STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225549	A. Building B. Wing	09/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brigham Health and Rehabilitation Center	77 High Street Newburyport, MA 01950

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on record review and interview, the facility failed to protect one Resident (#53) from neglect when the Resident was reported to have a significant change in condition out of a total sample of 29 residents. Specifically, on [DATE] Nurse #1 failed to assess the medical emergency timely and call 911 immediately when the Resident was found to have chest pain, was unable to sit up, had significantly elevated blood pressure (,d+[DATE]), a high pulse rate (119) and lost the ability to open his/her left eye. Furthermore, the Nurse failed to provide ongoing monitoring and assessment of the resident's condition. Resident #53 was transferred to the hospital and admitted to the intensive care unit over two hours after the change in condition was noted, where he/she died of septic shock and pneumonia. Findings include: Review of the facility policy titled Abuse Prohibition, dated 2022, indicated The facility prohibits the mistreatment, neglect, and abuse of residents/patients and misappropriation of resident/patient property by anyone including staff, family, friends, etc. The facility has designed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident/patient abuse, neglect, mistreatment, and/or misappropriation of property. Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents will not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers, and staff of other agencies serving the resident, family members or legal guardians, friends or other individuals. Staff will refrain from all actions that could be considered abuse, mistreatment, and/or neglect. Neglect, as defined at S483.5, means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. The American Nurses Association (ANA), Scope of Nursing Practice, Third Edition, indicated Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, facilitation of healing, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, groups, communities, and populations. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #53 was admitted to the facility in [DATE] with diagnosis including hypertension, fall with fracture, and atherosclerotic heart disease (narrowing of the arteries close to the heart). Review of Resident #53's Minimum Data Set assessment dated [DATE] indicated he/she scored 13 out of a possible 15 indicating he/she was cognitively intact and required assistance with bathing, dressing and toileting. Review of the clinical record indicated Resident #53 was a full code and his/her own decision maker. Review of Resident #53's nursing progress note dated [DATE] indicated the following: CNA (Certified Nursing Aide) came to this nurse at approximately 7:30 P.M., stated [Resident #53] was not looking right. Went to his/her room and he/she was lying in his bed. When sat up he/she fell [sic] back across the bed. Had two CNA's straighten him/her in bed HOB (head of bed) elevated. Resident stated he/she was having chest pain across his chest. When asked if his/her pain was only in his/her chest or was it radiating anywhere, he/she stated no only his/her chest. Attempted to get vital signs, but unable to get radial B/P or pulse. Tried with regular cuff still unable to obtain either. Checked chest with stethoscope very hard to hear a heart beat. Temp was 97.2. Finally in right wrist got B/P (blood pressure) of ,d+[DATE] and pulse of 119. (Resident #53's previously documented blood pressure on [DATE] at 12:09 P.M. was ,d+[DATE]). At this time his/her left eye was closed. Asked Resident #53 to open his/her eye and he/she stated it is open but it was not. 7:45 P.M. Call placed to NP (Nurse Practitioner) covering. No call back. 8:00 P.M. Repeat call to covering service. Call back about 10 minutes. Told her scenario and she stated send him/her to ER. 8:15 P.M. Call placed to [spouse] to inform he/she was having some trouble and we were sending over to the ER for evaluation. While on phone with [spouse], NP #1 called back again on other line and asked resident code status. Told her his/her status and she stated send him out right away 911 tell them with stroke sx (symptoms). 8:30 P.M. Call 911 told them patient with stroke sx. Stayed on phone until ambulance confirmed. Then got paperwork ready for them. 8:45 P.M. EMT's arrived. Upon exam they were unable to get B/P or pulse or sats (oxygen saturation). 9:00 P.M. Ambulance arrived and got signs. Low B/P and Pulse still no sats. Checked eye that was closed and noted pupil blown and right pupil sluggish. Review of Resident #53's medical record failed to indicate any other nursing assessments were performed after the intial assessment at 7:30 P.M. Review of Resident #53's active physician orders, dated [DATE], indicated Nitroglycerin Tablet Sublingual 0.4mg give one tablet sublingually every 5 minutes as needed for Chest Pain x (times) 3 doses, if no relief, Call MD. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #53's [DATE] Medication Administration Record (MAR), indicated Nurse #1 did not administer the Nitrogylcerin Tablet Sublingual 0.4mg when Resident #53 complained of chest pain. Review of the hospital paperwork indicated Resident #53 was admitted to the intensive care unit (ICU) on [DATE] and died hours later on [DATE] at 1:51 A.M. from septic shock and pneumonia. During an interview on [DATE] at 9:10 A.M., CNA #7 said she punched in around 6:30 P.M. on [DATE] and went right up to her assigned floor. CNA #7 said Resident #53's call light was going off when she arrived on the floor. She said Resident #53 complained of head pain and said he/she could not open one of his/her eyes. CNA #7 said she told the incoming Nurse (#1) right away around 6:40 P.M. that Resident #53 was not looking good and that she could not sit him/her up. CNA #7 said that was totally different for Resident #53 as he/she was supposed to be going home the next day. CNA #7 said the one other nurse in the building did not come to the floor to assist Nurse #1. CNA #7's