STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225054	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
John Scott House Nursing & Rehabilitation Center	233 Middle Street Braintree, MA 02184

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews for one of three sampled residents (Resident #1), who had an invoked Health Care Proxy (HCP), the Facility failed to ensure that staff promptly notified his/her Health Care Agent (HCA) and his/her Physician when he/she experienced a significant change in status related to a fall.Findings include:Review of Facility Policy titled Change in Resident Condition, dated as last revised 09/2025, indicated the Facility will promptly notify the resident, his or her Physician, and the resident representative of changes in the resident's medical/mental condition and/or status.The Policy indicated that the nurse would notify the resident's physician when there has been an accident or incident. During a telephone interview on 01/13/26 at 3:39 P.M., Family Member #1 said on 10/28/25, she went to visit Resident #1 and when she walked into his/her room she immediately noticed a bruise near his/her right eye and asked the nurse where the bruise had come from. Family Member #1 said that the nurse on duty reported to her that he thought Resident #1 had a fall the previous day. Family Member #1 said that no one from the Facility had notified her of a fall.Resident #1 was admitted to the Facility in 10/2025 diagnoses include status post fall with a subdural hematoma (brain bleed) requiring a right craniotomy (surgical procedure removing part of the skull to get to the brain), Parkinson's disease, and anticoagulation use. Review of Resident #1's Physician's Order, dated 10/27/25, indicated his/her Health Care Proxy (HCP) had been invoked.During a telephone interview on 01/15/26 at 1:55 P.M., Nurse #1 said on 10/27/25 at 7:15 A.M., she had been alerted by another nurse (later identified as Nurse #2) that Resident #1 had been found on the floor beside his/her bed.Nurse #1 said that Nurse #2 assisted her in getting him/her back into bed. Nurse #1 said that it was the end of her shift and that she had not completed any of the documentation that was required of nursing, after any Resident has a witnessed or unwitnessed fall. Nurse #1 said that Nurse #2 told her not to worry about it and said she (Nurse #1) assumed that Nurse #2 would complete the required documentation and any notifications needed. Nurse #1 said that she had not completed anything regarding the incident. Nurse #1 said she had not notified his/her physician or HCA. During an interview on 01/15/26 at 1:01 P.M., Nurse #2 said on 10/27/25, upon arriving at the unit, she observed Resident #1 on the floor next to his/her bed and got Resident #1's nurse (Nurse #1) for assistance.Nurse #2 said that after they assessed Resident #1 for injury and transferred him/her back into the bed, she left Nurse #1 to attend to him/her.Nurse #2 said she assumed Nurse #1 was going to fill out the proper documentation and make the required notifications but said she never checked up on it, to make sure the information was documented. Nurse #2 said that she had not reported to anyone that day that she had found Resident #1 on the floor earlier that morning until the following morning when giving the oncoming nurse report. Nurse #2 said she documented a late entry on 11/04/25 regarding the incident.Review of Resident #1's Medical Record, indicated that there was no documentation to support nursing had reported an unwitnessed fall to his/her physician until (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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/31/25. During an interview on 01/15/26 at 12:04P.M., the Staff Development Coordinator (SDC) said that she was not aware that on 10/27/25, Resident #1 had been found on the floor next to his/her bed.The SDC said that it is the Facility's expectation that when a resident is found on the floor the nurse must notify the appropriate parties, including the resident's physician and HCA.During an interview on 01/15/26 at 2:10 P.M., the Director of Nurses (DON) said that she was not made aware that on 10/27/25, Resident #1 had been found on the floor by his/her bed until she began an investigation into his/her bruise of unknown origin, that had been identified by Resident #1's HCA (10/28/25).The DON said that it is the Facility's expectation that when any resident has a witnessed or unwitnessed fall, the nurse must notify the physician and HCA in a timely manner.On 01/15/26, the Facility presented the Surveyor with a plan of correction with an effective date of 11/30/25 that addressed the area of concern identified in this survey, as follows:A) Resident #1 was transferred to the Hospital Emergency Department for Evaluation, he/she did not return to the facility.B) On 10/30/25, the incident was reviewed by the Director of Nurses (DON), Administrator, and Management Team during an Ad-[NAME] Quality Assurance and Performance Improvement (QAPI) meeting.C) On 10/30/25, the DON and/or designee completed an audit for all witnessed and unwitnessed falls the past 30 days to ensure proper notification had been completed in a timely manner. D) On 10/30/25, the DON and or designee began education for licensed staff regarding proper steps of notification after a resident sustains a fall or is found on the floor.E) All Falls will be reviewed by the management team for proper notification x three months, then 2 months or until 100% compliance is met.F) Results of audits will be brought to QAPI meetings and reviewed, which include the most recent QAPI meeting held on 11/03/25.G) The DON/designee are responsible for overall compliance.

