STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225274	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brush Hill Care Center	1200 Brush Hill Road Milton, MA 02186

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 46562 Based on observations, interviews, and record review, the facility failed to ensure a reasonable accommodation was made for one Resident (#68), of 24 sampled residents. Specifically, the facility failed to ensure the call system was accessible to the Resident to call for staff assistance. Findings include: Review of the facility's policy titled Call System, dated as revised September 2022, indicated but was not limited to: -each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. Resident #68 was admitted to the facility in March 2020 with the following diagnoses: dementia, venous insufficiency, and chronic wounds to lower extremities. Review of the Minimum Data Set (MDS) assessment, dated 7/29/24, indicated Resident #68 was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 10 out of 15. Further review of the MDS indicated Resident #68 had impaired mobility to both lower extremities. On 9/17/24 at 10:14 A.M., the surveyor observed Resident #68 lying in bed, on his/her right side positioned at an angle with the pillow only partially under his/her head, the call light was hanging against the wall and was not within reach. During an interview on 9/17/24 at 10:15 A.M., Resident #68 said he/she did not have any way of notifying the facility staff that he/she needed help. On 9/17/24 at 2:56 P.M., the surveyor observed Resident #68 lying in bed, the call light was hanging against the wall and was not within reach. On 9/18/24 at 8:22 A.M., the surveyor observed Resident #68 lying in bed, on his/her back with the head of bed elevated, the Resident was closer to the foot of the bed than the head of the bed and the call light was hanging against the wall and was not within reach. (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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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/24 at 11:22 A.M., the surveyor observed Resident #68 sitting in his/her wheelchair on the right side of the bed, the call light was hanging against the wall (on the left side of the bed) and was not within reach. On 9/19/24 at 1:56 P.M., the surveyor observed Resident #68 lying in bed on his/her right side, the call light was hanging against the wall and was not within reach. On 9/23/24 at 10:26 A.M., the surveyor observed Resident #68 lying in bed on his/her back positioned at an angle closer to the foot of the bed than the head of the bed, the call light was hanging against the wall and was not within reach. During an interview on 9/23/24 at 10:26 A.M., Resident #68 said he/she did not have any way to get help and that he/she would probably just holler. During an interview on 9/23/24 at 10:28 A.M., Rehab Staff #1 said Resident #68 could not reach his/her call light and whoever was with Resident #68 last should have made sure his/her call light was within reach and could have secured it to the railing. During an interview on 9/23/24 at 10:53 A.M., Certified Nursing Assistant (CNA) #4 said residents should always have a call light within reach. During an interview on 9/23/24 at 10:56 A.M., Unit Manager #2 said call lights should always be within reach. During an interview on 9/23/24 at 11:06 A.M., Nurse #4 said call lights should be within reach at all times. On 9/24/24 at 12:32 P.M., the surveyor observed Resident #68 lying in bed on his/her back positioned at an angle, with the pillow only partially under his/her head, the call light was hanging against the wall and was not within reach. During an interview on 9/24/24 at 12:35 P.M., the surveyor and Unit Manager #2 observed Resident #68 without access to his/her call light. Unit Manager #2 said Resident #68 should have his/her call light within reach at all times and maybe he/she should have a hand bell as an alternative. During an interview on 9/24/24 at 1:35 P.M., the Director of Nurses (DON) said call lights should be within reach at all times.

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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 0607 Level of Harm - Potential for minimal harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 34145 Based on record reviews and interview, the facility failed to ensure their abuse policy included written procedures for screening potential employees for a history of abuse, neglect, exploitation, or misappropriation of resident property as required. Findings include: During the entrance conference held on 9/17/24 at 11:55 A.M., the surveyor requested to review all of the facility's abuse prohibition policies and procedures. The Executive Director gave the survey team a three-ringed binder and said all of the abuse policies were in the binder for surveyor review. Review of the facility's survey binder indicated one policy titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, last revised September 2022. The policy failed to include written procedures for screening potential employees for a history of abuse, neglect, exploitation, or misappropriation of resident property including checking with the appropriate licensing boards and registries as required. During an interview on 9/25/24 at 11:35 A.M., the Human Resource Director said she was not aware of a policy that indicated screening potential employees for a history of abuse, neglect, exploitation, or misappropriation of resident property included checking appropriate registries was required. No additional documentation related to the facility's abuse policies was provided to the survey team prior to the exit conference on 9/25/24 at 3:30 P.M.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34145 Based on observation, interview, and record review, the facility failed to develop and implement an individualized, person-centered care plan to meet the physical, psychosocial, and functional needs for four Residents (#5, #112, #14, and #2), out of a total sample of 24 residents. Specifically, the facility failed to ensure: 1. For Resident #5, a comprehensive care plan was developed and implemented to address the Resident's constipation; 2. For Resident #112, a comprehensive care plan was developed to address the use of antipsychotic medication that identified target behaviors and individualized, measurable non-pharmacological interventions and measurable goals of treatment; 3. For Resident #14, a comprehensive care plan was a. implemented to monitor for adverse consequence (side effects) of antidepressant medications; and b. developed for an antipsychotic medication that identified target behaviors and individualized, measurable non-pharmacological interventions and measurable goals of treatment; and 4. For Resident #2, a comprehensive care plan was developed for an antipsychotic medication that identified target behaviors and individualized, measurable non-pharmacological interventions and measurable goals of treatment. Findings include: Review of the facility's policy titled Care Plans, Comprehensive Person-Centered, last revised July 2022, indicated but was not limited to: -The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. -The IDT includes, but is not limited to the resident's attending physician. -The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. -The comprehensive, person-centered care plan: -includes measurable objectives and timeframes; -describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being; (continued on next page)

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	225274	A. Building B. Wing	09/25/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-includes the resident's stated goals upon admission and desired outcomes; -builds on the resident's strengths; -reflects currently recognized standards of practice for problem areas and conditions -Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. -Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 1. Resident #5 was admitted to the facility in May 2021 with diagnoses including gastroesophageal reflux disease (GERD-chronic digestive disease where the liquid content of the stomach refluxes into the esophagus, the tube connecting the mouth and stomach). Review of the medical record indicated Resident #5 was sent to the hospital on three occasions within eight months and was treated for conditions including a new diagnosis of constipation: -On 1/10/24, Resident #5 was admitted to the hospital with nausea, coffee ground emesis (vomit that appears like coffee grounds due to presence of old, coagulated blood in the gastrointestinal tract) and abdominal pain. Review of hospital documentation, including the patient visit information and discharge summary, indicated Resident #5 had an abdominal computed tomography scan (CT scan-a medical imaging procedure that uses a combination of X-rays and computer technology to produce detailed images of the inside of your body) that revealed a moderate to large amount of solid colonic stool. The Resident was treated for constipation and discharged back to the facility on [DATE] with a new order for Polyethylene glycol (laxative used to treat constipation by softening hard stools or stimulating the bowels) 17 grams (gm) daily. Review of the Minimum Data Set (MDS) assessment, dated 1/10/24, indicated Resident #5 had a new diagnosis of constipation. Review of the medical record failed to indicate a comprehensive care plan that included a plan of care with measurable objectives and timeframes was developed and implemented for the Resident's new diagnosis of constipation. -On 7/1/24, Resident #5 was admitted to the hospital with vomiting dark colored vomit. An endoscopy (involves passing a tiny lighted camera down the throat, through the esophagus and into the stomach) was performed and revealed a food bezoar (large ball of undigested food in the stomach). The food bezoar was removed, the Resident was treated for constipation and discharged back to the facility on [DATE]. Discharge medications included but were not limited to the following laxatives: bisacodyl 10 milligram (mg) suppository daily as needed; lactulose 10 gm packet, one packet three times a day as needed (if no bowel movement (BM) for greater than 1 day); Senna 8.6 mg take two tablets two times a day, and Polyethylene glycol 17 gm, take 17 gm daily. Instructions listed on the discharge paperwork indicated the Resident should have at least one soft bowel movement every day. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record failed to indicate a comprehensive care plan that included interventions, measurable objectives and timeframes was developed and implemented for the Resident's ongoing diagnosis of constipation. -On 8/20/24, Resident #5 was transferred to the hospital with nausea and vomiting. Review of the hospital patient visit information indicated a CT scan was performed and showed the Resident had constipation and was treated. The Resident returned to the facility the same day with discharge instructions for Resident #5 to increase the frequency of administration of Polyethylene glycol 17 gm to twice daily. Review of comprehensive care plans failed to indicate a person-centered comprehensive care plan that included a plan of care with measurable objectives and timeframes was developed and implemented for the Resident's ongoing diagnosis of constipation. During an interview on 9/24/24 at 1:28 P.M., Unit Supervisor #6 reviewed Resident #5's medical record including comprehensive care plans and said there was no care plan in place to address the Resident's diagnosis of constipation. He said a care plan should have been developed and include the plan of care to treat the Resident's constipation. 2. Resident #112 was admitted to the facility in January 2024 and had diagnoses including dementia with agitation, depression, and anxiety. Review of the most recent MDS assessment, dated 7/3/24, indicated Resident #112 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 4 out of 15, and received antipsychotic medication daily. Review of Resident #112's medical record indicated Physician's Orders for the following antipsychotic medication: Zyprexa 2.5 mg, give 2.5 mg three times a day (1/9/24); and Zyprexa 5.0 mg, give 5.0 mg at bedtime (1/9/24) Review of January 2024 through September 2024 Medication Administration Records (MAR) indicated Zyprexa 2.5 mg and 5.0 mg were administered as ordered by the physician. Review of comprehensive care plans failed to indicate Resident #112 was prescribed antipsychotic medication and failed to identify specific targeted signs/symptoms, Resident specific interventions, including non-pharmacological approaches, and measurable goals for the use of antipsychotic medication to meet the Resident's needs. During an interview on 9/25/24 at 10:10 A.M., Social Worker #1 said nursing is responsible for developing care plans for psychotropic medication. She said she develops care plans for mood, behaviors, advanced directives, discharge planning and psychosocial needs. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/25/24 at 3:32 P.M., the Director of Nursing (DON) reviewed Resident #112's care plan and said a care plan had not been developed for his/her use of antipsychotic medication. She said a care plan should have been developed for his/her use of antipsychotic medication that included resident specific targeted behaviors, resident specific interventions, non-pharmacological approaches, and measurable goals. 48695 3. Resident #14 was admitted to the facility in May 2023 with diagnoses including major depressive disorder, anxiety, and psychosis. Review of Resident #14's MDS assessment, dated 8/1/24, indicated Resident #14 had a moderate cognitive impairment as evidenced by staff assessment for mental status. Further review of the MDS indicated Resident #14 had received antidepressant and antipsychotic medications daily. a. Review of Resident #14's current Physician's Orders indicated but was not limited to: - Duloxetine (antidepressant) 30 mg capsule, give 1 capsule by mouth two times a day (dated 5/30/23) - Remeron (antidepressant) 15 mg, give 15 mg by mouth at bedtime (6/3/24) Review of Resident #14's August and September MARs indicated he/she received Duloxetine and Remeron as ordered. Review of Resident #14's care plan included but was not limited to: - Focus: Resident #14 uses antidepressant medication r/t (related to) depression (date initiated 8/22/23) - Goal: Resident #14 will be free from discomfort or adverse reactions related to antidepressant therapy through the review date (date initiated 8/22/23) - Interventions: Administer antidepressant medications as ordered by physician. Monitor/document side effects and effectiveness every shift (date initiated 8/22/23) Further review of Resident #14's medical record indicated the facility failed to implement Resident #14's care plan to monitor potential side effects of antidepressant medications. During an interview on 9/24/24 at 12:43 P.M., Nurse #2 said Resident #14 was receiving antidepressant medication but was not being monitored for side effects of antidepressant medication. b. Review of Resident #14's current Physician's Orders indicated but was not limited to: - Olanzapine (antipsychotic medication) 2.5 mg, Give 1 tablet at bedtime (date 10/20/23) Review of Resident #14's August and September MARs indicated he/she received Olanzapine as ordered. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of comprehensive care plans failed to indicate Resident #14 was prescribed antipsychotic medication and failed to identify specific targeted signs/symptoms, Resident specific interventions, including non-pharmacological approaches, and measurable goals for the use of antipsychotic medication to meet the Resident's needs. During an interview on 9/25/24 at 10:10 A.M., Social Worker #1 said nursing is responsible for developing care plans for psychotropic medication. She said she develops care plans for mood, behaviors, advanced directives, discharge planning and psychosocial needs. During an interview on 9/25/24 at 3:32 P.M., the DON said any resident on an antipsychotic medication should have a care plan for the medication. The DON reviewed Resident #14's care plans and said he/she did not have a care plan for an antipsychotic medication. 4. Resident #2 was admitted to the facility in October 2021 with diagnoses including major depressive disorder. Review of Resident #2's MDS assessment, dated 9/9/24, indicated he/she was cognitively intact as evidenced by a BIMS score of 15 out of 15. Further review of the MDS indicated Resident #2 had received antipsychotic medications. Review of Resident #2's current Physician's Orders indicated but was not limited to: - Vraylar (antipsychotic) 1.5 mg, Give 1 capsule one time a day (date 6/10/2024) Review of comprehensive care plans failed to indicate Resident #2 was prescribed antipsychotic medication and failed to identify specific targeted signs/symptoms, Resident specific interventions, including non-pharmacological approaches, and measurable goals for the use of antipsychotic medication to meet the Resident's needs. During an interview on 9/25/24 at 3:32 P.M., the DON said any resident on an antipsychotic medication should have a care plan for the medication. The DON reviewed Resident #2's care plans and said he/she did not have a care plan for an antipsychotic medication but should have one.

