

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 05/10/2024
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)
<p>F 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.</p> <p>36431</p> <p>Based on record review and interview the facility failed to ensure residents who have their personal needs accounts maintained by the facility received quarterly statements as required. Specifically, the facility failed for 56 residents who have personal needs accounts held by the facility, to provide quarterly statements of the personal needs account balances for over one year.</p> <p>Findings include:</p> <p>During an interview during the initial tour on 5/7/24 at 9:56 A.M., a resident said he/she had questions about his/her finances and did not know his/her balance or even if he/she had a personal needs account.</p> <p>Review of the facility's document titled, Trial Balance, dated as of 5/9/24 indicated 56 residents have a personal needs account maintained by the facility.</p> <p>During an interview on 5/9/24 at 4:22 P.M., the Business Office Manager (BOM), said he has been working at the facility for about three months. The BOM said he was unable to locate any quarterly statements that were provided to residents or resident representatives since March 2023. The BOM said he did not send out the last quarterly personal needs statements. Review of a binder provided by the BOM, indicated statements were provided the first quarter of 2023. The BOM was unable to provide any further documentation since March 2023 that personal needs statements were provided for the last four quarters.</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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876</p> <p>Based on record review and interview, the facility failed to report an allegation of abuse within the required time frame for one Resident (#26) out of a total of 29 sampled residents.</p> <p>Findings include:</p> <p>Review of the facility's Abuse Neglect Exploitation and Misappropriation - Reporting and Investigation policy, dated September 2022 indicated that allegations of abuse are to be reported within two hours to the state agency.</p> <p>Resident #26 was admitted to the facility in January 2024 with diagnoses including anxiety disorder and seizure disorder.</p> <p>Review of the Minimum Data Set assessment dated [DATE] indicated Resident #26 scored an 11 out of a possible 15 on the Brief Interview for Mental Status Exam indicating he/she is moderately cognitively impaired.</p> <p>Review of Resident #26 clinical record indicated he/she is his/her own decision maker.</p> <p>During an interview on 5/9/24 at 2:28 P.M., Resident #26 said that the previous night (5/8/24) while he/she was in the unit kitchenette, a Certified Nursing Assistant (CNA) grabbed him/her by the genitals and left. Resident #26 said he/she reported the incident to Social Worker and Director of Nursing.</p> <p>Review of the facility reports filed to the state agency on 5/10/24 at 8:30 A.M., failed to indicate Resident #26's allegation of abuse was reported to the state agency.</p> <p>During an interview on 5/10/24 at 10:11 A.M., the Director of Nursing (DON) said that there had been multiple reportable events on 5/9/24 and staff had been assisting with filing the reports. The DON said that she thought the allegation had been reported as required.</p>

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876</p> <p>Based on observation, record review and interview, the facility failed to ensure one Resident (#10) returned to his/her original bed upon returning from a hospitalization out of a total of 29 sampled residents.</p> <p>Findings include:</p> <p>Review of the facility's Bed-hold and Returns policy, dated March 2017, indicated: The current bed-hold and return policy established by the state (if applicable) will apply to Medicaid residents in the facility.</p> <p>Review of the Commonwealth of Massachusetts MassHealth Provider Nursing Facility Manual, dated 10/1/23 indicated: 456.426: Medical Leave of Absence: Conditions of Payment. (A) When a member is transferred from a nursing facility to a hospital, the nursing facility must: (4) automatically reserve the same bed and room occupied by the member at the time the absence began for the member until the close of business on the second working day of the member's hospital stay; (6) if the estimated length of stay is 20 consecutive days or fewer, reserve the same bed and room occupied by the member at the time the absence began for the balance of the actual length of stay not to exceed 20 consecutive days from the date of admission to the hospital.</p> <p>Resident #10 was admitted to the facility in May 2020 with diagnoses including diabetes and cerebral vascular accident (stroke).</p> <p>Review of the Minimum Data Set assessment dated [DATE] indicated he/she scored 14 out of a possible 15 on the Brief Interview for Mental Status Exam (BIMS) indicating he/she is cognitively intact.</p> <p>Review of Resident #10's clinical record indicated his/her health care proxy was not activated and he/she is his/her own decision maker.</p> <p>The clinical record also indicated that Resident #10 was hospitalized on [DATE] and returned to the facility on [DATE]. Upon Resident #10's return to the facility, he/she was moved into a new room on a different floor.</p> <p>During an interview on 5/9/24 at 9:27 A.M., Nurse #2 said that Resident #10 was sent to the hospital for evaluation after he/she had a fall and when he/she was brought back, staff moved him/her to a room on the 3rd floor to be closer to the nurses station. Nurse #2 said that Resident #10 would not call for assistance and is a fall risk.</p> <p>During an interview on 5/9/24 at 9:35 A.M., Resident #10 said that after he/she was hospitalized , he/she was brought to his/her current room on the 3rd floor. Resident #10 said that he/she did not want to change rooms from his/her previous room on the 4th floor, was not notified that he/she was being moved to another room and that he/she wants to return to his/her old room on the 4th floor.</p> <p>(continued on next page)</p>

