STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225338	A. Building B. Wing	04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cape Regency Rehabilitation & Health Care Center	120 S Main Street Centerville, MA 02632

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. 40702 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who during the night shift (11:00 P.M. to 7:00 A.M.) on 03/07/25 into 03/08/25 had an unwitnessed fall, and was found in the bathroom kneeling on the floor, the Facility failed to ensure the Provider and Family Member #1, were notified. Findings include: Review of the Facility's Policy, titled Condition: Significant Change, dated April 2015, indicated the following: -staff will communicate with the physician, resident/patient, and family regarding changes in condition to provide timely communication of resident/patient status change which is essential to quality care management - the physician, resident/patient and/or responsible party will be notified by the nurse in the event of a change in condition -this notification shall be documented in the clinical record Review of the Facility's Policy, titled Falls Management, dated as reviewed/revised April 2024 indicated the following: -anytime a resident is found on the floor, a fall is considered to have occurred -post fall, once a resident/patient is clinically evaluated as being stable, vital signs, neurological signs, range of motion, and evaluation of cognitive status will be documented -neurological checks are to be documented on the neurological flow sheet for 72 hours in the following circumstances: resident/patient states that he/she hit head, physical evidence resident hit head, and an unwitnessed fall; resident/patient should continue to be monitored for 72 hours after a fall to evaluate for latent injury, with documentation in the medical record (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated as submitted 03/13/25, indicated on 03/08/25 at approximately 6:00 A.M., Resident #1 was found by a Certified Nurse Aide (CNA, later identified as CNA #1) kneeling on his/her right knee in the residents' shared bathroom. The Report indicated that the nurse (later identified as Nurse #1) on duty that day was notified. The Report further indicated that Nurse #1 gave Resident #1 his/her medications and he/she did not complain of pain. Resident #1 was admitted to the Facility in February 2025, diagnoses included displaced comminuted fracture (bone breaks into three or more pieces) of shaft of humerus (upper left arm), difficulty in walking, anxiety disorder, chronic kidney disease stage 2, hypertension, chronic obstructive pulmonary disease, and hyperlipidemia (high cholesterol). During an interview on 04/22/25 at 3:19 P.M., (which included review of her written statement) CNA #1 said on 03/08/25 around 6:00 A.M., she was called to Resident #1's room by his/her roommate, who told her that Resident #1 was on the floor in the bathroom. CNA #1 said she found Resident #1 kneeling on his/her right knee in front of the sink and as she approached Resident #1, he/she grabbed onto her (CNA#1) shirt and said, I just want to stand up, so she helped Resident #1 get up. CNA #1 said she asked Resident #1 if he/she fell and said Resident #1 told her (CNA #1) that he/she did not fall and had just slipped because there was water on the floor. CNA #1 said Resident #1 said he/she was okay, was not in pain, so she assisted him/her back to bed. CNA #1 said she told Nurse #1 she found Resident #1 on the bathroom floor, that he/she slipped in water, was not in pain and assisted him/her back to bed. During an interview on 04/28/25 at 10:54 A.M., (which included review of her written statement) Nurse #1 said on 03/08/25, CNA #1 told her that she found Resident #1 in the bathroom on the floor on one knee. Nurse #1 said she went to give Resident #1 his/her morning medication, he/she was in bed, and that she asked Resident #1 how he/she was. Nurse #1 said Resident #1 told her that he/she was fine. Nurse #1 said Resident #1 appeared to be in no apparent distress, that she assessed his/her range of motion (ROM), and he/she did not complain of pain. Nurse #1 said Resident #1 did not tell her that he/she had fallen. Nurse #1 said she did not think Resident #1's incident was an actual fall because she had not seen him/her on the floor. Nurse #1 said that CNA #1 had assisted him/her back to bed after being found on the bathroom floor and CNA #1 told her (Nurse #1) that Resident #1 had said he/she was okay. Nurse #1 said she did not complete an incident report regarding the fall. Nurse #1 said she did not document Resident #1's fall or her assessment of him/her after the fall and did not notify the Physician, or Family Member #1 of the unwitnessed fall. Nurse #1 said anytime a resident is found on the floor it is considered a fall. Nurse #1 said she did not follow the Facility's policies, but said she should have. Review of Resident #1's medical record indicated that there was no documentation to support that Nurse #1 notified his/her Physician and Family Member #1 of the unwitnessed fall. