STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225499	A. Building B. Wing	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Roxbury Health & Rehabilitation Center	5060 Washington Street West Roxbury, 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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 15203 Based on interviews and records reviewed, for one of three sampled residents (Resident #1), the Facility failed to ensure they supported each residents' right to self determination which included facilitating the resident's choice to smoke, when the Facility permanently revoked Resident #1's smoking privileges and refused to allow Resident #1 to join other residents who smoke during the Facility's supervised smoking times. Findings include: The Facility Smoking Policy and Procedure, dated as revised December 2018, indicated it is the policy of the Facility to allow residents to smoke tobacco-based products in the designated smoking area under staff supervision only. The Policy indicated smoking is allowed during designated hours and monitored by staff during these times. The Policy indicated residents could not possess smoking paraphernalia and items must be turned over to Facility staff members for storage. The Smoking Procedure indicated the Facility permitted smoking supervised by staff members during four smoking times: 9:00 A.M., 1:00 P.M., 4:00 P.M. and 7:00 P.M. daily. Review of Resident #1's clinical record indicated that he/she was admitted to the Facility during November of 2023, diagnoses included post-traumatic stress disorder, anxiety disorder, opioid dependence with opioid induced mood disorder, major depressive disorder, alcohol and other psychoactive substance abuse, orthopedic aftercare following fracture of the right tibia and hemiplegia and hemiparesis following cerebral infarction affecting left, non-dominant side. Review of Resident #1's Admission MDS, completed 11/12/23, indicated Resident #1 used tobacco. Review of Resident #1's most recent Quarterly Minimum Data Set (MDS) Assessment, completed 5/14/24, indicated he/she did not ambulate and used a wheelchair for mobility with assistance and/or supervision. The MDS indicated his/her cognitive patterns were intact. Review of Resident #1's Care Plan related to smoking, dated as initiated 11/14/23, indicated Resident #1 was a smoker and per Facility Policy needed to be supervised if out smoking at the Facility during supervised smoking times. Care Plan interventions included that Resident #1's smoking materials were to be locked up and handed to him/her only during designated smoke times. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Smoking assessments, dated 2/12/24 and 5/09/24, indicated he/she smoked. Resident #1's Care Plan related to smoking indicated that the care plan was resolved 5/21/24. During an interview on 6/10/24 at 10:45 A.M., the Administrator said that Resident #1's Care Plan related to smoking was resolved because the Facility revoked his/her smoking privileges. Review of the report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 5/20/24, indicated that Resident #1's smoking privileges were revoked following an incident in which he/she was found to have a vape pen (an electronic handheld device consisting of a battery attached to a cartridge filled with a liquid solution that is vaporized and simulates tobacco smoking), in his/her bed. The Surveyor was unable to interview Resident #1 at the time of the Survey because he/she was hospitalized . The Administrator said that the Facility revoked Resident #1's smoking privileges after staff members caught Resident #1 with smoking paraphernalia on several occasions while residing at the Facility. The Administrator said initially after the first two incidents of being caught with smoking paraphernalia on his/her person, Resident #1's smoking privileges were suspended for a period of time. The Administrator said that following a third incident which occurred 5/20/24, when staff found Resident #1 in bed with a vape pen, his/her smoking privileges were revoked permanently. The Administrator said that Resident #1 requested resumption of his/her smoking privileges following the incident on 5/20/24. The Administrator said she told Resident #1 that his/her smoking privileges at the Facility were permanently revoked. The Surveyor asked the Administrator how the Facility would support Resident #1's right to self-determination with regards to smoking and participation in the supervised smoking program at the Facility. The Administrator said that due to Resident #1's lack of adherence to the Facility's smoking policy, he/she would not be permitted to smoke during supervised smoking times. During an interview on 6/10/24 at 12:05 P.M., the Social Worker said that since Resident #1's smoking privileges were revoked, Resident #1 has requested to resume smoking during the Facility supervised smoking times. The Social Worker said that Resident #1 has begged and pleaded to be allowed to smoke. During telephone interviews on 6/20/24 at 1:40 P.M. with the Psychiatric Nurse Practitioner and on 6/20/24 at 3:37 P.M. with the Psychotherapist, they said that after each instance of the Facility's suspension of Resident #1's smoking privileges, Resident #1 continued to request to be allowed to join the other residents during the Facility's supervised smoking times.

