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	11/21/2025

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review and interview, it was determined the facility failed for one Resident (#10), out of a total sample of 25 residents, to refer to the state-designated authority for further evaluation of the diagnosis of a serious mental illness (SMI). This deficient practice has the potential to impact residents who are diagnosed with major mental illness, intellectual disability or related conditions if a state-designated authority did not evaluate a resident's mental health needs. Findings include: Review of the MassHealth Nursing Facility Bulletin 186, dated June 2024 indicated the following: Definition: Level I Screening- A preliminary screening of all nursing facility applicants, regardless of payer source, conducted prior to their admission to a nursing facility, as required by federal PASRR regulations at 42 CFR 483.100 et seq. using the Level 1 Screening Form. A level 1 Screening identifies whether an applicant has, or is suspected of having, ID (intellectual Disability), DD (Developmental Disability), and/or SMI (Serious Mental Illness). Specific Requirements for Individuals with SMI: C. Post-admission Level II Evaluations for Individuals with SMI. 1. A nursing facility must ensure an individual who has or is suspected of having an SMI is referred to DMH (Department of Mental Health) PASRR, in accordance with Section 3. A for a post-admission Level II Evaluation (i.e. Resident Review) in the following instances: b. When an individual who resides in a nursing facility has experienced a significant change or the individual is newly identified as having a condition that may impact the individual's PASRR disability status, the appropriateness of the individual's nursing facility placement, or the individual's need for specialized services and/or Behavioral Health Services. Resident #10 was admitted to the facility in May 2021 with diagnoses that include but are not limited to adult failure to thrive, unspecified dementia, and chronic kidney disease. Review of the Minimum Data Set (MDS) assessment, dated 9/26/25, indicated staff assessed Resident #10 as having moderately impaired cognition. Review of the Preadmission Screening and Resident Review (PASRR) Level 1 dated 5/14/21 documented Resident #10 as not having a serious mental health illness. Review of Resident #10's admission Record Face Sheet documented the diagnosis of schizoaffective disorder, unspecified with an onset date of 2/8/25, and present on admission. Review of the Psychiatric Evaluation and Consultation document, dated 2/8/25, indicated:Plan: will recommend changing Seroquel (an antipsychotic medication) indication to schizoaffective disorder, unspecified, as this is a diagnosis the patient has carried since before admission. During an interview on 11/20/25 at 12:19 P.M., the Social Worker said the diagnosis of schizoaffective disorder was not on Resident #10's PASRR Level 1 because it was not on the diagnoses list from the referring hospital. The Social Worker said the PASRR level I was not updated when the diagnosis of schizoaffective disorder was identified, nor was a referral made to the state-designated authority and should have been.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interview, the facility failed to ensure the resident environment remained free of unattended and unsecured medications for one Resident (#51), out of a total sample of 25 residents and for residents residing on the second-floor unit. Specifically, the facility failed:1. For Resident #51, to ensure medications were not kept at the bedside while staff were not present in a unit with known wandering residents; and2. For residents on the second-floor unit, to ensure medications were kept in a locked medication cart while staff were not present in the hallway.Findings include:1. Review of the facility's policy titled Self-Administration of Medication, dated and revised February 2021, indicated the following: -Any medications that are found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party. Resident #51 was admitted to the facility in September 2022 with diagnoses including metabolic encephalopathy and vascular dementia. Review of Resident #51's Minimum Data Set Assessments (MDS), dated [DATE], indicated that the Resident had a Brief Interview for Mental Status (BIMS) score of 1 out of 15 indicating severe cognitive impairment. Further review of the MDS indicated that the Resident is dependent on staff for all tasks. On 11/18/25 at 7:46 A.M., the surveyor observed Resident #51 sleeping in his/her bed. On his/her bedside table was a medicine cup with five different medications consisting of pills and capsules. Next to the medicine cup, was a full cup of water. There were no staff members in the room. Prior to entering the room, the surveyor observed a Resident wandering the hallway on the unit. During an interview on 11/18/25 at 7:53 A.M., Nurse #2 said that no residents on the unit are able to self-administer medications as all the residents have dementia. Nurse #2 and the surveyor entered Resident #51's room, and the nurse said the cup of pills should not have been left there and they are from yesterday. Nurse #2 said a