statements during the interview indicate that Resident #53's change of condition was brought to Nurse #1's attention at approximately 6:40 P.M., not 7:30 P.M. as documented in the clinical record. During an interview on [DATE] at approximately 7:45 A.M., Nurse #4 said that if a nurse assesses a Resident who is a full code having an acute change in condition, they should call 911 and then inform the physician. Nurse #4 said that it can take a while to get a call back if you call an answering service to speak to a covering physician. During an interview on [DATE] at 12:42 P.M., Nurse Practitioner (NP) #1 said that she told Nurse #1 to send Resident #53 out to the hospital as he/she was exhibiting symptoms of a stroke. NP #1 said she would expect staff to contact 911 urgently and if family needed to be notified, a second staff person should contact family while someone else contacts 911. During a follow up interview on [DATE] at 12:12 P.M., NP #1 said she received the page of Resident #53's change in condition at 8:47 P.M. on [DATE]; approximately 2 hours after Nurse #1 was alerted by CNA #7. NP #1 said the report said Resident #53 was experiencing shortness of breath, chest pain, facial droop, BP , d+[DATE], full code. NP #1 said she called Nurse #1 at 9:05 P.M. and again at 9:07 P.M. and said her order was to send Resident #53 to the Emergency Department for evaluation. NP #1 said she would expect staff to contact 911 urgently for someone who was exhibiting symptoms of a stroke. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interviews on [DATE] at 12:53 P.M., and [DATE] at 3:11 P.M., Nurse #1 said that on [DATE], a CNA (#7) told her that Resident #53 doesn't look too good. Nurse #1 said that Resident #53 was unable to hold his/her body up, his/her left eye was closed and he/she was unable to open it. Nurse #1 said she thought Resident #53 was having a stroke. Nurse #1 said that a CNA stayed with Resident #53 while she contacted the on-call and left a message, and then called again when she didn't hear back timely. CNA #7 had said that staff did not stay with the Resident but checked in on him/her. Nurse #1 said that the covering NP called back and said to send Resident #53 to the hospital because he/she was exhibiting symptoms of a stroke. Nurse #1 said she then contacted Resident #53's spouse to alert them about his/her change in condition and while she was on the phone with the spouse the NP called back a second time and again said to call 911 and send Resident #53 to the ER. Nurse #1 said that she called Resident #53's spouse before calling 911 because she wanted to make sure his/her family was aware. Nurse #1 said that she was told by the Director of Nursing (DON) that she should have sent Resident #53 to the hospital sooner. During a follow up interview on [DATE] at 7:17 A.M., Nurse #1 said she was unsure why there was such a delay to call the NP or to call 911 emergently after she assessed Resident #53. She said she was making phone calls and obtaining vital signs after she was made aware by CNA #7 that Resident #53 was not feeling well. Nurse #1 said she was unsure what nurse was the supervisor that night and said she never called the one other nurse who was in the building for help. Nurse #1 said she should have called 911 when the change in condition was first noticed and said she should not have waited to page the NP. Nurse #1 said she did not administer the Nirtoglycerin as ordered for chest pain. Nurse #1 said she did not call the one other nurse in the building for assistance during the medical emergency. Review of Nurse #1's timecard dated [DATE], indicated she punched in at 6:34 P.M. Review of CNA #7's timecard dated [DATE], indicated she punched in at 6:35 P.M. Review of Resident #53's Emergency Medical Services run report indicated 911 was called at 9:11 P.M. after the change of condition was observed hours prior. During an interview on [DATE] at 1:43 P.M., the DON said that Nurse #1 should have called 911 immediately after assessing Resident #53's condition and then notified the NP. The DON said that Nurse #1 should have contacted Resident #53's family after placing a call to 911 and not before. The DON said if the on call NP does not call back right away in an emergent situation 911 should be called right away and said not to wait for a call back order. See F726 On [DATE] at 2:25 P.M. the Administrator was provided with the Immediate Jeopardy Template.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on record review and interview, the facility failed to accurately code Minimum Data Set Assessment information correctly for two Residents (#53 and #50) out of a total of 29 sampled residents. Findings include: 1. Resident #53 was admitted to the facility in [DATE] with diagnosis including hypertension, fall with fracture, and atherosclerotic heart disease (narrowing of the arteries close to the heart). Review of the hospital paperwork indicated Resident #53 was transferred to the hospital and admitted to the intensive care unit (ICU) on [DATE] and died on [DATE] at 1:51 A.M Review of the MDS dated [DATE] indicated Resident #53 died at the facility. During an interview on [DATE] at 10:26 A.M., the MDS Nurse said she was not aware that Resident #53 had been admitted to the hospital and she would have to make a correction. 45984 2. Resident #50 was admitted to the facility in [DATE] with a diagnosis of cerebral infarction. Review of Resident #50's most recent MDS dated [DATE] indicated the Resident has a Brief Interview for Mental Status score of 14 out of 15 indicating that he/she is cognitively intact. Further review of the MDS indicated that Resident #50 requires extensive assistance with all activities of daily living. The MDS also indicated that Resident #50 was coded as Do not Resuscitate. Review of the clinical record indicated Resident #50's Massachusetts Medical Orders for Life-Sustaining Treatment (MOLST) was left blank, not indicating if the resident was a Full Code or Do not Resuscitate. Review of Resident #50's Physician Assistant/Nurse Practitioner progress notes indicated that Resident #50 is a full code. During an interview on [DATE] at 12:42 P.M., Nurse #2 said Resident #50's MOLST form should be filled out. After further review of Resident #50's medical record, Nurse #2 was not sure why his/her MDS was coded as Do not Resuscitate and the progress notes indicated Full code. During an interview on [DATE] at 12:52 P.M., the MDS Nurse said the previous Social Worker input Resident #50's code status incorrectly and he/she should be documented as Full Code in the MDS assessment. She said her expectation is for the MDS to be accurately assessed and documented.