| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225743 | A. Building<br>B. Wing | 11/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Baker-Katz Skilled Nursing and Rehabilitation Ctr | 194 Boardman Street<br>Haverhill, MA 01830 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>37330<br><br>Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who on 10/26/24 was found lying on the floor by Nurse #1 after an unwitnessed fall, the Facility failed to ensure nursing reported the incident to the Physician, his/her Guardian, Administrative staff and to the oncoming Nurse as required, and per Facility policy.<br><br>Findings Included:<br><br>Review of the Facility's policy, titled Resident Assessment, revised 08/30/24, indicated the Facility shall promptly notify the resident, his/her attending Physician and representatives of changes in the residents medical/mental condition and/or status including an accident or incident involving the resident.<br><br>Review of the Facility's policy, titled Accident and Incident Reports, undated, per Director of Nurses (DON) reviewed annually in December, indicated all accidents or incidents involving residents to notify the following; the attending Physician and follow any orders promptly, the DON within 24 hours of the incident or accident, the oncoming nurse, the family or responsible party and that it is imperative that this information is passed on in report to the oncoming nurse if they need to make a phone call to the family or responsible party.<br><br>Resident #1 was admitted to the Facility in June 2020, diagnoses included dementia, type II diabetes, hypertension, osteoarthritis, schizophrenia, delusional disorders, anxiety, depression, and history of falls.<br><br>Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 11/07/24, indicated that on 10/26/24, Resident #1 was transferred to the Hospital Emergency Department (ED) secondary to a high blood glucose level and mental status changes. The Report further indicated the Facility received a phone call from the Hospital ED Nurse indicating Resident #1 was found to have rib fractures, bruising and sepsis.<br><br>Review of the Facility Report, titled Summary of the Investigation, indicated on 10/26/24 Resident #1 had an unwitnessed fall at approximately 3:39 P.M., that the assigned Nurse (Nurse #1) had failed to report the incident to the Facility Physician/Nurse Practitioner, Resident #1's Responsible Party, the on coming shift nurse, or to Emergency Medical Services (EMS) and Hospital Emergency Department (ED) team.<br><br>(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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| Baker-Katz Skilled Nursing and Rehabilitation Ctr | 194 Boardman Street<br>Haverhill, MA 01830 |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #1's Medical Record indicated Resident #1 was appointed a Guardian, that his/her Guardian contact information and Family member contact information were clearly indicated in his/her record.<br><br>Review of Resident #1's Medical Record indicated that 10/26/24, there was no Nurse Progress Note, no Fall/Incident Report, and no documentation to support Resident #1 Guardian, Physician, Director of Nurses (DON) or the oncoming shift Nurse were notified of Resident #1's fall/incident.<br><br>During a telephone interview on 11/21/24 at 2:37 P.M., Nurse #1 said on 10/26/24, somewhere around 3:00 P.M. she found Resident #1 in an unoccupied room lying on the floor on his/her side. Nurse #1 said Resident #1 was moving around, trying to get him/herself off the floor, but was unable. Nurse #1 said she had assessed Resident #1, completed his/her vital signs, checked his/her skin for bumps, bleeding, if he/she had pain and said she did not see anything wrong. Nurse #1 said she asked Nurse #2 to assist her to transfer Resident #1 back to his/her room.<br><br>During a follow-up telephone interview on 11/21/24 at 3:28 P.M., Nurse #1 said on 10/26/24, somewhere around 6:30 P.M. a Certified Nurse Aide (CNA, later identified as CNA #1) approached her and said Resident #1 appeared to be pale, sweaty, and did not look well. Nurse #1 said she went to assess Resident #1 who was in bed, was pale, clammy, sweaty and had an elevated blood sugar. Nurse #1 said the Resident #1 told her that he/she did not eat and only had a small amount of water. Nurse #1 said she was unable to lower Resident #1's blood sugar, so she spoke to the Nurse Practitioner and they sent Resident #1 to the Hospital Emergency Department for further evaluation.<br><br>Nurse #1 said she did not report Resident #1's fall to the Physician, the Director of Nurses, the Emergency Medical Services, the Emergency Staff Nurse, to the oncoming staff or to the Resident #1's Guardian.<br><br>During a telephone interview on 11/21/24 at 12:25 P.M., Nurse #2 said on 10/26/24, Nurse #1 said Resident #1 had fallen and she needed help. Nurse #2 said upon arrival, Resident #1 was in an unoccupied room lying on the floor on his/her right side. Nurse #2 said she assisted Nurse #1 to transport Resident #1 to his/her room. Nurse #2 said Nurse #1 was assigned to Resident #1 and would have reported Resident #1's fall and completed his/her documentation relating to the fall, so she did not.<br><br>During an interview on 11/20/24 at 10:38 A.M., the Director of Nurses (DON) said Nurse #1 did not inform her of Resident #1's fall on 10/26/24. The DON said Nurse #1 had called her on 10/26/24 and reported that Resident #1's blood sugars were elevated, and she was unable to reach the Nurse Practitioner (NP). The Director of Nurses said she was able to reach the NP immediately after speaking to Nurse #1 and the NP gave an order to transfer Resident #1 out to the ED for evaluation.<br><br>During an interview on 11/20/24 at 10:40 A.M., the Administrator said Nurse #1 did not inform her of Resident #1's fall on 10/26/24. The Administrator said she received a phone call from the Nurse that worked the overnight shift on 10/26/27 into 10/27/24 who had informed that the Hospital called the Facility to inform them Resident #1 had fractures. The Administrator said she begun an investigation on 10/27/24, and was informed of Resident #1's fall on 10/26/24 during her investigation.