STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225718	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hancock Park Rehabiliation and Nursing Center	164 Parkingway 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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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 dehisced (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 Summery, 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 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 dehisced, 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