nurse should stay with residents to ensure they take their medication. When asked, what are the implications of Resident #51 not taking his/her medication, she said it is bad since he/she is behavioral. Nurse #2 said if a staff member observed the cup of medication at Resident #51's bedside they should notify a nurse. Nurse #2 said residents wander in this unit and a wandering resident could have taken the medication if they entered Resident #51's room. Review of Resident #51's Physician's Orders indicated the following that Nurse #2 was able to identify in the medicine cup: -Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125MG (milligram) - Give 4 tablet by mouth at bedtime for d/t breakthrough moods and aggressive behaviors -bupropion HCL ER (extended release) Oral Tablet 12 hour 200 MG - give 1 tablet by mouth one time a day related to major depressive disorder -hydralazine HCL tablet 25MG - give 12.5 mg by mouth two times a day for high bp (blood pressure) (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #51's Medication Administration Record (MAR) indicated that the Resident received his/her medications the night prior. Review of Resident #51's medical record failed to indicate any documentation that he/she is able to self-administer medication. During an interview on 11/19/25 at 9:02 A.M., the Director of Nursing (DON) said there should be a physician's order for residents to self-administer medications as well as a care plan. The DON said no residents on that unit are able to self-administer medications, including Resident #51, and medication should not be left at the bedside unattended by a nurse. The DON said if staff were to observe medication left unattended at the bedside, they should tell a nurse since the unit has wandering residents and they would be at risk of taking the medication. 2. Review of the facility's policy titled Medication Labeling and Storage, dated and revised February 2023, indicated the following: -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 surveyor made the following observations: On 11/20/25 at 8:51 A.M., the surveyor observed on the second-floor unit an unlocked and unattended medication cart. The medication cart had a cup of pills on the top of the cart. There was a Resident sitting in his/her wheelchair in the hallway nearby and there were no staff present in the hallway. On 11/20/25 at 8:54 A.M., the surveyor and the Director of Nursing (DON) observed the second-floor unit medication cart unlocked and unattended with a cup of pills on the top of cart. There was a Resident sitting in his/her wheelchair in front of the medication cart. The DON said that Nurse #3 should not have left an unlocked and unattended medication cart and Nurse #3 should not have left pills on top of the medication cart as there is risk of other residents accessing these medications. On 11/20/25 at 8:57 A.M., the surveyor observed Nurse #3 exit a room at the opposite end of the second-floor hallway. Nurse #3 returned to the medication cart and said that she should not have left the medication cart unlocked and unattended as it posed a risk to other residents.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for one Resident (#1), out of a total sample of 25 residents, the facility failed to ensure that his/her drug regime was free from unnecessary drugs. Specifically, for Resident #1, the facility failed to implement the ophthalmologist's (eye physician) recommendations resulting in Resident #1 receiving an excessive duration of eye drops. Findings include: Review of the facility's policy titled Medications and Treatment Orders, dated July 2016, indicated: 12. Orders not specifying the number of doses, or duration of medication, shall be subject to automatic stop orders.a. Drugs not specifically limited to duration of use and number of doses when ordered will be controlled by automatic stop orders. Resident #1 was admitted to the facility in April 2023 with diagnoses including diabetes, chronic diastolic heart failure, and cataracts (cloudy area in the eye's lens that causes blurry vision, faded colors, and difficulty seeing at night). Review of the Minimum Data Set (MDS) assessment, dated 9/29/25, indicated Resident #1 had a severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 7 out of 15. This MDS indicated Resident #1's vision was highly impaired. Review of Resident #1's consultant eye care after visit summary, dated 10/20/25, indicated:1. Ofloxacin (antibiotic) 0.3%, one drop to right eye four times a day.2. Prednisolone (steroid) Acetate 1%, one drop to right eye four times a day.3. Ketorolac (non-steroidal anti-inflammatory) 0.5%, one drop to right eye four times a day.4. Follow up appointment on 10/28/25. Review of Resident #1's Physician's Orders, dated 10/20/25, indicated:-Ofloxacin Otic Solution 0.3% (Ofloxacin (Otic), instill 1 drop in right ear [sic] four times a day for cataract.-Prednisolone Acetate Ophthalmic Suspension 1% (Prednisolone Acetate (Ophth), instill 1 drop in right eye four times a day for cataract.