around three weeks earlier during a therapy session with Resident #1. The OT said that the PTA leaned forward toward Resident #1's face and stated loudly to him/her, Get off the drugs. The OT said that she did not immediately report the incident to the Facility administration. The OT said that she believed the PTA's behavior was unprofessional not abuse and was why she had not reported it at that time. The OT said that she was aware of the Facility's abuse policy related to reporting and acknowledged her failure to report the incident, as required. During an interview on 12/03/25 at 3:12 P.M., the Administrator said that the Occupational Therapist (OT) failed to immediately report the incident involving alleged verbal abuse by the Physical Therapist Assistant (PTA), as required by Facility policy. The Administrator said that the OT did not follow the Facility's Abuse Prevention and Reporting Policy.</p>		