

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225718	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2025
NAME OF PROVIDER OR SUPPLIER Hancock Park Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 164 Parkway Quincy, MA 02169	
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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews for one of three sample residents (Resident #1), whose Hospital Discharge Summary included treatment orders related to his/her surgical incision staple removal, the Facility failed to ensure nursing provided care and services that met professional standards of practice, when nursing removed his/her staples two weeks prematurely, Resident #1 wound dehiscd (partially or completely reopened along the incision line) and he/she was transferred to the Hospital Emergency Department for evaluation of the wound. Findings include: Review of the Facility Policy titled, Physician's Orders, dated as last reviewed 09/2025, indicated that Physician's Orders will be transcribed by licensed nurses only. The order is entered into the electronic medical record (Point Click Care, PCC) and Medication and Treatment Administration Records will be updated as required. The Policy further indicated that if there is any question concerning interpretation of the Physician's Order, the nurse will contact the physician for verification of the order and nursing treatment orders must include specific treatment. Resident #1 was admitted to the Facility in October 2025, diagnoses include status post left iliac angioplasty (invasive procedure to treat narrowed or blocked iliac artery) and Percutaneous Transluminal Angioplasty (PTA) stent placement followed by a right femoral-popliteal bypass (surgical procedure that reroutes blood flow around a blockage in an artery) due to Peripheral Arterial Disease (PAD), Diabetes Mellitus (DM), and anemia. Review of Resident #1's Hospital Discharge Summary, dated 10/16/25, indicated that he/she required an outpatient follow up appointment two (2) weeks from discharge (on 10/30/25) with the vascular surgeon to reassess the surgical site and to remove his/her staples. Review of the Vascular Surgeon Note, dated 10/16/25, indicated that the surgeon would see Resident #1 in 2 weeks from 10/16/25 (on 10/30/25) at 9:00 A.M. to remove his/her staples. Review of Resident #1's Physician's Orders, dated 10/16/25, indicated that Nursing Supervisor #1 transcribed the order as follows, left groin thigh is status post vascular surgery and to remove staples every shift. The Orders also indicated a second transcribed order from Nursing Supervisor #1, staples needed to be removed, monitor surgical site every shift. Review of Resident #1's Medical Record, including but not limited to physician's orders, medication reconciliation form, nurse progress notes and Treatment Administration Record (TAR) indicated that there was no documentation to support nursing clarified the orders related to staple removal with the physician, to ensure they accurately reconciled an order that indicated that the surgeon would remove Resident #1's surgical staples on 10/30/25. During an interview on 11/18/25 at 3:20 P.M., Nursing Supervisor #1 said that on 10/16/25, she had transcribed and reconciled Resident #1's admission physician orders upon entry to the Facility from the Hospital DC summary. Nursing Supervisor #1 said that she recalled informing the provider that Resident #1 had a surgical incision, but that she could not recall seeing or getting an order for a treatment for the surgical incision or a specific order that the surgeon was going to remove his/her staples. Nursing Supervisor #1 said the two orders regarding his/her staples/incision she had entered into the computer were meant to merely inform the nursing staff that Resident #1 had a surgical wound with staples, and not to actually remove the staples at that time. Nursing Supervisor #1 said typically staples in a surgical wound are not removed until the resident is seen by the surgeon at a follow up appointment, where (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 225718	Facility ID: 225718 If continuation sheet Page 1 of 3