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Incident Report, dated 03/09/25, (completed by Nurse #4), indicated that Resident #1 stated to Nurse #4 that he/she fell in the bathroom at 6:00 A.M. (the previous day), that after using the toilet he/she took a step, then slipped in either water or urine, fell into the bathroom door and then fell to the floor hitting his/her right side in the rib area. The Report indicated that a CNA (identified as CNA #1) was called into the room by the resident in the adjoining room, and CNA #1 then helped him/her up off the floor. The Report indicated the Physician and Director of Nursing were notified (03/09/25). Review of Resident #1's Nurse Progress Note, dated 03/10/25, (written by Nurse #4), indicated that Resident #1 was noted to be in severe pain this A.M., and he/she complained of worsening right-sided pain. The Note indicated that Resident #1 was sent to the Hospital Emergency Department via rescue, and returned with a diagnosis of a T11 compression fracture and a new order for oxycodone (opioid, analgesic) as needed for severe pain. During a telephone interview on 05/01/25 at 11:14 A.M., the Director of Nursing (DON) said she was notified on 03/09/25 by Nurse #4 that Resident #1 had sustained an unwitnessed fall (on 03/08/25). The DON said she spoke to Nurse #1, who said CNA #1 informed her (Nurse #1) that she found Resident #1 kneeling on his/her right knee in the bathroom. The DON said Nurse #1 said she gave Resident #1 his/her morning medication and he/she did not complain of any pain or say he/she had fallen. The DON said Nurse #1 did not document Resident #1's fall in his/her medical record, and did not notify the Physician or Family Member #1. The DON said Nurse #1 did not follow the Facility's Policy. The DON said her expectation is always best practice, patient-centered care and that all Facility Protocols and Policies are being followed by the nurses.

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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. 40702 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who during the night shift (11:00 P.M. to 7:00 A.M.) on 03/07/25 into 03/08/25 was found on the bathroom floor after an unwitnessed fall by nursing staff, the facility failed to ensure he/she was provided care and services that met professional standards of nursing practice, when although Nurse #1 said she assessed Resident #1 after the incident, she did not document it, did not complete an incident report or write a progress note, and did not report the unwitnessed fall to the oncoming shift nurse, so he/she could be monitored. Findings include: Standard Reference: Standard of Practice Reference: Pursuant to Massachusetts General Law (M.G.L), chapter 112, individuals are given the designation of registered nurse and practical nurse which includes the responsibility to provide nursing care. Pursuant to the Code of Massachusetts Regulation (CMR) 244, Rules and Regulations 3.02 and 3.04 define the responsibilities and functions of a registered nurse and practical nurse bear full responsibility for systematically assessing health status and recording the related health status and recording the related health data. They also stipulate that both the registered and practical nurse incorporated into the plan of care and implement prescribed medical regimens. The rules and regulations 9. 03 define standards of Conduct for Nurses where it is stipulated that a nurse licensed by the Board shall engage in the practice of nursing in accordance with accepted standards of practice. Review of the Facility's Policy, titled Accidents/Incidents, dated April 2015, indicated the following: -it is the responsibility of the staff to report all accident and incidents which occur at the facility -reporting of accidents/incidents; must be reported to the supervisor, and appropriate documentation completed -the investigation of accident/incident form will be used for resident/patients; be completed for each incident -the Administrator and Director of Nursing will be made aware of all such incidents that have occurred, and will review completed reports Review of the Facility's Policy, titled Falls Management, dated