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on observation, record review and interview, the facility failed to review and revise the plan of care for one Residents (#20) out of a total of 29 sampled residents. Findings include: 1. Resident #20 was admitted to the facility in May 2020 with diagnoses including traumatic subarachnoid hemorrhage, cognitive communication deficit and dysphagia. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #20 is severely cognitively impaired and requires assistance with bathing, dressing and toileting. Review of Resident #20's nurse progress notes indicated the following: 7/26/23: Resident was found to be nibbling on an ice cream cup lid and earlier this week, doing the same with his/her paper napkin. Diet slip sent to the kitchen, NO PAPER PRODUCTS on meal trays. 8/5/23: Received in report that resident has been observed eating, chewing non-food items, paper items on tray, chewing his/her sheets. Review of Resident #20's care plans failed to indicate any care plan focus, interventions or methods or means for staff to monitor Resident #20's behavior of chewing non-food items was initiated. On 8/23/23 at 11:57 A.M., the surveyor observed Certified Nurses Aid (CNA) #4 serve Resident #20 his/her lunch meal. CNA #4 placed the tray in front of Resident #20, uncovered his/her plate and beverages and left the room. CNA #4 left a napkin, the meal ticket, and salt and pepper packets on the tray. (Resident #20's meal ticket failed to indicate no paper items on his/her tray as indicated in the 7/26/23 nursing note.) The surveyor also observed a large stack of napkins on the beside table and a yellow sticky note on the Resident #20's tray table. Resident #20 began to eat his/her meal with no staff in the room supervising to ensure he/she did not ingest any non-food items on the tray. During an interview on 8/23/23 at 11:59 A.M., Nurse #5 said that he had heard from other staff that Resident #20 had been chewing on paper products but he had not observed it. During an interview on 8/23/23 at 12:01 P.M., CNA #5 said that she is Resident #20's primary CNA and that Resident #20 eats things and cannot have paper items on his/her tray. The surveyor then informed CNA #5 of the surveyors observations and CNA #5 said she had to go and remove the items from Resident #20's tray.

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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** 46339 Based on observations, record reviews and interviews the facility failed to ensure professional standards of care were followed specifically related to physician's orders for two Resident's (#15 and #22) out of a total sample of 21 residents; Findings Include: 1. Resident admitted to the facility in February 2023 with diagnoses including diastolic congestive heart failure. Review of Resident #15's most recent Minimum Data Set (MDS) dated [DATE] indicated the Resident scored a 6 out of total 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The MDS further indicated the Resident requires total dependence of one-person physical assist for personal hygiene On 8/22/23 at 8:25 A.M., the surveyor observed Resident #15 sitting in his/her room. Resident #15 did not have tubi grips/ ted stocking on his/her legs. On 8/23/23 at 8:11 A.M., the surveyor observed Resident #15 sitting in his/her room. Resident #15 did not have tubi grips/ ted stockings on his/her legs. Review of current physician order indicated the following: Apply tubi-grips or teds (Stockings specially designed to help prevent blood clots and swelling in the legs) to bilateral lower extremities every AM prior to out of bed in the morning for edema. Review of the Treatment Administration Record (TAR) for August 2023 failed to indicate refusal of ted stockings. During an interview on 8/23/23 at 8:12 A.M., Certified Nursing Assistant (CNA) #3 said Resident #15 should have tubi grips or ted stockings on to his/her legs. She further said the night nurse is the one that puts them on. During an interview on 8/23/23 at 8:22 A.M., Nurse #2 said Resident #15 should have the tubi grips or ted stockings on to his/her bilateral lower extremities per the physician's orders. Nurse #2 further said nurses should not sign on the TAR that it was completed if not done. During an interview on 8/23/23 at 9:56 A.M., the Director of Nursing said it is the expectation that nurses follow the physician's orders and that night nurse should have put them on. 43882 2. Resident #22 was admitted to the facility in October 2017 with diagnoses including Alzheimer's disease, dysphagia, and vitamin B 12 deficiency. (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 most recent Minimum Data Set assessment dated [DATE], indicated Resident #22 was rarely understood and cognitive skills for decision making were severely impaired. The MDS further indicated Resident #22 was at risk for pressure ulcers. Review of Resident #22's medical record indicated the following: -Physician Order dated 2/22/23, to float heels every shift while in bed for redness. -Care Plan with revision date of 6/28/23 indicated Resident #22 was at risk for pressure ulcer development. On 8/22/23 at 9:02 A.M., 12:08 P.M. and 3:03 P.M., the surveyor observed Resident #22 lying in bed with his/her heels directly on the surface of the mattress. On 8/23/23 at 7:44 A.M., and 11:13 A.M., resident sitting up in bed with socks on but his/her heels were directly on the surface of the mattress. During an interview on 8/23/23 at 11:13 A.M., Nurse #5 said the expectation to follow physicians orders and he did not follow the order to float Resident #22's heels.