

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225767	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/07/2025
NAME OF PROVIDER OR SUPPLIER Continuing Care at Brooksby Village		STREET ADDRESS, CITY, STATE, ZIP CODE 400 Brooksby Village Drive Peabody, MA 01960	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>41601</p> <p>Based on records reviewed and interviews for one of three sampled residents (Resident #1), who on 12/12/24 was noted by nursing to have a bruised area on his/her right arm, and reported to nursing that a staff member had been physically abusive with him/her during care, the facility failed to ensure staff implemented and followed their abuse policy, when although Nurse #1 immediately reported Resident #1's allegation to the Nurse Supervisor, the Nurse Supervisor did not immediately report the abuse allegation to the Director of Nursing, as required.</p> <p>Findings include:</p> <p>Review of the Facility Policy titled Abuse Policy and Procedure, with a revision date of 2021, indicated the Facility is committed to providing an environment where residents' rights are protected and residents remain free from abuse, neglect, exploitation, and mistreatment, including injuries of unknown source or misappropriation of property.</p> <p>-Further review of the policy indicated allegations involving abuse, neglect, exploitation, and mistreatment, including injuries of unknown source or misappropriation of resident property, are reported immediately.</p> <p>Resident #1 was admitted to the Facility in December 2022, with diagnoses that included Advanced dementia with psychotic disturbance, left total knee replacement, rheumatoid arthritis, cerebral infarction, chronic pain syndrome, and fibromyalgia.</p> <p>Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 12/22/24, indicated he/she was moderately cognitively impaired, and his/her Healthcare Proxy was invoked. The MDS also indicated that Resident #1 required assistance from two staff members to meet his/her care needs.</p> <p>The Facility's Internal Investigation, dated 12/12/24, indicated that during the early morning care, Nurse #1 noticed a bruise on Resident #1's right arm. The Investigation indicated that Resident #1 reported to Nurse #1 that one of the Certified Nurse Aides (CNAs) that had cleaned him/her last evening had been rough with him/her and pushed him/her because he/she was turning too slowly onto his/her other side.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Investigation indicated that on 12/12/24 at 06:30 A.M., Nurse #1 reported the incident/allegation to the Nurse Supervisor, and at 08:30 A.M., the Nurse Supervisor reported to the Director of Nursing (DON) that there was a report of a concern during care for Resident #1, not allegations of abuse. The Investigation indicated that at 02:30 P.M., upon reviewing the nursing documentation, the DON determined that the incident was an allegation of abuse, and not a concern about how care was provided.</p> <p>During a telephone interview on 01/09/25 at 08:32 A.M., Nurse #1 said that on 12/12/24 at around 06:30 A.M., when she was providing care, she noticed Resident #1 had a bruise on his/her right arm. Nurse #1 said she asked Resident #1 about the bruise, and Resident #1 reported that one of the CNA's that had cleaned him/her last evening had been rough with him/her and pushed him/her because he/she was turning too slowly to the other side. Nurse #1 said she immediately reported to the Nurse Supervisor about Resident 1 having a bruise on his/her right arm, and what Resident 1 had reported about how he/she got the bruise.</p> <p>During a telephone interview on 01/13/25 at 09:49 A.M., the Nurse Supervisor said that on 12/12/24 at 08:30 A.M., she reported to the Director of Nursing (DON) that there was a concern about care provided by the one CNA's. The Nurse Supervisor said she did not recall the exact time Nurse #1 reported the incident to her to her that day. The Nurse Supervisor said she knows the Facility's Abuse Policy and believes she reported the incident to the DON as allegations of abuse.</p> <p>During an interview on 01/07/25 at 1:15 P.M., the Director of Nursing (DON) said the Nurse Supervisor did not follow the Facility's Abuse Policy because she did not immediately report the abuse allegations reported by Nurse #1 at approximately 06:30 A.M., on 12/12/24 to her, as required.</p>		