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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	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 sampled residents (Resident #1), who experienced an unwitnessed fall, the Facility failed to ensure he/she was provided care and treatment that met professional standards for quality of care, when he/she was not adequately assessed and monitored by nursing after being found on the floor after an unwitnessed fall.Findings include:Review of the Facility Policy titled Falls Program Policy, dated as last reviewed 09/2025, indicated that the documentation of a fall should include;-Notification to Physician and family;-Complete Fall Incident Report;-Fall investigation Report and obtain witness statements;-Monitor Vital Signs; and-Neurological Checks for any unwitnessed falls. Resident #1 was admitted to the Facility in 10/2025 diagnoses include status post fall sustaining a subdural hematoma (brain bleed) requiring a right craniotomy (surgical procedure removing part of the skull to get to the brain), Parkinson's disease, and anticoagulation use. Review of Resident #1's Physician's Order, dated 10/27/25, indicated his/her Health Care Proxy (HCP) had been invoked.During a telephone interview on 01/15/26 at 1:55 P.M., Nurse #1 said on 10/27/25 at 7:15 A.M., she had been alerted by another nurse (later identified as Nurse #2) that Resident #1 had been found on the floor beside his/her bed.Nurse #1 said Nurse #2 assisted her in getting him/her back into bed. Nurse #1 said it was the end of her shift, and that she had not completed any of the medical record documentation required by nursing when a Resident falls. Nurse #1 said that Nurse #2 told her not to worry about it, so she assumed that Nurse #2 would complete the required documentation and notifications.Nurse #1 said she had not obtained vital signs, had not completed neurological checks, had not done any assessments (fall, skin, pain), had not initiated a facility incident report, had not written a nursing progress note that day, but wrote one as a late entry on 11/04/25.During an interview on 01/15/26 at 1:01 P.M., Nurse #2 said on 10/27/25, upon arriving at the unit, she noted Resident #1 on the floor next to his/her bed and informed his/her nurse (Nurse #1) for assistance.Nurse #2 said that after she and Nurse #1 transferred him/her back into the bed, she left Nurse #1 to attend to Resident #1.Nurse #2 said she had assumed Nurse #1 was going to fill out the required nursing documentation. Nurse #2 said she never followed up on the incident and had not reported the incident to anyone that day that she had found Resident #1 on the floor until the following morning when giving the oncoming nurse report. During an interview on 01/15/26 at 12:04P.M., the Staff Development Coordinator (SDC) said that she was not aware that on 10/27/25, Resident #1 had been found on the floor next to his/her bed.The SDC said that it is the Facility's expectation that when a resident is found on the floor, witnessed or unwitnessed, the nurse must complete specific documentation and notify the appropriate parties, including the resident's physician and HCA.During an interview on 01/15/26 at 2:10 P.M., the Director of Nurses (DON) said that she was not aware that Resident #1 had been found on the floor by his/her bed on 10/27/25, until she began the investigation of the bruise of unknown origin, that had been identified by Resident #1's HCA on 10/28/25.The DON said that it is the Facility's expectation that when any resident has witnessed or unwitnessed fall, the nurse responding to the fall must immediately complete a physical assessment on the resident. The DON also said the Nurse must complete all required assessments and documentation such as, obtain vital signs, initiate neurological checks, perform a skin, fall, and pain assessment. On 01/15/26, the Facility presented the Surveyor with a plan of correction with an effective date of 11/20/25 that addressed the area of concern identified in this survey, as follows:A) Resident #1 was transferred to the Hospital Emergency Department for Evaluation, he/she did not return to the facility.B) On 10/30/25, the incident was reviewed by the Director of Nurses (DON), Administrator, and Management Team during an Ad-[NAME] Quality (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assurance and Performance Improvement (QAPI) meeting.C) On 10/30/25, the DON and/or designee completed an audit for all witnessed and unwitnessed falls the past 30 days to ensure proper notification had been completed in a timely manner. D) On 10/30/25, the DON and or designee began education for licensed staff regarding proper steps of notification after a resident sustains a fall or is found on the floor.E) All Falls will be reviewed by the management team for proper notification x three months, then 2 months or until 100% compliance is met.F) Results of audits will be brought to QAPI meetings and reviewed, which include the most recent QAPI meeting held on 11/03/25.G) The DON/designee are responsible for overall compliance.