DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225223	A. BUILDING ______ B. WING ______	C 06/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENTWOOD REHABILITATION AND HEALTHCARE CTR (THE)	**56 LIBERTY STREET DANVERS, MA 01923**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS ACTS Reference Numbers; # MA00026232, #MA00026233, #MA00026281 and #MA00026327 A complaint survey was conducted on 6/14/17 and 6/15/17 to determine compliance for the following Conditions of Participation related to Long Term Care: #MA00026232 and #MA00026281 42 CFR 483.10 Resident Rights 42 CFR 483.25 Quality of Care No deficiencies were generated as a result of these complaint investigations. #MA00026233 and # MA00026327 42 CFR 483.10 Resident Rights 42 CFR 483.25 Quality of Care A statement of deficiencies was generated in conjunction with the investigation of these complaints.	F 000		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or	F 225		8/4/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/14/2017

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.

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F 225	Continued From page 1 mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 225		

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F 225	Continued From page 2 (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on records reviewed and interviews, for one of six sampled Residents (Resident #1) the Facility failed to report an alleged incident of abuse to the Department of Public Health (DPH) within two hours. -On 04/15/17, at approximately 1:15 P.M., Certified Nursing Assistant (CNA) #1 witnessed CNA #5 forcefully push Resident #1's forehead in an aggressive manner using the palm of her hand, causing Resident #1's head to be jerked backwards onto the bed and immediately reported the incident to Nurse #8. Nurse #8, however, failed to report the alleged incident of abuse to the Administrator or the designee, and the facility did not report the incident to DPH until 4/16/17. Finding include: The Policy titled, Abuse Investigation and Reporting, dated 05/2017, indicated the facility	F 225	The Brentwood provides this plan of correction without the validity or existence of the alleged deficiencies. The Plan of corrections is prepared and executed solely because it is required by federal and state laws. F225 The Resident was immediately assessed and found without injury. Nurse # 8 was suspended on 4/16/2017 while an investigation was conducted. She was reeducated on 4/26/2017 on the facility policy regarding Abuse Investigation and Reporting Policy with special attention given to the timeliness of reporting. An In-Service was started on 4/17/17 for all staff by the SDC/Designee on the Abuse Investigation and Reporting Policy with special attention given to the timeliness of reporting. This education is	

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F 225	Continued From page 3 would ensure an incident or suspected abuse, neglect, exploitation, mistreatment, and any injury of unknown source be thoroughly investigated and reported to the Department of Public Health within two hours. The Policy indicated the investigation of the reported incident shall be conducted by the Administrator or their designee. The Quarterly Minimum Data Set (MDS), dated 04/10/17, indicated Resident #1's medical diagnoses included; Aphasia (loss of ability to understand or express speech caused by brain damage), Cerebral Infarction (stroke) and Major Depression Disorder. The MDS indicated Resident #1's Brief Interview of Mental Status (BIMS) score was 3 (score range 1-15, 0-7 indicates severe cognitive impairment.) The Facility's Incident Report, dateless, indicated the date of the alleged abuse incident occurred at approximately 1:15 P.M. on 04/15/17. The Incident Report indicated CNA #1 reported CNA #5 pushed Resident #1 on the forehead in an aggressive manner at the end of a transfer back to bed. The Incident Report indicated it was submitted on 04/16/17 by the Director of Nursing. The Healthcare Facility Reporting System (HCFRS) indicated the Facility reported the alleged incident of abuse of Resident #1 by CNA #5 at 10:01 P.M. on 04/16/17, which was more than thirty-three hours after the alleged incident occurred.	F 225	ongoing and is now part of general orientation. Education will be completed for all employees no later than 8/4/2017 The administrator or their designee will record timeline of all investigation of abuse. This will include but will not be limited to the following: Time incident first reported and to whom? Time alleged abuse reported to the DPH. This will be reported to the QAPI Committee. The QAPI Committee will evaluate the data and act on the information as indicated. This will continue to be reported until 100% compliance has been achieved for three consecutive months.	
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12	F 226		8/4/17

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F 226	Continued From page 4 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on records reviewed and interviews, for one of six sampled Residents (Resident #1) the Facility failed to ensure staff immediately reported an allegation of suspected resident abuse to the Administrator or their designee and did not follow its Policies and Procedures for Abuse Investigation and Reporting.	F 226	F226 The Resident was immediately assessed and found without injury. Nurse # 8 was suspended on 4/16/2017 while an investigation was conducted. She was reeducated on 4/26/2017 on the facility policy regarding Abuse Investigation and	