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/9/24 at 10:33 A.M., the Social Worker said that it was her understanding that residents on MassHealth and who are hospitalized have a 20 day bed hold in place to ensure they have a bed available. The Social Worker said that she believed that the decision to move Resident #10 to the 3rd floor was to be closer to the nurses station as he/she is a fall risk. The Social Worker said that she did not know if Resident #10 was notified prior to his/her return to the facility and was not aware that Resident #10 did not want to have his/her room changed.</p> <p>During an interview on 5/10/24 at 10:08 A.M., the Director of Nursing (DON) said that the decision to have Resident #10 return to the facility in a different room on a different unit, was based on safety and she met with Resident #10 to discuss his/her return to a different room when Resident #10 returned from the hospital.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>36876</p> <p>Based on record review and interview, the facility failed to ensure baseline care plans indicated the level of assistance related to Activities of Daily Living (ADLs) and mobility for one Resident (#273) out of a total of 29 sampled residents.</p> <p>Findings include:</p> <p>Resident #273 was admitted to the facility in April 2024 with diagnoses including cerebral palsy and disorder of kidney and ureter.</p> <p>There was no Minimum Data Set Assessment (MDS) available regarding Resident #273 at the time of survey.</p> <p>Review of Resident #273's current baseline care plans indicated:</p> <p>Focus: The resident has an ADL self care performance deficit r/t (related to) chronic back pain and limited mobility, dated 4/30/24</p> <p>Interventions: Toilet Use: The resident required (X) staff participation to use the toilet. Transfer: The resident requires (X) staff participation with transfers. Bathing: The resident requires (X) staff participation with bathing/showers. Personal hygiene: The resident requires (specify assistance; cueing with short simple instructions such as hold your brush, wash your hands, over hand guidance; physical assistance; (complete help) with personal hygiene care. Dressing: The resident requires (X) staff participation to dress.</p> <p>Focus: The resident has limited physical mobility, dated 4/30/24. Interventions: Mobility: The resident required (X) staff participation.</p> <p>The care plans failed to indicate the level of assistance from staff that Resident #273 required for mobility and activities of daily living.</p> <p>During an interview on 5/9/24 at 1:38 P.M., the Director of Nursing said that she would expect resident baseline care plans to include information related to ADL care. The surveyor and the DON reviewed Resident #273's ADL and mobility care plans and she was not aware that the care plans failed to indicate the level of assistance Resident #273 requires for care.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984</p> <p>Based on observation, record review, and interview, the facility failed to follow professional standards of nursing practice for three Residents (#422, #29, #24) out of a total sample of 29 residents. Specifically, 1) for Residents #422 and #29, the facility failed to measure the external measurement of the Peripherally Inserted Central Catheter (PICC) line as ordered by the physician, and 2) for Resident #24, the facility failed to identify and treat oral thrush (a fungal infection of the mouth).</p> <p>Findings include:</p> <p>1. a) Review of the facility policy titled Central Venous Catheter Care and Dressing Changes, dated and revised March 2022 indicated the following:</p> <ul style="list-style-type: none"> - The purpose of this procedure is to prevent complications associated with intravenous therapy, including catheter-related infections that are associated with contaminated, loosened, soiled, or wet changes. - General Guidelines: Measure the length of the external central vascular access device with each dressing change or if catheter dislodgement is suspected. Compare with the length documented at insertion. <p>Review of the facility policy titled Central Venous Catheter Care and Dressing Changes, dated and revised March 2022 indicated the following:</p> <ul style="list-style-type: none"> - The purpose of this procedure is to prevent complications associated with intravenous therapy, including catheter-related infections that are associated with contaminated, loosened, soiled, or wet changes. - General Guidelines: Measure the length of the external central vascular access device with each dressing change or if catheter dislodgement is suspected. Compare with the length documented at insertion. <p>Resident #422 was admitted to the facility in April 2024 with diagnoses including osteomyelitis, Diabetes Mellitus, and sepsis.</p> <p>Review of Resident #422's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 15 out of a possible 15 indicating intact cognition.</p> <p>During an observation on 5/8/24 at 7:43 A.M., the surveyor observed Resident #422 having a Peripherally Inserted Central Catheter (PICC) (a tube that is inserted into a vein in the upper arm and guided into a large vein above the right side of the heart to provide medication) in his/her left upper arm.