STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225297	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lighthouse Rehabilitation and Healthcare Center	204 Proctor Avenue Revere, MA 02151

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 0689 Level of Harm - 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, interviews and record review, the facility failed to ensure the Resident's environment was free from accident hazards, for one Resident #126, out of a sample of 30 Residents. Specifically, the facility failed to implement a fall care plan intervention which led to Resident #126 falling and sustaining a fracture.Findings include:A review of the facility policy titled ?Falls-Clinical Protocol' with a revision date of September 2012 indicated the following:-The staff will document risk factors for falling in the resident's record and discuss the resident's fall risk. Risk factors for falling include environmental hazards.-The staff will evaluate and document falls that occur while the individual is in the facility, for example when and where they happen, any observations of the events, etc.-For an individual who has fallen, staff will attempt to define possible causes within 24 hours of the fall. Causes refer to factors that are associated with or that directly result in a fall.-Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling.Resident #126 was admitted to the facility in January 2025 with diagnoses including Dementia and a history of falling.Review of the most recent Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 0 out of a possible 15 indicating severe cognitive impairment.Review of the Activities of Daily Living (ADL) care plan indicated the following:-Dressing: I require 1 staff assist with dressing. Care plan initiated,1/31/25.-Transfers: I require 1 staff assist for transfers. Care plan initiated,1/31/25. Review of the Health Care Proxy dated 11/18/19 indicated it was invoked on 12/16/25.Review of a Fall report titled ?Full QA Report' dated 11/10/25 indicated the following:Fall Details-During round, about 3:30 A.M., resident found sitting up right, on the floor at his/her bedside. Calm, alert, and verbally responsive per baseline. Denied pain. Stated that he/she did not hit his/her head. When asked resident what happened? he/she said he/she was getting out of bed; lost balance and fell on his/her bum. Resident assisted from the floor to bed by 2 staff members. Footwear-non-skid socks. Injuries-No Injuries noted. Actions-Care plan updated and Resident education (This writer educated the Resident to use the call light for help and wait for help to arrive.)Investigate/conclusion-Removed slippers and family member will bring in new slippers with closed back for better grip. Problem statement-Resident lost his/her balance while getting out of bed. Why-maybe weakness, unsteady, forgetful/dementia. Root cause-Resident lost his/her balance while getting out of bed and fell. Review of a Fall report titled ?Full QA Report' dated 12/24/25 indicated the following:Fall Details: Resident ambulating in room, found lying on back on floor. Footwear: Slippers/nonskid socks. Injuries-No injuries noted. Actions-Care plan updated.Investigate/conclusion-Resident fell while ambulating, the resident had slippers with no back and slightly too big. Family to bring in slippers with back. Problem statement-Older backless slippers. Why-Slippers a little big but resident refuses to change. He/she was also wearing nonskid socks. Root cause: Family will bring better fitting slippers with backs so that his/her feet are secure. Review of a Fall report titled ?Full QA Report' dated 2/11/26 indicated the following:Fall Details/type-Resident found on floor, lying on right side with right hand on his/her face. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225297	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lighthouse Rehabilitation and Healthcare Center	204 Proctor Avenue Revere, MA 02151

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 0689 Level of Harm - Actual harm Residents Affected - Few	Footwear-Slippers/nonskid socks. Injuries-Closed fracture of the nasal bone and facial hematoma. Actions-Care plan updated.Investigate/conclusion-Resident was found in the bathroom lying on his/her right side. He/she had blood coming out of the right side of his/her nose and facial hematoma. Resident was able to move all extremities and assisted back to bed. MD (Medical Doctor) and family notified. Resident sent to hospital for evaluation and sustained a nose fracture and facial hematoma. Slippers were removed from the room and family educated not to bring in slippers with no backs. Resident is wearing slipper socks now. Resident to be toileted during am and pm care, after meals, during rounds and as needed. Problem statement-Resident fell in the bathroom. Why-Resident lost his/her balance due to resident's shoes, slippers have no backs. Root cause-Staff will encourage resident to wear nonskid socks only when ambulating with his/her rolling walker. Slippers have been removed. Review of the Fall care plan interventions initiated 12/24/25 indicated the following:-Family