STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225497	A. Building B. Wing	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health and Rehabilitation Center	1190 Vfw Parkway Boston, MA 02132

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41601 Based on records reviewed, interviews and review of surveillance camera video footage, for one of three sampled residents (Resident #1), who had a diagnosis of Alzheimer's disease and was cognitively impaired, the Facility failed to ensure he/she was treated in a respectful and dignified manner which included being free from the use of restraints, when on 05/01/25, nursing staff used a bed sheet wrapped around the Resident #1's chest then tucked it under his/her arms and tied behind Resident #1's wheelchair, to keep him/her from getting up. Findings include: Review of the facility policy titled Physical Restraints, dated December 2022, indicated the facility recognizes each resident's right to be free from any physical restraint imposed for the purpose of discipline or convenience and not required to treat a medical condition. Further review indicated the facility recognizes the necessity of maintaining a systematic method of evaluating and monitoring restraint use and any resident who is utilizing a device that could constitute a restraint will be evaluated to determine if the device is a restraint. Resident #1 was admitted to the Facility in June 2023, diagnoses included parkinsonism, Alzheimer's disease, acute kidney failure, and a history of cerebrovascular accident with right-sided hemiplegia (weakness on one side to upper and/or lower extremities). Review of Resident #1's Quarterly Minimum Data Set (MDS), dated [DATE], indicated he/she was cognitively impaired and had an invoked Health Care Proxy (HCP). Review of the Facility's Internal Investigation, dated 05/01/25, indicated that a staff member reported to the administration that a resident was seen with a sheet wrapped around him/her and then tied to the back of his/her wheelchair. The Resident was identified (as Resident #1), was assessed, no injuries were noted and he/she was found to be in his/her normal state. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Internal Investigation indicated the Facility maintains a surveillance camera system that records various areas of the Facility. The Investigation indicated that the video recording (which has no audio capability) from the dayroom where incident took place, was reviewed. The Investigation indicated Resident #1 was in a wheelchair, was non-ambulatory at the time and had a cast on his/her right lower leg secondary to a past injury. The Investigation indicated that based on review of the camera feed, there were two staff members on duty, (Nurse #1 and Certified Nurse Aide (CNA) #1) at the time of the alleged incident. Review of the surveillance camera video footage clips provided by the Facility, from the overnight shift (11:00 P.M. to 7:00 A.M.) dated 05/01/25 from 5:14:00 A.M. to 6:23:25 A.M., illustrated the following: At 5:14:00, Resident #1 was wheeled into the dining/dayroom by CNA #1. Nurse #1 who was also in the dayroom, can be seen greeting Resident #1 and CNA #1. At 5:14:45, Resident #1 is in his/her wheelchair and positioned in front of a dining table. At 5:15:00, Nurse #1 and CNA #1 ensure Resident #1 is positioned correctly. At 5:16:45, CNA #1 leaves the dayroom, returns shortly with a bed sheet in hand. At 5:17:02, CNA #1 can be seen pulling the sheet apart, holds it up, looks in Nurse 1's direction and Nurse #1 can be seen, shaking her head up and down in a Yes type motion. At 5:17:09, CNA #1 then puts the sheet across the front of Resident #1 under his/her arms and wrapping it behind the wheelchair. Resident #1 is calm, showing no signs of agitation or stress. At 5:17:20, Nurse #1 sits down at the same table as Resident #1, and CNA #1 exits the day room. At 5:17:30, Nurse #1, gets up, offers Resident #1 a box of diversional activities and sits back down at the table. At 5:20:10, Resident #1 can then be seen seen lifting the sheet, which was loose, over his/her head and throwing it behind his/her back. Resident #1 showed no signs of agitation and remained calm. At 5:20:39, Nurse #1, gets up again, places the sheet back around Resident #1, under his/her arms across the abdomen, around to the back of the chair, and then secures it to the back of the wheelchair. Nurse #1 then sits back down at the table and remains with Resident #1. At 6:09:00, Nurse #1 gets up and leaves the dayroom, Housekeeper (HK) #1 enters the room, waves to Resident #1, and goes over to speak to him/her. At 6:09:44, HK #1 sees the sheet wrapped around and tied behind Resident #1's wheelchair, and it looks like she tries to untie it, but does not. From 6:16:00 to 6:17:23, HK #1 remains in the room with Resident 1. HK #1 sees another staff member enter the room, and points to the sheet tied secured behind Resident 1's wheelchair. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 6:20:40, HK #1 can be seen speaking to the Housekeeping Supervisor, who entered the room, and points out the sheet out to him. At 6:21:56, the Housekeeping Supervisor returns to the dayroom with Nurse #1, and he points the sheet the was tied behind Resident #1 out to her, and Nurse #1 can be seen removing the sheet from Resident #1's wheelchair. At 6:23:25, Nurse #1 leaves the room. During an interview on 05/20/25 at 1:10 P.M., Housekeeper (HK) #1 said that she arrived at the unit on 05/01/25 around 6:00 A.M., and one of her first tasks was to clean the dayroom. HK #1 said that when she entered the dayroom, she saw Resident #1 seated at a table, went to greet Resident #1 and noticed there was a bed sheet wrapped around his/her chest, under his/her arms and then tied behind his/her wheelchair. HK #1 said she wondered why the bed sheet was tied behind Resident #1's wheelchair. HK #1 said she was uncertain whether she should untie the sheet and began searching for another staff member for help. HK #1 said that the