STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225486	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presentation Rehab and Skilled Care Center	10 Bellamy Street Boston, MA 02135

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review, interview, and observation, the facility failed to follow the plan of care for the use of a hand splint for one Resident (Resident #10), of 25 sampled residents.Findings include:Resident #10 was admitted to the facility in March 2022 and has active diagnoses which include Parkinson's disease (a progressive neurological disorder that primarily affects movement and is characterized by the degeneration of nerve cells in the brain leading to disturbed motor and non-motor functions) and dementia.Review of Resident #10's most recent Minimum Data Set (MDS) assessment, dated 12/9/25, indicated a Brief Interview for Mental Status Exam score of 12 out of 15, signifying moderately impaired cognitive skills. Resident #10 had no impairments in upper extremities and was able to feed self with some assistance. The Resident was dependent on staff for all other activities of daily living.Review of Resident #10's Physician's Order, dated 2/24/23, indicated Left upper extremity resting hand splint to be worn daily for 4-5 hours daily as tolerated. On with A.M. care off in afternoon.Review of Resident #10's Activity of Daily Living (ADL) care plan, dated 12/17/25, indicated he/she had an ADL deficit related to activity intolerance due to Parkinson's disease. Interventions included, but were not limited to, Left upper extremity resting hand splint for use up to 4-5 hours a day (Patient declines at times) on in AM off in afternoon.Review of Resident #10's Nursing Notes, dated between 11/1/25 and 3/11/26, indicated there was one documented refusal to wear the hand splint on 1/30/26.Review of Resident #10's most recent Occupational Therapy notes for December 2025 and January 2026 indicated he/she used a resting hand splint on the left hand. On 3/10/26 at 8:37 A.M., the surveyor observed Resident #10 awake in bed. The fingers on the Resident's left hand appeared splayed and limp. The Resident was not wearing a left-hand splint.Review of Resident #10's Treatment Administration Record (TAR) dated 3/10/26 indicated he/she was wearing a left upper extremity resting hand splint, contrary to the surveyor's observations.On 3/11/26 at 9:04 A.M., the surveyor observed Resident #10 sitting in his/her room in a wheelchair. The Resident was not wearing a splint on his/her left hand. Review of Resident #10's TAR dated 3/11/26 indicated he/she was wearing a left upper extremity resting hand splint, contrary to the surveyor's observations.During an interview with Resident #10 on 3/11/26 at 1:05 P.M., accompanied by Unit Manager #1, Resident #10 said he/she had not worn the hand splint for a long time. The Resident said the splint may have fallen apart. Resident #10 said that if a splint was available he/she may wear it. The surveyor and Unit Manager #1 looked in the room for the splint but were unable to locate it.On 3/11/26 at 1:10 P.M., Unit Manager #1 said she had been aware that Resident #10's hand splint had been missing. Unit Manager #1 said Certified Nurse Aides are responsible for applying the hand splint and licensed nursing staff are responsible for accurately documenting the use in the TAR. Unit Manager #1 said it is the expectation that licensed nursing staff follow the physician's orders and notify the physician if an order is unable to be completed.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. Based on record review and interview, the facility failed to arrange for an appointment for one Resident (#38), out of a total of 25 sampled residents. Specifically, the facility failed to reschedule a cancelled Ear, Nose and Throat (ENT) specialist appointment for Resident #38.Findings include: Resident #38 was admitted to the facility in May 2025 with diagnoses including chronic diastolic congestive heart failure, major depressive disorder, and type two diabetes. Review of the Minimum Data Set (MDS) assessment, dated 12/10/25, indicated Resident #38 was cognitively intact as evidenced by a score of 15 out of 15 on the Brief Interview for Mental Status (BIMS) exam. During an interview on 3/10/26 at 8:24 A.M., Resident #38 reported that he/she had asked for an ENT appointment to be rescheduled a couple months ago due to the snow. Resident #38 said that Unit Manager #1 said that she would reschedule it but hasn't. Review of Resident #38's clinical record indicated: Nurse Progress