</p> <p>Review of Resident #422's physician's orders indicated the following:</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Dated 4/25/24: IV-Central Line-(all types): measure external catheter length on admission, with each dressing change and PRN (as needed).</p> <p>- Dated 5/2/24: IV-Central Line-(all types): change transparent dressing on admission, weekly and PRN.</p> <p>Review of Resident #422's hospital discharge documentation dated 4/9/24 failed to indicate the external length of the PICC line upon insertion.</p> <p>Review of Resident #422's Medication Administration Records (MAR) for the months of April and May 2024 failed to indicate that measurements of the external PICC line were obtained as ordered.</p> <p>Review of Resident #422's nursing progress notes failed to indicate that measurements of the external PICC line were documented.</p> <p>During an interview on 5/9/24 at 10:09 A.M., Nurse #2 said PICC line measurements should be in Resident #422's medical record since they need to be done with each dressing change. Nurse #2 and the surveyor reviewed Resident #422's medical record and were unable to locate measurements, Nurse #2 said she was not sure why they were not documented on admission or with the Resident's last dressing change.</p> <p>During an interview on 5/9/24 at 11:18 A.M., the Director of Nursing (DON) said PICC line measurements should be obtained on admission and weekly with dressing changes and they should be documented in the medical record.</p> <p>During an interview on 5/9/24 at 1:39 P.M., the DON said Resident #422's PICC line measurements are not in his/her medical record, but they should have been.</p> <p>1. b) Review of the facility policy titled Central Venous Catheter Care and Dressing Changes, dated and revised March 2022 indicated the following:</p> <p>- The purpose of this procedure is to prevent complications associated with intravenous therapy, including catheter-related infections that are associated with contaminated, loosened, soiled, or wet changes.</p> <p>- General Guidelines: Measure the length of the external central vascular access device with each dressing change or if catheter dislodgement is suspected. Compare with the length documented at insertion.</p> <p>Review of the facility policy titled Central Venous Catheter Care and Dressing Changes, dated and revised March 2022 indicated the following:</p> <p>- The purpose of this procedure is to prevent complications associated with intravenous therapy, including catheter-related infections that are associated with contaminated, loosened, soiled, or wet changes.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- General Guidelines: Measure the length of the external central vascular access device with each dressing change or if catheter dislodgement is suspected. Compare with the length documented at insertion.</p> <p>Resident #29 was admitted to the facility in January 2024 with diagnoses including Parkinson's Disease, ulcerative colitis, and sepsis.</p> <p>Review of Resident #29's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the resident had a Brief Interview for Mental Status score of 12 out of a possible 15 indicating moderate cognitive impairment. Further review of the MDS indicated that Resident #29 is dependent on staff for all Activities of Daily Living.</p> <p>During an observation on 5/8/24 at 7:47 A.M., the surveyor observed Resident #29 having a Peripherally Inserted Central Catheter (PICC) (a tube that is inserted into a vein in the upper arm and guided into a large vein above the right side of the heart to provide medication) line in his/her left upper arm.</p> <p>Review of Resident #29's Physician's orders dated 5/1/24 indicated the following:</p> <p>- IV-Central Line- (all types): measure external catheter length on admission, with each dressing change and PRN (as needed).</p> <p>- IV-Central Line- (all types): change transparent dressing on admission, weekly and PRN.</p> <p>Review of Resident #29's hospital discharge documentation dated 3/29/24 failed to indicate the external length of the PICC line upon insertion.</p> <p>Review of Resident #29's Medication Administration Records (MAR) for the months of March, April and May 2024 failed to indicate that measurements of the external PICC line were obtained as ordered.</p> <p>Review of Resident #29's nursing progress notes failed to indicate that measurements of the external PICC line were documented.</p> <p>During an interview on 5/9/24 at 10:09 A.M., Nurse #2 said PICC line measurements should be in Resident #29's medical record since they need to be done with each dressing change. Nurse #2 and the surveyor reviewed Resident #29's medical record and were unable to locate measurements, Nurse #2 said she was not sure why they were not documented on admission or with the Resident's last dressing change.</p> <p>During an interview on 5/9/24 at 11:18 A.M., the Director of Nursing (DON) said PICC line measurements should be obtained on admission and weekly with dressing changes and they should be documented in the medical record.</p> <p>During an interview on 5/9/24 at 1:39 P.M., the DON said Resident #29's PICC line measurements are not in his/her medical record, but they should have been.</p> <p>2. Review of the facility policy titled Mouth Care, dated and revised February 2018, indicated the following:</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- The purposes of this procedure are to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth, and to prevent oral infection.</p> <p>- Documentation: The date and time the mouth care was provided. The name and title of the individual(s) who provided the mouth care. All assessment data obtained concerning the resident's mouth. The certified nursing assistant should report to the licensed nurse to record in the medical record.