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on record reviews, observations and interviews the facility failed to ensure two Residents (#26 and #15) were provided required care out of a total sample of 29 residents. Specifically; 1. For Resident #26 the facility failed to provide with supervision with meals, and 2. For Resident #15 the facility failed to provide nail care to a dependent resident. Findings include: Review of the facility policy titled Activities of Daily Living, dated 12/22, indicated A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 1. Resident #26 was admitted to the facility in November 2017 with diagnoses including Alzheimer's disease, dysphagia, adult failure to thrive, and anorexia. Review of Resident #26's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she scored a 7 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS). Further review of the MDS indicated Resident #26 required supervision for eating. On 8/22/23 from 8:06 A.M. to 8:12 A.M., the surveyor observed Resident #26 in bed with their breakfast tray set up in front of him/her. Resident #26 was observed to be reaching for his/her plate with his/her eyes closed. No staff were present in his/her room. On 8/22/23 from 11:58 A.M. to 12:03 P.M., the surveyor observed Resident #26 in bed with their lunch tray set up in front of him/her. Resident #26 was observed to be reaching for his/her plate with his/her eyes closed. No staff were present in his/her room. On 8/23/23 from 8:07 A.M. to 8:24 A.M., the surveyor observed Resident #26 in bed with their breakfast tray set up in front of him/her. Resident #26 was observed to be sleeping through the meal. No staff were present in his/her room. Review of Resident #26's physician orders, dated 5/3/23, indicated Full assist with all meals. Review of Resident #26's Activity of Daily Living (ADL), dated 5/19/2023, indicated EATING: I am supervised to eat. Sometimes I need assistance depending on how I am feeling. Review of Resident #26's Certified Nurse Aide (CNA) ADL Flow Sheet, dated August 2023, indicated CNAs were coding, Eating: Continual Supervision/Cueing 1:8 Ratio. During an interview on 8/23/23 at 8:25 A.M., CNA #1 and CNA #2 said that Resident #26 does need assistance to supervision with meals and said that staff should be in the room with him/her during meals. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/23/23 at 8:26 A.M., Nurse #2 said Resident #26 does need supervision with meals and said staff normally go in once they are done with tray pass. 46339 2. Resident #15 was admitted to the facility in February 2023 with diagnoses including Dementia, and Alzheimer's. Review of Resident #15's most recent Minimum Data Set (MDS) dated [DATE] indicated the Resident scored a 6 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The MDS further indicated the Resident requires total dependence of one person physical assist for personal hygiene. On 8/22/23 at 7:43 A.M., Resident #15 was observed sitting in his/her room, Resident #15 had long jagged fingernails. Resident #15 said no one here trims them. On 8/22/23 at 11:59 A.M., Resident #15 was observed sitting in his/her room having lunch. Resident #15 was washed and dressed for the day. Resident #15 had long jagged fingernails. On 8/23/23 at 8:12 A.M., Resident #15 was observed sitting in his/her room dressed for the day. Resident #15 had jagged fingernails. Review of Resident #15's care plan dated 11/13/2017 indicated: I have an ADL self-care performance deficit r/t (related to) Dementia, Fatigue, Impaired balance, decreased tolerance to activity, weakness. Intervention: I need extensive assist-dependent on 1 staff member for personal hygiene dependent on my level of fatigue and motivation. During an interview on 8/23/23 at 8:15 A.M., Certified Nursing Assistant (CNA) #3 said they offer nail trimming during resident's shower days and as needed. She further said Resident #15 does not refuse care. During an interview on 8/23/23 at 8:26 A.M., Nurse #2 said Resident #15 does not refuse care and if there was any refusal the CNAs would notify the nurse. During an interview on 8/23/23 at 9:57 A.M., the Director of Nursing said the expectation is that fingernails will be trimmed by the CNAs when they are long.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876 Based on observation, record review and interview, the facility failed to provide audiology services for one Resident (#2) out of a total sample of 29 residents. Findings include: Resident #2 was admitted to the facility in November 2020 with diagnoses including bell's palsy, bilateral hearing loss, cognitive communication deficit, and mild cognitive impairment. Review of the Minimum Data Set Assessment (MDS), dated [DATE], indicated the Resident scored 4 out of a possible 15 on the Brief Interview for Mental Status Exam (BIMS) indicating severe cognitive impairment. The MDS also indicated Resident #2 requires extensive assistance from staff for functional daily tasks. On 8/22/23 at 8:22 A.M., Resident #2 was observed sitting on the edge of his/her bed eating breakfast unassisted. Resident #2 did not respond to questions when asked and did not acknowledge the surveyor when knocking on the door. Review of Resident #2's medical record indicated an audiology referral on 1/10/23 due to recent fall and/or imbalance. Review of the audiology visit note dated 1/31/23 indicated the following recommendation: *Could not establish hearing loss in both ears. Wax is too deep for curette removal - both ears. Wax occluding canals and removal is needed. Recommendations include slow clear speech with visual cues. Wax needs removal in the left ear. Wax needs removal in the right ear. Re-evaluate patient after wax removal. Review of Resident #2's medical record indicated an audiology visit note dated 2/27/23 with the same recommendations from the audiology visit on 1/31/23: *Could not establish hearing loss in both ears. Wax is too deep for curette removal - both ears. Wax occluding canals and removal is needed. Recommendations include slow clear speech with visual cues. Wax needs removal in the left ear. Wax needs removal in the right ear. Re-evaluate patient after wax removal. During an interview on 8/22/23 at 1:36 A.M., Certified Nursing Assistant (CNA) #3 said he/she doesn't talk and just smiles because he/she can't hear you. CNA #3 said Resident #2 has never had hearing aids in his/her room. During an interview on 8/23/23 at 8:06A.M., the Director of Nursing (DON) said she schedules audiology appointments in a book for all residents. The DON said recommendations are to be followed up on and additional appointments to be made. The DON said Resident #2 should have been seen again after the audiology recommendations for assessment.