

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225549	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2024
NAME OF PROVIDER OR SUPPLIER Brigham Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 77 High Street Newburyport, MA 01950	

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)
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>37375</p> <p>Based on records reviewed, interviews and observations for one of three sampled residents (Resident #1), the Facility failed to ensure they maintained Resident #1's dignity when he/she was observed with stains and what appeared to be dried food on the front of both of his/her sneakers.</p> <p>Findings Include:</p> <p>The Facility Policy titled Resident Rights, dated as revised 12/06/21, indicated a Facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.</p> <p>The Policy indicated that the facility would make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity.</p> <p>Resident #1 was admitted to the Facility in March 2016, diagnoses included hemiplegia (partial paralysis on one side of the body) affecting the right non-dominant side, psychotic disorder with delusions, vascular dementia with behavioral disturbance, anxiety, depression, cerebral infarction (stroke, disrupted blood flow to the brain), dysphagia (difficulty swallowing), muscle weakness, and abnormality of gait and mobility.</p> <p>During a tour of the first floor Unit, on 03/26/24 at 8:10 A.M., the Surveyor observed Resident #1 seated in his/her wheelchair in his/her room. Resident #1 had on a pair of sneakers that were dirty, soiled with a dried red liquid and what appeared to be dried food particles on the front of both sneakers.</p> <p>On 03/26/24 at 9:35 A.M., the Surveyor observed Resident #1 seated in his/her wheelchair in the activity room, his/her sneakers had not been cleaned and were still in the same dirty condition that the Surveyor had observed earlier that morning.</p> <p>During an interview on 03/26/24 at 10:54 A.M., Family Member #1 said that Resident #1 was a messy eater and often times would spill food items that stained his/her clothing while eating and said nursing staff would leave him/her in stained clothing.</p> <p>(continued on next page)</p>

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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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/26/24 at 12:58 P.M., Certified Nurse Aide (CNA) #3 said Resident #1 was on her assignment and said she had observed his/her sneakers with food on them. CNA #3 and said Resident #1's sneakers should have been scrubbed clean.</p> <p>During an interview on 03/26/25 at 3:55 P.M. and on 04/04/24 at 3:59 P.M., the Director of Nursing (DON) said (after seeing the pictures of Resident #1's soiled sneakers shown to her by the Surveyor) that nursing staff should not have put the sneakers on Resident #1 in that condition. The DON said her number one concern was that it (wearing soiled, dirty sneakers) was a resident dignity issue.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>37375</p> <p>Based on records reviewed, interviews and observations, for one of three sampled residents (Resident #1), the Facility failed to ensure that staff provided a clean homelike environment when his/her wheelchair was observed to be dirty with dried food stuck to the seatbelt of Resident #1's wheelchair, with dried food also noted to be stuck to each side of his/her wheelchair.</p> <p>Findings Include:</p> <p>The Facility Policy titled Resident Rights, dated as revised 12/06/21, indicated a Facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.</p> <p>The Policy indicated that each resident's rights included the resident has a right to a safe, clean, comfortable, and homelike environment.</p> <p>Resident #1 was admitted to the Facility in March 2016, diagnoses included hemiplegia (partial paralysis on one side of the body) affecting the right non-dominant side, psychotic disorder with delusions, vascular dementia with behavioral disturbance, anxiety, depression, cerebral infarction (stroke, disrupted blood flow to the brain), dysphagia (difficulty swallowing), muscle weakness, and abnormality of gait and mobility.</p> <p>During a tour of the first floor Unit, on 03/26/24 at 8:10 A.M., the Surveyor observed Resident #1 seated in his/her wheelchair in his/her room and observed his/her wheelchair to have multiple areas of what appeared to be dried food caked to the sides of the wheelchair and to his/her alarmed seat belt that was on the wheelchair.</p> <p>On 03/26/24 at 9:35 A.M., the Surveyor observed Resident #1 seated in his/her wheelchair in the activity room and his/her wheelchair was in the same condition as the Surveyor had observed earlier that morning.</p> <p>Review of the Housekeeping Wheelchair Washing Schedule indicated that Resident #1's wheelchair had not been washed since 02/14/24 (which had been approximately 6 weeks prior to the date of the survey).</p> <p>During an interview on 03/26/24 at 12:58 P.M., Certified Nurse Aide (CNA) #3 said Resident #1's wheelchair had been on a cleaning schedule and said it used to be cleaned weekly in the past but said she did not think it had been cleaned weekly since the former Administration had left.</p> <p>CNA #3 said Resident #1 was on her assignment and she had observed his/her wheelchair had food on it. CNA #3 said she was unable to use Resident #1's wheelchair tray for his/her breakfast because the tray was filthy. CNA #3 said Resident #1's wheelchair should have been scrubbed clean before using it.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/36/24 at 1:26 P.M., Nurse # 2 said some resident's wheelchairs were dirtier than others depending on how they feed themselves and said Resident #1's wheelchair was a mess.</p> <p>During an interview on 03/26/24 at 2:25 P.M., the Housekeeping Director said that wheelchairs were supposed to be washed at least once monthly and but also more often if needed. The Housekeeping Director said that Resident #1's wheelchair was supposed to be washed more often (than once monthly) because his/her wheelchair became dirty more often (however, according to the wheelchair washing schedule it had been almost six weeks since housekeeping had washed the wheelchair).</p> <p>The Surveyor showed the Housekeeping Director pictures she had taken of Resident #1's wheelchair. The Housekeeping Director said Resident #1's wheelchair appeared dirty and said his/her chair usually appeared that dirty when it needed to be washed and said his/her wheelchair should have been washed. The Housekeeping Director said that because he was filling in for another staff member, wheelchair cleaning had not been consistent for several weeks.</p> <p>During an interview on 03/26/25 at 3:55 P.M. and on 04/04/24 at 3:59 P.M., the Director of Nursing (DON) said(after seeing the pictures of the condition of Resident #1's wheelchair shown to her by the Surveyor), that Resident #1's wheelchair should have been cleaned right away when staff observed his/her wheelchair in the condition it had been in and said staff should not have put Resident #1 into the wheelchair.</p>		