</p> <p>- Reporting: Report other information in accordance with facility policy and professional standards of practice.</p> <p>Resident #24 was admitted to the facility in July 2021 with diagnoses including traumatic subdural hemorrhage, dysphagia, and convulsions.</p> <p>Review of Resident #24's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 00 indicating that the Resident has severe cognitive impairment. Further review of the MDS indicated that Resident #24 is dependent on all Activities of Daily Living and requires a feeding tube for eating.</p> <p>During an observation on 5/8/24 at 8:05 A.M., 5/9/24 at 7:28 A.M., and 5/9/24 at 12:08 P.M., Resident #24 was observed having a thick, white coating on his/her tongue and lips.</p> <p>Review of Resident #24's physician's orders indicated the following:</p> <ul style="list-style-type: none"> - Dated 7/12/23: NPO (nothing by mouth) diet - Dated 11/1/22: Oral care/mouth care every shift. <p>Review of Resident #24's dependent on ADL's care plan indicated the following interventions:</p> <ul style="list-style-type: none"> - Dated 8/24/23: daily oral care - Dated 5/18/23: I am dependent on 1 staff to provide my enteral feed (tube feeding). I am NPO. <p>Review of Resident #24's Treatment Administration Record (TAR) indicated that staff have performed oral care every day on every shift.</p> <p>During an interview on 5/9/23 at 7:34 A.M., Certified Nursing Assistant (CNA) #3 said we perform oral care daily for Resident #24 with brushes or sponges. She continued to say the white layer on his/her tongue does not go away and it has always been there since she could remember. CNA #3 said nursing should be aware of it.</p> <p>During an interview on 5/9/24 at 12:30 P.M., Nurse #2 said the Nurse Practitioner and doctor were aware of the oral thrush and tried something in past, but nothing seemed to work. She continued to say that Resident #24 has had oral thrush for a long time.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/9/24 at 2:48 P.M., the Nurse Practitioner (NP) said she was not aware that Resident #24 currently had oral thrush and that no one has told her. She continued to say she tried a medication in 2022 but it did not work. The NP continued to say she has not seen Resident #24 in a while but if she knew about the oral thrush, she would have implemented an intervention. She then said there are ways to administer medication to Resident #24's mouth despite him/her being NPO. The NP said it is concerning to her that no one told her about the oral thrush.</p> <p>During an interview on 5/10/24 at 8:06 A.M., Nurse #2 said Resident #24 has had oral thrush for a long time and she thought someone knew about it and it was taken care of. She said she did not know the NP was not aware of it since Resident #24 has had it for so long. Nurse #2 said they have just been doing daily oral care and they assumed nothing could be done to fix it.</p> <p>During an interview on 5/10/24 at 7:07 A.M., the Director of Nursing (DON) said if staff knew about Resident #24's oral thrush they should have told someone so interventions could have been implemented.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846</p> <p>Based on observations, record review, policy review and interviews, the facility failed to provide supervision and assistance with Activities of Daily Living (ADLs), for three Residents (#25, #92 and #69) out of a total sample of 29 residents. Specifically, the facility failed to</p> <ol style="list-style-type: none"> 1.) provide supervision with meals for two Residents (#25, #92) and 2.) provide assistance with meals for one Resident (#69). <p>Findings include:</p> <p>Review of the facility policy titled Activities of Daily Living (ADL) Supporting, dated March 2018, indicated Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: D. dining (meals and snacks).</p> <p>1. a) Resident #25 was admitted to the facility August 2011 dysphagia, traumatic brain injury, hemiplegia and hemiparesis, and dementia.</p> <p>Review of Resident #25's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident is cognitively intact.</p> <p>On 5/8/24 at 8:55 A.M., the surveyor observed Resident #25 in bed with their privacy curtain pulled to the foot of the bed with his/her breakfast meal. The Resident was unable to be seen from the hallway, no staff were present in the room.</p> <p>On 5/9/24 from 8:37 A.M. to 8:47 A.M., the surveyor observed Resident #25 in bed with their privacy curtain pulled to the foot of the bed with his/her breakfast meal not initiating to eat the meal. The Resident was unable to be seen from the hallway, no staff were present in the room.</p> <p>On 5/9/24 from 12:26 P.M. to 12:35 P.M., the surveyor observed Resident #25 in bed with their privacy curtain pulled to the foot of the bed with his/her lunch meal not initiating to eat the meal. The Resident was unable to be seen from the hallway, no staff were present in the room.</p> <p>On 5/10/24 from 8:30 A.M. to 8:38 A.M., the surveyor observed Resident #25 in bed with their privacy curtain pulled to the foot of the bed with his/her breakfast meal not initiating to eat the meal. The Resident was unable to be seen from the hallway, no staff were present in the room.</p> <p>Review of Resident #25's Activity of Daily Living (ADL) care plan, dated 4/25/23, indicated Eating: Continual supervision.</p> <p>(continued on next page)</p>

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 05/10/2024