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	225274	A. Building B. Wing	09/25/2024

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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. 34145 Based on observation, interview, record review, and policy review, the facility failed to review and revise the care plan for one Resident (#31), out of a total sample of 24 residents. Specifically, the facility failed to ensure the care plan was updated to reflect the discontinuation of anticoagulant therapy (medication to break down existing clots or prevent clots from forming). Findings include: Review of the facility's policy titled Care Plans, Comprehensive Person-Centered, last revised July 2022, indicated but was not limited to: -The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. -The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. -Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. Resident #31 was admitted to the facility in August 2017 and had diagnoses including a history of traumatic fracture and presence of right artificial knee joint. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/2/24, indicated Resident #31 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 and did not receive anticoagulant therapy. Review of the medical record indicated Resident #31 had surgery to his/her right knee in June 2023 and had physician's ordered for Eliquis (anticoagulant) 2.5 milligrams (mg), give one tablet by mouth every 12 hours for prophylaxis for deep vein thrombosis (DVT-a condition in which blood clots form in veins located deep inside the body, usually in the thigh or lower legs) for 14 days (initiated 6/26/23). Review of Resident #31's comprehensive care plans indicated but was not limited to: -Focus: Resident is on anticoagulation therapy related to post-surgical right knee replacement (initiated 6/27/23) -Interventions: Administer anticoagulant medications as ordered by the physician. Monitor for side effects and effectiveness every shift; Monitor bleeding every shift (initiated 6/27/23) -Goal: Resident will be free from discomfort or adverse reactions related to anticoagulant use through the review date (initiated 6/27/23; target date: 10/8/24) (continued on next page)

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	225274	A. Building B. Wing	09/25/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the medical record indicated on 6/27/23, Resident #31 had bleeding from the surgical site and was sent out to hospital for evaluation. The order for Eliquis was discontinued on 6/27/23 and a new order for aspirin enteric coated 81 mg twice daily was initiated for 30 days, from 6/28/23 to 7/26/23. Review of interdisciplinary care plan meeting documentation indicated care plan meetings were held on 11/22/23, 3/6/24, 4/10/24 and 7/24/24 without a revision to the care plan to reflect the discontinuation of Eliquis on 6/27/23. During an interview on 9/23/24 at 2:22 P.M., Unit Supervisor #6 reviewed Resident #31's care plan for anticoagulant therapy. He said 81 mg of aspirin is not considered anticoagulant therapy and the care plan should have been revised to reflect the discontinuation of anticoagulant therapy when the Eliquis was discontinued on 6/27/23.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34145 Based on observation, interview, and record review, the facility failed to ensure residents were provided care in accordance with professional standards of practice for seven Residents (#5, #68, #19, #73, #85, #76 and #92), out of a total sample of 24 residents. Specifically, the facility failed to ensure: 1. For Residents #5, medication reconciliation process was conducted thoroughly and included all medications approved by the physician upon readmission to the facility, and as needed (PRN) interventions implemented according to physician's orders to potentially prevent hospital intervention to treat constipation, and failed to consistently monitor the Resident's response to interventions to prevent constipation; 2. For Resident #68, all components of wound recommendations were implemented; 3. For Resident #19, implement recommendations from the Wound Consultant; 4. For Resident #73, implement recommendations from the Wound Consultant; 5. For Resident #85, obtain a physician's order for transfer to the hospital; 6. For Resident #76, to notify the Physician when the Resident's blood sugar reading was greater than 400 or 451; and 7. For Resident #92, to notify the Physician when the Resident's gastric residual (a volume of fluid remaining in the stomach at a point in time during enteral feeding) reading was greater than or equal to 100. Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated but was not limited to: Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. (continued on next page)

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	225274	A. Building B. Wing	09/25/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 respectively. The regulations stipulate that both the Registered Nurse and Practical Nurse bear full responsibility for systematically assessing health status and recording the related health data. They also stipulate that both the Registered Nurse and Practical Nurse incorporate 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. 1. Review of the facility's policy titled Bowel (lower gastrointestinal tract) disorders-clinical protocol, last revised September 2017, indicated but was not limited to: -Treatment/Management: The physician will identify and order pertinent cause-specific and symptomatic interventions; for example, institute a regimen to prevent constipation. -Monitoring and Follow-Up: the staff and physician will monitor the individual's response to interventions and overall progress for example, overall degree of comfort or distress, frequency and consistency of bowel movements, and the frequency, severity, and duration of abdominal pain, etc. Review of the facility's policy titled Reconciliation of Medications on Admission, dated 2001, indicated but was not limited to: -The purpose of this procedure is to ensure medication safety by accurately accounting for the resident's medications, routes and dosages upon admission or readmission to the facility. -Preparation: Gather the information needed to reconcile the medication list: a. Approved medication reconciliation form b. Discharge summary from referring facility. c. Admission order sheet d. All prescription and supplement information obtained from the resident/family during the medication history; and e. Most recent medication administration record (MAR), if this is a readmission. General Guidelines: -Medication reconciliation is the process of comparing pre-discharge medications to post-discharge medications by creating an accurate list of both prescription and over the counter medications that includes the drug name, dosage, frequency, route, and indication for use for the purpose of preventing unintended changes or omissions at transition points in care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225274	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brush Hill Care Center	1200 Brush Hill Road Milton, MA 02186

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Medication reconciliation reduces medication errors and enhances resident safety by ensuring that the medications the resident needs and has been taking continue to be administered without interruption, in the correct dosages and routes, during the admission/transfer process. -Medication reconciliation helps to ensure that all medications, routes, and dosages on the list are appropriate for the resident and his/her condition, and do not interact in a negative way with other medications/supplements on the list. -Medication reconciliation helps to ensure that medications, routes, and dosages have been accurately communicated to the Attending Physician and care team. Resident #5 was admitted to the facility in May 2021 with diagnoses including gastroesophageal reflux disease (GERD- chronic digestive disease where the liquid content of the stomach refluxes into the esophagus, the tube connecting the mouth and stomach). Review of the medical record indicated Resident #5 was sent to the hospital on three occasions within an eight-month period of time and was treated for constipation in the hospital: -On 1/10/24, Resident #5 was admitted to the hospital with nausea, coffee ground emesis (vomit that appears like coffee grounds due to presence of old, coagulated blood in the gastrointestinal tract), and abdominal pain. Review of the hospital documentation including the patient visit information and discharge summary indicated Resident #5 had an abdominal and pelvic computed tomography scan (CT scan-a medical imaging procedure that uses a combination of X-rays and computer technology to produce detailed images of the inside of your body) for evaluation of abdominal pain and vomiting. The results revealed a mild distal esophageal wall thickening, and likely a small epiphrenic esophageal diverticulum (an outpouching or pocket that develops on the inside of your esophagus) as well as moderate to large amount of solid colonic stool without gastrointestinal obstruction. The Resident was treated for constipation and discharged back to the facility on [DATE] with new orders including, but not limited to Polyethylene glycol (laxative used to treat constipation by softening hard stools or stimulating the bowels) 17 grams (gm) daily. Review of January 2024 Physician's Orders indicated but was not limited to: -Polyethylene glycol 17 gm/scoop daily, give one scoop one time a day for constipation (1/12/24) Review of the January 2024 Medication Administration Record (MAR) indicated the Polyethylene glycol was administered as ordered by the physician. Review of January 2024 bowel and bladder documentation (every shift) failed to indicate staff documented the Resident's bowel movements in monitoring his/her response to laxative treatment for 38 out of 93 shifts. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 7/1/24, Resident #5 was admitted to the hospital with vomiting dark colored vomit. The hospital after visit summary indicated an endoscopy (involves passing a tiny lighted camera down the throat, through the esophagus and into the stomach) was performed and found no signs of bleeding in the esophagus or stomach. The imaging revealed a food bezoar (large ball of undigested food in the stomach), and it was removed. The summary indicated a concern that the Resident's bowels may not be moving very well, causing constipation. The Resident was given medication to help him/her have a bowel movement and was discharged back to the facility on [DATE]. Discharge medications included but were not limited to the following laxatives: bisacodyl 10 milligram (mg) suppository daily as needed; lactulose 10 gm packet, one packet three times a day as needed (if no bowel movement (BM) for greater than 1 day); Senna 8.6 mg take two tablets two times a day, and Polyethylene glycol 17 gm, take 17 gm daily. Instructions listed on the discharge paperwork indicated the Resident should have at least one soft bowel movement every day. Review of a Nursing Progress Note, dated 7/5/24 and written by Unit Supervisor #6, indicated Resident #5 returned from the hospital, medications were reviewed, confirmed, and approved with Nurse Practitioner #1 who was on-call for the Resident's attending Physician. Review of July 2024 Physician's Orders indicated but was not limited to: -Polyethylene glycol 17 gm/scoop daily, give one scoop one time a day for constipation (1/12/24) -Bisacodyl Rectal Suppository 10 mg, insert 10 mg rectally as needed for constipation daily (7/5/24) -Lactulose Oral Solution 10 gm/15 milliliters (ml), give 15 ml by mouth every 8 hours as needed for constipation, no BM >1 a day (7/5/24) The physician's orders failed to include Senna 8.6 mg, two tablets two times a day and failed to include the correct dosage identified on the hospital's discharge medication list: lactulose 10 gm packet, one packet three times a day as needed. Review of the July 2024 MAR indicated the Polyethylene glycol was administered as ordered by the physician. Review of July 2024 bowel and bladder documentation and July 2024 MAR indicated Resident #5: -had no BM for six consecutive days (from 7/6/24 to 1/12/24) and was not administered PRN laxative medication according to physician's orders -had no BM for three consecutive days (from 7/12/24 to 1/15/24) and was not administered PRN laxative medication according to physician's orders -had no BM for three consecutive days (from 7/28/24 to 7/30/24) and was not administered PRN laxative medication according to physician's orders Further review of the July 2024 bowel and bladder documentation failed to indicate staff documented the Resident's bowel movements in monitoring his/her response to laxative treatment for 26 out of 78 shifts. (continued on next page)