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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. 15203 Based on interviews and records reviewed, 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 Resident #1 was free from physical restraint when, on 5/20/24 around 5:40 A.M., Nurse #1, Certified Nurse Aide (CNA) #1 and CNA #2 used physical force to confiscate a vape pen (an electronic handheld device consisting of a battery attached to a cartridge filled with a liquid solution that is vaporized and simulates tobacco smoking) from Resident #1, which he/she had hidden under his/her clothing. Findings include: Review of the Facility Policy titled Physical Restraints, last revised December 2023, indicated that the Facility recognized each resident's right to be treated with respect and dignity and to be free from physical restraint imposed for the purposes of discipline and convenience and not required to treat the resident's medical condition. The Policy defined restraint to include any manual method, physical or mechanical device, equipment or material that is attached to the resident's body, cannot be removed easily by the resident and restricts the resident's freedom of movement or normal access to their body. Review of Resident #1's clinical record indicated that he/she was admitted to the Facility during November of 2023, diagnoses included post-traumatic stress disorder, anxiety disorder, opioid dependence with opioid induced mood disorder, major depressive disorder, alcohol and other psychoactive substance abuse, orthopedic aftercare following fracture of the right tibia and hemiplegia and hemiparesis following cerebral infarction affecting left, non-dominant side. Review of Resident #1's most recent Quarterly Minimum Data Set Assessment, completed 5/14/24, indicated he/she did not ambulate and used a wheelchair for mobility with assistance and/or supervision. The MDS indicated his/her cognitive patterns were intact. Review of the report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 5/20/24, indicated that Resident #1 reported that Nurse #1, CNA #1 and CNA #2 attacked him/her in bed while trying to confiscate his/her smoking vape pen. The Surveyor was unable to interview Resident #1 at the time of Survey because he/she was hospitalized at the time of the survey. On 6/10/24, the Administrator provided the Surveyor with an unsigned, typed statement which she said documented her interview with Resident #1 regarding the allegation. The Statement indicated Resident #1 told the Administrator he/she was attacked by Nurse #1, CNA #1 and CNA #2 when they tried to take his/her vape pen away. The Statement indicated Resident #1 told the Administrator that Nurse #1, CNA #1 and CNA #2 beat him/her and pulled his/her hair. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Disabled Persons Protection Commission (DPPC) Report, dated 5/23/24, indicated that on 5/20/24, Resident #1 reported to the police that he/she attempted to conceal a restricted vape pen from Nurse #1 and, when Nurse #1 and Resident #1 struggled over the vape pen, CNA #1 and CNA #2 came to Resident #1's bedside and held Resident #1 down. The Report indicated Resident #1 said that he/she felt Nurse #1, CNA #1 and CNA #2 were overly aggressive when confiscating the vape pen. During a telephone interview on 6/18/24 at 11:30 A.M. Nurse #1 said around 5:30 A.M. on 5/20/24, she entered Resident #1's room and saw Resident #1 asleep in bed with a vape pen in his/her hand. Nurse #1 said that moments later, Resident #1 awoke and moved the vape pen to between his/her legs. Nurse #1 said she asked Resident #1 what he/she was hiding and Resident #1 told her nothing. Nurse #1 said she told Resident #1 that it did not matter where he/she hid the vape pen, that she was going to get it. Nurse #1 said she left Resident #1's room and asked CNA #1 and CNA #2 to come to Resident #1's room to assist her. During telephone interviews on 6/11/24 at 4:16 P.M. with CNA #1 and 6/11/24 at 4:31 P.M. with CNA #2, they said Nurse #1 asked for assistance with taking an item away from Resident #1. CNA #1, CNA #2 and Nurse #1 said they went to Resident #1's bedside, CNA #1 and CNA #2 said they held Resident #1's hands for less than one minute while Nurse #1 removed the vape pen from Resident #1's incontinence brief. The Surveyor asked Nurse #1 for the reason why CNA #1 and CNA #2 held Resident #1's hands and Nurse #1 said that because Resident #1 refused to give her the vape pen and he/she struggled against her efforts to confiscate it, CNA #1 and CNA #2 held Resident #1's hands still in order for her to take the vape pen away from Resident #1. During interviews on 6/10/24 at 10:45 A.M. with the Administrator and by telephone on 6/11/24 at 2:30 P.M with the Director of Nursing, the Administrator and Director of Nursing said that the Facility Internal Investigation indicated that on 5/20/24, Nurse #1, CNA #1 and CNA #2 confiscated a vape pen from Resident #1 after he/she was found in bed with it.