as reviewed/revised April 2024 indicated the following: -anytime a resident is found on the floor, a fall is considered to have occurred -post fall, once a resident/patient is clinically evaluated as being stable, vital signs, neurological signs, range of motion, and evaluation of cognitive status will be documented (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-neurological checks are to be documented on the neurological flow sheet for 72 hours in the following circumstances: resident/patient states that he/she hit head, physical evidence resident hit head, and an unwitnessed fall; resident/patient should continue to be monitored for 72 hours after a fall to evaluate for latent injury, with documentation in the medical record Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 03/13/25, indicated on 03/08/25 at approximately 6:00 A.M., Resident #1 was found by a Certified Nurse Aide (CNA, later identified as CNA #1) kneeling on his/her right knee in the residents' shared bathroom. The Report further indicated that Resident #1 was sent to the hospital (on 3/09/25) for complaints of flank (area between the ribs and hip on either side of the body) pain and an X-ray indicated he/she had a small compression fracture in his/her thoracic vertebrae. Resident #1 was admitted to the Facility in February 2025, diagnoses included displaced comminuted fracture (bone breaks into three or more pieces) of shaft of humerus (upper left arm), difficulty in walking, anxiety disorder, chronic kidney disease stage 2, hypertension, chronic obstructive pulmonary disease, and hyperlipidemia (high cholesterol). During an interview on 04/22/25 at 3:19 P.M., (which included review of her written statement) CNA #1 said on 03/08/25 around 6:00 A.M. she was called to Resident #1's by his/her roommate who reported that Resident #1 was on the floor in the bathroom. CNA #1 said she found Resident #1 kneeling on his/her right knee in front of the sink and as she approached Resident #1, he/she grabbed onto her (CNA#1) shirt and said, I just want to stand up. CNA #1 said Resident #1 told her (CNA #1) that he/she did not fall but had just slipped because there was water on the floor. CNA #1 said Resident #1 told her he/she was okay, said he/she was not in pain, that she helped Resident #1 change his/her clothes because they were wet and then assisted him/her back to bed. CNA #1 said she reported to Nurse #1 that she found Resident #1 on the bathroom floor, that he/she reported he/she had slipped in water, was not in pain and that she assisted him/her back to bed. During an interview on 04/28/25 at 10:54 A.M., (which included review of her written statement) Nurse #1 said on 03/08/25 sometime after 6:00 A.M., CNA #1 told her that she found Resident #1 in the bathroom on the floor on one knee. Nurse #1 said when she went to give Resident #1 his/her morning medication, he/she was in bed, and she asked Resident #1 how he/she was. Nurse #1 said Resident #1 told her that he/she was fine. Nurse #1 said Resident #1 appeared to be in no apparent distress, that she assessed his/her range of motion (ROM), and he/she did not complain of pain or say that he/she had fallen. Nurse #1 said she did not think Resident #1's incident was an actual fall because she did not see him/her on the floor. Nurse #1 said that CNA #1 also told her (Nurse #1) that Resident #1 had said he/she was okay. Nurse #1 said that anytime a resident is found on the floor it is considered a fall. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse #1 said she did not complete an incident report regarding the unwitnessed fall, and did not document Resident #1's fall or her assessment of him/her after the fall. Nurse #1 she did not notify the Physician, or Family Member #1 of the unwitnessed fall. Nurse #1 said she could not recall if she informed the oncoming shift nurse during change of shift report that morning about Resident #1's unwitnessed fall. Review of Resident #1's medical record indicated that there was no documentation to support that Nurse #1 assessed Resident #1 for potential injury or pain on 03/08/25 after he/she had an unwitnessed fall, including completing an incident report related to being found on the floor by staff, or that the DON and/or Administrator were notified, as required. During an interview on 04/28/25 at 11:33 A.M., Nurse #2 said on 03/08/25 she worked the 7:00 A.M. to 3:00 P.M. shift, and that she was not informed during change of shift report by the 11:00 P.M. to 7:00 A.M. nurse (Nurse #1) that Resident #1 was found on the floor earlier that morning. Nurse #2 said Resident #1 received his/her scheduled pain medication and did not