-Ketorolac Tromethamine Ophthalmic Solution 0.5% (Ketorolac Tromethamine (Ophth), instill 1 drop in right eye four times a day for cataracts. Review of Resident #1's nursing progress note, dated 10/28/25 at 9:43 P.M., indicated:-Resident was picked up for his/her scheduled appointment by agent of the transportation agency and wheeled out of the facility escorted by a staff. Resident return from his/her appointment, no new order, new appointment for [DATE]th at 10:20 A.M., ride booked with transportation for a 9:15 A.M. pick-up Review of Resident #1's consultant eye care after visit summary, located in the medical record at the nursing station, dated 10/28/25, indicated:1. Moxifloxacin (tan top): 1 drop into the right eye, 4 times every day for 1 more week, then stop.2. Prednisolone (pink top) and ketorolac (gray top): For both of these drops, use them 4 times every day for 1 week (10/28 - 11/3), then 3 times every day for 1 week (11/4 - 11/10), then 2 times every day for 1 week (11/11 - 11/17), then 1 time every day for 1 week (11/18 - 11/24), then stop. Review of Resident #1's Physician's Orders and Medication Administration Record on 11/20/25 failed to indicate that nursing implemented the ophthalmologist's recommendations, and Resident #1 continued to receive moxifloxacin, prednisolone, and ketorolac four times a day. During an interview on 11/20/25 at 8:31 A.M., Nurse #1 said Resident #1 is receiving eye drops four times day after his/her cataract surgery. Nurse #1 said that the duration of the eye drops is based on the recommendations from the ophthalmologist. Nurse #1 reviewed the note he wrote on 10/28/25 and he said he was not aware that Resident #1 returned with new orders to decrease his/her eye drops. Nurse #1 said that he would have to call the physician to obtain new orders. During an interview on 11/20/25 at 9:16 A.M., the Unit Manager said he wasn't aware of the recommendations from 10/28/25 and he said that the nurse working should have notified the physician and obtained new orders to decrease the frequency of the eye drops. During an interview on 11/20/25 at 9:45 A.M., the Director of Nursing said that Nurse #1 and the Unit Manager should have reviewed the ophthalmologist's recommendations and decreased the frequency of Resident #1's eye drops. During an interview on 11/20/25 at 10:13 A.M., the Physician said that nursing should have notified him of the ophthalmologist's recommendations and that nursing should have implemented the recommendations from the ophthalmologist and decreased the eye drop frequency.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to store food from outside sources safely to prevent potential foodborne illness for one Resident (#121), out of a total sample of 22 residents. Findings include:Review of the facility's policy titled Food Brought by Family/Visitors, revised March 2022, indicated the following: - Family/visitors are asked to prepare and transport food using safe food handling practices, including: a. safe cooling and reheating processes;b. holding temperatures - Food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that it is clearly distinguishable from facility-prepared food. b. Perishable foods are stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers are labeled with the resident's name, the item and the use by date. - Potentially hazardous foods that are left out for the resident without a source of heat or refrigeration longer than 2 hours are discarded. Resident #121 was admitted in October 2025 with diagnoses including cancer and malnutrition. Review of the Minimum Data Set (MDS) assessment, dated 10/29/25, indicated Resident #121 scored 14 out of 15 on the Brief Interview for Mental Status exam, indicating intact cognition. On 11/18/25 at 12:08 P.M., the surveyor observed Resident #121 lying in bed with a bedside table next to him/her that contained old food in a container that appeared to be from family/ a visitor. There were two other containers containing food on his/her nightstand. During an observation with interview on 11/19/25 at 8:31 A.M., the surveyor observed Resident #121 lying in bed with two containers of food on his/her nightstand and an open container of ramen soup with a chicken thigh inside. Resident #121 told the surveyor that the food had been there since last night and that he/she orders food out. During an interview on 11/19/25 at 12:15 P.M., Unit Manager #1 said that Resident #121 sometimes gets food from outside of the building and keeps it in his/her room. Unit Manager #1 said that Resident #121 does not like putting his/her food in the unit refrigerator because he/she is afraid someone will take his/her food, even if it is labeled/dated. During an interview on 11/20/25 at 9:02 A.M., the Food Service Director said that if a family member brings in food from the outside to a Resident, then the leftovers should be labeled and dated and put into the unit refrigerator. The Food Service Director said that she was not aware Resident #121 had been keeping food in his/her room and if the Resident was refusing to put the food in the unit refrigerator, then the facility would try to get him/her a refrigerator for his/her room to use. During an interview on 11/21/25 at 7:20 A.M., the Food Service Director said that Resident #121's family has been bringing in containers of food, and the facility is going to reach out to the family to get Resident #121 a refrigerator for his/her room to store the food closer to Resident #121.