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 11/05/2024
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)
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. 37330 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who during the overnight shift on 10/04/24 into 10/05/24 was found sitting on the floor by Nurse #1 and CNA #1 after an unwitnessed fall, the Facility failed to ensure nursing reported the incident to the Physician, his/her Health Care Agent, Administrative staff and to the oncoming shift Nurse (Nurse #2) as required, and per Facility policy. Findings include: Review of the Facility's policy, titled Notification of Changes, dated 03/04/24, indicated the purpose of this Policy is to ensure the Facility promptly informs the resident's Physician; notifies, consistent with his or her authority, the resident's Representative when there is a change requiring notification. The Policy indicated circumstances requiring notification include accidents with potential to require Physician interventions. The Policy indicated additional considerations included that for competent individuals, the Facility must still contact the resident's Physician and notify resident's Representative. Review of the Facility's policy, titled Fall Prevention Program, dated 03/04/24, indicated when any resident experiences a fall, the Facility will notify residents Physician and Family. Review of Facility's policy, titled Incidents and Accidents, dated 03/04/2024, indicated staff to alert Risk Management and/or Administration of occurrences that could result in claims or further reporting requirements. The Policy indicated staff will notify the Supervisor or other Designee of the incident/accident. The Policy indicated the Nurse will contact the resident's Physician and Family to inform them of the incident/accident. Resident #1 was admitted to the Facility in September 2024, diagnoses included congestive heart failure, atrial fibrillation, hypertension, shortness of breath, and muscle weakness. (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	Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 10/15/24, indicated that on 10/05/24, Resident #1's daughters were visiting Resident #1, he/she complained of back pain, told them he/she had fallen overnight, and the family requested Resident #1 be transferred to the hospital. The Report further indicated that Resident #1's fall was unwitnessed, Nursing assessment at the time of the fall did not reveal any acute injury, that Resident #1 had been toileted, place back into bed and had not complained of pain until later in the morning. The Report indicated Resident #1 was transferred to the hospital (during the day shift on 10/05/24), was diagnosed with edema and fracture of S3-S4 (break in the sacrum) and T11 (on of the 12 vertebrae of the thoracic spine). Review of Resident #1's Medical Record indicated his/her Family was involved in his/her care. Resident #1 was his/her own person, that his/her Health Care Agent contact information and Family member contact information were clearly indicated in his/her record. Review of Resident #1's Medical Record indicated that for overnight shift (10/04/24 into 10/05/24), there was no Nurse Progress Note, no Incident Report and no documentation to support Resident #1's Health Care Agent, Physician, Director of Nurses (DON) or the oncoming day shift Nurse were notified of Resident #1's fall/incident. During a telephone interview on 11/12/24 at 2:32 P.M., (which included a review of her Written Witness Statement, dated 10/09/24), Nurse #1 said on 10/05/24, somewhere around 2:00 A.M. she heard a sound, like a walker falling on the floor, that she went into Resident #1's room, and found him/her sitting on his/her buttocks on the floor. Nurse #1 said Resident #1 was able to move his/her legs, arms and denied having any pain or hitting, his/her head. Nurse #1 said she was satisfied with her assessment and waited to perform vital signs once Resident #1 was in bed since he/she had to go to the bathroom. Nurse #1 said she and CNA #1 helped Resident #1 ambulate to the bathroom with his/her walker, but upon return from the bathroom they transferred Resident #1 via wheelchair since Resident #1 said he/she was tired. Nurse #1 said she did not report Resident #1's fall to the Physician, the DON or to Resident #1's Health Care Agent. Nurse #1 said she was aware of the Facility's Policy related to Fall Prevention Program, Incidents and Accidents and Documentation, which included reporting any incidents and accidents. Nurse #1 said on 10/09/24 she wrote and provided the Facility with a written statement, in which she documented Resident #1's fall. Nurse #1 said looking back she should of followed the Facility's Policy and reported Resident #1's fall to the Physician, to the oncoming shift Nurse, the DON, his/her Health Care Agent and documented the incident for Resident #1's safety and for other staff to be able to identify any changes that may occur with him/her. Review of Resident #1's Hospital Magnetic Resonance Imaging (MRI) Report, dated 10/06/24, indicated that Resident #1 had a fall, pain, and a Thoracic spine/Lumbar MRI was completed. The Report indicated Resident #1 had a T11 vertebral body acute fracture/edema (bottom part of the thoracic spine) and a fracture of his/her S3 and S4 fracture (a break in the sacrum, a triangular bone at the base of the spine, between the hips). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/05/24 at 2:39 A.M. the Director of Nurses (DON) said she was not informed of Resident #1's fall by the Nurse (identified as Nurse #1) that worked the overnight shift on 10/04/24 into 10/05/24. The DON said she and Nurse #2 assessed Resident #1 on 10/05/24, after Resident #1's family members notified them that Resident #1 had a fall on the overnight shift and wanted him/her to be transferred to the hospital immediately. The DON said she went to assess Resident #1, who reported that he/she had fallen sometime during the overnight shift, that he/she fell landing on his/her buttocks, staff picked him/her up off the floor, placed him/her in a wheelchair, toileted him/her and then placed him/her back into bed. The DON said she could not find any documentation in Resident #1's Medical Record regarding his/her fall on 10/05/24, including any assessments or an Incident Report. The DON said it was her expectation that Nurse #1 should have assessed Resident #1 for injury, initiated obtaining neurological signs (fall was unwitnessed), and completed pain and skin assessments. The DON said Nurse #1 should have also notified the Physician, facility administrative staff, documented the incident in a progress note, completed an Incident Report, notified the oncoming shift nursing staff, and obtained staff members written statements, but she had not. The DON said she began an investigation on 10/05/24 after being informed of Resident #1's fall. The DON said she had Nurse #1 complete all the Resident #1's fall documentation as a late entry, but that Nurse #1 did not do so until several days after the Resident #1's fall since Nurse #1 was not returning her phone calls or texts. The DON said Nurse #1 told her she did not report Resident #1's fall on 10/05/24, because she had forgotten to report and document the incident.