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F 226	Continued From page 5 -On 04/15/17, at approximately 1:15 P.M., Certified Nursing Assistant (CNA) #1 witnessed CNA #5 forcefully push Resident #1's forehead in an aggressive manner using the palm of her hand, causing Resident #1's head to be jerked backwards onto the bed and immediately reported the incident to Nurse #8. Nurse #8, however failed to follow facility policy and did not report the alleged incident of abuse to the Administrator or the designee that day or the following day. An investigation was not initialed by the facility until approximately thirty-three hours after the alleged incident occurred, when Director of Nurse's #1, heard about the incident from another staff member. Finding include: The Policy tilted, Abuse Investigation and Reporting, dated 05/2017, indicated the facility would ensure an incident or suspected abuse, neglect, exploitation, mistreatment, and any injury of unknown source be thoroughly investigated and reported to the Department of Public Health (DPH) within two hours. The Policy indicated the investigation of the reported incident shall be conducted by the Administrator or their designee. Surveyor #1 and Surveyor #2 interviewed CNA #1 at 2:50 P.M. on 06/14/17. CNA #1 said on 4/15/17 at approximately 1:15 P.M., she with the help of CNA #5 transferred Resident #1 into bed. CNA #1 said she was standing at the foot of the bed, placed Resident #1's feet on the bed, then witnessed CNA #5, who was standing next to her at the head of the bed, using the palm of her right hand, forcefully and quickly hit Resident #1's forehead causing his/her head to be jerked back	F 226	Reporting Policy with special attention given to the timeliness of reporting. An In-Service was started on 4/17/17 for all staff by the SDC/Designee on the Abuse Investigation and Reporting Policy with special attention given to the timeliness of reporting. This education is ongoing and is now part of general orientation. The education will be completed for all employees no later than 8/4/2017. The administrator or their designee will record timeline of all investigation of abuse. This will include but will not be limited to the following: Time incident first reported and to whom? Time alleged abuse reported to the DPH. This will be reported to the QAPI Committee. The QAPI Committee will evaluate the data and act on the information as indicated. This will continue to be reported until 100% compliance has been achieved for three consecutive months.	

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F 226	Continued From page 6 onto the bed. CNA #1 said CNA #5 did not speak and left the room. CNA #1 said she reported the incident immediately to Nurse #8, and said Nurse #8 responded back by saying "it was not nice" or words to that effect. CNA #1 said the following day she told CNA #4 (lead CNA) about the incident because she was not happy with the response she received from Nurse #8. CNA #1 said she was not asked to write a written statement until a few days after the incident occurred. Surveyor #1 and Surveyor #2 interviewed CNA #5 at 2:42 PM. on 06/16/17. CNA #5 said she was standing at the foot of the bed, placed Resident #1's feet on the bed, took off Resident #1's shoes, and left the room. CNA #5 said she never touched Resident #1's head at all, and said the transfer from chair to bed was uneventful. Surveyor #2 interviewed Nurse #8 at 2:55 P.M. on 06/19/17. Nurse #8 said she remembered CNA #1 telling her on 04/15/17 about CNA #5 pushing Resident #1 with her fingers on his/her forehead. Nurse #8 said she did not report the allegation of abuse or complete an assessment on Resident #1. Surveyor #1 and Surveyor #2 interviewed Director of Nurses (DON) #1 at 12:26 P.M. on 06/15/17. DON #1 said she received a telephone call on 4/16/17 from CNA # 7 in regards to another concern and said CNA #7 mentioned during the same telephone call that she overheard staff talking about CNA #5 having pushed Resident #1's head back onto his/her pillow. DON #1 said it was late in the evening on 4/16/17 when she	F 226		

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F 226	Continued From page 7 found out about the allegation of abuse that occurred the day before, on 04/15/17.	F 226		
F 456 SS=E	483.90(d)(2)(e) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION (d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. (e) Resident Rooms Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. This REQUIREMENT is not met as evidenced by: Based on observations, records reviewed and interviews the Facility failed to ensure that emergency supplies and equipment on the Emergency Code Carts were available and functioning for three out of four resident units. -At approximately 12:20 P.M. through 1:40 P.M. on 06/14/17, Surveyor #1 and Surveyor #2 observed that three out of four Emergency Code Carts were not adequately stocked with properly functioning suction equipment, respiratory equipment and supplies needed to respond to resident's in cardiac or respiratory arrest. At the time of the survey 53 resident's out of a total census of 136 resident's were full codes (in event of cardiac or respiratory arrest, attempts at resuscitation will be made). Findings include: The Policy, titled, Emergency Equipment, dated 02/2015, indicated, emergency equipment would be kept in a clearly designated location, available	F 456	F456 On 6/14/17 all code carts were uniformly stocked according to the code cart check sheet and all equipment was tested for proper functioning. On 6/14/17 education of Licensed Staff was started by SDC/Designee on Code Cart Checks to ensure that all Licensed Nurses understand the importance of code cart checks, replacement of all used products and functioning of suction machine. This will remain ongoing and will be added to Nursing Orientation. An audit is being conducted weekly of the code carts by the Unit Managers. The audit is to ensure that the daily checks are being completed and that all items are present on the cart and properly stored as well as the proper functioning of suction	8/4/17

