STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225367	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookhaven at Lexington	1010 Waltham Street Lexington, MA 02421

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 15016 Based on observation, record review, and interview, the facility failed for one Resident (#5) to follow the physician's order to obtain an apical pulse prior to administering the heart medication Digoxin, out of a total sample of ten residents. Findings include: Resident #5 was admitted to the facility in March 2018 and has active diagnoses which include heart failure, atrial fibrillation, seizures, and stroke. Review of Resident #5's most recent Minimum Data Set assessment, dated 9/3/24, indicated a Brief Interview for Mental Status exam score of 5 out of a possible 15, indicating severe cognitive impairment. Review of Resident #5's current physician orders indicated the following order: - Digoxin, 125 mcg (0.125 mg) tablet. Give 1 tablet by oral route once daily. Hold if AP [apical pulse] less than 60. Monitoring: pulse (apical). Digoxin is a medication used to treat heart failure and atrial fibrillation. On 10/22/24 at 10:05 A.M., during a medication pass with Nurse #1, the surveyor observed Nurse #1 place a pulse oximeter over one of Resident #5's fingers. The pulse oximeter read 93 heart beats per minute. Nurse #1 then administered the tablet of Digoxin to Resident #5. A pulse oximeter is a device placed over a finger used to measure the body's heart rate and oxygen levels. During an interview on 10/22/24 at 10:11 A.M., Nurse #1 said she normally obtains Resident #5's pulse through the pulse oximeter, prior to administering Resident #5's Digoxin. Nurse #5 said she would only obtain an apical pulse from a resident if the physician order required it to be done. (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
	225367	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookhaven at Lexington	1010 Waltham Street Lexington, MA 02421

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nurses (DON) on 10/22/24 at 11:00 A.M., she said that obtaining an apical pulse prior to administering Digoxin is only required if the physician orders it to be done. The DON said that if the physician does not include a requirement to obtain an apical pulse, then the use of a pulse oximeter or heart rate obtained from the wrist is acceptable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225367	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookhaven at Lexington	1010 Waltham Street Lexington, MA 02421

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15016 Based on observation, record review and interview, the facility failed for one Resident (#5), to follow the professional standard for monitoring heart rate by apical pulse prior to administering the heart medication Digoxin, out of a total sample of ten residents. Findings include: Review of the [NAME] Drug Guide, 19th edition, 2024, indicated: - Monitor apical pulse for one full minute before administering oral Digoxin. Hold dose and notify health care professional if pulse rate is less than 60 beats per minute in an adult. The apical pulse is a pulse point located on the chest at the bottom tip (apex) of the heart. A stethoscope is used to hear the arterial pulse rate as the heart contracts and pumps out blood. Resident #5 was admitted to the facility in March 2018 and has active diagnoses which include heart failure, atrial fibrillation, seizures, and stroke. Review of Resident #5's most recent Minimum Data Set assessment, dated 9/3/24, indicated a Brief Interview for Mental Status exam score of 5 out of a 15, indicating severe cognitive impairment. Review of Resident #5's current physician orders indicated: - Digoxin, 125 mcg (0.125 mg) tablet. Give 1 tablet by oral route once daily. Hold if AP [apical pulse] less than 60. Monitoring: pulse (apical). Digoxin is a medication used to treat heart failure and atrial fibrillation. On 10/22/24 at 10:05 A.M., during a medication pass with Nurse #1, the surveyor observed Nurse #1 place a pulse oximeter over one of Resident #5's fingers. The pulse oximeter read 93 heart beats per minute. Nurse #1 then administered the tablet of Digoxin to Resident #5. A pulse oximeter is a device placed over a finger used to measure the body's heart rate and oxygen levels. During an interview on 10/22/24 at 10:11 A.M., Nurse #1 said she normally obtains Resident #5's pulse through the pulse oximeter, prior to administering Resident #5's Digoxin. Nurse #5 said she would only obtain an apical pulse from a resident if the physician order required it to be done. Nurse #5 did not think it was a nursing standard of practice to obtain an apical pulse prior to administering Digoxin. During an interview with the Director of Nurses (DON) on 10/22/24 at 11:00 A.M., she said that obtaining an apical pulse prior to administering Digoxin is only required if the physician orders it to be done. The DON said that if the physician does not include a requirement to obtain an apical pulse, then the use of a pulse oximeter or heart rate obtained from the wrist is acceptable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225367	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookhaven at Lexington	1010 Waltham Street Lexington, MA 02421

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 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. 15016 Based on observation and interview, the facility failed to secure medications left on top of the medication cart during the medication pass. Findings include: On 10/22/24 at 9:51 A.M., during a medication pass with Nurse #1, the surveyor observed a small pink pill in a medication cup, located on top of the medication cart. Between 9:51 A.M. and 10:11 A.M., Nurse #1 left this medication unattended at various times, including while she was in a resident's bedroom administering medications. On 10/22/24 at 10:01 A.M., during a medication pass with Nurse #1, the surveyor observed Nurse #1 pour medications for a resident and place one tablet of Carbamazepine (an anticonvulsant) into a medication cup, located on top of the medication cart. Nurse #1 gathered the other medications and entered a resident's bedroom, leaving the Carbamazepine unsecured on top of the cart. At approximately 10:09 A.M., eight minutes after entering the resident's bedroom, Nurse #1 re-entered the hallway, closed the bedroom door, and stood by the medication cart. During an interview with Nurse #1 on 10/22/24 at 10:11 A.M., she said the small pink pill was Lisinopril (a blood pressure medication) and that she had intended to administer it earlier in the morning to a resident but forgot to do this. Nurse #1 said the large pink pill was chewable Carbamazepine, and that she had forgotten to administer it to the resident. Nurse #1 said that medications are not allowed to be left unsecured on top of the medication cart when she is not present to supervise them. During an interview with the Director of Nurses on 10/22/24 at 11:00 A.M., she said it was her expectation that nursing staff be present to supervise any medications left unlocked on top of the medication cart.