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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. 37330 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who during the overnight shift (on 10/04/24 into 10/05/24) was found sitting on the floor by Nurse #1 and Certified Nurse Aide (CNA) #1 after an unwitnessed fall, the Facility failed to ensure he/she was provided with nursing care and treatment that met professional standards of quality care, when although Nurse #1 said she assessed Resident #1 prior to moving him/her off the floor, there was no documentation to support she adequately assessed Resident #1 after his/her fall for potential injury. The following day shift (7:00 A.M. to 3:00 P.M.) Resident #1 verbalized complaints of pain, reported he/she had fallen during the previous overnight shift, and was transferred to the Hospital Emergency Department (ED) for evaluation. Resident #1 was diagnosed with a T11 vertebral body acute fracture/edema (bottom part of the thoracic spine) and fractures of S3 and S4 fracture (a break in the sacrum, a triangular bone at the base of the spine, between the hips). 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 respectively. The regulations stipulate that both the registered nurse and practical nurse bear full responsibility for systematically assessing 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 defined 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 Policy titled, Fall Prevention Program, dated 03/04/24, indicated when any resident experiences a fall the Facility will: -Assess the resident. -Complete a post-fall assessment. -Complete an incident report. -Notify Physician and family. -Review the Resident's care plan and update as indicated. -Document all assessments and actions. -Obtain witness statements in the case of injury. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Facility Policy titled, Accidents and Incidents, dated 03/04/24, indicated for Facility Staff to utilize Point Click Care (PCC) risk management to report and investigate any accidents or incidents that occur on Facility property involving a Resident. The Policy indicated staff to initiate the following: -Falls require an incident/accident report. -The Supervisor or other designee will be notified of the incident/accident. -The Nurse will contact the resident's practitioner to inform them of the incident/accident, report any injuries or other findings, and obtain orders, if indicated, which may include transportation to the hospital dependent upon the nature of the injury. -In the event of an unwitnessed fall, the nurse will initiate neurological checks as per protocol, document on the neurological flow sheet and abnormal findings will be reported to the Practitioner. -The resident's Family or Representative will be notified of the incident/accident and any orders obtained or if the resident is to be transported to the hospital. -Documentation should include the date, time, nature of the incident, location, initial findings, immediate interventions, notifications, and orders obtained or follow-up interventions. Resident #1 was admitted to the Facility in September 2024, diagnoses included congestive heart failure, atrial fibrillation, hypertension, shortness of breath, and muscle weakness. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 10/15/24, indicated that on 10/05/24, Resident #1's daughters were visiting Resident #1, he/she complained of back pain, told them he/she had fallen overnight, and the family requested Resident #1 to be transferred to the hospital. The Report indicated Resident #1's fall was unwitnessed, and nursing assessment at the time of the fall did not reveal any acute injury. The Report indicated Resident #1 had been toileted, placed back into bed and had not complained of pain until later in the morning. The Report indicated Resident #1 was transferred to the Hospital Emergency Department where he/she was diagnosed with edema and fractures of S3-S4 and T11. During a telephone interview on 11/12/24 at 3:54 P.M., (which included a review of her Written Witness Statement, undated), CNA #1 said on 10/05/24, somewhere around 2:00 A.M. (exact time unknown) she heard a bang, went into Resident #1's room, and found him/her sitting on his/her buttocks on the floor. CNA #1 said Resident #1's walker was tipped over on the floor next to him/her and that Resident #1 said he/she was going to the bathroom. CNA #1 said Resident #1 said he/she was alright, so she and Nurse #1 assisted (lifted) Resident #1 up off the floor, assisted him/her to the bathroom, toileted him/her and then transferred Resident #1 back into bed. CNA #1 said prior to them moving Resident #1 off the floor she did not see Nurse #1 perform an assessment on Resident #1, other than hearing Nurse #1 ask Resident #1 if he/she was in pain. (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	During a telephone interview on 11/12/24 at 2:32 P.M., (which included a review of her Written Witness Statement, dated 10/09/24), Nurse #1 said on 10/05/24, somewhere around 2:00 A.M. (exact time unknown) she heard a sound, like a walker falling on the floor, went into Resident #1's room, and found him/her sitting on his/her buttocks on the floor. Nurse #1 said Resident #1 was able to move his/her legs, arms, denied hitting his/her head and did not report having pain. Nurse #1 said she was satisfied with her initial assessment and waited to perform