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	225274	A. Building B. Wing	09/25/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/13/24, a new order was initiated for Bisacodyl (stool softener) Oral Tablet Delayed Release 5 mg, give one tablet by mouth at bedtime every other day for constipation. Review of the August MAR indicated the Polyethylene glycol and Bisacodyl every other day was administered as ordered by the physician. Review of August 2024 bowel and bladder documentation and August 2024 MAR indicated Resident #5: -had no BM for two consecutive days (from 8/15/24 and 8/16/24) and was not administered PRN laxative medication according to physician's orders -had no BM on 8/18/24 and was administered PRN lactulose on 8/19/24 -On 8/20/24, Resident #5 was transferred to emergency department for evaluation of nausea and vomiting. Review of the hospital patient visit information indicated a CT scan was performed and the Resident was found to be constipated and was treated. The Resident returned to the facility the same day with discharge instructions for Resident #5 to increase the frequency of administration of Polyethylene glycol 17 gm to twice daily. Review of August 2024 physician's orders indicated, but was not limited to: -Polyethylene glycol 17 gm/scoop daily, give one scoop two times a day for constipation (8/6/24) -Bisacodyl Rectal Suppository 10 mg, insert 10 mg rectally as needed for constipation daily (7/5/24) -Lactulose Oral Solution 10 gm/15 ml, give 15 ml by mouth every 8 hours as needed for constipation, no BM >1 a day (7/5/24) Review of the August 2024 MAR indicated Polyethylene glycol 17 gm twice daily was administered as orderd by the physician. Review of August 2024 bowel and bladder documentation indicated Resident #5: -had no BM for two consecutive days (from 8/21/24 and 8/22/24) and was not administered PRN laxative medication according to physician's orders On 8/23/24, the physician order for Bisacodyl Delayed Release 5 MG was changed to be administered daily. Further review of the August 2024 bowel and bladder documentation indicated Resident #5: -had no BM for four consecutive days (from 8/27/24 and 8/30/24) and was not administered PRN laxative medication according to physician's orders. Further review of the August 2024 bowel and bladder documentation failed to indicate staff documented the Resident's bowel movements in monitoring his/her response to laxative treatment for 28 out of 93 shifts. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interviews on 9/19/24 at 1:04 P.M. and 9/24/24 at 1:28 P.M., Unit Supervisor #6 said the process for medication reconciliation is that the receiving nurse calls the on-call Nurse Practitioner (NP) and reviews all medications listed on the discharge paperwork. He reviewed Resident #5's medical record and said he was the nurse that did the medication reconciliation when he/she was readmitted from the hospital. He said he reviewed all of the medications and instructions on the discharge paperwork with the NP over the phone and she approved it. He said he entered the orders into the computer. However, he said he entered the lactulose order inaccurately, missed entering the order for Senna and did not enter instructions that Resident #5 should have at least one soft bowel movement every day. Unit Supervisor #6 said that Resident #5 should have received the PRN laxative medication every time he/she did not have a BM for greater than one day. 46562 2. Resident #68 was admitted to the facility in March 2020 with the following diagnoses: dementia, venous insufficiency, and chronic wounds to lower extremities. Review of the Minimum Data Set (MDS) assessment, dated 7/29/24, indicated Resident #68 was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 10 out of 15. Review of Resident #68's Physician's Orders indicated but were not limited to: -Left lower extremity vascular wound: wash with normal saline, pat dry, apply xeroform (sterile wound dressing that is non-adherent), cover with ABD pad (an absorbent pad) and wrap with kerlix (bandage roll), every day shift, dated 9/17/24 and discontinued 9/19/24 -Lymphademic (sic) wound (wound related to chronic lymphedema, also known as lymphoedema and lymphatic edema, a condition of localized swelling caused by a compromised lymphatic system) of the right shin: wash with normal saline, apply xeroform, cover with ABD pad and wrap with kerlix, every day shift, dated 9/20/24 -Lymphademic wound of the left shin: wash with normal saline, apply xeroform, cover with ABD pad and wrap with kerlix, every day shift, dated 9/20/24 Review of Resident #68's September Treatment Administration Record (TAR) indicated his/her lower extremity treatments had been completed per physician orders. Review of Resident #68's Wound Evaluation and Management Summary Report, dated 9/16/24, indicated the recommended treatment included but were not limited to: -Lymphademic wound of the left shin: skin prep (liquid that when applied to the skin forms a protective film or barrier) apply every shift -Lymphademic wound of the right shin: xeroform gauze apply once daily, followed by an ABD pad apply once daily, gauze roll (kerlix) daily and an ACE bandage once daily. Treatment to the periwound (skin surrounding the wound): skin prep apply once daily. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #68's Wound Evaluation and Management Summary Report, dated 9/18/24, indicated the recommended treatment included but were not limited to: -Lymphademic wound of the left shin: xeroform gauze apply once daily, followed by an ABD pad apply once daily, gauze roll (kerlix) daily and an ACE bandage once daily. Treatment to the periwound: skin prep apply once daily. During an interview on 9/23/24 at 3:38 P.M., Nurse #5 said the Wound Consultant saw residents weekly on Wednesdays and the Director of Nurses (DON) or another facility nurse completed wound visits with him. Nurse #5 said if there were new recommendations they were verbalized during wound rounds and documented on the wound evaluation and management summary report. Nurse #5 said the nurse conducting wound rounds followed up with Wound Consultant recommendations. During an interview on 9/24/24 at 1:00 P.M., Unit Manager #2 said Resident #68 was followed by the Wound Consultant due to his/her chronic lower extremity wounds. Unit Manager #2 said the DON or another nurse conducted wound rounds with the Wound Consultant and followed through with his/her wound recommendations. Unit Manager #2 reviewed Resident #68's Wound Evaluation and Management Summary Reports, dated 9/16/24 and 9/18/24, and compared them to the current physician's orders. Unit Manager #2 said not all the recommended components had been implemented. During an interview on 9/24/24 at 1:35 P.M., the DON said wound rounds were conducted weekly with the Wound Consultant. The DON said the Wound Consultant verbally makes recommendations but also provides a Wound Evaluation and Management Summary Report which included his assessment and recommendations. The DON reviewed the 9/16/24 and 9/18/24 Wound Evaluation and Management a Summary Reports and the DON said she was not sure why all the recommended components were not implemented when the new orders were transcribed and she must have missed parts of it. 48695 3. Resident #19 was admitted to the facility in January 2024 with diagnoses including peripheral vascular disease, end stage renal disease (ESRD) and diabetes mellitus. Review of the MDS assessment, dated 7/3/24, indicated Resident #19 had a moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 9 out of 15. Review of Resident #19's current Physician's Orders indicated but was not limited to: - Arterial wound of the left shin Wash W (with) NS (normal saline) pat dry, apply calcium alginate (a dressing used to treat wounds because it absorbs drainage and forms a gel that helps promote healing), cover w (with) gauze island. Apply skin to periwound area. Every evening shift AND as needed (dated 8/30/2024) Review of Resident #19's September TAR indicated his/her lower extremity treatments had been completed per physician's orders. Review of Resident #19's Wound Evaluation Management and Summary Report, dated 9/11/24, indicated the recommended treatment included but were not limited to: (continued on next page)

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	225274	A. Building B. Wing	09/25/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Arterial wound of the left shin: xeroform gauze, followed by gauze island dressing once daily. Treatment to the peri wound: skin prep once daily. Review of Resident #19's Wound Evaluation Management and Summary Report, dated 9/18/24, indicated the recommended treatment included but were not limited to: -Arterial wound of the left shin: xeroform gauze, followed by gauze island dressing once daily. Treatment to the periwound: skin prep once daily. During an interview on 9/24/24 at 8:58 A.M., Nursing Supervisor #6 said the Wound Consultant would come in on Wednesdays and would complete wound rounds with the DON or designee. Nursing Supervisor #6 said the DON would then receive the recommendations from the Wound consultant and would follow-up with the physician. During an interview with record review on 9/24/24 at 3:32 P.M., the DON and surveyor reviewed Resident #19's current physician orders and recommendations form the Wound Consultant date 9/11/24 and 9/18/24. The DON said the recommendations from the Wound Consultant should have been reviewed with the Physician and been implemented. During a telephonic interview on 9/25/24 at 3:18 P.M., Wound Consultant #1 said his expectation was for his recommendations to be implemented. 4. Resident #73 was admitted to the facility in May 2021 with diagnoses including cellulitis of the left lower limb and peripheral venous insufficiency. Review of the MDS assessment, dated 9/19/24, indicated Resident #73 had moderate cognitive impairment as evidenced by staff assessment for mental status. Review of Resident #73's current Physician's Orders indicated but was not limited to: -Non-Pressure wound of the left, dorsal (back of), first toe: wash with NS (normal saline) pat dry, apply skin prep three times daily, (dated 8/9/24, discontinued on 8/15/24) Review of Resident #73's Wound Evaluation Management and Summary Report, dated 8/4/24, indicated the recommended treatment included but was not limited to: -Skin prep apply Q-shift (every shift) Review of Resident #73's Wound Evaluation Management and Summary Report, dated 8/7/24, indicated the recommended treatment included but was not limited to: -Skin prep apply Q-shift (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/24/24 at 12:43 P.M., Nurse #2 said the Wound Consultant would come in weekly on Wednesdays and could be available accessible via phone in between visits if needed. Nurse #2 said the Wound Consultant would do rounds with the DON and me. Nurse #2 said the wound doctor would give a verbal recommendation and then would send the written consultation into the resident's electronic medical record. Nurse #2 said the DON or nurse supervisor will follow up with the doctor and put the order into the resident's medical record. During an interview on 9/24/24 at 3:32 P.M., the DON and surveyor reviewed Resident #73's August physician's orders and recommendations from the Wound Consultant dated 8/4/24 and 8/7/24. The DON said the recommendations from the Wound Consultant should have been reviewed with the Physician and been implemented. During a telephonic interview on 9/25/24 at 3:18 P.M., Wound Consultant #1 said his expectation was for his recommendations to be implemented. 5. Resident #85 was admitted to the facility in July 2022 with the following diagnoses ESRD, dependence on renal dialysis, and diabetes mellitus. Review of Resident #85's MDS assessments, dated 4/18/24 and 6/28/24, indicated he/she was discharged to the hospital with return anticipated. Review of Resident #85's Nursing Progress Note, dated 4/18/24, indicated he/she was transferred to the emergency department. Review of Resident #85's Nursing Progress Note, dated 6/28/24, indicated he/she was transferred to the hospital. Review of Resident #85's Order Listing Report for 4/1/24 through 9/25/24 failed to indicate an order to transfer him/her to the hospital on 4/18/24 or 6/28/24. During an interview on 9/25/24 at 11:48 A.M., Nurse #1 said when a resident is sent out to the hospital, the nurse would call the Physician/NP and obtain an order to send the resident to the hospital and then put the order into the resident's medical record. During an interview on 9/25/24 at 3:32 P.M., the DON reviewed Resident # 85's medical record and physician's orders and said there was no order to transfer Resident #85 to the hospital on 4/18/24 or 6/28/24. The DON said a physician's order should be obtained when a Resident is transferred to the hospital. [NAME], [NAME] R. 6. Review of the facility's policy titled Change in a Resident's Condition or Status, dated as revised February 2021, indicated but was not limited to the following: -Policy Statement: our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (for example, changes in level of care, billing/payments, resident rights, etc.). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The nurse will notify the resident's attending physician or physician on call when there has been a: i. specific instruction to notify the physician of changes in the resident's condition. Resident #76 was admitted to the facility in April 2023 with diagnoses that included Type 2 Diabetes Mellitus (a condition in which the body does not produce enough insulin and has trouble controlling blood sugar levels) with unspecified diabetic retinopathy, diabetic neuropathy, End Stage Renal Disease, and dependence on renal dialysis. Review of Resident #76's MDS assessment, dated 6/18/24, indicated Resident #76 received insulin injections. Review of Resident #76's active Physician's Orders included but were not limited to the following: -Insulin Glargine Subcutaneous Solution Pen-injector 100 units/milliliter (mL). Inject 7 units subcutaneously every 12 hours related to Type 2 diabetes mellitus (T2DM) with unspecified diabetic retinopathy without macular edema; Active 9/9/24. -Insulin Lispro Injection Solution 100 units/mL. Inject 3 units subcutaneously two times a day every Monday, Wednesday, Friday related to T2DM with unspecified diabetic retinopathy without macular edema; Active 9/16/24. Insulin Lispro Injection Solution 100 units/mL. Inject as per sliding scale if: 200 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; 401 - 450 = 10 units; 451 - 999 = 12 units Call Medical Doctor (MD) if blood sugar (BS) is greater than 450, subcutaneously two times a day every Monday, Wednesday, Friday related to T2DM with unspecified diabetic retinopathy without macular edema and Inject 3 units subcutaneously two times a day every Monday, Wednesday, Friday related to T2DM with unspecified diabetic retinopathy without macular edema; Active 9/16/24. Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 UNIT/mL - Inject 3 units subcutaneously with meals every Tuesday, Thursday, Saturday, Sunday related to T2DM with unspecified diabetic retinopathy without macular edema and Inject as per sliding scale if: 200 - 250 = 2 units; 251 - 300 = 4 units; (continued on next page)

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	225274	A. Building B. Wing	09/25/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	301 - 350 = 6 units; 351 - 400 = 8 units; 401 - 450 = 10 units; 451+ = 12 units; 451 and higher administer 12 units and call MD; subcutaneously with meals every Tuesday, Thursday, Saturday, Sunday related to T2DM with unspecified diabetic retinopathy without macular edema; Active 9/17/24. Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 units/mL. Inject as per sliding scale if: 200 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; 401 - 450 = 10 units; 451+ = 12 units; 451 and higher administer 12 units and call MD; subcutaneously with meals every Tuesday, Thursday, Saturday, Sunday related to T2DM with unspecified diabetic retinopathy without macular edema; Active 9/17/24. May perform finger stick to obtain blood for blood sugar before meals and at bedtime; Active 9/16/24. Insulin Lispro Injection Solution. Inject 6 units subcutaneously every 6 hours as needed for hyperglycemia 400 and above. Notify MD; Active 10/9/23. Insulin Lispro Injection Solution. Inject 6 units subcutaneously one time only related to T2DM with unspecified diabetic retinopathy without macular edema until 9/23/24 23:59. Administer 6 units subcutaneously one time only for elevated blood sugar; Active 9/23/24. Further review of Resident #76's past Physician's orders included but were not limited to the following: -Active 8/25/24-9/16/24: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 UNIT/mL Inject as per sliding scale if: 200 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; 401 - 450 = 10 units; 451+ = 12 units; 451 and higher administer 12 units and call MD, subcutaneously with meals related to T2DM with unspecified diabetic retinopathy without macular edema. Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 UNIT/mL. Inject 3 units subcutaneously with meals related to T2DM with unspecified diabetic retinopathy without macular edema. -Active 8/25/24-9/8/24: Insulin Glargine Subcutaneous Solution Pen-injector 100 UNIT/mL. Inject 5 units subcutaneously every 12 hours related to T2DM with unspecified diabetic retinopathy without macular edema. -Active 7/13/24-8/25/24: Insulin Lispro Injection Solution 100 UNIT/mL. Inject as per sliding scale if: 150 - 200 = 1 unit; 201 - 250 = 2 units; 251 - 300 = 3 units; 301 - 350 = 4 units; 351 - 400 = 5 units; call MD if BS is greater than 400; Subcutaneously with meals related to T2DM without complications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225274	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brush Hill Care Center	1200 Brush Hill Road Milton, MA 02186