NAME OF PROVIDER OR SUPPLIER Watertown Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Coolidge Hill Road Watertown, MA 02472	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #25's Certified Nurse Aide (CNA) Kardex, dated 5/9/24, indicated Eating: Continual supervision.</p> <p>During an interview on 5/10/24 at 9:59 A.M., CNA #2 said each resident has a Kardex that staff follow. CNA #2 said that if a Resident should be supervised then staff should be in the room supervising them at meal times.</p> <p>During an interview on 5/10/24 at 10:01 A.M., Nurse #4 said each resident has a Kardex and care plan that explains how each resident should be cared for and said it should be followed.</p> <p>45343</p> <p>1 b) Resident #92 was admitted to the facility in June 2023 with diagnoses including hemiplegia and hemiparesis following a cerebral infarct affecting left non-dominant side, dysphagia (difficulty swallowing), and pneumonitis due to inhalation of other solids and liquids.</p> <p>Review of Resident #92's most recent Minimum Data Set (MDS) assessment dated [DATE] indicated the Resident had Brief Interview for Mental Status score of 12 out of a possible 15 indicating that he/she is moderately cognitively impaired. Further review of the MDS indicated Resident #92 currently requires dependent assistance for activities of daily living.</p> <p>On 5/9/24 at 8:15 A.M., 8:22 A.M., 8:41 A.M., 12:15 P.M., and 12:22 P.M., and 5/10/24 at 8:09 A.M., and 8:22 A.M., Resident #92 was observed eating in his/her room. There were no staff present to provide supervision.</p> <p>During a record review on 5/9/24 at 8:18 A.M., Resident #92's care plan last updated on 6/7/23 indicated the following: Eating: Resident requires supervision for all meals by staff. Further review of Resident #92's Kardex (a form indicating level of assistance a resident requires) indicated the following: Eating: Resident requires supervision for all meals by staff.</p> <p>During an interview on 5/10/24 at 8:20 A.M., Nurse #3 said Resident #92 does require supervision but most of the time we set up his/her tray and he/she will eat on his/her own.</p> <p>During an interview on 5/10/24 at 8:47 A.M., the Director of Nursing said Resident #92 should be supervised by staff for the entire meal per their care plan.</p> <p>45984</p> <p>2) Resident #69 was admitted to the facility in June 2023 with diagnoses including dementia and anxiety disorder.</p> <p>Review of Resident #69's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 00 indicating severe cognitive impairment. Further review of the MDS indicated that Resident #69 is dependent on staff for all Activities of Daily Living, including eating.</p> <p>The surveyor made the following observations:</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- On 5/8/24 at 7:42 A.M., Resident #69 was observed sitting in a chair in his/her room eating breakfast with no assistance from staff.</p> <p>- On 5/9/24 from 8:13 A.M. to 8:40 A.M., Resident #69 was observed sitting in a chair eating breakfast in his/her room with no assistance from staff.</p> <p>- On 5/9/24 at 12:26 P.M., Resident #69 was observed sitting in a chair in his/her room eating lunch with no assistance from staff.</p> <p>- On 5/10/24 from 8:26 A.M. to 8:39 A.M., Resident #69 was observed sitting in a chair in his/her room eating breakfast with no assistance from staff.</p> <p>Review of Resident #69's Kardex (a nursing care card), indicated the following under the eating section:</p> <p>- EATING: The resident requires (1) staff participation to eat.</p> <p>Review of Resident #69's ADL self-care performance deficit related to dementia care plan dated 6/13/23 indicated the following intervention:</p> <p>- EATING: The resident requires (1) staff participation to eat.</p> <p>During an interview on 5/10/24 at 9:46 A.M., Certified Nursing Assistant (CNA) #3 said Resident #69 is very confused and he/she only requires set up assistance with feeding and does not need help from staff.</p> <p>During an interview on 5/10/24 at 10:27 A.M., Nurse #2 said Resident #69 can feed him/herself. Nurse #2 and the surveyor reviewed Resident #69's chart and she was not aware it said the Resident was dependent on one staff for feeding.</p> <p>During an interview on 5/10/24 at 11:20 A.M., the Regional Nurse and Director of Nursing said Resident #69's MDS, Kardex and care plans should be followed and he/she should be receiving assistance from one staff member while eating meals.</p>		

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NAME OF PROVIDER OR SUPPLIER Watertown Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Coolidge Hill Road Watertown, MA 02472	

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846</p> <p>Based on observations, record reviews and interviews, the facility failed to ensure that one Resident (#25) received treatment and care in accordance with professional standards of practice out of a total sample of 29 residents. Specifically, for Resident #25, the facility failed to complete a dressing change in accordance with physician's orders.</p> <p>Findings Include:</p> <p>Resident #25 was admitted to the facility August 2011 dysphagia, traumatic brain injury, hemiplegia and hemiparesis, and dementia.</p> <p>Review of Resident #25's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident is cognitively intact.</p> <p>On 5/8/24 at 8:17 A.M., the surveyor observed the Resident in bed without a dressing on his/her nose.</p> <p>On 5/9/24 at 7:42 A.M., the surveyor observed the Resident in bed without a dressing on his/her nose.</p> <p>On 5/9/24 at 8:30 A.M. and 10:40 A.M., the surveyor observed the Resident in bed without a dressing on his/her nose.</p> <p>On 5/10/24 at 8:30 A.M., the surveyor observed the Resident in bed without a dressing on his/her nose.