will supply resident with his/her sneakers removed slippers and family will bring in new slippers with closed back for better grip. Review of the hospital Discharge summary dated [DATE] indicated the following:Diagnoses-Fall, initial encounter, closed fracture of nasal bone, initial encounter, facial hematoma, initial encounter. On 2/19/26 at 7:40 A.M., the surveyor observed backless slippers in the Resident's room. Resident #126 was seated on his/her bed wearing nonskid socks.On 2/19/26 at 11:14 A.M., the surveyor observed Resident #126 in the Activity room wearing nonskid socks and backless slippers.A review of the progress notes dated 12/24/25 indicated the following:-Family aware of fall and asked if he could bring slippers with a back. A review of the progress note dated 12/25/25 indicated the following:-Status post fall, denied pain when asked, neurological tests as ordered. Continues to be unsafe.A review of the progress notes dated 2/16/26 indicated the following:-This writer notified family about a possible room change, due to resident's fall risks. Family stated that he wants resident to remain in his/her room due to resident liking his/her room and liking his/her current roommate. This writer educated family about slippers not being safe for the resident in which he verbalized understanding. Will continue to monitor resident and maintain safety precautions. Further review of progress notes between 12/24/25 and 2/16/26's communication to the Resident's son failed to indicate the Resident being encouraged to wear nonskid socks while the facility waited for the son to bring in slippers with a back.During a telephone interview on 2/20/26 at 10:48 A.M., Certified Nurse's Assistant (CNA) #3 said she provided Activities of Daily Living (ADL) care for the Resident yesterday, 2/19/26. CNA #3 said she did see backless slippers in the Resident's room during ADL care. CNA #3 said she did not put the backless slippers on the Resident because the Resident could fall. CNA #3 said the Resident did try to put on the backless slippers on his/her own. CNA #3 redirected him/her to not wear the backless slippers. CNA #3 said the Resident is able to put the backless slippers on his/her own. CNA #3 was not able to tell the surveyor if she can view the Kardex (documentation that serves as a concise and quick reference for patient care) on the electronic health record she has access to, CNA #3 said she had no idea how to view the Resident's fall care plan from the electronic health record she has access to.During a telephone interview on 2/20/26 at 11:15 A.M., Resident #126's family member and Health Care Proxy said he was made aware by the facility of the concerns of the backless slippers for first time yesterday, 2/19/26. The Health Care Proxy said he visits the Resident daily; the backless slippers are the Resident's favorite footwear and are always in the room. The Health Care Proxy said the Resident can put on the backless slippers on his/her own. The Health Care Proxy said the facility did inform him about all of the Resident's falls, however they never emphasized the backless slippers concerns. The Health Care Proxy said if the facility had informed him about the backless slippers concerns, he would have asked the facility to dispose them. The Health Care Proxy said after he was told about the concerns with the backless slippers, on 2/19/26, he asked the facility to dispose the backless slippers immediately.During an interview on 2/20/26 at 11:23 A.M., Unit Manager #3 said the backless slippers were in the Resident's room yesterday, 12/19/26. Unit Manager #3 said the Resident is not supposed to have the backless slippers in his/her room. Unit Manager #3 said she talked to the Resident's (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225297	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lighthouse Rehabilitation and Healthcare Center	204 Proctor Avenue Revere, MA 02151

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 0689 Level of Harm - Actual harm Residents Affected - Few	family member who is also the Health Care Proxy, to get permission to dispose the backless slippers. Unit Manager #3 said the family member had been made aware about the backless slippers concerns prior to yesterday, but it is the facility's responsibility to maintain the Resident's safety by implementing the fall care plan interventions. Unit Manager #3 said she was not sure if CNAs can access the Kardex on the electronic health record they have access to.During an interview on 2/20/26 at 12:02 P.M., the Director of Nurses said the 12/24/25 and 2/11/26 falls were caused by the Resident's backless slippers. The DON said the Resident's family was notified about bringing in slippers with a closed back. The DON said it is the facility's responsibility to maintain regular communication with the Resident's family member if the family member is not following through with the communication to bring in closed back slippers for the Resident. The DON said it is the facility's responsibility to make sure the backless slippers are not in the Resident's room to maintain the Resident's safety. The DON said if the