STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305095	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Derry Center for Rehabilitation and Healthcare	20 Chester Road Derry, NH 03038

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 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. Based on interview and record review the facility failed to document post fall assessments for 2 of 3 residents reviewed for falls. (Resident identifiers are #1 and #2.)Findings include:Review on 2/6/26 of Journal of Nursing; AJN, November 2007 Vol. 107, No. 11. retrieved from https://www.nursingcenter.com/pdfjournal?AID=751198&an=00000446-200711000-00030&Journal_ID=54030 on 2/6/26 revealed, When a Fall Occurs . Step one: assessment. When a patient falls, don't assume that no injury has occurred-this can be a devasting mistake. Before moving the patient . conduct a comprehensive assessment . Step three: monitoring and reassessment. After the patient returns to bed, perform frequent neurologic and vital sign checks . Step four: documentation. Follow your facility's policies and procedures for documentation a fall . documentation for a fall should include: all observations. patient statements. assessments, notifications. interventions. evaluations . Resident #1 Interview on 2/5/26 at 10:25 a.m. with Staff C (Registered Nurse) revealed that on 1/21/26 they had assessed Resident #1 after a fall on 1/21/26. Staff C revealed that Resident #1 was on the floor leaning against the wall complaining that their head hurt. Staff C revealed they assessed Resident #1 to have an egg (a lump) on the back of their head and pointed to their groin area and complained it was painful and sensitive. Staff C revealed that they transferred Resident #1 to a chair with a Licensed Nursing Assistant and then transferred Resident #1 to bed (with Staff B). Staff C revealed that once in bed, Resident #1 had increased pain in the right leg. Staff C revealed that they themself had assessed Resident #1 after the fall but did not document any findings in Resident #1's medical record. Review on 2/5/26 of Resident #1's progress notes revealed the following:On 1/21/26 at 1:50 p.m. [Resident #1] was found on floor in [pronoun omitted] room by staff nurse. [Resident #1 was c/o (complaining of) severe pain on [pronoun omitted] right parietal scalp and in [pronoun omitted] right leg/hip/pelvis area. [Pronoun omitted] was unable to extend [pronoun omitted] leg out straight due to the pain. Provider notified and ordered. sent to the ER for evaluation. This was signed by Staff B (Assistant Director of Nursing). On 1/22/26 at 4:04 p.m. IDT (Interdisciplinary Team) NOTE: [Resident #1] was found on the floor by staff nurse and stated that [pronoun omitted] hit her right side of her head and a small abrasions was noted, a full body assessment was done and no other injuries noted but [name omitted] would not extended [sic] her leg straight out and due to [pronoun omitted] impaired cognition [pronoun omitted] could not articulate if [pronoun omitted] was having pain. [Resident #1] was assisted back to chair and that time [pronoun omitted] c/o pain in [pronoun omitted] right leg. [Resident #1] was lifted to bed without weight bearing on [pronoun omitted] right lower extremity. We were unable to assess her RLE (right lower extremity) for shortening or rotation because [pronoun omitted] pain would not allow. Provider ordered xrays [sic] and they were not able to be completed due to [pronoun omitted] pain. INTERVENTION: Per provider [pronoun omitted] was sent to the ER for (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evaluation. This was signed by Staff B. Review on 2/5/26 of Resident #1's medical record revealed there were no vital signs or neurological checks were documented, and no documentation by Staff C of the assessment that was performed while Resident #1 was on the floor. Interview on 2/5/26 at 2:00 p.m. with Staff A (Director of Nursing) confirmed documentation regarding Resident #1's fall in the chart. Staff A confirmed that there was no documented vital signs or neurological checks in Resident #1's medical record after the fall despite remaining at the facility for approximately 2 hours before being transported to the hospital. Staff A revealed that Resident #1 should not have been moved if they were complaining of pain. Resident #2 Review on 2/5/26 of Resident #2's medical record revealed a progress note, dated 1/19/26, that revealed: pt [patient] found on floor next to bed when asked why [pronoun omitted] didn't wait for help [pronoun omitted] stated because I don't want to wait pt no skin issues moved from floor to w/c [wheelchair]. Further review of Resident #2's medical record revealed an IDT (Interdisciplinary Team) note dated 1/20/26 that revealed: [Name omitted] had a fall on 1/19 at 1440 in [pronoun omitted] room while trying to transfer [pronoun omitted] from bed to chair. No injuries were noted on full body assessment by unit manager. [Name omitted] was assessed back to bed . No other progress notes or documentation of residents assessment after the fall found. Interview on 2/5/26 with Staff B (Assistant Director of Nursing) at approximately 1:10 p.m. revealed that any documentation of the full body assessment referred to in the above IDT note. Review on 2/5/26 of the facility's policy tilted Assessing Falls and Their Causes with a revision date of March 2018 revealed, . After a Fall: 1. If a resident has just fallen, or is found on the floor without a witness to the event, evaluate for possible injuries to the head, neck, spine, and extremities. 2. Obtain and record vital signs as soon as it is safe to do so. 3. If there is evidence of injury, provide appropriate first aide and/or obtain medical treatment immediately. 4. If an assessment rules out significant injury, help the resident to a comfortable sitting, lying, or standing position, and then document relevant details. Documentation: When a resident falls, the following information should be recorded in the resident's medical record: 1. The condition in which the resident was found (e.g., resident found lying on the floor between bed and chair). 2. Assessment data, including vital signs and any obvious injuries. 3. Interventions, first aide, or treatment administered. Review on 2/5/26 of the facility's policy titled Accident and Incidents – Investigation and Reporting revised July 2017 revealed, . The following data, as applicable, shall be included on the Report of Incident/Accident form. i. The condition of the injured person, including his/her vital signs. k. Any corrective action taken.