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a follow-up interview on 11/20/24 at 2:22 P.M., the Director of Nurses said she could not find any documentation in Resident #1's Medical Record regarding his/her fall on 10/26/24, including any assessments or a Fall/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 the Fall Packet. The DON said Nurse #1 should have also notified the Physician, Facility Administration staff, Resident #1's Guardian, documented the fall incident in a progress note, completed a Fall/Incident Report, notified the oncoming shift nursing staff, and obtained staff written statements, but she had not. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>37330<br><br>Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who on 10/26/24, was found lying on the floor by Nurse #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 of the floor, there was no documentation to support she adequately assessed Resident #1 after his/her fall for potential injury.<br><br>Findings include:<br><br>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.<br><br>Review of the Facility's policy, titled Resident Assessment, revised 08/30/24, indicated the Facility shall promptly notify the resident, his/her attending Physician and representatives of changes in the residents medical/mental condition and/or status including an accident or incident involving the resident.<br><br>Review of the Facility's policy, titled Accident and Incident Reports, undated, per Director of Nurses (DON) reviewed annually in December, indicated all accidents or incidents involving residents to notify the following; the attending Physician and follow any orders promptly, the DON within 24 hours of the incident or accident, the oncoming nurse, the family or responsible party and that it is imperative that this information is passed on in report to the oncoming nurse if they need to make a phone call to the family or responsible party.<br><br>The Policy indicated an unwitnessed fall, document a complete set of vital signs, complete neuro assessment in the nurse's note and document the fall on the 24 hour report book. The Policy indicated the incident report needs to be brought to morning meeting and followed up to ensure that all documentation is completed.<br><br>Resident #1 was admitted to the Facility in June 2020, diagnoses included dementia, type II diabetes, hypertension, osteoarthritis, schizophrenia, delusional disorders, anxiety, depression, and history of falls.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 11/07/24, indicated that on 10/26/24, Resident #1 was transferred to the Hospital Emergency Department secondary to a high blood glucose level and mental status changes. The Report further indicated the Facility received a phone call from the Hospital ED Nurse indicating Resident #1 was found to have rib fractures, bruising and sepsis.<br><br>During a telephone interview on 11/21/24 at 2:37 P.M., Nurse #1 said on 10/26/24, somewhere around 3:00 P.M. she found Resident #1 in an unoccupied room lying on the floor on his/her side. Nurse #1 said Resident #1 was moving around, trying to get him/herself off the floor, but was unable. Nurse #1 said she assessed Resident #1, completed his/her vital signs, checked his/her skin for bumps, bleeding, if he/she had pain and said she did not see anything wrong. Nurse #1 said she asked Nurse #2 to assist her to transfer Resident #1 back to his/her room.<br><br>However, although Nurse #1 said she assessed Resident #1 after his/her fall, there was no documentation in Resident #1's Medical Record to support Nurse #1 had completed any type of assessment, including that she had obtained Resident #1's vital signs on 10/26/24, after his/her unwitnessed fall.<br><br>During a follow-up telephone interview on 11/21/24 at 3:28 P.M., Nurse #1 said on 10/26/24, that although she did not document Resident #1's fall on 10/26/24, that she did assess him/her for potential injury before having Nurse #2 help her get Resident #1 up and back to his/her own room. Nurse #1 said she was aware of the Facility's Policy related to Resident Assessment and Accident/Incident Report, the Fall Packet, Procedures, and what was required of nursing if a resident had an unwitnessed fall. Nurse #1 said on 10/29/24, (three days after the incident) she provided a written statement and documented Resident #1's unwitnessed fall in his/her medical record including Resident #1's Neurological assessment.<br><br>During a telephone interview on 11/21/24 at 12:25 P.M., Nurse #2 said on 10/26/24, Nurse #1 said Resident #1 had fallen and she needed help. Nurse #2 said upon arrival, Resident #1 was in an unoccupied room lying on the floor on his/her right side. Nurse #2 said Nurse #1 told her she had already assessed Resident #1 for potential injury. Nurse #2 said she assisted Nurse #1 to transport Resident #1 to his/her room. Nurse #2 said Resident #1 did not verbalize pain or discomfort. Nurse #2 said Resident #1's facial expression did not show signs of pain or discomfort and Resident #1 was able to ambulate, which was his/her baseline.<br><br>Nurse #2 said on 10/27/24 she was asked by the Administrator and Director of Nurses if anything had happened on 10/26/24 to Resident #1 since he/she was not doing well. Nurse #2 said she had said no but shared details of the fall.<br><br>During an interview on 11/20/24 at 10:40 A.M., the Administrator said she had received a phone call from the Nurse that worked the overnight shift on 10/26/27 into 10/27/24 to inform her the Hospital called the Facility to inform them Resident #1 had fractures. The Administrator said she had not been informed of Resident #1's fall on 10/26/24 until during her investigation.<br><br>During an interview on 11/20/24 at 2:22 P.M., the Director of Nurses said she could not find any documentation in Resident #1's Medical Record regarding his/her fall on 10/26/24, including any assessments or a Fall/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 the Fall Packet. |