Resident refuses to remove the backless slippers, staff should contact the Health Care Proxy for a final decision. The DON said CNAs do have access to the Kardex on the electronic health record they have access to. The DON said this access allows them to read Residents' care plans. The DON said the original care plan has to have the initial 'K' so the CNAs can view the Kardex on their electronic health record. The DON said Resident #126's fall care plan did not have the initial 'K' so the CNAs could not view the Kardex on their electronic health record. The DON said fall care plan interventions should be implemented after fall investigations are completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225297	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lighthouse Rehabilitation and Healthcare Center	204 Proctor Avenue Revere, MA 02151

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation and interview, the facility failed to ensure that services provided met professional standards of practice for one Resident (#31) out of a total sample of 30 Residents. Specifically, for Resident #31 the facility failed to administer medications timely and in accordance with physician's orders.Findings include: Review of facility policy titled Administering Medications, dated as revised April 2019, indicated the following:-Medications are administered in a safe and timely manner, and as prescribed.-Medications are administered within one hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). Resident #31 was admitted to the facility in October 2025 with diagnoses that included acute post hemorrhagic anemia and pulmonary embolism.Review of the most recent Minimum Data Set (MDS) assessment, dated 1/15/26, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. Review of physician's orders indicated the following:-Ferrous Sulfate Tablet 325 mg (milligrams) by mouth one time daily, every other day to be administered at 9:00 A.M., dated 10/22/25.-Lisinopril 2.5 mg one time a day to be administered at 9:00 A.M., dated 10/22/25.-Eliquis oral tablet 5 mg two times daily for pulmonary embolism, to be administered at 9:00 A.M. and 9:00 P.M., dated 10/21/25-Multiple Vitamin give one tablet one time a day, to be administered at 9:00 A.M., dated 10/22/25.-Cetirizine 10 mg give 0.5 tablet one time a day, to be administered at 9:00 A.M., dated 10/22/25.-Cholecalciferol 125 mcg one tablet one time a day, to be administered at 9:00 A.M., dated 10/22/25.-Calcium-Vitamin D3 oral tablet 600-10 mg-mcg give one tablet by mouth two times a day, to be administered at 9:00 A.M. and 9:00 P.M., dated 10/22/25 During an observation on 2/19/26 at 12:10 P.M., the surveyor observed Nurse #1 preparing medications for administration. Review of the medication administration screen indicated that she was preparing to administer 9:00 A.M. medications to Resident #31. Review of the Medication Administration Audit Report, dated 2/19/26, indicated that Resident #31's 9:00 A.M. medications were administered between 12:11 P.M., and 12:15 P.M., over three hours after they were indicated to be administered per physician's orders. During an interview on 2/20/26 at 7:34 A.M., Unit Manager #1 said that medications should be given within one hour before or one hour after the administration time indicated in the physician's orders. He said that the Resident's medication should not have been given that late. During an interview on 2/20/26 at 8:49 A.M., the Director of Nurses said that it is unacceptable that medications were being administered that late. She said that the expectation is that medications are administered within the time frame of one hour before or one hour after the indicated administration time in the order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225297	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lighthouse Rehabilitation and Healthcare Center	204 Proctor Avenue Revere, MA 02151

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for two Residents (#11 and #14) out of a total of 30 sampled residents. Specifically,1. For Resident #11 the facility failed to provide assistance to shave unwanted facial hair. 2. For Resident #14 the facility failed to provide assistance to cut fingernails. Findings include: Review of the facility policy titled Activities of Daily Living (ADL), Supporting, dated 2001 indicated the following: Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. 