Note dated 1/28/26: Resident refused to go to ENT appointment this AM and requested it be rescheduled for a different day and in the afternoon. Call placed to [physician's] office to reschedule, awaiting call back.Nurse Practitioner Note dated 3/4/26: Patient reports that he/she continues with some nasal congestion. He/she previously canceled his/her ENT appointment. Encouraged him/her to follow-up with nursing regarding when it has been rescheduled for. I did discuss with him/her that likely there is a long wait time and that it is important that he/she keeps his/her appointments. Discussed with staff.Review of clinical progress notes and unit appointment book failed to indicate Resident #38 had a re-scheduled appointment with ENT. During an interview on 3/11/26 at 12:24 P.M., Unit Manager #1 said that Resident #38 refused to go to his/her ENT appointment, so it was cancelled. Unit Manager #1 reviewed the nurse progress note and said that she thought the appointment may have been re-booked. Unit Manager #1 then reviewed the unit appointment book but was unable to find an appointment booked for Resident #38. Unit Manager #1 said that she would usually call an office within a few days if she doesn't hear back but could not recall if she had done so to obtain an appointment for Resident #38. On 3/11/26 at approximately 12:30 P.M., Unit Manager #1 said she had obtained an appointment for Resident #38 for 3/19/26. During interviews on 3/11/26 at 12:44 P.M. and at approximately 2:30 P.M., the Director of Nursing (DON) said that the facility does not have a policy on arranging outside appointments. The DON said nursing staff are expected to call outside offices timely to arrange resident appointments.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and observation, the facility failed to accurately document the use of a hand splint during the survey period for one Resident (Resident #10), of 25 sampled residents. Findings include:Resident #10 was admitted to the facility in March 2022 and has active diagnoses which include Parkinson's disease (a progressive neurological disorder that primarily affects movement and is characterized by the degeneration of nerve cells in the brain leading to disturbed motor and non-motor functions) and dementia.Review of Resident #10's most recent Minimum Data Set (MDS) assessment dated [DATE] indicated a Brief Interview for Mental Status Exam score of 12, signifying moderately impaired cognitive skills. Resident #10 had no impairments in upper extremities and was able to feed self with some assistance. The Resident was dependent on staff for all other activities of daily living.Review of Resident #10's Physician's Order, dated 2/24/23, indicated Left upper extremity resting hand splint to be worn daily for 4-5 hours daily as tolerated. On with A.M. care off in afternoon.Review of Resident #10's Activity of Daily Living (ADL) care plan, dated 12/17/25, indicated he/she had an ADL deficit related to activity intolerance due to Parkinson's disease. Interventions included, but were not limited to, Left upper extremity resting hand splint for use up to 4-5 hours a day (Patient declines at times) on in AM off in afternoon.Review of Resident #10's Nursing notes, dated between 11/1/25 and 3/11/26, indicated there was one documented refusal to wear the hand splint on 1/30/26.Review of Resident #10's Treatment Administration Record (TAR), dated 1/30/26, indicated he/she wore the left-hand splint, contrary to the nursing documentation.On 3/10/26 at 8:37 A.M., the surveyor observed Resident #10 awake in bed. The Resident was not wearing a splint on the left hand.Review of Resident #10's TAR, dated 3/10/26, indicated he/she was wearing a left upper extremity resting hand splint, contrary to the surveyor's observations.On 3/11/26 at 9:04 A.M., the surveyor observed Resident #10 sitting in his/her room in a wheelchair. The Resident was not wearing a splint on his/her left hand. Review of Resident #10's TAR, dated 3/11/26, indicated he/she was wearing a left upper extremity resting hand splint, contrary to the surveyor's observations.During an interview with Resident #10 on 3/11/26 at 1:05 P.M., accompanied by Unit Manager #1, Resident #10 said he/she had not worn the hand splint for a long time. On 3/11/26 at 1:10 P.M., Unit Manager #1 said she had been aware that Resident #10's hand splint had been missing. Unit Manager #1 said Certified Nurse Aides are responsible for applying the hand splint and licensed nursing staff are responsible for accurately documenting the use in the TAR.