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Insulin Lispro Injection Solution 100 UNIT/mL. Inject 3 units subcutaneously with meals related to Type 1 Diabetes Mellitus with hypoglycemia without coma. -Active 7/12/24-8/25/24: Insulin Glargine Subcutaneous Solution 100 UNIT/mL. Inject 5 units subcutaneously every 12 hours related to T2DM without complications. Insulin Lispro Injection Solution 100 UNIT/mL. Inject as per sliding scale if: 200 - 250 = 1 unit; 251 - 300 = 2 units; 301 - 350 = 3 units; 351 - 400 = 4 units; call MD if blood sugar (BS) is greater than 400; Subcutaneously at bedtime related to T2DM without complications. -Active 4/8/23-9/16/24: May perform finger stick to obtain blood for blood sugar before meals and at bedtime. Review of Resident #76's Medication Administration Record (MAR) for July 2024, August 2024, and September 2024 indicated the following blood sugar values: 9/16/24 at 6:00 A.M., BS = 460; 8/29/24 at 4:30 P.M., BS = 451; 8/25/24 at 12:00 P.M., BS = 500; 8/5/24 at 11:30 A.M., BS = 450; 7/1/24 at 9:00 P.M., BS = 594; 7/1/24 at 4:30 P.M., BS = 445. Further review of Resident #76's medical record did not indicate there was documentation that the Physician was notified of the elevated BS value. During an interview on 9/24/24 at 10:30 A.M., Nurse #3 and Nurse #10 said when a resident's blood sugar values are above the threshold indicated in the physician's order, they notify the Physician and document the notification in the Nursing Progress notes. (continued on next page)

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	225274	A. Building B. Wing	09/25/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/25/24 at 2:57 P.M., the DON said she could not find documentation in Resident #76's medical record that the Physician was notified of elevated blood sugars for the dates above, but she expects nurses to document that the Physician was notified. 7. Resident #92 was admitted to the facility in April 2023 with diagnoses that included cerebral infarction, dysphagia (difficulty swallowing), and gastrostomy (a surgical procedure for inserting a tube through the abdomen wall and into the stomach for feeding or drainage) status. Review of Resident #92's MDS assessment, dated 9/2/24, indicated Resident #92 had a feeding tube. Review of Resident #92's active Physician's Orders included but were not limited to the following: -Enteral Feed, every shift, Jevity 1.5 calorie formula to run at 50 milliliters (mL) per hour continuous; Active 5/12/24. -Enteral: Check Residual every 4 hours, if residual is greater than or equal to 100 hold feed and call MD; Active 4/16/2024. Review of Resident #92's MAR indicated but was not limited to the following: 9/14/24 at 4:00 P.M., gastric residuals (GR) = 100; 9/05/24 at 4:00 P.M., GR = 100; 9/02/24 at 4:00 P.M., GR = 240; 8/31/24 at 8:00 P.M., GR = 100; 8/25/24 at 8:00 P.M., GR = 100; 8/14/24 at 4:00 P.M., GR = 100; 8/13/24 at 4:00 P.M., GR = 240; 7/29/24 at 8:00 P.M., GR = 100; 7/14/24 at 8:00 P.M., GR = 100. Review of Resident #92's medical record failed to indicate there was documentation that the Physician was notified of gastric residuals at or above 100. During an interview on 9/24/24 at 9:40 A.M., Nurse #9 said if Resident #92's gastric residuals were over 100, then the tube feeding is held and the Physician is notified. Nurse #9 said a Nursing Progress note is then written to document the Physician notification. (continued on next page)

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	225274	A. Building B. Wing	09/25/2024

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/25/24 at 4:30 P.M., the DON said she reviewed Resident #92's medical record and did not see Nursing Progress notes or documentation indicating the Physician was notified of gastric residuals at or above 100 from July 2024 through September 2024. The DON said she expects nursing to document they notified t[TRUNCATED]

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	225274	A. Building B. Wing	09/25/2024

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 46562 Based on observation and interviews, the facility failed to ensure its staff provided a meaningful and engaging activity program for residents residing on one Unit (3A), out of four units in the facility. Specifically, the facility failed to ensure residents were involved in activities. Findings include: Review of the facility's policy titled Activity Programs, last revised June 2018, indicated but was not limited to: -The activities program is ongoing and includes facility-organized group activities, independent individual activities and assisted individual activities -Activities are considered any endeavor, other than routine activities of daily living, in which the resident participates, that is intended to enhance his or her sense of well-being and to promote or enhance, physical, cognitive or emotional health -Activities are scheduled seven days a week and residents are given an opportunity to contribute to the planning, preparation, conducting cleanup and critique of the programs -Activities are not necessarily limited to formal activities being provided only by activities staff On the following days of survey, the surveyor made the following observations of the 3A Unit Resident Lounge (activity/dining room): -9/17/24 at 10:20 A.M., 15 residents with one staff member present who was sitting in the corner of the room not engaging with the residents, the television was on but none of the residents were looking in the direction of the television, with no evidence of meaningful activity -9/17/24 at 11:12 A.M., 16 residents with one staff member present who was sitting in the corner of the room not engaging with the residents, the television was on but none of the residents were looking in the direction of the television, with no evidence of meaningful activity -9/17/24 at 2:46 P.M., 10 residents with two staff members present in the room not engaging with the residents, the television was on, with no evidence of meaningful activity -9/17/24 at 4:46 P.M., nine residents with two staff members present in the room not engaging with the residents, the television was on with no evidence of meaningful activity -9/18/24 at 11:23 A.M.,16 residents with two staff members in room, 4 of 16 residents were eating/drinking cookies and coffee, the television was on, staff not engaging with the residents, with no evidence of meaningful activity (continued on next page)

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	225274	A. Building B. Wing	09/25/2024

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-9/18/24 at 3:29 P.M.,12 residents with one staff member present in the room not engaging with the residents, the television was on, no residents were looking in the direction of the television, with no evidence of meaningful activity -9/19/24 at 8:20 A.M., six residents with one staff member present in the room not engaging with the residents, the television was on, no residents were looking in the direction of the television, with no evidence of meaningful activity -9/19/24 at 1:55 P.M., seven residents with two staff members present in the room not engaging with the residents, the television was on, no residents were looking in the direction of the television with no staff engagement and no evidence of meaningful activity -9/23/24 at 10:06 A.M.,11 residents with one staff member present in the room not engaging with the residents, the television was on, 2 of 11 residents were independently completing their weekly menu, 9 of 11 residents with no evidence of meaningful activity -9/23/24 at 3:36 P.M., 11 residents with one staff member present in the room not engaging with the residents, the television was on, no residents were looking in the direction of the television; 1 of 11 residents was repeatedly banging on the table in front of him/her, with no evidence of meaningful activity -9/23/24 at 4:25 P.M., 14 residents with one staff member present in the room not engaging with the residents, the television was on, no residents were looking in the direction of the television, with no evidence of meaningful activity -9/24/24 at 12:33 P.M., seven residents with one staff member present in the room not engaging with the residents, the television was on, no residents were looking in the direction of the television; and 1 of 7 residents repeatedly rubbing circles on the table in front of him/her, with no evidence of meaningful activity On the following days of survey, the surveyor made the following observations of the 3A Nurses' Station Hallway/Corridor, not in the Resident Lounge: -9/17/24 at 4:46 P.M., eight residents some of whom were talking amongst themselves with no staff engagement and no evidence of meaningful activity -9/19/24 at 1:55 P.M., six residents with no staff engagement, with no evidence of meaningful activity During an interview on 9/17/24 at 10:14 A.M., Resident #68 said there was not much to do as far as activities go and he/she stayed in bed most of the time. During an interview on 9/17/24 at 10:28 A.M., Resident #273 said he/she did not do much during the day; he/she said the facility had not provided him/her with activities. During an interview on 9/17/24 at 10:37 A.M., Resident #75 said he/she was not offered activities. (continued on next page)

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	225274	A. Building B. Wing	09/25/2024

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/17/24 at 11:07 A.M., Resident #117 said the facility had an activity department but never do what was scheduled. Resident #117 said he/she was not invited to attend activities off the unit. During an interview on 9/17/24 at 3:34 P.M., Resident Representative #1 said Resident #90 was always observed in his/her bed and never in the activity room. Resident Representative #1 said when she visits the facility the residents in the activity room are just sitting and were never involved in an activity. During an interview on 9/23/24 at 10:50 A.M., Certified Nursing Assistant (CNA) #3 said the CNAs rotate in the activity room every 30 minutes to make sure the residents are safe. During an interview on 9/23/24 at 10:53 A.M., CNA #4 said the staff take turns watching the residents in the activity/dining room to make sure they are safe. During an interview on 9/23/24 at 11:06 A.M., Nurse #4 said the 3A Residents receive activities during the coffee social and there will sometimes be music in the room. Nurse #4 said some of the residents leave the unit for activities. Nurse #4 said there was always a CNA in the room to make sure they were safe. During an interview on 9/24/24 at 1:15 P.M., Unit Manager #2 said the 3A unit activities consist of a coffee social in the morning. Unit Manager #2 said the staff tried to encourage residents to attend activities on the 2BC Unit. Unit Manager #2 said the facility could be doing more activities with the residents. During an interview on 9/24/24 at 11:14 A.M., the Activity Director said the activity department consisted of herself, one activity assistant and 2 activity aides. The Activity Director said the role of the activity assistant was mostly paperwork and administrative and the activity aide conducted the activities. The Activity Director said for residents who do not attend activities on other units she tried to visit them at least monthly to offer books or other activities. The Activity Director said the 3A Unit has a monthly game of Shaboom (a musical version of bingo), the coffee social daily, and there is always an activity on Saturdays at 11 A.M. During an interview on 9/24/24 at 2:23 P.M., the Administrator said the Activity Department needed some enhancements and the facility should be offering more than they were.

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	225274	A. Building B. Wing	09/25/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 49428 Based on observations, interviews, and policy review, the facility failed to maintain an environment free of accident hazards. Specifically, the facility failed to ensure smoking material was stored securely for one Resident (#100), out of 17 identified facility smokers, out of 24 sampled residents. Findings include: Review of the facility's policy titled Smoking Policy & Procedure, undated, indicated but was not limited to: -[Facility Name] shall establish and maintain safe resident smoking practices. -No lighters or matches will be retained in the possession of the residents. -All lighting material will be kept with staff to be given out to independent smokers as they go out and shall be returned to the designated area once done with your cigarette, either at the front desk or nurses' station. -Staff will ensure smoking materials are stored safely. Review of the facility provided list of residents who smoke indicated Resident #100 was an independent smoker. Resident #100 was admitted to the facility in April 2024 with the following diagnoses including peripheral vascular disease and hypertension. Review of Resident #100's medical record indicated smoking assessments were completed on 6/25/24 and 4/26/24 which indicated the Resident could smoke independently. During an interview on 9/19/24 at 10:10 A.M., Resident #100 said he/she stores his/her lighter in their locked bedside drawer. During an interview on 9/24/24 at 12:57 P.M., Resident #100 said he/she keeps his/her lighter in their room. During an interview on 9/24/24 at 1:24 P.M., Unit Supervisor #6 said lighters are kept at the front desk. Unit Supervisor #6 said he believed that independent smokers could keep their own smoking materials, including lighters, in their rooms. During an observation with interview on 9/25/24 at 9:05 A.M., the surveyor observed Resident #100 returning to his/her room from smoking. Resident #100 said he/she had their lighter on their person and he/she kept it close. (continued on next page)

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	225274	A. Building B. Wing	09/25/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/25/24 at 11:00 A.M., the Director of Nursing (DON) said she expected independent smokers to store lighting materials at the front desk and not in a resident's room or on their person. During an interview on 9/25/24 at 11:01 A.M., the front desk secretary said she has one lighter, securely stored, for residents who smoke. The front desk secretary said Resident #100 sometimes has his/her own lighter and does not use the secured lighter stored at the front desk. The front desk secretary said she did not exchange a lighter with Resident #100 today. On 9/25/24 at 1:05 P.M., the surveyor observed Resident #100 coming out of the elevator, bypassing the front desk, and going straight to the outdoor smoking area. The surveyor observed Resident #100 retrieve a lighter from his/her personal bag and light his/her cigarette.