vital signs once Resident #1 was in bed, since Resident #1 said he/she had to go to the bathroom. Nurse #1 said she and CNA #1 helped Resident #1 ambulate to the bathroom with his/her walker but upon return from the bathroom they transferred Resident #1 via wheelchair since Resident #1 said he/she was tired. Nurse #1 said she did not document or complete any documentation related to Resident #1 fall and did not report Resident #1's fall on 10/05/24 to the next shift staff because Resident #1 said he/she was alright. Nurse #1 said she did not initiate neurological checks after Resident #1's unwitnessed fall since Resident #1 said he/she did not hit his/her head. However, although Nurse #1 said she assessed Resident #1 immediately after the fall, and that she had decided to wait and obtain a set of vitals after she and CNA #1 assisted Resident #1 back to bed, there was no documentation in Resident #1's medical record to support Nurse #1 had completed any type of assessment or that she had obtained Resident #1's vital signs on 10/05/24, after his/her unwitnessed fall. Nurse #1 said she was aware of the Facility's Policy related to Fall Prevention Program, Incidents/Accidents, Procedures, and what was required of nursing if a resident had an unwitnessed fall. Nurse #1 said on 10/09/24, (five days after the incident) she provided a written statement to the Facility and that was also when she documented Resident #1's unwitnessed fall in his/her medical record. During an interview on 11/05/24 at 4:02 P.M., (which included a review of her Written Witness Statement, dated 10/05/24), Nurse #2 said on 10/05/24 she worked the 7:00 A.M. to 3:00 P.M. shift and when she came on duty, she received change of shift report from Nurse #1 who had worked the overnight shift (from 10/04/24 into 10/05/24). Nurse #2 said during the change of shift report, Nurse #1 told her that Resident #1 had chronic pain, was on scheduled pain medications and had a wound that was not new to his/her coccyx area. Nurse #2 said Nurse #1 did not say anything in report to her about Resident #1 falling during the overnight shift. Nurse #2 said, on 10/05/24, she administered Resident #1's medications later in the morning (exact time unknown) which included scheduled pain medications, and shortly after that CNA #2 reported to her that Resident #1 said he/she was in pain due to a fall. Nurse #2 said since she had just administered pain medication to Resident #1, and she had not been informed of a fall in the change of shift report, she thought Resident #1 might have been talking about a fall he/she may have previously had at home. Nurse #2 said she was at the nursing station with the Director of Nursing (DON) when CNA #2 came to the desk a second time, reported that Resident #1 said he/she was still in pain and that Resident #1 had also said he/she had fallen during the previous overnight shift. Nurse #2 said shortly after she spoke with CNA #2, Resident #1's Family members came to the nursing station and questioned them saying he/she had a fall last night and you are not going to send him/her out to the hospital and that the family members continued to repeat that statement. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse #2 said she and the DON immediately went to assess Resident #1. Nurse #2 said upon entering Resident #1's room, Resident #1 was grimacing, as if he/she was in pain. Nurse #2 said Resident #1 was sent to the hospital via Emergency Medical Services (911). Review of Resident #1's Hospital Magnetic Resonance Imaging (MRI) Report, dated 10/06/24, indicated that Resident #1 had a fall, was in pain, and a Thoracic spine/Lumbar MRI was completed. The Report indicated Resident #1 had a T11 vertebral body acute fracture/edema (bottom part of the thoracic spine) and a fracture of his/her S3 and S4 fracture (a break in the sacrum, a triangular bone at the base of the spine, between the hips). During an interview on 11/05/24 at 2:39 P.M. the Director of Nurses (DON) said she was not informed of Resident #1's fall during the overnight shift (10/04/24 into 10/05/24) by Nurse #1. The DON said she assessed Resident #1 after Resident #1's family members notified them that Resident #1 told them he/she had a fall on the overnight shift and that they wanted him/her to be transferred to the hospital immediately. The DON said when she went to assess Resident #1, he/she said she/he had fallen sometime on the overnight shift, landed on his/her buttocks, and that staff had picked him/her up off the floor, placed him/her in the wheelchair, toileted him/her and then put him/her back into bed. The DON said she could not find any documentation in Resident #1's Medical Record regarding his/her unwitnessed fall on 10/05/24, including any type of nursing assessments or incident report. The DON said it was her expectation that Nurse #1 would have assessed Resident #1 for any potential injury, initiated obtaining neurological signs (since his/her fall was unwitnessed), completed pain and skin assessments, and notified the Physician and herself, The DON said Nurse #1 should have documented the fall in a Progress Note, and notified the oncoming shift nurse of the fall, but she had not. The DON said it was several days after the Resident #1's fall before she was able to speak to Nurse #1 regarding Resident #1's fall and determine what happened that night. The DON said Nurse #1 did not follow Facility's Procedures and Policy's.