</p> <p>Review of Resident #25's actual skin alteration left side of nasal care plan, dated 10/20/2023, indicated treatment as ordered.</p> <p>Review of Resident #25's physician order, dated 4/18/24, indicated L (left) Nose: Cleanse with NS (normal saline), apply bacitracin and cover with DSD (dry sterile dressing) every day shift for wound care and as needed for soiled dressing.</p> <p>Review of Resident #25's wound physician's wound evaluation and management summary, dated 5/8/24, indicated the Resident has a full thickness wound to the left side of his/her nose. The wound evaluation summary further indicated that the wound physician surgically debrided the area on 5/8/24 to remove necrotic tissue and to continue to treatment of apply Bacitracin to the wound and cover with a gauze sponge daily.</p> <p>Review of Resident #25's nursing progress note, dated 5/8/24, indicated Note Text: alert and verbally responsive, nasal biopsy site dry, tx (treatment) a/o (as ordered).</p> <p>Further review of the nursing progress notes did not indicate that the Resident refused his/her nasal wound treatment or had behaviors of removing the dressing.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/10/24 at 10:00 A.M., Nurse #4 said when she came in today for her shift Resident #25 did not have a dressing on his/her nose as ordered. Nurse #4 said there should be a dressing in place at all times and said nurses should write notes if there was any issues with the Resident and their dressing.</p> <p>During an interview on 5/10/24 at 11:46 A.M., the Director of Nurses (DON) said the Resident should have a dressing on his/her nose at all times. The DON said that if the Resident had taken it off or the dressing could not be completed then it should be documented in a nursing progress note.</p>		

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NAME OF PROVIDER OR SUPPLIER Watertown Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Coolidge Hill Road Watertown, MA 02472	

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984</p> <p>Based on observation, record review and interview, the facility failed to address the nutrition status of one Resident (#422) out of a total sample of 29 residents. Specifically, for Resident #422, the facility failed to provide the ordered diet of double protein with meals to help promote wound healing.</p> <p>Findings include:</p> <p>1) Review of the facility policy titled Therapeutic Diets, dated and revised October 2017, indicated the following:</p> <ul style="list-style-type: none"> - Diet will be determined in accordance with the resident's informed choices, preferences, treatment goals and wishes. - A therapeutic diet is considered a diet ordered by a physician, practitioner or dietitian as part of treatment for a disease or clinical condition, to modify nutrients in the diet, or to alter the texture of a diet. <p>Resident #422 was admitted to the facility in April 2024 with diagnoses including osteomyelitis, Diabetes Mellitus and sepsis.</p> <p>Review of Resident #422's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 15 out of a possible 15 indicating intact cognition.</p> <p>During an interview on 5/8/24 at 7:43 A.M., Resident #422 said he/she wanted double protein with his/her breakfast, and he/she has not been getting it.</p> <p>Review of Resident #422's physician's orders indicated the following:</p> <ul style="list-style-type: none"> - Dated 4/25/24: No concentrated sweets diet (NCS), regular texture, thin consistency, double protein. - Dated 5/4/24: Right lower extremity wounds: (right plantar medial foot, right third toe) - Dated 5/4/24: Left lower extremity wounds: (left plantar first toe, left lateral fifth toe, left distal plantar medical foot) <p>Review of Resident #422's Kardex (a nursing care card) indicated the following under the Eating section:</p> <ul style="list-style-type: none"> - Provide diet as ordered: NCS (double protein) <p>Review of Resident #422's pressure ulcer care plan dated 4/25/24 indicated the following intervention:</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Monitor nutritional status. Serve diet as ordered, monitor intake and record.</p> <p>Review of Resident #422's nutritionally at-risk care plan dated 4/26/24 indicated the following interventions:</p> <p>- Honor food preferences</p> <p>- Provide diet as ordered: NCS (double protein)</p> <p>Review of Resident #422's Nutritional Risk Evaluation documented by the Registered Dietitian (RD) on 4/26/24 indicated the following:</p> <p>- On visit he/she reports a strong appetite (wants double protein)</p> <p>- Recs (Recommendations): add double protein to diet order</p> <p>Review of the Physician's progress note dated 4/26/24 at 11:20 A.M., indicated the following:</p> <p>- At risk for malnutrition due to multiple medical comorbidities and variable oral intake. Follow Dietitian recommendations and monitor nutritional status, weight trend.</p> <p>Review of the RD's progress note dated 5/3/24 at 6:55 P.M., indicated the following:</p> <p>- Resident #422 has recently reported that he/she is not receiving enough food on tray. He/she is ordered for double protein r/t (related to) wound healing and history of T2DM (type 2 diabetes).</p> <p>During an observation on 5/9/24 at 8:15 A.M., the surveyor observed Resident #422's breakfast meal. There was only one serving of scrambled eggs and no double portion of protein. Review of the meal ticket failed to indicate Resident #422 should be getting double protein with meals.</p> <p>During an observation on 5/9/24 at 12:25 P.M., the surveyor observed Resident #422's lunch meal containing cheese lasagna and a dinner roll. The meal contained very little protein and no double portion of protein. Review of the meal ticket failed to indicate Resident #422 should be getting double protein with meals.