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F 456	Continued From page 8 to all staff members. The Policy indicated, the Facility would attach an emergency checklist form to the Emergency Code Cart. The Facility's "Emergency Cart Checklist" indicated all equipment and supplies, including oxygen tubing and masks, suction equipment, will be monitored daily during the 11:00 P.M. to 7:00 A.M. shift to ensure all items are accounted for and to test all equipment is functioning. The Emergency Cart Checklist indicated items removed from the cart must be replaced immediately. On 06/14/17 at approximately 1:00 P.M., Surveyor #2 accompanied by the Assistant Director of Nursing (ADON), made observations of the Emergency Code Cart on Unit "1 West". Documentation indicated, that the Emergency Code Cart Checklist was signed as checked off by nursing daily from 06/01/17 through 06/14/17, indicating supplies were in working order and in place as readily available. -Upon entering the clean utility room where the Emergency Code cart was stored, Surveyor #2 observed the Director of Maintenance looking at the suctioning machine on the Emergency Code Cart. The Director of Maintenance said he was checking to make sure all the connections on the suctioning machine were present and said it was nursing's responsibility to check if the suctioning machine was functioning properly. Surveyor #2 observed and confirmed by the ADON at 1:05 P.M. on 06/14/17, the following items were missing or found to be contaminated on the Emergency Code Cart on Unit "1 West";	F 456	machine. Unit Manager findings will be reported to the QAPI Committee, monthly. The QAPI Committee will evaluate the data and act on it as indicated. This will continue to be reported on until 100% compliance has been achieved for 3 consecutive months. The DON/designee will audit 20% of the code carts monthly for compliance. This information will also be submitted to the QAPI committee and acted on as indicated.	

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F 456	Continued From page 9 -suctioning tubing/yankauer on the canister was not in a protective sleeve, -three yankauer's (oral suctioning tool) missing, -the blood pressure gauge was not working properly, unable to visualize a blood pressure reading, - no connecting tubing (clear plastic tubing line that can be connected to medical devices), -three sterile waters missing, -no oxygen tubing/masks, -a nebulizer mask with a resident's name was in a plastic bag on the Emergency Code Cart. This was not consistent with the documentation completed on the Emergency Code Cart Checklist, signed as last checked on 06/14/17, which indicated all supplies were in place and emergency equipment was functioning. Director of Nurses (DON) #2 joined the ADON and Surveyor #2 to review the Emergency Code Cart and said he would ensure all the Emergency Code Carts were immediately stocked and all equipment working properly. On 06/14/17 at approximately 12:20 P.M., Surveyor #2 accompanied by Unit Manger #4 made observations of the Emergency Code Cart on Unit "1 East". Documentation indicated, that the Emergency Code Cart Checklist was signed as checked off daily by nursing from 06/01/17 through 06/14/17, indicating supplies were in working order and in place as readily available.	F 456		

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F 456	Continued From page 10 Surveyor #2 observed and confirmed by the Unit Manager #4 at 12:20 P.M. on 06/14/17, the following items on the Emergency Code Cart "1 East" Unit; the following items were found to be missing, contaminated or not functioning properly; -suction machine was not set up correctly and an extra suction canister was missing, -suctioning tubing/yankauer on the canister was not in a protective sleeve, -the suctioning machine not functioning properly, would not start when turned on, -there was no oxygen wrench (opens the oxygen tank), -the blood pressure bulb and value were missing from the blood pressure cuff, -one adult oxygen mask was open and not in a protective package, -eight plastic cups were not in a protective package. This was not consistent with the documentation completed on the Emergency Code Cart Checklist, signed as last checked on 06/14/17, which indicated all supplies were in place and emergency equipment was functioning. Surveyor #1 observed and confirmed by DON #2 at 12:30 P.M. on 06/14/17, the following items on the Emergency Code Cart "2 West" Unit; the following items were found to be missing or not functioning properly;	F 456		

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F 456	Continued From page 11 -the suctioning machine not functioning properly, unable to provide suction when tested, -missing three bottles of sterile water. This was not consistent with the documentation completed on the Emergency Code Cart Checklist, signed as last checked on 06/14/17, which indicated all supplies were in place and emergency equipment was functioning. Surveyor #1 and Surveyor #2 interviewed DON #2 at 12:30 P.M. on 06/14/17 and throughout the survey. Don #2 said he was aware that the documentation requirements for the Emergency Code Cart Checklist were inconsistent from floor to floor throughout the facility.	F 456		