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 43882 Based on observation, record review and interview the facility failed to ensure an air mattress was on the correct setting for one Resident (#45) who had actual skin breakdown out of a total sample of 29 Residents. Findings include: Resident #45 was admitted to the facility in January 2022 with diagnoses including, adult failure to thrive, Parkinson's disease, and hemiplegia of nondominant side. Review of the most recent Minimum Data Set (MDS) assessment, dated 5/29/23, indicated a Brief Interview for Mental Status Score of 15 out of possible 15 indicating intact cognition. Further review of the MDS indicated Resident #45 has a stage 4 pressure ulcer which is full thickness tissue loss with exposed bone, tendon or muscle. On 8/22/23 at 9:04 A.M., Resident #45 was observed lying in bed with an air mattress set to a setting of 100 (lbs.) pounds. On 8/22/23 at 3:02 P.M., Resident #45 was observed lying in bed asleep with an air mattress set to a setting of 100 lbs. On 8/23/23 at 7:50 A.M., 10:50 A.M., and 11:29 A.M., Resident #45 was observed lying in bed with an air mattress set to a setting of 100 lbs. Review of Resident #45's physician orders indicated the following: - Order date 2/15/23 indicated air mattress check for proper function/setting every shift, setting at alternating pressure 150 lbs. Review of Resident #45's Care Plan indicated the following: - Skin at risk for pressure ulcer revision date 3/21/22 indicated Resident #45 has an air mattress on bed. Review of the Nurse Practitioner (NP) progress note dated 8/9/23 indicated the following: - Follow up for stage 4 coccyx wound which requires specialty air mattress and ongoing wound care. Recommendation to continue air mattress. During an interview on 8/23/23 at 11:31 A.M., Nurse #5 said the expectation is to follow physician orders and he was unsure why the air mattress was not set to 150 lbs.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on observation, record review, and interviews, the facility failed to ensure nursing provided respiratory care consistent with professional standards of practice for two Residents (#1 and #13), out of a total sample of 29 residents. Specifically, the facility failed: 1. For Resident #1 to ensure nursing changed oxygen tubing as ordered; and 2. For Resident #13, to ensure nursing provided the correct concentration of Oxygen as ordered. Findings include: 1. Resident #1 was admitted to the facility in October 2019 with diagnoses including chronic diastolic heart failure, COVID-19, dysphagia and hypertension. Review of Resident #1's most recent Minimum Data Set (MDS), dated [DATE], indicated he/she was assessed by staff to have severe cognitive impairments. The MDS further indicated he/she was dependent on staff for activities of daily living. On 8/22/23 at 7:38 A.M., the surveyor observed Resident #1 in bed with oxygen on, the oxygen tubing was not dated. Resident #1 said that no one ever comes in to change their oxygen tubing. On 8/22/23 at 11:59 A.M., the surveyor observed Resident #1 in bed with oxygen on, the oxygen tubing was not dated. On 8/23/23 at 8:22 A.M., the surveyor observed Resident #1 in bed with oxygen on, the oxygen tubing was not dated. Review of Resident #1's physician orders, dated 8/4/23, indicated change and date oxygen tubing every night shift every Sat (Saturday). During an interview on 8/23/23 at 9:22 A.M., Nurse #3 said the expectation is that oxygen tubing is changed weekly as ordered and said the tubing should be dated. 2. Resident #13 was admitted to the facility in March 2021 with diagnoses including congestive heart failure, and respiratory failure with hypoxia. Review of Resident #13's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident scored 14 out of a possible 15, on the Brief Interview for Mental Status Exam (BIMS) indicating intact cognition. The MDS also indicated Resident #13 requires extensive assistance from staff for activities of daily living. On 8/22/23 at 8:15 A.M., 8/22/23 at 1:19 P.M., 8/23/23 at 7:25 A.M. and 8/23/23 at 11:42 A.M. Resident #13 was observed in bed with humidified oxygen on via nasal cannula. The oxygen flow rate was set at 3 Liters. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #13's clinical record included a physicians order dated 11/18/22, indicating: Oxygen 0-2 liters/min via nasal cannula to maintain sat >90% every shift. Review of Resident #13's medical record failed to indicate any behavior notes or care plan interventions that Resident #13 changes the oxygen setting him/herself. During an interview on 8/23/23 at 11:55 A.M., Nurse #2 said orders for oxygen should be followed as ordered and changed appropriately. During an interview on 8/23/23 at 8:20 A.M., the Director of Nursing (DON) said oxygen orders need to be followed and residents on oxygen have parameters that nurses are expected to follow. The DON said the resident should not be receiving 3 liters/min of oxygen if the order parameter is 0-2 liters/min.