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	225274	A. Building B. Wing	09/25/2024

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. 46562 Based on observations, interviews, and record review, the facility failed to implement nutritional interventions as ordered to maintain acceptable parameters of nutritional status for one Resident (#90), with an unplanned gradual weight loss, in a total sample of 24 residents. Specifically, the facility failed to provide as needed nutritional supplements when his/her meal intake was less than 50% as ordered. Findings include: Resident #90 was admitted to the facility in February 2022 with the following diagnoses: dementia, adult failure to thrive, and moderate protein-calorie malnutrition. Review of the Minimum Data Set (MDS) assessment, dated 7/26/24, indicated Resident #90 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of 15. Further review of the MDS indicated Resident #90 was 63 inches, weighted 95 pounds, had experienced weight loss and was not on a prescribed weight loss regimen. Review of Resident #90's medical record indicated he/she had progressive weight loss as evidenced by the following weights: -1/08/24 = 110.4 pounds (sitting) -2/08/24 = 108.4 pounds (sitting) -3/04/24 = 105.2 pounds (sitting) -4/05/24 = 101.6 pounds (sitting) -5/05/24 = 100.4 pounds (sitting) -5/07/24 = 101.2 pounds (sitting) -6/03/24 = 100.1 pounds (sitting) -7/05/24 = 95.9 pounds (sitting) -7/19/24 = 95.2 pounds (sitting) -7/26/24 = 95.0 pounds (sitting) -8/06/24 = 96.6 pounds (sitting) -9/09/24 = 93.6 pounds (both sitting and standing) -9/24/24 = 94.0 pounds (wheelchair) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225274	A. Building B. Wing	09/25/2024

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Brush Hill Care Center	1200 Brush Hill Road Milton, MA 02186

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #90's dietary note, dated 8/31/24, indicated but was not limited to: -Resident with varied oral intake consumes 0 to 75% of meals per staff records. Receives a no added salt diet, soft and bite size texture thin liquids, red lip plate, super cereal at breakfast, house shakes offered with poor oral intake. House nutrition supplement eight ounces three times per day. Review of Resident #90's Physician's Orders indicated but were not limited to: -House Supplement every eight hours as needed for poor meal percentage, 120 milliliters (ml) to be provided for meal intake of less than 50% as needed three times per day, dated 2/25/22 Review of the August 2024 Documentation Survey Report indicated Resident #90 consumed 0-25% of his/her meal on 38 occasions. Review of the August 2024 Medication Administration Record (MAR) failed to indicate evidence that the as needed house supplement was provided to Resident #90 on all 38 occasions. Review of the September 2024 Documentation Survey Report indicated Resident #90 consumed 0-25% of his/her meal on 25 occasions. Review of the September 2024 MAR failed to indicate evidence that the as needed house supplement was provided to Resident #90 on all 25 occasions. During an interview on 9/24/24 at 12:21 P.M., Nurse #7 said Resident #90 had a poor appetite and eats his/her meals in the unit dining room so that cueing could be provided. Nurse #7 said Resident #90 gets a house supplement three times per day as ordered and receives additional supplements if he/she asks for them. Nurse #7 said she was not sure about the as needed house supplement order. During an interview on 9/24/24 at 1:06 P.M., Unit Manager #2 said Resident #90 was currently 94 pounds and has been followed by the dietitian due to continued weight loss. Unit Manager #2 reviewed Resident #90's medical record and said he/she has current orders for a house supplement three times per day and an as needed order. Unit Manager #2 said when Resident #90 consumed less than 50% of his/her meal the facility should be offering house supplement and documenting it in the MAR. During an interview on 9/24/24 at 11:52 A.M., the Dietitian said she has been following Resident #90 due to gradual weight loss. The Dietitian said Resident #90 had orders for house supplement eight ounces three times per day and an additional order for house supplement if he/she consumed less than 50% of his/her meal. The dietitian said she would expect the supplements to be provided as ordered but did not monitor the documentation and administration of the as needed supplements. During an interview on 9/25/24 at 9:29 A.M., Physician Assistant (PA) #2 said Resident #90 had documented weight loss despite orders for pharmaceutical aids and nutritional supplements being in place. PA #2 said the expectation was for all nutritional interventions to be implemented as ordered and the facility should follow the current treatment plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225274	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/24/24 at 1:35 P.M., the Director of Nurses (DON) said the resident has been followed for his/her weight loss for a while. The DON reviewed Resident # 90's medical record and said the Resident has scheduled and as needed orders for a nutritional supplement. The DON said the administration of the as needed house supplement should be provided as ordered and documented in the medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 48695 Based on interview and record review, the facility failed to ensure staff implemented dialysis care and services consistent with professional standards of practice for two Residents (#19 and #76), out of 24 sampled residents. Specifically, the facility failed to provide ongoing communication between the nursing facility and dialysis facility. Findings include: Review of the facility's policy titled Care of a Resident with End-Stage Renal Disease, last revised September 2010, indicated but was not limited to: -Policy Statement with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of practice. -Agreements between this facility and the contracted ESRD facility include all aspects of how the resident's care will be managed, including: b) how information will be exchanged between the facilities. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated the following: -Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. 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 respectively. The regulations stipulate that both the Registered Nurse and Practical Nurse bear full responsibility for systematically assessing health status and recording the related health data. They also stipulate that both the Registered Nurse and Practical Nurse incorporate 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. 1. Resident #19 was admitted to the facility in January 2024 with diagnoses including end stage renal disease (ESRD) and diabetes mellitus. Review of Minimum Data Set (MDS) assessment, dated 7/3/24, indicated Resident #19 had a moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 9 out of 15. Further review of the MDS indicated Resident #19 had received dialysis. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225274	A. Building B. Wing	09/25/2024

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #19's current Physician's Orders indicated but was not limited to: - Dialysis Center T (Tuesday)/TH (Thursday)/SAT (Saturday) one time a day every Tue, Thu, Sat for Dialysis Center- dated 1/30/24 - Sevelamer Carbonate (medication used to lower phosphorus levels in the blood) 800 milligrams (mg), Give 3 tablets with meals- dated 5/10/2024 Review of Resident #19's Dialysis Communication Book indicated a recommendation from the dialysis center Dietitian dated 9/12/24 but was not limited to: - Please hold phosphorus binder Sevelamer due to low phos (phosphorus) 2.3 per MD (medical doctor) Further review of Resident #19's Dialysis Communication Book indicated on 9/10/24 he/she had a phosphorus level of 2.3 mg (milligrams)/dL(deciliter). Review of Resident #19's nurses note, dated 9/12/24 indicated but was not limited to: - Resident returned from dialysis with a request from the MD to hold Sevelamer due to low phos (2.3). No stop date noted. Further Review of Resident #19's medical record failed to indicate the Physician or Physician Extender was notified of the recommendation and review of the Medication Administration Record (MAR) indicated Sevelamer had been administered for 18 extra doses. During an interview on 9/19/24 at 3:05 P.M., Nurse #19 said when a resident returns from dialysis the nurse is responsible for checking his/her dialysis communication book and communicating the recommendations to the Physician/Nurse Practitioner (NP). During an interview on 9/19/24 at 3:06 P.M., Unit Supervisor #6 reviewed Resident #19's dialysis communication book and medical record and said the dialysis recommendations were not reported to the Physician/NP and were not followed-up on. During an interview on 9/19/24 at 3:19 P.M., the Director of Nursing (DON) reviewed Resident #19's dialysis recommendations from 9/12/24 and his/her medical record. The DON said the Physician/NP should have been notified of the recommendations and implemented if ordered by the Physician/NP. During an interview on 9/25/24 at 8:58 A.M., NP #1 said she was not notified of the recommendation from the dialysis center and if she had been then she would have implemented it. During a telephonic interview on 9/25/24 at 12:42 P.M., NP #3 said she was not notified of the recommendations from the dialysis center. 49428 2. Resident #76 was admitted to the facility in April 2023 with diagnoses including ESRD and dependence on renal dialysis. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225274	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #76's MDS assessment, dated 6/18/24, indicated Resident #76 received dialysis services. Review of the Nursing Home Dialysis Transfer Agreement, dated as revised April 2016, indicated but was not limited to the following: -Facility shall ensure that all appropriate medical, social, administrative, and other information accompany all Designated Residents at the time of transfer to the Center. This information shall include, but is not limited to, where appropriate, the following: e) treatment presently being provided to the Designated Resident, including medications and any changes in a patient's condition (physical or mental), change of medication, diet or fluid intake. h) any other information that will facilitate the adequate coordination of care as reasonably determined by Center. Resident #76's Dialysis Communication Book contained several Dialysis Communication Records, which are forms filled out by both the facility and the dialysis center as a means to relay clinical information and coordinate care for the Resident. During an interview on 9/24/24 at 9:23 A.M., Nurse #3 and the surveyor reviewed Resident #76's Dialysis Communication Record, dated 9/23/24, together. Nurse #3 said the section titled Facility to Complete Prior to Dialysis was incomplete as 3 out of 14 fields were blank. Nurse #3 said nursing should be completing Facility to Complete Prior to Dialysis or Day of Dialysis (Pre-Dialysis) sections, depending on the communication sheet that was used, and the section should be completed in its entirety. Nurse #3 said this included checking any applicable boxes, the nurse's signature, and the time the Resident left for dialysis. Nurse #3 also said one Dialysis Communication Records sheet was to be completed each time Resident #76 left the facility for dialysis. Review of a sample of the Resident's Dialysis Communication Record sheets, specifically the sections titled Complete Prior to Dialysis or Day of Dialysis (Pre-Dialysis), dated from 8/2/24 through 9/23/24, indicated but was not limited to the following: 8/2/24- 4 of 10 fields not completed; 8/5/24- 14 of 14 fields not completed; 8/7/24- 8 of 14 fields not completed; 8/9/24- 5 of 14 fields not completed; 8/10/24- 14 of 14 fields not completed; 8/12/24- 14 of 14 fields not completed; 8/14/24- Review of two Medication Administration notes, both dated 8/14/24, stated Resident #76 was at dialysis. No Dialysis Communication Record sheet for this date was observed in the Resident's medical record; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225274	A. Building B. Wing	09/25/2024

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/16/24- 5 of 14 fields not completed; 8/19/24- 14 of 14 fields not completed; 8/21/24- 4 of 14 fields not completed; 8/23/24- 4 of 14 fields not completed; 8/26/24- Review of a Nursing Progress note, dated 8/26/24, stated Resident #76 returned from dialysis that day at 10:30 A.M. No Dialysis Communication Record sheet for this date was observed in the Resident's medical record; 8/28/24- 7 of 10 fields not completed; 8/30/24- 5 of 14 fields not completed; 9/2/24- 10 of 14 fields not completed; 9/4/24- 1 of 10 fields not completed; 9/6/24- 2 of 10 fields not completed; 9/9/24- Review of four Medication Administration notes, all dated 9/9/24, stated Resident #76 was at dialysis; no Dialysis Communication Record sheet for this date was observed in the Resident's medical record; 9/13/24- 1 of 14 fields not completed; 9/16/24- 14 of 14 fields not completed; 9/17/24- 9/21/24- Resident was on Medical Leave of Absence (MLOA) from the facility; 9/23/24- 3 of 14 sections not completed. During an interview on 9/25/24 at 10:36 A.M., the DON and the surveyor reviewed several of Resident #76's Dialysis Communication Records sheets from the month of August. The DON said the section titled Facility to Complete Prior to Dialysis or Day of Dialysis (Pre-Dialysis), depending on which communication form was used, should be entirely completed including all applicable boxes checked, a nurse's signature, and the time the Resident left for dialysis. The DON said the weight field was the only acceptable field to remain empty. The DON said the reviewed Dialysis Communication Record sheets from the month of August were incomplete. The DON also said she expected a communication sheet to be completed fully (minus the weight section) each time Resident #76 left the facility for dialysis.

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	225274	A. Building B. Wing	09/25/2024

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 34145 Based on record review and interview, the facility failed to assess a history of trauma and failed to assess and to develop a plan of care accounting for Resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization for one Resident (#31), with a history of trauma, out of a total sample of 24 residents. Findings include: Resident #31 was admitted to the facility in April 2022 with diagnoses including schizoaffective disorder, major depressive disorder, anxiety disorder, and post-traumatic stress disorder (PTSD- occurs in some individuals who have encountered a shocking, scary, or dangerous situation). Review of the Minimum Data Set (MDS) assessment, dated 7/12/24, indicated that Resident #31 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 and had PTSD. Review of the facility's consultant psychiatric service provider's documentation indicated the clinician identified trauma as one of the areas of focus for the therapy sessions on 5/22/24, 6/13/24, and 6/19/24. Review of the medical record indicated Resident #31's diagnosis of PTSD was identified in social service progress notes dated 8/2/23 and 11/14/23. However, further review of the medical record failed to indicate that neither an assessment for trauma nor a care plan with individualized interventions for the prevention of potential re-traumatization had been developed. During an interview on 9/24/24 at 2:10 P.M., Certified Nursing Assistant (CNA) #7 said he is not aware Resident #31 had any past trauma. During an interview on 9/24/24 at 2:24 P.M., Nurse #9 said she is not aware Resident #31 had any past trauma. During an interview on 9/25/24 at 10:10 A.M., Social Worker #1 said they don't do PTSD or trauma assessments. She said she has mentioned the lack of assessment tools to the administration and was told they would look into it, but it has never been implemented. She said she usually develops a care plan for residents with PTSD but must have missed it for Resident #31. The Social Worker said she is aware Resident #31 has a diagnosis of PTSD but does not know any specifics about the trauma or any triggers to prevent re-traumatization of the Resident.