complain of any pain during her shift. Review of Resident #1's Nurse Progress Note, dated 03/08/25 (written by the Assistant Director Nursing (ADON), indicated that Resident #1 complained of back pain, stated he/she had a fall the night prior. The Note indicated that the day shift nurse reported she was not informed (by the night shift nurse) that Resident #1 fell during the overnight shift. The Note indicated Resident #1 was questioned and stated that he/she did not fall, said he/she slipped in the bathroom and stumbled. The Note indicated that Resident #1 requested to be transferred to the hospital for an X-ray of his/her back but was advised (by the ADON) that an X-ray could be ordered in house, and he/she agreed. During an interview on 04/22/25 at 4:03 P.M., the ADON said she worked from 4:00 P.M. to 11:00 P.M. on 03/08/25 on Resident #1's unit. The ADON said Resident #1 complained of back pain and she asked him/her what happened, and Resident #1 told her (ADON) that he/she fell the night before. The ADON said she then asked Resident #1 where he/she fell , and Resident #1 said I did not fall, I stumbled in the bathroom. The ADON said she called Nurse #2 who had worked on the unit from 7:00 A.M. to 3:00 P.M. and asked her (Nurse #2) if Resident #1 had fallen. The ADON said Nurse #2 told her Resident #1 had no complaints and had not reported to her that he/she fell . Review of Resident #1's Incident Report, dated 03/09/25, (completed by Nurse #4), indicated that Resident #1 stated to Nurse #4 that he/she fell in the bathroom (on 3/08/25) at 6:00 A.M., that after using the toilet he/she took a step, then slipped in either water or urine, fell into the bathroom door and then reported that he/she fell to the floor hitting the right side his/her ribs. The Report indicated that a CNA (CNA #1) was called into the room by the resident in the adjoining room, and CNA #1 then helped him/her up off the floor. The Report indicated the Physician and Director of Nursing were notified (on 03/09/25). Review of Resident #1's Nurse Progress Note, dated 03/09/25 (written by Nurse #4), indicated that Resident #1 complained of right sided rib pain, reported that he/she may have a fracture because he/she hit his/her ribs during a fall. The Note indicated that Resident #1 reported that he/she did not tell the nurse because he/she was afraid it would hold up his/her upcoming discharge from the Facility. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Note further indicated that Resident #1's pain level was a 9/10 (a pain scale where 0 is no pain and 10 is the worst pain possible), he/she appeared visibly distressed, was given ibuprofen and a STAT (immediately or without delay) X-ray was ordered. Review of Resident #1's Nurse Progress Note, dated 03/10/25, (written by Nurse #4), indicated Resident #1 noted to be in severe pain this A.M., he/she complained of worsening right-sided pain. The Note indicated that Resident #1 was sent to the Hospital Emergency Department via rescue, and he/she returned with a diagnosis of a T11 compression fracture and a new order for oxycodone, as needed for severe pain. Review of Resident #1's Hospital After Visit Summary, dated 03/10/25, indicated he/she was seen for a chief complaint of rib injury. The Summary indicated Resident #1's Computed Tomography (CT) scan (imaging test that uses X-rays) of his/her chest, abdomen, and pelvis showed a new mild compression deformity (small compression fracture) of the superior endplate (the top surface of a vertebral body in the spine) of his/her T11 (eleventh thoracic vertebra in the spine). During a telephone interview on 05/01/25 at 11:14 A.M., the Director of Nursing (DON) said she was notified on 03/09/25 by Nurse #4 that Resident #1 had sustained an unwitnessed fall (on 03/08/25). The DON said she spoke to Nurse #1, who said CNA #1 informed her (Nurse #1) that she found Resident #1 kneeling on his/her right knee in the bathroom. The DON said Nurse #1 said that when she gave Resident #1 his/her morning medication, he/she did not complain of any pain or say he/she had fallen. The DON said Nurse #1 did not complete any assessments, did not document Resident #1's unwitnessed fall in his/her medical record, and did not inform the oncoming shift Nurse. The DON said Nurse #1 should have assessed Resident #1 and followed the Facility's Policy related to an unwitnessed fall, but she did not. The DON said her expectation is always best practice, patient-centered care and that all Facility Protocols and Policies are being followed by the nurses. The DON said she holds the nurses to the highest standard for professional conduct for residents' safety.