1. Resident #11 was admitted to the facility in October 2024 with diagnoses including anxiety disorder, depression and schizophrenia. Review of the Minimum Data Set assessment, dated 11/14/25, indicated that Resident #11 is cognitively intact, scoring a 15 out of 15 on the Brief Interview for Mental Status exam. Further review indicated that Resident #11 requires supervision/touching assistance for personal hygiene. Review of the care plan indicated a focus of the following: I have an ADL (activity of daily living) Self Care Performance Deficit r/t Activity Intolerance, Fatigue. with an intervention of the following: PERSONAL HYGIENE: I require staff assistance with grooming/personal hygiene. Date Initiated: 10/01/25. Further review failed to indicate that Resident #11 refuses care. Review of the progress notes failed to indicate Resident #11 refuses care.On 2/18/26 at 8:20 A.M., the surveyor observed Resident #11 to have significant chin and upper lip hair. During an interview on 2/18/26 at 8:20 A.M., Resident #11 said he/she wants the hair removed. Resident #11 said that the hair is embarrassing but nobody will do anything about it.On 2/18/26 at 1:57 P.M., the surveyor observed Resident #11 in the main dining room, participating in activities, with the same amount of chin and upper lip hair.On 2/19/26 at 7:39 A.M. the surveyor observed Resident #11 to have significant chin and upper lip hair. On 2/19/26 at 1:39 P.M., the surveyor observed Resident #11 in the main dining room, participating in activities, with the same amount of chin and upper lip hair.During an interview on 2/19/26 at 1:45 P.M., Nurse #1 said that the Certified Nurse's Aides (CNA's) are responsible to help residents shave.During an interview on 2/19/26 at 1:45 P.M., CNA #1 said that the CNA's are responsible for shaving the residents, but she didn't realize Resident #11 wanted to be shaved.2. Review of the facility policy titled Activities of Daily Living (ADL), Supporting, dated 2001 indicated the following: Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Resident #14 was admitted to the facility in August 2025 with diagnoses including stroke, cancer and malnutrition. Review of the Minimum Data Set assessment dated [DATE] indicated that Resident #14 is cognitively intact, scoring a 15 out of 15 on the Brief Interview for Mental Status exam. Further review indicated that Resident #14 is dependent on staff for all activities of daily living. Review of the current care plan indicated that Resident #14 is dependent for all activities of daily living. Further review failed to indicate that Resident #14 refuses care. Review of the progress notes failed to indicate that Resident #14 refuses care.On 2/18/26 at 7:49 A.M., the surveyor observed Resident #14 in bed with a contracted right arm and hand. The surveyor then observed Resident #14's right hand fingernails to be long and curling over the tip of his/her fingers. On 2/19/26 at 8:52 A.M., the surveyor and Nurse #1 observed Resident #14 in bed with a contracted right arm and hand. The surveyor and Nurse #1 then observed Resident #14's right hand fingernails to be long and curling over the tip of his/her fingers. During an interview on 2/19/26 at 8:52 A.M., Resident #14 said that the Certified Nurse's Aides (CNA's) are supposed to cut his/her fingernails, but no one has recently. During an interview on 2/19/26 at 8:53 A.M., Nurse #1 said that the CNA's are supposed to cut fingernails and if for some reason they can't they are to notify the nurse. Nurse #1 then said that Resident #14's fingernails are not supposed to be that long. During an interview on 2/19/26 at 8:58 A.M., CNA #1 said (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225297	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lighthouse Rehabilitation and Healthcare Center	204 Proctor Avenue Revere, MA 02151

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that she has Resident #14 for the 7:00 A.M.-3:00 P.M. shift but has not seen his/her nails as she works mainly on another floor. CNA #1 then said that CNAs are responsible for cutting fingernails and nails should never get so long as to curl over the tip of the finger. CNA #1 then said that if she couldn't cut the nails then she would get the nurse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225297	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lighthouse Rehabilitation and Healthcare Center	204 Proctor Avenue Revere, MA 02151

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, record review and interview the facility failed to implement interventions to prevent pressure ulcers from developing for one Resident (#40) out of a total sample of 30 residents. Specifically, the facility failed to ensure Resident #40's heels were elevated off the mattress. Findings include: Review of the facility policy titled Pressure Ulcers/Skin Breakdown-Clinical Protocol, dated 2001, failed to indicate that staff are to follow the care plan interventions to prevent and heal pressure areas. Resident #40 was admitted to the facility in December 2023 with diagnoses including muscle wasting and atrophy, major depressive disorder and osteoarthritis. Review of the Minimum Data Set assessment, dated 1/15/26, indicated that Resident #40 scored a 3 out of 15 on the Brief Interview for Mental Status exam, indicating severe cognitive impairment. Further review indicated that Resident #40 is totally dependent for all activities of daily living and at risk for the development of pressure ulcers. Review of the active care plan indicated a focus of risk for skin breakdown with an intervention of elevate heels while in bed as tolerated. Further review failed to indicate that Resident #40 refuses care. Review of the progress notes failed to indicate Resident #40 refuses to have his/her feet elevated off of the mattress. On 2/18/26 at 7:55 A.M., the surveyor observed Resident #40 lying in bed with both heels directly on the mattress. On 2/18/26 at 10:23 A.M., the surveyor observed Resident #40 lying in bed with both heels directly on the mattress. On 2/18/26 at 1:43 P.M., the surveyor observed Resident #40 lying in bed with both heels directly on the mattress. On 2/19/26 at 7:26 A.M., the surveyor observed Resident #40 lying in bed with both heels directly on the mattress. On 2/19/26 at 11:05 A.M., the surveyor observed Resident #40 lying in bed with both heels directly on the mattress. Review of the physician orders dated February 2026 indicated an order to Elevate heels while in bed as tolerated every shift. During an interview on 2/19/26 at 11:03 A.M., Certified Nurse's Aide (CNA) #2 said that it is the responsibility of the CNA to follow the care plan and elevate heels off of the mattress if that is what the care plan says to do. During an interview on 2/19/26 at 11:05 A.M., Nurse #1 said that it is the CNA's and nurse responsibility to ensure the care plan is followed. Nurse #1 said that Resident #40 should have his/her heels elevated off of the mattress. Nurse #1 then said that if a resident refuses or isn't tolerating an intervention then it should be documented in the medical record. During an interview on 2/19/26 at 11:06 A.M., Unit Manager #1 said that it is the CNA's and nurse responsibility to ensure the care plan is followed. Unit Manager #1 said that Resident #40 should have his/her heels elevated off of the mattress. Unit Manager#1 then said that if a resident refuses or isn't tolerating an intervention then it should be 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
	225297	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lighthouse Rehabilitation and Healthcare Center	204 Proctor Avenue Revere, MA 02151

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observation, record review and interview the facility failed to provide care consistent with professional standards of practice for one Resident (#132) with a peripherally inserted central catheter (PICC) line (a long, flexible catheter inserted into a vein in the upper arm and threaded into a large central vein near the heart to deliver medications, fluids, or nutrition and to draw blood) out of a total sample of 30 Residents. Specifically, the facility failed to change the PICC line dressing on admission as indicated in the physician's orders or when the PICC line dressing was lifting on the edges. Findings include: Review of facility policy titled Central Venous Catheter Care and Dressing Changes, dated as revised October 2024, indicated the following:-A physician's order is needed for this procedure.-Assess central venous access devices with each infusion and at least daily.-Remove any non- transparent dressing and visually inspect the insertion site if any signs or symptoms of complication are present.-Perform site care and dressing change at established intervals or immediately if the integrity of the dressing is compromised (e.g., damp, loosened or visibly soiled)-Change the dressing if it becomes damp, loosened or visibly soiled and: immediately if the dressing or site appears compromised-Assessment: Observe insertion site and surrounding area for complications. Resident #132 was admitted to the facility in February 2026 with diagnoses that included Sepsis due to methicillin resistant staphylococcus aureus and depression. There was no Minimum Data Set data available for the Resident. During an observation and interview on 2/19/26 at 7:25 A.M., the surveyor observed Resident #132 awake in bed. The Resident had a PICC line to the left upper arm. There was a dressing in place dated 2/14/26. The dressing was peeling and lifting along the sides. The insertion site was not visible due to a tan foam under the transparent dressing. The Resident said the dressing had been peeling off for a few days now and had not been changed since being admitted to the facility despite the Resident having asked staff to change it. On 2/19/26 at 11:12 A.M., the surveyor observed the Resident in bed. The Resident was receiving intravenous antibiotics at this time. The same PICC line dressing remained in place, dated 2/14/26 and peeling and lifting on the edges. The insertion site was not visible. On 2/19/26 at 1:13 P.M., the surveyor observed the Resident's PICC line dressing. There was a dressing in place dated 2/14/26. The dressing was peeling and lifting along the sides. The insertion site was not visible due to a tan foam under the transparent dressing. On 2/20/26 at 7:07 A.M., the surveyor observed the Resident's PICC line dressing. The dressing had been changed and was dated 2/20/26. The insertion site was visible, and the dressing edges were reinforced with tape that was peeling up. Review of Physician's orders indicated the following:-Vancomycin HCl Intravenous Solution 750 MG/150ML (Vancomycin HCl), use 250 ml intravenously every 12 hours for infection bacteremia until 02/26/2026 23:59 vancomycin 750mg/250ml sol IVPB, dated 2/17/26.