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43882 Based on record review and interview, the facility failed to ensure licensed nursing staff had the appropriate competencies and skill set to identify, assess, and respond to a significant change in condition, for one Resident (#53), out of a total sample of 29 Residents. Specifically, the facility failed to alert EMS of a significant change in condition for greater than two hours when Resident #53 was identified as complaining of chest pain, could not sit up independently, had elevated blood pressure (,d+[DATE]), an elevated pulse (119) and the inability to open his/her left eye. When on [DATE] Resident #53 presented with a change in condition at approximately 6:40 P.M., with symptoms including chest pain, elevated blood pressure and pulse, weakness, and the inability to open his/her left eye. Nurse #1 failed to identify and respond timely to Resident #53 when informed of the change in condition by Certified Nursing Assistant (CNA) #7. Nurse #1 notified Nurse Practitioner #1 at approximately 8:47 P.M. about the change in condition and was then instructed to send Resident #53 out emergently. EMS was called at 9:11 P.M., Resident #53 was transferred and died at the hospital. Findings include: A competency can be described as according to the Board of Registration in Nursing, 244 CMR 9.00: Standards of Conduct, a competency is defined as the application of knowledge and the use of affective, cognitive, and psychomotor skills required for the role of a nurse licensed by the Board and for the delivery of safe nursing care in accordance with accepted standards of practice. Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. Resident #53 was admitted to the facility in [DATE] with diagnosis including hypertension, fall with fracture, and atherosclerotic heart disease (narrowing of the arteries close to the heart). Review of Resident #53's Minimum Data Set assessment dated [DATE] indicated he/she scored 13 out of a possible 15 indicating he/she was cognitively intact and required assistance with bathing, dressing and toileting. Review of the Facility Assessment (a document with a competency-based approach produced by the facility assessing the capability of the facility and its population) updated date of [DATE] includes the following: -The facility accepts residents with combinations of conditions that require complex care and management. -Annual Training topics include identification of resident changes in condition, including how to identify medical issues appropriately, how to determine if symptoms represent problems in need of intervention. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Staff Competencies include resident assessment and examination, admissions assessment, skin assessment pressure injury assessment, neurological check, lung sounds, nutritional check, observations of response to treatment, pain assessment. During an interview conducted on [DATE] beginning at 7:17 A.M., Nurse #1 said she thought she needed an order to send a Resident out by 911 when Resident #53 presented with a change in condition. Nurse #1 said she was very concerned with Resident #53's vital signs and said she knew something was off when she saw his/her pupil (left eye being closed). Nurse #1 said she has never had to send a Resident out by 911 before. Nurse #1 said she had not received emergency training by the facility but was CPR certified. On [DATE] at 9:01 A.M., the Administrator handed this surveyor the Change in Condition policy and said there was no policy for a medical emergency. Review of Nurse #1's education file included an initial nursing competency assessment packet dated , d+[DATE]. The education packet indicates the packet to be completed during initial orientation, [DATE] days after hire and annually thereafter. Topics include recognizing changes in resident acuity, report pertinent information/significant changes in a timely manner to appropriate persons with evaluation completion date of , d+[DATE]. There was no additional education that pertained to emergency medical management or initiating a call to 911. During interviews on [DATE] at 7:21 A.M. and 11:30 A.M. the Staff Development Coordinator (SDC) said competencies are completed yearly and the topics are included in the orientation packet. The SDC said there is currently a Change in Condition policy, and the facility needs more education on emergency procedures and handling a code situation/medical emergency. The SDC said the last time any type of emergency training was completed was possibly a year ago, she said when staff got the Automatic External Defibrillator (AED) and they went over how to use it. During an interview on [DATE] at 1:43 P.M., the DON said that Nurse #1 should have called 911 immediately after assessing Resident #53's condition.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 36876 Based on observation, interview, and policy review, the facility failed to ensure open medications were dated as required on two out of four sampled medication carts. Findings include: Review of the facility policy titled, Medication Storage in the Facility, dated October 2019, indicated the following: -Beyond use dating, after initially entering or opening multi-dose containers is 30 days unless otherwise specified by the manufacturer. -No expired medication will be administered to a resident. -All expired medications will be removed from the active supply and destroyed in the facility regardless of the amount remaining. On 8/23/23, at 09:41 A.M., the surveyor observed the following in the second floor Unit medication cart: -One Fluticasone Propionate Nasal Spray 50 mcg (micrograms) dated as opened on 4/30/23. No expiration date indicated. Review of the manufacturer's instruction indicated it expires two months after opening. -One Albuterol inhaler 90 mcg dated as opened 1/20/23. No expiration date indicated. Review of the manufacturer's instruction indicated that the inhaler expires two months after opening. -Two boxes Carbamide Peroxide 6.5% Ear Drops open and undated. Unable to determine expiration date. On 8/23/23, at 10:13 A.M., the surveyor observed the following in the first floor Unit medication cart: -One bottle Sodium Bicarb 5 gr. (gram) dated as opened 9/1/21. No expiration date indicated. The manufacturer's expiration date on the bottle indicates medication expired in April 2023. -One box Banophen Allergy Capsules open and undated. Manufacturer's expiration date on the box indicated it expired in January 2023 -One bottle Fiber Therapy Psyllium Husk opened and undated. The manufacturer's expiration date on the box indicated it expired in July 2023. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/23/23, at 11:03 A.M., Nurse #3 said medications need to be dated when opened and expired medication should be discarded. During an interview on 8/23/23 at 12:53 P.M., the Director of Nursing (DON) said medications should be dated when opened and have an expiration date listed. The DON said all expired medications should be removed from the cart and not given to patients.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45984 Based on observation and interview, the facility failed to follow proper sanitation and food handling practices during meal service to prevent the risk of foodborne illness. Findings include: During the lunch service line on 8/22/23 the surveyor made the following observations in the kitchen: *At 11:27 A.M., the cook was observed touching hamburger buns and sliced cheese directly with gloved hands. The cook was then observed touching utensils with the same hands. The cook was then observed touching his glasses repeatedly with gloved hands. The cook then proceeded to touch food directly with the same gloved hands without performing hand hygiene or changing gloves. *At 11:31 A.M., the cook left the serving line to get a bowl, he then proceeded to change his gloves without washing his hands. He was then observed touching his glasses with his gloved hands and then directly touching hamburger buns and sliced cheese repeatedly with the same gloved hands. *At 11:46 A.M., the cook grabbed a metal cart and then the meal delivery cart with his gloved hands. He then proceeded to change his gloves without performing hand hygiene. He then was observed directly touching hamburger buns with the same gloved hands. During an interview on 8/23/23 at 9:23 A.M., the morning cook said the expectation is to perform hand hygiene between changing gloves. He continued to say staff should not be touching their glasses with gloved hands and then touch food directly. He said he should have changed his gloves and performed hand hygiene after touching his glasses.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43882 Based on record reviews and interviews, the facility failed to maintain accurate medical records for four Residents (#22, #45, #13 and #15) out of a total sample of 29 residents. Findings include: 1. Resident #22 was admitted to the facility in October 2017 with diagnoses including Alzheimer's disease, dysphagia, and vitamin B12 deficiency. Review of the most recent Minimum Data Set assessment dated [DATE], indicated Resident #22 was rarely understood and cognitive skills for decision making were severely impaired. The MDS further indicated Resident #22 was at risk for pressure ulcers. On 8/22/23 at 9:02 A.M., 12:08 P.M. and 3:03 P.M., the surveyor observed Resident #22 lying in bed with heels directly on the surface of the mattress. On 8/23/23 at 7:44 A.M., and 11:13 A.M., resident sitting up in bed socks on and his/her heels directly on the surface of the mattress. Review of Resident #22's medical record indicated a physician's order dated 2/22/23, to float heels every shift while in bed for redness. Review of the Treatment Administration Record (TAR) for August 2023 indicated staff had completed the treatment of floating heels while in bed on 8/22/23 day, evening, and night shift and 8/23/23 day shift, contradicting the surveyors observations. During an interview on 8/23/23 at 11:13 A.M., Nurse #5 said the expectation for documentation is for it to be accurate and said he did not complete the treatment as documented. 2. Resident # 45 was admitted to the facility in January 2022 with diagnoses including, adult failure to thrive, Parkinson's disease, and hemiplegia of nondominant side. Review of the most recent Minimum Data Set (MDS) assessment, dated 5/29/23, indicated a Brief Interview for Mental Status Score of 15 out of possible 15 indicating intact cognition. On 8/22/23 at 9:04 A.M., Resident #45 was observed lying in bed with an air mattress set to a setting of 100 (lbs.) pounds. On 8/22/23 at 3:02 P.M., Resident #45 was observed lying in bed asleep with an air mattress set to a setting of 100 lbs. On 8/23/23 at 7:50 A.M., 10:50 A.M., and 11:29 A.M., Resident #45 was observed lying in bed with an air mattress set to a setting of 100 lbs. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #45's medical record included a physician's order dated 2/15/23 indicating: air mattress check for proper function/setting every shift, setting at alternating pressure 150 lbs. Review of the Treatment Administration Record (TAR) for August 2023 indicated on 8/22/23 day, evening and night shift Air Mattress was checked for proper function and setting at 150 lbs. TAR also indicated on 8/23/23 the air mattress was checked during the day for correct settings, contradicting the surveyors observations. During interviews on 8/23/23 at 11:13 A.M. and 11:31 A.M., Nurse #5 said nursing documentation should be accurate. 3. Resident #13 was admitted to the facility in March 2021 with diagnoses including congestive heart failure, and respiratory failure with hypoxia. Review of Resident #13's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident scored 14 out of a possible 15, on the Brief Interview for Mental Status Exam(BIMS) indicating intact cognition. The MDS also indicated Resident #13 requires extensive assistance from staff for activities of daily living. On 8/22/23 at 8:15 A.M., 8/22/23 at 1:19 P.M., 8/23/23 at 7:25 A.M. and 8/23/23 at 11:42 A.M. Resident #13 was observed in bed with humidified oxygen on via nasal cannula. The oxygen flow rate was set at 3 Liters. Review of Resident #13's physician orders, dated 11/18/22, indicated: Oxygen 0-2 liters/min via nasal cannula to maintain sat >90% every shift. Review of the August 2023 Treatment Administration Record (TAR) indicated the nurse marked the above order as completed on 8/22/23 and 8/23/23, contradicting the surveyors observations. During an interview on 8/23/23 at 11:55 A.M., Nurse #2 said the Residents order for oxygen should have been followed and checked for correct settings. During an interview on 8/23/23 at 8:08 A.M., the Director of Nursing (DON) said oxygen orders need to be followed and nurses should not document incorrect settings. 