Housekeeping Supervisor entered the dayroom, so she reported that Resident #1 was restrained in his/her wheelchair and pointed it out to him. During an interview on 05/20/25 at 1:55 P.M., the Housekeeping Supervisor said that on 05/01/25, around 6:20 A.M., he entered the dayroom and Housekeeper (HK) #1 called him over to where Resident #1 was seated in his/her wheelchair at a table. The Housekeeping Supervisor said that HK #1 showed him that a bed sheet was wrapped around Resident #1, and tied behind the back of the wheelchair. The Housekeeping Supervisor said that he reported the incident to Nurse #1, who was at the nurses' station, and then returned with Nurse #1 to the dayroom. The Housekeeping Supervisor said Nurse #1 removed the sheet from Resident 1's wheelchair. During a telephone interview on 05/21/25 at 9:00 A.M., Certified Nurse Aide (CNA) #1 said Resident #1, was up, restless, during the overnight shift (on 05/01/25) and was attempting to get out of bed. CNA #1 said that she assisted Resident #1 into the wheelchair and escorted him/her to the dayroom. CNA #1 said she positioned Resident #1's wheelchair in front of the dining table, and then informed Nurse #1, who was new to the Unit, that Resident #1 was restless and at risk of falling. CNA #1 said she was afraid that Resident #1 would slip forward in his/her chair and hurt his/her leg that was in the cast. CNA #1 said that Nurse #1 had approved and told her it would be okay to use a sheet to prevent Resident #1 from slipping forward, so she lightly wrapped a bed sheet around Resident #1, tucked it behind the wheelchair and loosely secured the ends of the sheet in back of the wheelchair. CNA #1 said she did not believed it was a restraint because Nurse #1 had approved it, that she had not intended to restrain him/her, but only meant to keep Resident #1 safe. The Surveyor was unable to interview Nurse #1 as she did not respond to the Department of Public Health's telephone call or letter requests for an interview. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/20/25, at 2:40 P.M., the Administrator said that on 05/01/25, the Housekeeping Supervisor reported that Resident #1 had been found with a sheet wrapped around him/her, that was tied to the wheelchair, and it appeared to be a restraint. The Administrator said that he initiated an internal investigation, which included reviewing the Facility's video surveillance camera footage and interviewing staff members on duty during the 11:00 P.M. to 7:00 A.M. shift from April 30, 2025, to May 1, 2025. During an interview on 05/01/25 at 3:41 P.M., the [NAME] President of Clinical Services (VPCS) said that on 05/01/25 when she and Administrator interviewed CNA #1 in person, CNA #1 admitted that she wrapped a sheet around Resident #1's waist, and tied it in back of his/her wheelchair. The VPCS said CNA #1 told them she did it to keep him/her from slipping forward, and that she thought doing this was only way of keeping Resident #1 safe. The VPCS said that CNA #1 reported that, since Nurse #1 was present and approved it, she did not consider it a restraint. The VPCS said when they interviewed Nurse #1 over the phone, Nurse #1 said that She knew nothing about the sheet being on the resident until the Housekeeping Supervisor told her. However, Nurse #1's statement to the facility administration contradicts what was captured on facility surveillance camera footage which shows her shaking her head in a yes type motion when CNA #1 unfolds and shows her the sheet. After Resident #1 pulled the sheet off and threw it behind him/herself, Nurse #1 is the one who is seen reapplying the sheet around Resident #1, tying it in back of his/her wheelchair and then sitting back down at the table where she remained for quite some time, during which the sheet she had secured, was still in place around the resident. The [NAME] President of Clinical Services (VPCS) said that the Facility prides itself on being restraint-free and that Nurse #1 and CNA #1 should not have tied the sheet around Resident #1. The VPCS said that tying a sheet around a resident in his/her chair was not an appropriate safety intervention and that it was considered a restraint. The VPCS said the Facility's investigation substantiated the improper use of physical restraint, and that CNA #1 was reeducated about restraints and Nurse #1 was terminated. On 05/20/25, the Facility was to be in Past Non-Compliance and presented the Surveyor with a plan of correction which addressed the area(s) of concern as evidenced by: A. Resident #1 was immediately assessed for any sign of injury or distress, none were noted, and he/she remained at baseline. B. Social Services and nursing staff continue to monitor and support Resident #1 for the potential for emotional distress, or adverse reaction to use of a restraint, there have been no changes observed. C. On 05/01/25, all residents on the unit were immediately assessed to ensure no other restraints were in place. D. On 5/02/25, re-education was initiated by Director of Nursing (DON), for all staff on abuse prevention, including but not limited restraints and the appropriate uses of assistive devices for positioning/safety. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	E. The Interdisciplinary Team (IDT) reviewed the current residents who have positioning needs or who have agitation (or both) to ensure that the staff understand appropriate interventions to use for residents' comfort and safety. F. Starting 05/01/25, daily nursing rounds were initiated and included the need for nursing to check for inappropriate device use. Daily checks by nursing to be continued for the next four weeks, and then continue weekly for four months. The results will be reviewed by the Administrator and the Director of Nursing (DON). G. The results of audits will be presented to the Facility's Quality Assurance and Performance Improvement (QAPI) Committee at monthly meetings for review. H. The Administrator and the Director of Nursing are responsible for overall compliance.