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 15203 Based on interviews and records reviewed, for one of three sampled residents (Resident #1), who was cognitively intact, the Facility failed to ensure that staff implemented and followed the Facility Abuse Prohibition Policy when, on 5/20/24 around 6:00 A.M., Certified Nurse Aide (CNA) #2 told Nurse #1 that Resident #1 alleged that they (CNA #1, CNA #2 and Nurse #1) had assaulted him/her, however Nurse #1 did not immediately report the allegation to the Administrator. As a result, the Administrator only became aware of the allegation after police officers arrived at the Facility in response to Resident #1's call to them, which was more than five hours after the incident occurred and after CNA #2 had made Nurse #1 aware of Resident #1's allegation. Findings include: Review of the Facility Policy titled Abuse Prohibition, last revised 7/13/22, indicated that the Facility implemented processes which strive to ensure the reporting of alleged abuse. Abuse. The Policy indicated that the shift supervisor/charge nurse/manager would be notified immediately of all alleged violations and would report the incident immediately to the Director of Nursing or Administrator, Review of the report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 5/20/24, indicated that Resident #1 reported that Nurse #1, CNA #1 and CNA #2 attacked him/her in bed while trying to confiscate a smoking vape pen (an electronic handheld device consisting of a battery attached to a cartridge filled with a liquid solution that is vaporized and simulates tobacco smoking). Review of Resident #1's clinical record indicated that he/she was admitted to the Facility during November of 2023, diagnoses included post-traumatic stress disorder, anxiety disorder, opioid dependence with opioid induced mood disorder, major depressive disorder, alcohol and other psychoactive substance abuse, orthopedic aftercare following fracture of the right tibia and hemiplegia and hemiparesis following cerebral infarction affecting left, non-dominant side. Review of Resident #1's most recent Quarterly Minimum Data Set Assessment, completed 5/14/24, indicated he/she did not ambulate and used a wheelchair for mobility with assistance and/or supervision. The MDS indicated his/her cognitive patterns were intact. The Surveyor was unable to interview Resident #1 at the time of the Survey because he/she was hospitalized . During telephone interviews on; - 6/18/24 at 11:30 A.M. with Nurse #1, - 6/11/24 at 4:16 P.M. with CNA #1 and, (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 6/11/24 at 4:31 P.M. with CNA #2, they said that around 5:30 A.M. on 5/20/24, they confiscated a vape pen from Resident #1. Nurse #1, CNA #1 and CNA #2 said that the vape pen was hidden inside Resident #1's incontinence brief. CNA #1 and CNA #2 said they held Resident #1's hands while Nurse #1 removed the vape pen from his/her incontinence brief. CNA #2 said that shortly have leaving Resident #1's bedside with Nurse #1 and CNA #1, she responded to Resident #1's sounding call light. CNA #2 said that Resident #1 asked her to plug in his/her cell phone for charging because he/she wanted to call the police. CNA #2 said Resident #1 told her that he/she intended to report to the police that they (CNA #1, CNA #2 and Nurse #1) had assaulted him/her during the incident in which they confiscated his/her vape pen. CNA #2 said she reported Resident #1's allegation to Nurse #1. Nurse #1 said CNA #2 had reported to her that Resident #1 had alleged that they (CNA #1, CNA #2 and Nurse #1) had assaulted him/her when they confiscated his/her vape pen, and that he/she was going to call the police. Nurse #1 said she did not immediately notify the Administrator of Resident #1's allegation. During an interview on 6/10/24 at 11:30 A.M., the Administrator said that she first became aware of Resident #1's allegation that he/she was assaulted by Nurse #1, CNA #1 and CNA #2 around 12:00 P.M. on 5/20/24, when police officers arrived at the Facility to speak to Resident #1 about an incident that he/she had reported to them. The Administrator said this was about six hours after CNA #2 had reported to Nurse #1 that Resident #1 had said he/she was going to call the police to report being assaulted by staff.