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	225274	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 46562 Based on interview and record review, the facility failed to act promptly upon recommendations made by the Consultant Pharmacist during the monthly Medication Regimen Reviews (MRR) for two Residents (#10 and #69), out of a total sample of 24 residents. Specifically, the facility failed to act on the consultant pharmacist's recommendations to obtain labs in order to help assess the efficacy of medications. Findings include: Review of the facility's policy titled Medication Regimen Review (MRR), dated as revised May 2019, indicated but was not limited to: -the consultant pharmacist provides the director of nursing services and medical director with a written, signed and dated copy of all medication regimen reports -the attending physician documents in the medical record that the irregularity has been reviewed and what (if any) action was taken to address it -copies of medication regimen review reports, including physician responses, are maintained as part of the permanent medical record 1. Resident #10 was admitted to the facility in August 2023 with diagnoses which included dementia and hyperlipidemia (high cholesterol). Review of Resident #10's medical record indicated he/she was seen by the Consultant Pharmacist in March 2024 and recommendations were made. Further review of Resident #10's medical record indicated no documented evidence of a March 2024 MRR. After inquiry, the facility provided Resident #10's March 2024 MRR which indicated recommendations to obtain a Valproic Acid (used to treat seizure disorders) Level, Liver Function Tests (LFTs), and a Vitamin D level in order to assess efficacy and potential side effects of medication use. Further review of the March 2024 MRR indicated the physician/prescriber response section was blank. During an interview on 9/19/24 at 11:57 A.M., Unit Manager #2 said the MRR reports were sent from the Consultant Pharmacist to the Executive Director or the Director of Nurses (DON) who then gave them to the prescriber. Unit Manager #2 said the prescriber should review the MRR and sign the form with their response. (continued on next page)

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	225274	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brush Hill Care Center	1200 Brush Hill Road Milton, MA 02186

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/23/24 at 12:50 P.M., the DON said the facility did not provide the physician/provider with Resident #10's March MRR until last week and it had not been implemented prior to that. 2. Resident #69 was admitted to the facility in November 2019 with diagnoses which included dementia and heart disease. Review of Resident #69's medical record indicated he/she was seen by the Consultant Pharmacist in February 2024 and recommendations were made. Further review of Resident #69's medical record indicated no documented evidence of a February 2024 MRR. After inquiry, the facility provided Resident #69's February 2024 MRR which indicated recommendations to obtain LFTs, a Vitamin B12 level, and a folate level in order to assess efficacy and potential side effects of medication use. Further review of the February 2024 MRR indicated the physician/prescriber response section was blank. During an interview on 9/23/24 at 5:00 P.M., the DON said Resident #69's February MRR had not been provided to the provider.

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	225274	A. Building B. Wing	09/25/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 34145 Based on record review and interview, the facility failed to ensure that as needed (prn) orders for psychotropic medications were limited to 14 days, unless otherwise documented by the attending physician or prescribing practitioner that it was appropriate to extend beyond 14 days for three Residents (#31, #112, and #173), out of a total sample of 24 residents. Specifically, the facility failed to ensure: 1. For Resident #31, that the prn order for Ativan (antianxiety) was limited to 14 days and was reviewed by the Physician with a documented rationale for its continued use; 2. For Resident #112, that the prn order for Valium (hypnotic) was limited to 14 days and was reviewed by the Physician with a documented rationale for its continued use; and 3. For Resident #173, that the prn order for Valium was limited to 14 days and was reviewed by the Physician with a documented rationale for its continued use. Findings include: Review of the facility's policies titled Psychotropic Medication Use and Antipsychotic Medication Use, last revised July 2022, indicated but were not limited to: -Residents will not receive prn doses of psychotropic medications unless that medication is necessary to treat a specific condition that is documented in the clinical record. -The need to continue prn orders for psychotropic medications beyond 14 days requires that the practitioner document the rationale for the extended order. The duration of the prn order will be indicated in the order. 1. Resident #31 was admitted to the facility in April 2022 with diagnoses including anxiety. Review of the Minimum Data Set (MDS) assessment, dated 7/2/24, indicated Resident #31 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 15 out of 15, and received psychotropic medication daily. Review of Physician's Orders indicated but was not limited to: -Ativan 0.5 milligrams (mg) every four hours as needed for anxiety (9/3/24) During an interview on 9/25/24 at 8:58 A.M., Nurse Practitioner #1 said she is aware that prn orders for psychotropic medications must be limited to 14 days but had not been notified by the facility yet that the order was open-ended. She said she would follow up with nursing. (continued on next page)

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	225274	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brush Hill Care Center	1200 Brush Hill Road Milton, MA 02186

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #112 was admitted to the facility in January 2024 with diagnoses including dementia with agitation, depression, and anxiety disorder. Review of the MDS assessment, dated 7/3/24, indicated Resident #112 had severe cognitive impairment as evidenced by a BIMS score of 4 out of 15, and received psychotropic medication daily. Review of Physician's Orders indicated, but was not limited to: -Valium 5 mg every six hours as needed (6/6/24) Review of the June 2024 through September 2024 MARs indicated Valium was administered: -June 2024: Five times -July 2024: Five times -August 2024: Seven times -September 2024: Eight times Review of the entire medical record failed to indicate the prn orders for Valium from June 2024 through September 2024 were re-evaluated and a clinical rationale for its continued use was documented in the medical record by either the Physician (MD) or Nurse Practitioner (NP). During an interview on 9/23/24 at 2:22 P.M., Unit Supervisor #6 said the prn order for Valium should have a stop date, but it was missed. During an interview on 9/25/24 at 8:58 A.M., Physician Assistant #2 said he is aware of the requirement for prn orders to have a stop date and documented clinical rationale for continued use and Resident #112's order should have a stop date. 3. Resident # 173 was admitted to the facility in July 2024 with diagnoses including anxiety. Review of the MDS assessment, dated 7/17/24, indicated Resident #173 had moderate cognitive impairment as evidenced by a BIMS score of 9 out of 15, and received psychotropic medication daily. Review of Physician's Orders indicated but was not limited to: -Diazepam (Valium) 2 mg as needed daily for anxiety (8/9/24) Review of August 2024 and September 2024 MAR indicated Valium was administered: -August: three times -September: four times (continued on next page)

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	225274	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brush Hill Care Center	1200 Brush Hill Road Milton, MA 02186

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the entire medical record failed to indicate the prn orders for Valium from August 2024 through September 2024 were re-evaluated and a clinical rationale for its continued use was documented in the medical record by either the Physician (MD) or Nurse Practitioner (NP). During a telephonic interview on 9/27/24 at 12:51 P.M., Physician #2 said he was not aware that prn orders for psychotropic medication are limited to 14 days and a clinical rationale must be documented in the medical record to extend the prn order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225274	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brush Hill Care Center	1200 Brush Hill Road Milton, MA 02186

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 34145 Based on observation, interview, and policy review, the facility failed to ensure all drugs and biologicals were stored in a safe and secure manner as required. Specifically, the facility failed for one Resident (#173), out of a total sample of 24 residents, to ensure medicated mouthwash was not left unsecured and unattended in the Resident's room. Findings include: Review of the facility's policy titled Medication Labeling and Storage, dated 2001, indicated but was not limited to the following: Medication Storage - The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. -The nursing staff are responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Resident #173 was admitted to the facility in July 2024 with diagnoses including presence of a gastrostomy (feeding tube). Review of the Minimum Data Set (MDS) assessment, dated 7/17/24, indicated Resident #173 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 9 out of 15, and had a feeding tube. Review of Physician's Orders indicated but was not limited to: -Chlorhexidine Gluconate Mouth/Throat Solution 0.12%, give 10 milliliters by mouth one time a day (7/15/24) On 9/20/24 at 10:22 A.M., the surveyor observed a 16-ounce bottle of prescription Chlorhexidine Gluconate mouthwash on Resident #173's overbed table. The Resident said earlier that morning, he/she told the nurse that he/she didn't want the mouthwash that day, and the nurse left it on the table. According to the National Capital Poison Center (poison.org), Chlorhexidine is not well absorbed when swallowed, and some stomach irritation or nausea is typically all that will occur after ingestion of small amounts. However, serious adverse effects can occur when larger amounts of chlorhexidine are swallowed. During an interview on 9/20/24 at 10:31 A.M., Nurse #6 picked up the prescription mouthwash off the overbed table in Resident #173's room and said she should not have left it at the Resident's bedside. (continued on next page)

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	225274	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brush Hill Care Center	1200 Brush Hill Road Milton, MA 02186

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/23/24 at 2:22 P.M., Unit Supervisor #6 said the prescription mouthwash should have been securely stored and not left out at the Resident's bedside.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225274	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brush Hill Care Center	1200 Brush Hill Road Milton, MA 02186

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48695 Based on observation, test tray results, and interview, the facility failed to ensure staff served food that was palatable and at an appetizing temperature for 1 out of 2 test trays conducted. Findings include: During the initial resident screening on 9/17/24, the residents expressed the following concerns about the food at the facility: - Food usually comes up cool - Food is always cold - Food usually comes up cool, even the hot foods - The food is cold sometimes. - Food is often cold; the facility has a tough time controlling that - Food is often cold Review of Food Committee Meeting Minutes, dated 8/27/24, indicated but was not limited to: - French fries are cold Review of Food Committee Meeting Minutes, dated 7/31/24, indicated but was not limited to: - Hard boiled eggs are sometimes undercooked Review of Food Committee Meeting Minutes, dated 4/23/24, indicated but was not limited to: - Food Temps (temperatures) inconsistent On 9/19/24 at 11:53 A.M., the surveyor requested a lunch test tray to the 2A Unit. The food truck left the kitchen at 11:55 A.M., and arrived at the unit at 11:57 A.M. The test tray was conducted with the Food Service Director (FSD) at 12:12 P.M. with the following results in degrees Fahrenheit (F): - Pasta [NAME]: 134 F lukewarm to taste - Broccoli: 132.6 F cold to taste - Garlic Bread: 113 F cold to taste - Cranberry Juice: 53 F cold to taste/touch (continued on next page)

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	225274	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brush Hill Care Center	1200 Brush Hill Road Milton, MA 02186

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/19/24 at 12:20 P.M., the FSD said the temperatures were not within the appropriate ranges, and the hot items should have been hotter for the residents. The FSD said that they have been having a hard time keeping hot foods hot. The FSD said he conducts a test tray maybe monthly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225274	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48695 Based on observations, interviews, and policy review, the facility failed to follow professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to maintain the ice machine in a clean and sanitary manner in three out of four kitchenettes. Findings include: Review of the facility's policy titled Ice Machines and Ice Storage Chests, undated, indicated but was not limited to: - Policy Statement: Ice machines and ice storage/distribution containers will be used and maintained to assure a safe and sanitary supply of ice. - Policy Interpretation and Implementation: - Our facility has established procedures for cleaning and disinfecting ice machines and ice storage chests which adhere to manufacturer's instructions. The infection preventionist (or designee) maintains a copy of these procedures. On 9/17/24 at 10:37 A.M., the surveyor observed the following in the 2A Unit kitchenette: - Inside the ice machine there was yellowish residue/discoloration on one of the plastic components. The discolored component had water dripping down into the ice cubes. - Ice Maker Cleaning Schedule posted indicated the months of January, February, March, April, May, June, July, August, and September were blank. On 9/17/24 at 10:57 A.M., the surveyor observed the following in the 2BC Unit kitchenette: - Inside the ice machine there was yellowish and black residue/discoloration on one of the plastic components. The discolored component had water dripping down into the ice cubes. - Ice Maker Cleaning Schedule was not posted. On 9/17/24 at 12:26 P.M., the surveyor observed the following in the 2BC Unit kitchenette: - Inside the ice machine there was yellowish and black residue/discoloration on one of the plastic components. The discolored component had water dripping down into the ice cubes. On 9/17/24 at 12:36 P.M., the surveyor observed the following in the 2A Unit kitchenette: - Inside the ice machine there was yellowish residue/discoloration on one of the plastic components. The discolored component had water dripping down into the ice cubes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225274	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brush Hill Care Center	1200 Brush Hill Road Milton, MA 02186

