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	11/17/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on records reviewed and interviews, for one of three sampled residents (Resident #1), the Facility failed to ensure nursing notified his/her physician of a change in condition related to the development a new pressure injury on his/her right heel.Findings include: The Facility's Policy, titled Change in Resident's Condition or Status and Notification, dated as revised 01/01/2020, indicated nursing would notify the Resident's Physician when there had been a significant change in the resident's medical or mental condition or status.The Facility's Policy, titled Skin Body Audit, dated 03/12/13, indicated nursing would perform weekly skin audits on all residents, and any significant abnormal findings would be reported to the resident's physician and family.A deep tissue injury (DTI) is a form of pressure-induced damage to underlying tissues, including muscles, bones, and subcutaneous layers, while the skin surface might remain intact. It typically results from sustained pressure or shear forces that compromise blood flow, leading to ischemia and subsequent tissue necrosis. Recognizing a suspected deep tissue injury is crucial for timely intervention to prevent progression to more severe wounds.Resident #1 was admitted to the Facility in July 2025, diagnoses included traumatic subarachnoid hemorrhage, dementia, adult failure to thrive, and falls at home.Review of Resident #1's Weekly Skin Assessment, dated 08/28/25, indicated he/she had no open areas or marks on his/her skin.Review of Resident #1's Weekly Skin Assessment, dated 09/04/25, indicated he/she had a quarter sized black dry area on his/her right heel.During an interview on 11/17/25 at 01:10 P.M., Nurse Supervisor #1 said that on 09/04/25 she was assigned to Resident #1's unit on the 03:00 P.M, to 11:00 P.M., shift, completed his/her Weekly Skin Assessment, and said she assessed that he/she had a quarter sized black, dry area on his/her right heel. Nurse Supervisor #1 said the area appeared to be a deep tissue injury (DTI) and said she offloaded Resident #1's heel using pillows. Nurse Supervisor #1 said she notified the nurse who worked the 11:00 P.M., to 07:00 A.M., shift of Resident #1's new pressure injury, but did not notify his/her physician or the on-call physician and did not obtain new orders to treat the pressure injury.Review of Resident #1's Weekly Skin Assessment, dated 09/09/25, indicated he/she had small dry black patches on his/her right heel.Nurse Supervisor #1 said about a week after she had first assessed Resident #1's right heel DTI, she told the Director of Nurses that Resident #1 had the pressure injury, that the physician had not been notified, that there were no treatments ordered, and said she did not notify the Physician at that time either. Nurse Supervisor #1 said she should have notified the physician.Review of Resident #1's Weekly Skin Assessment, dated 09/12/25, indicated he/she did not have any open areas or marks on his/her skin. During an interview on 11/17/25 at 12:44 P.M., Nurse #1 said that he was the nurse assigned to care for Resident #1 on 09/12/25 and said he completed his/her Weekly Skin Assessment. Nurse #1 said Resident # still 1have a blackened area on his/her right heel, but that he did not document it on the Skin Assessment because it was not a new skin abnormality.Review of Resident #1's Medical Record indicated he/she had a significant change in medical condition and was transferred to the Hospital Emergency Department on 09/21/25.Review of Resident #1's Hospital Record, dated 09/21/25, also indicated he/she had a Deep Tissue Injury (DTI) on his/her right heel upon admission to the Hospital.Further review of Resident #1's Medical Record indicated there was no documentation to support that his/her Physician was notified of the pressure injury on his/her right heel.During an interview on 11/17/25 at 08:58 A.M., The Director of Nurses (DON) said Nurse Supervisor #1 should have notified Resident #1's physician or the on-call physician of the new pressure injury on his/her right heel but had not.On 11/17/25, the Facility was found to be in Past Non-Compliance and presented the Surveyor with a plan of correction, with an effective date of 10/02/25, which addressed the area(s) of concern as evidenced by:A. 09/30/25, The Facility conducted an Ad-Hoc Quality Assurance Performance Improvement meeting, which indicated the Facility Leadership developed an action plan to correct the deficient practice, and ensure that nursing notifies the physician of any new skin alteration to determine if a treatment order is necessary, that a progress note is written in the resident's medical record documenting this notification including details of any new order.B. 09/30/25, The Regional Director of Clinical Operations conducted a Facility wide audit of all skin assessments.C. 09/30/25, The Regional Director of Clinical Operation ensured that notification was made to the providers of any newly identified skin concerns, and any new orders were implemented.D. 09/30/25, The Director of Nurses (DON)/designee re-educated licensed staff and CNAs to the Facility's policy Change in Condition or Status Notification and educated licensed staff to document a progress note that included physician notification for any Resident change in condition.E. 10/02/25, Resident #1 was re-admitted to the Facility, the Physician was