46339 4. Resident #15 was admitted to the facility in February 2023 with diagnoses including chronic diastolic congestive heart failure. Review of Resident #15's most recent Minimum Data Set (MDS) dated [DATE] indicated the Resident scored a 6 out of total 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. On 8/22/23 at 8:25 A.M., 8/22/23 at 11:59 A.M., and 8/23/23 at 8:11 A.M., the surveyor observed Resident #15 without tubi grips/ted stockings, (stockings specially designed to help prevent blood clots and swelling in the legs). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of current physician order indicated the following: Apply tubi-grips or teds to bilateral lower extremities every AM prior to out of bed in the morning for edema. Review of the August 2023 Treatment Administration Record (TAR) indicated the nurse marked the above order as completed on 8/22/23 and 8/23/23, contradicting the surveyors observations. During an interview on 8/23/23 at 8:22 A.M., Nurse #2 said Resident #15 should have the tubi grips or ted stockings on his/her bilateral lower extremities per the physician's orders. Nurse #2 said nurses should not sign on the TAR that it was completed if not done.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 43882 Based on observation, record review and interview the facility failed to implement practices for the prevention of potential infection on 2 out of 2 resident units. Specifically, nursing staff failed to 1. perform adequate hand hygiene during a dressing change, 2. failed to perform hand hygiene and disinfect equipment used for multiple residents during the medication pass. Findings include: Review of the facility policy titled, Hand Hygiene effective date 3/8/20 included the following: -Alcohol based hand sanitizers are the most effective product for reducing the number of germs on the hands and is the preferred method of cleaning the hands in most clinical situations. Soap and water is appropriate for use whenever hands are visibly dirty, before eating and after using the restroom. Gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, before touching patient or the patient environment. -Perform hand hygiene immediately after removing gloves. Use alcohol-based hand rub: -After touching a patient or the patients immediate environment -After contact with blood, body fluids or contaminated surfaces -Immediately after glove removal 1. On 8/23/23 at 10:45 A.M., the surveyor observed a dressing change on the second floor unit. Nurse #5 performed hand hygiene prior to donning gloves and setting up supplies. At 10:52 A.M., Nurse #5 closed the residents privacy curtain with gloved hands, doffed one glove and put on a new glove without performing hand hygiene. Nurse #5 removed the soiled dressing, doffed both gloves and donned clean gloves without performing hand hygiene. At 10:55 A.M. Nurse #5 cleansed the wound, doffed a pair of gloves, and failed to perform hand hygiene before donning a clean pair of gloves. Nurse #5 then dried the wound bed with gauze and doffed gloves and donned a clean pair without performing hand hygiene. At 10:56 A.M., Nurse #5 packed the residents wound, doffed the pair of gloves and donned a pair of clean gloves without performing hand hygiene. During an interview on 8/23/23 at 11:08 A.M., Nurse #5 said the expectation was to wash hands before and after glove use. 2. On 8/23/23 at 7:35 A.M., Nurse #2 was observed preparing medication for administration, Nurse #2 was observed using her bare finger to place the medication in the medication cup. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225549	A. Building B. Wing	09/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brigham Health and Rehabilitation Center	77 High Street Newburyport, MA 01950

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/23/23 at 8:20 A.M., Nurse #2 said should have not touched the medication with her bare hand. On 8/23/23 at 7:40 A.M., Nurse #2 was observed entering a resident's room to check his/her blood sugar. Nurse #2 was then observed wiping down the glucometer (machine used for checking blood sugar levels) with an alcohol wipe. (Alcohol is not an approved disinfectant for healthcare settings.) During an interview on 8/22/23 at 8:22 A.M., Nurse #2 said she uses alcohol wipes to disinfect the glucometer and did not know she was supposed to use any other wipe. On 8/23/23 at 8:14 A.M., Nurse #2 was observed donning Personal Protective Equipment (PPE), walking into a resident's room who is on contact precautions. Nurse #2 was observed checking the resident's blood pressure and oxygen saturation, with equipment removed from her pocket, located under her (PPE). Nurse #2 then used her gloved hand and placed the blood pressure cuff and pulse oximeter into her pocket. Nurse #2 then removed her PPE and exited the resident's room. Nurse #2 then removed the blood pressure cuff and pulse oximeter from her pocket with her bare hands and placed them on her med cart. Nurse #2 then used the same blood pressure cuff and pulse oximeter on a second resident without disinfecting the equipment. During an interview on 8/23/23 at 8:21 A.M., Nurse #2 said she should disinfect the blood pressure cuff and pulse oximeter between each resident use. On 8/23/23 at 9:44 A.M., Nurse #6 was observed checking a resident's blood pressure and pulse saturation and returned the blood pressure cuff and pulse oximeter to the nurse's station without disinfecting it. Nurse #6 was observed using the same equipment for another resident without disinfecting the equipment between the two patients. During an interview on 8/23/23 at 9:50 A.M., Nurse #6 said the facility no longer uses rolling vital sign machines and that she should have disinfected the equipment prior to using it on another resident. During an interview on 8/23/23 at 12:28 P.M., the Director of Nursing (DON) said nurses are to use disinfectant wipes with purple covers (sani-cloth) to disinfect shared medical equipment. The DON said alcohol wipes should not be used to disinfect shared medical equipment. The DON said nurses should not be placing equipment in pockets or touching contaminated equipment with their bare hands.