-IV: (Midline, PICC, CVAD) Change Transparent Dressing on admission and then every 7 days; Caps to be changed during dressing change, dated 2/18/26. Review of Resident #132's medical record on 2/19/26 failed to indicate that the PICC line dressing had been changed since admission to the facility Review of Resident #132's Nursing progress note written 2/19/26 at 1:00 P.M., indicated the following:Resident is currently receiving IV [intravenous] antibiotics(vancomycin)for infection. Medication administers as ordered. IV site assessed clean, dry and intact, with no sign of infection noted vital sign checked and stable. Will continue to monitor resident condition closely and observe for any adverse reaction and patient's condition. [sic] During an interview on 2/20/26 at 7:10 A.M., Nurse #3 said that he had worked overnight. He said that he assisted the 3:00 P.M. - 11:00 P.M. nurse change the PICC line dressing overnight. He said that he was not sure if the edges were peeling on the dressing, but he said that on admission when Resident #132 was admitted the insertion site was not able to be assessed because there was a small foam dressing under the clear dressing. He said that generally when a Resident was admitted with a PICC line they do not change the dressing but change it every week or as needed. He said if a PICC line dressing was peeling or lifting, or the insertion site was not visible then the dressing should be (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225297	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lighthouse Rehabilitation and Healthcare Center	204 Proctor Avenue Revere, MA 02151

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changed. During an interview on 2/20/26 at 7:16 A.M., Unit Manager #2 said that PICC line dressing changes were done weekly, but not necessarily on admission unless there were orders to change it, or it was not intact. She said that if the PICC line dressing was assessed to be lifting, then it should be reinforced or changed if needed. She said it was not necessarily concerning to not see the insertion site. She said if there was an order to change the PICC line dressing on admission that it should have been changed, and if for some reason it was not changed then it should have been documented in the progress notes. During an interview on 2/20/26 at 9:19 A.M., the Director of Nurses said that nurses must assess a PICC line and the dressing on admission, and every shift or when administering intravenous medications. She said the insertion site needs to be visible in order to assess it. If it was not visible, the dressing needed to be changed. She also said that if the dressing was lifting it should be changed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225297	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lighthouse Rehabilitation and Healthcare Center	204 Proctor Avenue Revere, MA 02151

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed provide for one Resident (#79) the necessary respiratory care and services that is in accordance with professional standards of practice and the Resident's care plan out of a total sample of 30 residents. Specifically, the facility failed to ensure Resident #79's oxygen was administered according to physician orders.Findings include: Review of the facility policy titled Oxygen Administration, dated 2001, indicated that staff are to adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered. Resident #79 was admitted to the facility in December 2022 with diagnoses including chronic obstructive pulmonary disease, heart disease and high blood pressure. Review of the Minimum Data Set assessment dated [DATE] indicated that Resident #79 is cognitively intact, scoring a 15 out of 15 on the Brief Interview for Mental Status exam. Further review indicated that Resident #79 requires supervision/touching assistance with most activities of daily living. Review of the physician's orders indicated an order, dated 9/11/25, for Oxygen at 2L/min via Nasal Cannula PRN (as needed). Review of the care plan failed to indicate that Resident #79 adjusts the oxygen flow rate. Review of the progress notes failed to indicate that Resident #40 self-adjusts the flow rate of the oxygen. On 2/18/26 at 8:01 A.M., the surveyor observed Resident #79 in bed receiving oxygen (O2) via nasal cannula. The surveyor observed the O2 concentrator to be set at 3.5 liters/minute (L/min).On 2/18/26 at 11:08 A.M. the surveyor observed Resident #79 in bed receiving oxygen (O2) via nasal cannula. The surveyor observed the O2 concentrator to be set at 3.5 L/min. During an interview on 02/18/26 at 11:08 A.M., Resident #79 said that he/she does not set the flow rate of oxygen, the nurse does. On 2/18/26 at 1:51 P.M. the surveyor observed Resident #79 in bed receiving oxygen (O2) via nasal cannula. The surveyor observed the O2 concentrator to be set at 3.5 L/min. On 2/19/26 at 8:30 A.M., the surveyor and Nurse #2 observed Resident #79 in bed receiving oxygen (O2) via nasal cannula. The surveyor and Nurse #2 observed the O2 concentrator to be set at 3.5 L/min. During an interview on 2/19/26 at 8:30 A.M., Resident #79 said that he/she does not mess with the dial. During an interview on 2/19/26 at 8:30 A.M., Nurse #2 said that the oxygen is supposed to be set at 2L/min.