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/17/24 at 12:39 P.M., the surveyor observed the following in the 1A Unit kitchenette: - Inside the ice machine there was yellowish residue/discoloration on one of the plastic components. The discolored component had water dripping down into the ice cubes. - Ice Maker Cleaning Schedule posted last signed off January 2024. The months of February, March, April, May, June, July, August, and September were blank. On 9/17/24 at 3:14 P.M., the surveyor observed the following in the 2BC Unit kitchenette: - Inside the ice machine there was yellowish and black residue/discoloration on one of the plastic components. The discolored component had water dripping down into the ice cubes. On 9/18/24 at 7:13 A.M., the surveyor observed the following in the 2A Unit kitchenette: - Inside the ice machine there was yellowish residue/discoloration on one of the plastic components. The discolored component had water dripping down into the ice cubes. On 9/18/24 at 7:15 A.M., the surveyor observed the following in the 2BC Unit kitchenette: - Inside the ice machine there was yellowish and black residue/discoloration on one of the plastic components. The discolored component had water dripping down into the ice cubes. During an interview on 9/17/24 at 12:40 P.M., Certified Nursing Assistant (CNA) #1 said the ice machine is used for the residents. CNA #1 said the ice was given to the residents in their water or as ice chips. During an interview on 9/17/24 at 3:35 P.M., Nurse #19 said the ice from the ice machine was used for the residents, to give them a cup of ice water, ice chips, or to fill the water pitcher used for medication pass. During an interview with observation on 9/17/24 at 12:45 P.M., the Food Service Director (FSD) said the ice machines were checked monthly but were not cleaned monthly. The FSD said the ice machines on the 1A, 2A, and 2BC units were dirty and not as clean as they should have been. The FSD director said he did not know how to clean the ice machines or who was responsible for cleaning them. During an interview on 9/17/24 at 1:41 P.M., the Director of Operations said the expectation is for the ice machines to have been checked monthly and the Ice Maker Cleaning Schedule log to have been filled out. The Director of Operations said he was not sure who was responsible for cleaning the ice machines, either housekeeping or dietary was responsible. During an interview on 9/24/24 at 3:35 P.M., the Administrator said the facility did not have a procedure for cleaning the ice machines but there should have been one.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 46562 Based on observations and interviews, the facility failed to ensure it was administered in a manner that enabled it to use resources effectively to attain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, the facility failed to effectively manage and utilize their administrative team and stay up to date with current Centers for Disease Control and Prevention (CDC), Centers for Medicare and Medicaid Services (CMS), and Massachusetts Department of Public Health (MDPH) guidance. Findings include: During the recertification survey on 9/17/24 through 9/20/24 and 9/23/24 through 9/25/24 the survey team determined: -the activity department was not meeting the needs of all residents and the activity calendar was not being reviewed and monitored as evidenced by lack of meaningful and engaging activities on all units -the business office was located out of state, and activity related to residents' personal needs accounts and residents access to their funds was managed by the Activity Director -the human resources department was located out of state, and 5/5 employee records were incomplete or out of date -the role of the Infection Preventionist was vacant and was not effectively being covered by current facility staff as evidenced by no antibiotic stewardship program, no infection surveillance and failure to implement enhanced barrier precautions (EBP, an infection control measure for residents with chronic wounds and/or indwelling devices putting them at increased risk for infection) During an interview on 9/24/24 at 11:14 A.M., the Activity Director said she was the liaison between the business office in New York and the facility and was responsible for managing and accessing the residents' funds from their Personal Needs Accounts (PNA). The Activity Director said the responsibility of managing the PNA has interfered with her ability to be hands-on in the activity department and the residents could only access their funds when she was working. During an interview on 9/24/24 at 2:23 P.M., the Administrator said the monthly activity calendar was not reviewed by the leadership team but she was aware the activities department could use some enhancements. During an interview on 9/25/24 at 11:19 A.M., the Administrator said the Human Resources department was off-site but the scheduler was taking care of some new-hire credential verification in house. The Administrator said she was aware employee files were missing some things and could be better. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 9/24/24 at 9:48 A.M., the Director of Clinical Operations said the Staff Development Coordinator (SDC) was also the Infection Control Nurse. The Director of Clinical Operations said the Infection Control Nurse position had been vacant and the SDC had been covering that role since March. He said a job description had not been signed indicating her understanding of this expectation. The Director of Clinical Operations said a monthly infection control report with infection surveillance was not provided by the SDC but a listing of residents on antibiotics was discussed weekly at the risk meeting. During an interview on 9/24/24 at 9:48 A.M., the Director of Nurses said there had not been an actual designated Infection Control Nurse since last year, but the SDC was supposed to be covering the role. During an on 9/24/24 at 9:48 A.M., the Administrator said the SDC was learning and that she and the Director of Clinical Operations had provided the SDC with guidance. The Administrator said the facility was working to find someone who was qualified to be the Infection Control Nurse. During an interview on 9/24/24 at 9:48 A.M., the Director of Operations said the Infection Preventionist job had been posted off and on in 14-30 day increments, and that it was taken down every so often so the same job was not posted for an extended period of time. Review of the facility provided job postings indicated the Infection Control Nurse position had been posted on 7/26/23, 4/2/24, 5/20/24, and 7/12/24. During an interview on 9/24/24 at 10:26 A.M., the SDC said she was hired as the SDC and not an Infection Control Nurse. The SDC said, in March of this year, she told the leadership team she could help with the infection control program until an Infection Control Nurse was hired. The SDC said her job description was never adjusted and her understanding was that she would be responsible for education and helping with the vaccinations. The SDC said she did not complete a line listing or perform an analysis of antibiotics/infections and had never done that for the facility. The SDC said she was not involved in an antibiotic stewardship program. During an interview on 9/24/24 at 2:23 P.M., the Administrator and the DON said they were unaware of how to find new CDC, CMS, and MDPH guidance and how to stay up to date with changes in facility expectations. The Administrator and DON said they were unaware of regulations related to some of the concerns the surveyors had. The DON said she did not receive any memos from CMS of DPH and did not know when guidelines changed. Refer to 882

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 46562 Based on document review and interview, the facility failed to develop and implement their facility assessment (a document assessing the capability of the facility and its resources to provide both emergency and day to day care of the population the facility currently serves). Specifically, the facility failed to: 1. Ensure active involvement of all required members when conducting the facility assessment; and 2. Implement the identified competency-based training as indicated. Findings include: Review of the Centers for Medicare and Medicaid Services (CMS) guidance, dated 6/18/24, indicated but was not limited to: -In conducting the facility assessment, the facility must ensure active involvement of the following participants in the process: a. Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and b. Direct care staff, including but not limited to, Registered Nurses, Licensed Practical Nurses/Licensed Vocational Nurses, Nursing Assistants, and representatives of the direct care staff, if applicable c. The facility must also solicit and consider input received from residents, resident representatives, and family members. Review of the facility's policy titled Facility Assessment, dated as revised October 2018, indicated but was not limited to: -The team responsible for conducting, reviewing and updating the facility assessment includes the following: a. the administrator; b. a representative of the governing body; c. the medical director; d. the director of nursing services; e. the infection preventionist; and (continued on next page)

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	225274	A. Building B. Wing	09/25/2024

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	f. the director (or designee) from the following departments: environmental services, physical operations, dietary services, social services, activity services, and rehabilitative services 1. Review of the Facility Assessment, dated July 2024, indicated but was not limited to: -Names/Titles of individuals involved in completing the assessment: Administrator, Director of Nurses, Medical Director, Director of Social Services, Director of Clinical Operations and Food Service During an interview on 9/25/24 at 3:32 P.M., the Administrator said the facility assessment was last updated July 2024. The Administrator said the process for updating the facility assessment was to review the previous assessment page by page and make sure no changes had occurred in staffing or resident care needs. The Administrator said the leadership team/department heads were involved in updating and formulating the facility assessment. 2. Review of the Facility Assessment, dated July 2024, indicated but was not limited to: -Competency Based Training: All staff are required to complete a comprehensive orientation upon hire and annually thereafter including but not limited to the following requirements: a. Dementia training: original eight hours and four hours annually Review of the staff education records for Nurses #14, #15, #16, and #18 failed to include mandatory dementia training. During an interview on 9/25/24 at 12:54 P.M. and 1:11 P.M., the Staff Development Coordinator said there are approximately 80 relevant employees at the facility, and she could not find any evidence that the annual four-hour dementia training was completed as required in 2023. She said when she began working at the facility, four months ago, there was no staff education program in place. During an interview on 9/25/24 at 11:35 A.M., the Administrator and the facility Scheduler said there was no formal dementia training in the facility at that time. The Administrator and Scheduler said the dementia training should be conducted prior to the completion of orientation and then annually. Refer to F949

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	225274	A. Building B. Wing	09/25/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 48695 Based on observation, record review, and interview, the facility failed to maintain accurate medical records in accordance with professional standards and practices for two Residents (#19 and #112), out of a total sample of 24 residents. Specifically, the facility failed: 1. For Resident #19, to document weekly comprehensive skin assessment per physician orders; and 2. For Resident #112, to ensure a diagnosis of allergic dermatitis from adhesives, diagnosed by the facility's consultant wound physician, was prominently documented in the medical record as an allergy. Findings include: 1. Review of the facility's policy titled Prevention of Pressure Injuries, last revised April 2020, indicated but was not limited to: - Purpose: The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. - Preparation: Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. - Risk Assessment: 1. Assess the resident on admission (within eight hours) for existing pressure injury risk factors. Repeat risk assessment weekly and upon any changes in condition. 1. Resident #19 was admitted to the facility in January 2024 with diagnoses including peripheral vascular disease (a slow and progressive disorder of the blood vessels) and diabetes mellitus. Review of Resident #19's current Physician's Orders indicated but was not limited to: - Weekly Skin Assessment every evening shift every Fri (Friday) open assessments tab to complete BHCC - Skin Assessment, dated 1/3/2024 Review of Resident #19's July, August, and September Treatment Administration Records (TAR) indicated a nurse had signed off weekly skin checks as being completed on 7/5/24, 7/12/24, 7/19/24, 7/26/24, 8/2/24, 8/9/24, 8/16/24, 8/23/24, 8/30/24, 9/6/24, 9/13/24, and 9/20/24. Further Review of Resident #19's medical record failed to indicate a weekly skin check assessment form had been filled out on the following days: - 7/12/24 (continued on next page)

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	225274	A. Building B. Wing	09/25/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 7/19/24 - 7/26/24 - 8/2/24 - 8/23/24 - 9/13/24 - 9/20/24 During an interview on 9/24/24 at 8:58 A.M., Unit Supervisor #6 said skin checks are completed weekly. Unit Supervisor #6 said the nurse assigned to a resident would sign off on the TAR that a skin check was completed, then the nurse would fill out skin assessment utilizing the Skin Assessment user defined assessment. Unit Supervisor #6 reviewed Resident #19's TAR and user defined assessments and said Resident #19 was missing numerous skin assessments and should not be missing them. During an interview with record review on 9/25/24 at 3:32 P.M., the Director of Nursing (DON) said skin checks are completed weekly on shower days and should be signed off on the TAR and a skin assessment should be completed. The DON reviewed Resident #19's TAR and skin assessments and said Resident #19 did have his/her weekly skin checks signed off on the TAR, but he/she was missing some skin assessments. 34145 2. Resident #112 was admitted to the facility in January 2024 with a tracheostomy (a surgical procedure that creates an opening in the neck into the windpipe (trachea) to allow air to flow into the lungs). Review of the medical record included a wound evaluation and management summary, dated 4/3/24, from the facility's consultant wound physician. The physician's evaluation note indicated the Resident had a rash at the tracheostomy site and diagnosed the rash as allergic dermatitis to adhesives. The note indicated the patient's plan of care was discussed with a nursing staff member and clinical documentation for this consultation was made available for access to the appropriate personnel and placement in the medical record. Further review of the medical record failed to indicate Resident #112's allergic dermatitis for adhesives was added to the medical record as an allergy. During an interview on 9/23/24 at 2:22 P.M., Unit Supervisor #6 reviewed the consultant wound physician's 4/3/24 note and said the diagnosis of allergic dermatitis to adhesives should have been added to Resident #112's allergy list so the attending physician and Nurse Practitioner/Physician's assistant would be aware of the allergy. During an interview on 9/25/24 at 9:29 A.M., Physician's Assistant #1 said he was not aware that Resident #112 had an allergy to adhesives. He said if the allergy is not documented under allergies in the medical record, there is no way he would know about it.