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the staples are removed by the surgeon. Nursing Supervisor #1 said she should have clarified the treatment order for Resident #1's surgical wound and staple removal with the physician before entering it into the PCC system. Review of Resident #1's Nurse Progress Note, dated 10/20/25 indicated that Nurse #1 removed the staples to his/her left groin per physician's order with some bleeding noted, the bleeding stopped by applying pressure, this nurse applied steri-strips and the bleeding subsided. Review of Resident #1's admission Nurse Practitioner (NP) Note, dated 10/20/25, indicated that his/her staples had been removed by the nursing staff, however according to the post-op orders, he/she was to follow up with vascular surgeon in 2 weeks for staple removal and reassessment of the wound. The NP Note indicated that the wound had been bleeding, and the wound had dehiscence. The Vascular Surgeon was notified and ordered to have Resident #1 transported to the Hospital Emergency Department for evaluation. Review of Resident #1's Hospital Emergency Department (ED) Note, dated 10/20/25, indicated that the staples had been removed prematurely and there had been significant drainage and bleeding from the wound. The ED Note further indicated that the surgical wound at the medial (midline) aspect of the left thigh appears to be partially dehiscent, a dressing was placed and Resident #1 required intravenous antibiotics as a precaution. During an interview on 11/18/25 at 12:45 P.M., Resident #1's Physician said that she did not get a detailed report for Resident #1 upon admission when the Facility called to reconcile Resident #1's medications and treatment orders and said that she was unaware that Resident #1 had a surgical wound at that time. The Physician said that no provider, including herself, would have given such an incomplete treatment order [surgical wound care and staple removal] for a resident. During a telephone interview on 11/18/25 at 1:06 P.M., Nurse #1 said that on 10/19/25 she had worked a double shift (7:00 A.M.-11:00 P.M.), she said she saw the physician's order to remove Resident #1's staples from his/her surgical wound and had noted that the previous shifts nurses had not yet removed the staples. Nurse #1 said during the evening shift, she removed Resident #1's staples from his/her incision and that there had been some bleeding noted, she applied pressure along with steri-strips and the bleeding stopped. Nurse #1 said that she should have looked at the original physician's order and reviewed the hospital discharge summary before removing Resident #1's staples and should have questioned why the previous nurses had not removed his/her staples. During an interview on 11/18/25 at 2:24 P.M., the Director of Nurses (DON) said that she was not aware that Resident #1 had an incomplete physician's order related to the removal of his/her staples and said she was not aware that his/her staples were removed almost 2 weeks prior to what had been indicated on his/her Hospital DC summary. The DON said Nursing Supervisor #1, who reconciled Resident #1's orders upon admission wrote an incomplete and vague order to remove his/her staples and said that Nurse #1 never should have removed his/her staples without clarifying the order. The DON said that it is the Facility's expectation to clearly reconcile all medications and treatments upon admission with the resident's provider and if any physician's order is incomplete call the provider for clarification. On 11/18/25, the Facility was found to be Past Non-Compliance and presented the Surveyor with a plan of correction, with an effective date of 10/25/25, which addresses the area(s) of concern as evidence by: A) On 10/20/25 Resident #1 was immediately assessed by the DON and Nurse Practitioner, the vascular surgeon was notified, and Resident #1 was sent to the Hospital Emergency Department for evaluation and treatment. B) On 10/20/25, the DON/designee began re-education for both the Nursing Supervisor and Nurse #1 including but not limited to reading a hospital discharge summary, physician's orders and clarification of orders. C) On 10/22/25, 11/13/25, and 11/22/25, the facility held Ad [NAME] QAPI meetings to review and implement the Facility POC. D) On 10/21/25 the SDC/DON/ADON began Facility wide education for Nursing staff including, but not limited to reading a discharge summary, transcription, physician's orders, change in condition, documentation, clarification of orders, and new three step admission process. E) On 10/23/25 Management Clinical Staff began auditing all admissions for the past 30 days to ensure no transcription errors were identified and if found, were addressed immediately. F) The Nurse Management Team will complete (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	audits all new admissions and readmissions for 60 days and 2 times a week until compliance is achieved.G) Audit results will be reported to the DON or designee weekly and brought to Quality Assurance and Performance Improvement (QAPI) meeting monthly until 100 percent compliance is achieved for three consecutive months.H) The Director of Nurses and/or designee are responsible for overall compliance.		