</p> <p>During an observation on 5/10/24 at 8:29 A.M., the surveyor observed Resident #422's breakfast meal. There was only one serving of an egg bake and no double portion of protein. Review of the meal ticket failed to indicate Resident #422 should be getting double protein with meals.</p> <p>During an observation on 5/10/24 at 7:53 A.M., Nurse #5 said to Nurse #2 that Resident #422 needs his double protein. Nurse #2 said it is not in Resident #422's diet orders or on his/her meal ticket and the RD needs to put it in. Nurse #5 proceeded to cancel the request with the kitchen for double protein.</p> <p>During an observation on 5/10/24 8:31 A.M., Resident #422 asked Nurse #5 for double protein with his/her breakfast as he/she did not receive it on his/her breakfast tray.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Watertown Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Coolidge Hill Road Watertown, MA 02472	
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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/10/24 at 7:31 A.M., the Food service Director said the RD puts each resident's diet on the meal ticket and the kitchen prints them and the kitchen staff will follow what the meal ticket says.</p> <p>During an interview on 5/10/24 at 9:51 A.M., the Registered Dietitian said she has been working in the facility for three weeks and sees all residents on a routine schedule. She said if a resident requires a special diet or supplement, she would let the kitchen know and they would put the request on the resident's meal ticket to make sure the kitchen staff provides it. The RD said one of Resident #422's biggest complaints is that he/she has not been getting his/her double protein with his/her meals. The RD said he/she should be getting the extra protein to help with his/her wounds healing. The RD and surveyor reviewed the photos taken of Resident #422's meal and meal tickets and she the RD said he/she has not been getting double protein portions and she was not aware it was not listed on his/her meal tickets.</p> <p>During an interview on 5/10/24 at 10:27 A.M., Nurse #2 said if the double protein was listed on Resident #422's meal ticket we could make sure he/she was getting it with all his/her meals.</p> <p>During an interview on 5/10/24 at 11:20 A.M., the Regional Nurse and the Director of Nursing said Resident #422's diet should be on his/her meal ticket so he/she is served the correct diet.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>36876</p> <p>Based on record review and interview, the facility failed to ensure the ongoing communication and collaboration with the dialysis facility regarding dialysis care and services for one Resident (#273) out of a total of 29 sampled residents.</p> <p>Findings include:</p> <p>Resident #273 was admitted to the facility in April 2024 with diagnoses including cerebral palsy and disorder of kidney and ureter.</p> <p>There was no available Minimum Data Set Assessment (MDS) available regarding Resident #273 at the time of survey.</p> <p>Review of the facility's policy titled 'Care of a Resident with End-Stage Renal Disease', dated June 2023, indicated: Communication sheet to be sent with resident to dialysis filled out of by SNF (skilled nursing facility) to include medication administration-meds held or discontinued, advanced directives, nutrition/fluid management, including compliance with fluid restriction. Upon return, the facility will review the dialysis communication for tolerance of treatment, and recommendations made by the dialysis center to be reviewed with the primary physician. Signs and symptoms of depression or mental status, changes, decline in conditions and any adverse events which may have occurred at the external dialysis center.</p> <p>During an interview on 5/8/24 at 9:10 A.M., Resident #273 said he/she goes to dialysis three days a week.</p> <p>Review of Resident #273 clinical record indicated he/she receives dialysis treatments three days a week Mondays, Wednesdays and Fridays and the facility coordinates transportation to and from the dialysis center.</p> <p>Review of Resident #273's dialysis communication binder and clinical progress notes failed to indicate any ongoing communication occurred between the facility and the dialysis treatment center.</p> <p>During an interview on 5/9/24 at 8:07 A.M., Nurse #1 said that when residents are on dialysis, the expectation is for staff to send a communication binder with the resident and to review any information sent back from the dialysis center regarding the resident. Nurse #1 reviewed the communication book with the surveyor and there was one pre-dialysis entry for 5/3/24. There were no other entries in the communication book. Nurse #1 said that sometimes the dialysis center does provide or complete the communication form. Nurse #1 said she was not sure if any staff nurses have called to follow up to obtain updates or information regarding Resident #273's status during his/her treatments.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/9/24 at 1:36 P.M., the Director of Nursing (DON) said that it is expected for ongoing communication between the facility and the dialysis center to take place while residents are on dialysis and that the facility utilizes a communication book for Resident #273. The DON said that she would expect staff to contact the dialysis center and document a progress note if the communication book is blank after a dialysis appointment. The DON was not aware that Resident #273's dialysis communication book did not include information related to his/her post dialysis treatments or that there were progress notes indicating ongoing communication between the facility and the dialysis clinic.