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was assessed by nursing to have a new pressure injury to his/her right heel, the Facility failed to ensure he/she received treatment and services consistent with professional standards of practice when physician orders for treatment of a new pressure injury were not obtained timely from the provider. Findings include:The Facility's Policy, titled Pressure Ulcer Prevention, dated 12/22/22, indicated the appropriate care and services would be provided to the Facility's residents to assist in the prevention of pressure ulcers and to promote optimal healing. Wounds would be reviewed by the interdisciplinary team and recommendations would be made on a weekly basis.A deep tissue injury (DTI) is a form of pressure-induced damage to underlying tissues, including muscles, bones, and subcutaneous layers, while the skin surface might remain intact. It typically results from sustained pressure or shear forces that compromise blood flow, leading to ischemia and subsequent tissue necrosis. Recognizing a suspected deep tissue injury is crucial for timely intervention to prevent progression to more severe wounds.Resident #1 was admitted to the Facility in July 2025, diagnoses included traumatic subarachnoid hemorrhage, dementia, adult failure to thrive, and falls at home.Review of Resident #1's Weekly Skin Assessment, dated 08/28/25, indicated he/she had no open areas or marks on his/her skin.Review of Resident #1's Weekly Skin Assessment, dated 09/04/25, indicated he/she had a quarter sized black dry area on his/her right heel.Review of Resident #1's Weekly Skin Assessment, dated 09/09/25, indicated he/she had small dry black patches on his/her right heel.Review of Resident #1's Treatment Administration Record (TAR) for the month of September 2025, indicated that despite identification of new area of pressure to his/her right heel, on his/her weekly skin assessments by nursing on 09/04/25 and 09/09/25, there was no documentation to support the nursing obtained physician's order for the treatment of his/her right heel pressure injury.Review of Resident #1's Medical Record indicated he/she had a significant change in medical condition and was transferred to the Hospital Emergency Department on 09/21/25.Review of Resident #1's Hospital Record, dated 09/21/25, also indicated that he/she had a Deep Tissue Injury (DTI) on his/her right heel upon admission to the Hospital.During an interview on 11/17/25 at 01:10 P.M., Nurse Supervisor #1 said that on 09/04/25 she was assigned to Resident #1's unit on the 03:00 P.M, to 11:00 P.M., shift, completed his/her Weekly Skin Assessment, and said she assessed that he/she had a quarter sized black, dry area on his/her right heel. Nurse Supervisor #1 said the area appeared to be a deep tissue injury (DTI) and said she offloaded Resident #1's heel using pillows. Nurse Supervisor #1 said she did not notify his/her physician or the physician on call to obtain new orders to treat the pressure injury. During an interview on 11/17/25 at 12:44 P.M., Nurse #1 said that he was the nurse assigned to care for Resident #1 on 09/12/25 and said he completed his/her Weekly Skin Assessment. Nurse #1 said Resident #1 did still have a blackened area on his/her right heel. Nurse #1 said he thought Resident #1's physician was aware of the pressure injury, but also said there was no physician's order in place for treatment.During an interview on 11/17/25 at 08:58 A.M., The Director of Nurses (DON) said Nurse Supervisor #1 should have notified Resident #1's physician or the on-call physician to obtain orders for treatment but had not.On 11/17/25, the Facility was found to be in Past Non-Compliance and presented the Surveyor with a plan of correction, with an effective date of 10/02/25, which addressed the area(s) of concern as evidenced by:A. 09/30/25, The Facility conducted an Ad-Hoc Quality Assurance Performance Improvement meeting, which indicated the Facility Leadership developed an action plan to correct the deficient practice, and ensure that nursing notifies the physician of any new skin alteration to determine if a treatment order is necessary, that a progress note is written in the resident's medical record documenting this notification including details of any new order.B. 09/30/25, The Regional Director of Clinical Operations conducted a Facility wide audit of all skin assessments.C. 09/30/25, The Regional Director of Clinical Operation ensured that notification was made to the providers of any newly identified skin concerns, and any new orders were implemented.D. 09/30/25, The Director of Nurses (DON)/designee re-educated licensed staff and CNAs to the Facility's policy Change in Condition or Status Notification and educated licensed staff to document a progress note that included physician notification for any Resident change in condition.E. 10/02/25, Resident #1 was re-admitted to the Facility, the Physician was notified of his/her skin alterations, and a Plan of Care was developed and implemented including treatment to his/her right heel pressure injury.F. The DON/designee will conduct daily audits of all skin checks performed to ensure any newly identified skin integrity concerns have been reported to the provider and the notification has been documented in the medical record.G. The