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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. 46562 Based on observation, interview, and policy review, for five Residents (#68, #173, #112, #31, and #19), of 24 sampled residents, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and potential transmission of communicable diseases and infections. Specifically, the facility failed to implement Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities) for the following Residents: A. For Resident #68, who has chronic wounds, putting him/her at increased risk for infection; B. For Resident #173, who has wounds and a gastrostomy tube; C. For Resident #112, who has a gastrostomy tube and a tracheostomy; D. For Resident #31, who has an indwelling urinary catheter; and E. For Resident #19, who has a wound, putting him/her at increased risk for infection. Findings include: Review of the Centers for Medicare and Medicaid Services (CMS) guidance titled Enhanced Barrier Precautions in Nursing Homes, dated 3/20/24, indicated but was not limited to: -Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities. -EBP are used in conjunction with standard precautions and expand the use of personal protective equipment (PPE) to donning (putting on) of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing -EBP are indicated for residents with any of the following: a. Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or b. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO -EBP should be used for any residents who meet the above criteria, wherever they reside in the Facility Review of the facility's policy titled Enhanced Barrier Precautions, dated August 2022, indicated but was not limited to: (continued on next page)

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	225274	A. Building B. Wing	09/25/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-EBPs are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms to residents. -EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply a. gloves and gown are applied prior to performing the high contact resident care activity -Examples of high contact resident care activities include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care -EBP are indicated for residents with wounds and/or indwelling medical devices regardless of MDRO colonization -Signs are posted in the door or wall outside the resident room indicating the type of precaution and PPE required -PPE is available outside of the residents' rooms A.Resident #68 was admitted to the facility in March 2020 with the following diagnoses: venous insufficiency and chronic wounds to lower extremities. Review of Resident #68's medical record indicated he/she had chronic wounds to his/her lower extremities and was followed by the wound consultant. On the following dates of survey, the surveyor did not observe an EBP sign on the Resident's bedroom door, or anywhere in the immediate vicinity of the Resident's room, and no PPE was available outside or inside the room for staff to use in the event the Resident should require assistance: -9/17/24 at 10:14 A.M. -9/17/14 at 2:56 P.M. -9/18/24 at 8:22 A.M. -9/18/24 at 11:22 A.M. -9/19/24 at 1:56 P.M. -9/23/24 at 10:26 A.M. -9/23/24 at 4:08 P.M. -9/24/24 at 8:05 A.M., the surveyor observed Certified Nursing Assistant (CNA) #5 positioning Resident #68 in bed. CNA #5 was wearing only gloves as PPE. -9/24/24 at 12:32 P.M. (continued on next page)

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	225274	A. Building B. Wing	09/25/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-9/24/24 at 12:55 P.M., the surveyor observed two facility staff members transferring Resident #68 from his/her bed to chair. The staff members were wearing only gloves as PPE. Review of Resident #68's Physician's Orders failed to indicate he/she was on EBP. During an interview on 9/24/24 at 12:21 P.M., Nurse #7 and Nurse #4 said there were no residents on that unit requiring any precautions in addition to standard precautions. Nurse #7 and Nurse # 4 said they did not know what EBP was and did not know when or why they would be required. During an interview on 9/24/24 at 12:57 P.M., Unit Manager #2 said Resident #68 did have chronic wounds but was not on any precautions. Unit Manager #2 said she was not aware of EBP. During an interview on 9/24/24 at 1:35 P.M., the Director of Nurses (DON) said Resident #68 had chronic wounds to his/her bilateral lower extremities and was followed by the wound consultant weekly. The DON said Resident #68 did not require any precautions in addition to standard precautions because he/she was not infected with a MDRO. The DON said the EBP program had not been implemented. 34145 B. Resident #173 was admitted to the facility in July 2024 with diagnoses including multiple third degree burns on his/her body, and a gastrostomy tube (feeding tube). Review of the Minimum Data Set (MDS) assessment, dated 7/17/24, indicated Resident #173 had multiple unhealed pressure ulcers, surgical wounds and burns. Review of the medical record indicated Resident #173 was receiving treatment for multiple pressure ulcers, wounds, and gastrostomy tube. Review of the entire medical record failed to indicate an order for EBP for high contact resident care activities. C. Resident #112 was admitted to the facility in January 2024 and had diagnoses including presence of a gastrostomy and a tracheostomy. Review of the MDS assessment, dated 7/3/24, indicated Resident #112 had a gastrostomy and tracheostomy. Review of the medical record indicated Resident #112 was receiving care and treatment for a gastrostomy tube and tracheostomy. Review of the entire medical record failed to indicate an order for EBP for high contact resident care activities. D. Resident #31 was admitted to the facility in August 2017 and had diagnoses including a history of urinary tract infections and urinary retention. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225274	A. Building B. Wing	09/25/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS assessment, dated 7/2/24, indicated Resident #31 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 and had an indwelling urinary catheter. Review of the medical record indicated Resident #31 was receiving care and treatment for a urinary catheter. Review of the entire medical record failed to indicate an order for EBP for high contact resident care activities. On 9/20/24 at 10:13 A.M., the surveyor observed CNA #6 standing at Resident #31's bedside, the privacy curtain was drawn halfway alongside the bed exposing the Resident's legs. The CNA was observed providing a sponge bath to the Resident's legs while wearing gloves and no gown. The surveyor did not observe an EBP sign on the Residents #173, #112 and #31's bedroom doors, or anywhere in the vicinity of the Residents' rooms, no personal protective equipment was available outside or inside the Residents' rooms for staff to use for high contact resident care activities on the following occasions: -9/18/24 at 9:00 A.M. and 12:00 P.M. -9/19/24 at 1:06 P.M. -9/20/24 at 10:00 A.M. -9/23/24 at 2:10 P.M. -9/24/24 at 7:30 A.M. and 2:00 P.M. -9/25/24 at 10:30 A.M. During an interview on 9/24/24 at 1:57 P.M., Nurse #13 said residents with wounds or indwelling medical devices should be on EBP. She said she doesn't know why Residents #173, #112 and #31 were not placed on EBP. During an interview on 9/24/24 at 10:26 A.M., the Staff Development Coordinator said she is helping with the facility's infection control program until they hire someone to take that role. She said she has not implemented EBP in the facility yet and residents with gastrostomy tubes, catheters and wounds should be on EBP. 48695 E. Resident #19 was admitted to the facility in January 2024 with diagnoses including peripheral vascular disease, end stage renal disease (ESRD), and diabetes mellitus. Review of Resident #19's medical record indicated he/she had an arterial wound to his/her left shin and was followed by the wound consultant. (continued on next page)

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	225274	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brush Hill Care Center	1200 Brush Hill Road Milton, MA 02186

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On the following dates of survey, the surveyor did not observe an EBP sign on the Resident 19's bedroom door, or anywhere in the immediate vicinity of the Resident's room, and no PPE was available outside or inside the room for staff to use in the event the Resident should require assistance: - 9/17/24 10:22 A.M. - 9/18/24 12:04 P.M. - 9/19/24 12:54 P.M. - 9/19/24 2:47 P.M. - 9/23/24 11:13 A.M. - 9/24/24 8:42 A.M. - 9/24/24 9:14 A.M. Review of Resident #19's entire medical record failed to indicate an order for EBP for high contact resident care activities. During an interview on 9/24/24 at 9:14 A.M., Nurse #13 said any resident with an open wound should be on EBP but was not. During an interview on 9/25/24 at 3:32 P.M., the DON said she could not speak to EBP because the facility had not implemented them yet in the facility. Refer to 882

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 28450 Based on document review and interview, the facility failed to implement an Antibiotic Stewardship Program to promote and monitor the appropriate use of antibiotics which are used to guide decisions for evaluating antibiotic prescribing patterns in accordance with the Antibiotic Stewardship Program. Findings include: Review of the Centers for Disease Control and Prevention (CDC) guidance titled The Core Elements of Antibiotic Stewardship for Nursing Homes, undated, indicated but was not limited to the following: - The purpose of an antibiotic stewardship program is to improve the use of antibiotics in healthcare to protect patients and reduce the threat of antibiotic resistance. - Antibiotic stewardship refers to a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. - The CDC recommends that all nursing homes take steps to improve antibiotic prescribing practices and reduce inappropriate use. - Any action taken to improve antibiotic use is expected to reduce adverse events, prevent emergence of resistance, and lead to better outcomes for residents in this setting. The facility failed to provide the surveyor with their Antibiotic Stewardship Policy for review. The facility failed to provide the surveyor with evidence of antibiotic use protocols and a system to monitor antibiotic use (i.e., infection surveillance and/or a line listing). The facility provided the surveyor with a 3-inch binder labeled Antibiotic Stewardship which contained no information for the past year and contained information dated 2018. During an interview on 9/24/24 at 9:48 A.M., the surveyor met with the Administrator, the Director of Nurses (DON), the Director of Clinical Services, and the Director of Operations. The Director of Clinical Services said the Staff Development Coordinator was responsible for the Infection Control Program and was the Infection Control Nurse. The Director of Clinical Services said the SDC was responsible for the infection surveillance and antibiotic stewardship program. He said what was provided to the surveyor is what the facility was able to provide. During the above noted interview, on 9/24/24 at 9:48 A.M., the Administrator said the facility discussed antibiotics weekly at the risk meeting and kept track of them in an ongoing spreadsheet, but the SDC would be the one to complete the actual surveillance report. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/24/24 at 10:26 A.M., the SDC said she was not the Infection Control Nurse and had never formally agreed to be responsible for the antibiotic stewardship program or infection surveillance. The SDC said the only aspect of infection control she was responsible for was education and helping with the vaccination effort in the facility. The SDC said since she has been employed by the facility, since February of this year, there has never been an infection control nurse and there has never been an antibiotic line listing/surveillance. The facility failed to have a system of monitoring and tracking in place to improve the use of antibiotics within the facility, to protect residents and reduce the threat of antibiotic resistance. As of the end of survey, on 9/25/24, the survey team did not receive any additional information regarding the antibiotic stewardship or infection surveillance. Refer to 882

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 28450 Based on record review and interview, the facility failed to ensure the designated Infection Control Nurse (ICN) adequately assessed, developed, implemented, monitored, and managed the infection prevention and control program. Specifically, the ICN failed to: 1. Ensure enhanced barrier precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities) were implemented; and 2. Implement an Antibiotic Stewardship Program to promote and monitor the appropriate use of antibiotics which are used to guide decisions for evaluating antibiotic prescribing patterns in accordance with the Antibiotic Stewardship Program. Findings include: 1. On multiple days of survey, the surveyors observed several residents, who met criteria for EBP, but did not have EBP in place. During an interview on 9/24/24 at 10:26 A.M., the Staff Development Coordinator said she has not implemented EBP in the facility. During an interview on 9/24/24 at 1:35 P.M., the Director of Nurses (DON) said the EBP program had not been implemented. 2. During survey, the facility was unable to provide evidence of infection surveillance and of an Antibiotic Stewardship Program. During an interview on 9/24/24 at 9:48 A.M., the surveyor met with the Administrator, the Director of Nurses (DON), the Director of Clinical Services, and the Director of Operations. The Director of Clinical Services said the Staff Development Coordinator was responsible for the Infection Control Program and was the ICN. The Director of Clinical Services said the SDC was responsible for the infection surveillance and antibiotic stewardship program. He said what was provided to the surveyor is what the facility was able to provide. During an interview on 9/24/24 at 10:26 A.M., the SDC said she was not the ICN and had never formally agreed to be responsible for the antibiotic stewardship program or infection surveillance. The SDC said the only aspect of infection control she was responsible for was education and helping with the vaccination effort in the facility. The SDC said since she has been employed by the facility, since February of this year, there has never been an ICN and there has never been an antibiotic line listing/surveillance.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 34145 Based on interviews and staff education records reviewed for five direct care staff employees (Nurse #14, Nurse #15, Nurse #16, Nurse #17 and Nurse #18) of five employees reviewed, the facility failed to ensure that training on behavioral health was included as mandatory training for direct care staff. Findings include: Review of the facility's policy titled Behavioral Health Services, last revised July 2022, indicated but was not limited to: -Staff must promote dignity, autonomy, privacy, socialization and safety as appropriate for each resident and are trained in ways to support residents in distress; -Staff training regarding behavioral health services includes, but is not limited to: a. recognizing changes in behavior that indicate psychological distress; b. implementing care plan interventions that are relevant to the resident's diagnosis and appropriate to his/her needs; c. monitoring care plan interventions and reporting changes in condition; and d. protocols and guidelines related to the treatment of mental disorders, psychosocial adjustment difficulties, history of trauma and post-traumatic stress disorder. Review of the staff education records for Nurse #14, Nurse #15, Nurse #16, Nurse #17 and Nurse #18 failed to include mandatory training on care specific to the individual needs of residents that are diagnosed with a mental, psychosocial, or substance use disorder, a history of trauma and/or post-traumatic stress disorder, or other behavioral health condition; and care specific to the individual needs of residents that are diagnosed with dementia. During an interview on 9/25/24 at 12:54 P.M. and 1:11 P.M., the Staff Development Coordinator said she could not find any evidence that Nurse #14, Nurse #15, Nurse #16, Nurse #17, Nurse #18 or any other staff had received required behavioral health training. She said there are approximately 80 relevant employees at the facility, and she could not find any evidence that behavioral health training was completed as required in 2023. She said when she began working at the facility four months ago, there was no staff education program in place. The facility failed to provide the survey team with any additional documentation by the time of the exit conference on 9/25/24.