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>36797</p> <p>Based on observation, policy review and interview the facility failed to ensure medications and biological's were stored in a safe and secure manner in two of four medication carts and two of four units.</p> <p>Findings include:</p> <p>Review of the facility policy titled Storage of Medications and dated revised November 2020, indicated that the facility stores all drugs and biological's in a safe, secure, and orderly manner. Further review indicated that drugs and biological's are stored in locked compartments and only persons authorized to prepare and administer medications have access to locked medications. Further review indicated that medications requiring refrigeration are stored in a refrigerator located in the drug room at the nurse's station.</p> <p>On 5/9/24, at 8:15 A.M. the surveyor observed Nurse #6 on the fourth floor, open the medication cart for the surveyor and leave the surveyor alone with the open medication cart.</p> <p>On 5/9/24, at 8:19 A.M. the surveyor observed the following in the 4th floor medication cart.</p> <p>A) 1 bottle of Moxifloxacin ophthalmic solution. (used to treat eye infections)</p> <p>B) 1 Glargine-yfgn insulin pen unopened and not refrigerated. (used to treat diabetes)</p> <p>During an interview on 5/9/24, at 8:26 A.M. Nurse #6 said that the insulin pen was supposed to be refrigerated. Nurse #6 also said that the eye drops should be dated when opened. Nurse #6 then said that he thought that if the narcotic box in the medication cart was locked that he could leave the surveyor alone with the medication cart.</p> <p>On 5/9/24, at 8:54 A.M., the surveyor observed the following in the third floor medication cart.</p> <p>1 tube Santyl (used to treat wounds)</p> <p>1 Anoro inhaler open and without a date opened. (used to treat asthma)</p> <p>On 5/9/24, at 9:08 A.M., the surveyor observed Nurse #4 give a resident a cup full of medication. Nurse #4 then left the room without observing the resident take the medication, to get more medication from the medication cart in the hallway. Nurse #4 then reentered the resident's room and the cup full of medication was gone.</p> <p>During an interview on 05/9/24 at 9:18 A.M., Nurse #4 said the inhaler should be dated. Nurse #4 also said that she knows that treatments are not supposed to be stored in the medication cart. Nurse #4 then said that she should not have left the resident's room without observing the resident taking the medication.</p>

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 05/10/2024
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45984</p> <p>Based on observation and interview, the facility failed to follow infection control protocols to prevent the possible spread of infection by failing to follow proper hand hygiene protocols and the use of Personal Protective Equipment (PPE) for an Enhanced PPE Precaution room.</p> <p>Review of the facility policy titled Isolation - Categories of Transmission-Based Precautions, dated and revised September 2022, indicated the following:</p> <ul style="list-style-type: none"> -Standard precautions are used when caring for residents at all times regardless of their suspected or confirmed infection status. -Transmission-based precautions are additional measures that protect staff, visitors and other residents from becoming infected. -When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door. - The signage informs the staff of the type of CDC precaution(s), instructions for use of PPE. <p>1. Outside of room [ROOM NUMBER], a Contact Precautions sign was hanging beside the door indicating the following:</p> <ul style="list-style-type: none"> - Everyone must clean their hands, including before entering and when leaving the room. -Providers and staff must also: put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. <p>The surveyor made the following observations:</p> <ul style="list-style-type: none"> -On 5/9/24 at 8:22 A.M., a Certified Nursing Assistant (CNA) was observed delivering a breakfast tray to a resident in room [ROOM NUMBER]. The CNA entered the room without performing hand hygiene and not wearing gloves or a gown. The CNA then exited the room without performing hand hygiene, grabbed a different resident's breakfast tray from the meal cart and delivered it to a different room. The same CNA then went back into room [ROOM NUMBER] to deliver another breakfast tray without gloves or a gown. The CNA was observed leaving room [ROOM NUMBER] without performing hand hygiene and grabbed another resident's meal tray from the meal cart and delivered it to another room without performing hand hygiene. 2. Outside of room [ROOM NUMBER] was a sign indicating Enhanced PPE Precautions stating the following: <ul style="list-style-type: none"> - Clean hands when entering and exiting, high contact care * gown - change between each resident, mask, eye protection, high contact care * gloves during high contact care. - Examples of high contact care include: Changing linens. <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The surveyor made the following observation:</p> <p>- On 5/9/24 at 12:06 P.M., a housekeeper was observed changing bed linens for both beds in room [ROOM NUMBER]. The housekeeper was observed not wearing a gown.</p> <p>During an interview on 5/10/24 at 11:20 A.M., the Regional Nurse and Director of Nursing said all staff should be following hand hygiene and PPE precautions when indicated by signage outside of each resident's room.</p>