STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225483	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Rehabilitation and Healthcare Center	11 Pontiac Avenue Webster, MA 01570

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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
	225483	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Rehabilitation and Healthcare Center	11 Pontiac Avenue Webster, MA 01570

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and observations, the facility failed to maintain a clean and homelike environment for one Resident (#56) and 12 out of 15 rooms observed on two Units ([NAME] and [NAME]) out of two resident units. Specifically, the facility failed to ensure that room of the day deep-cleaning were completed relative to the room of the day cleaning schedule for:-Resident #56's bedroom.-rooms [ROOM NUMBER] on the [NAME] Unit.-Rooms 201, 202, 204, 206, 207, 208, 209, 221, and 224 on the [NAME] Unit. Findings include: Review of the facility policy titled Room of The Day, revised February 2021, included but was not limited to: -Residents are provided with safe, clean, comfortable and homelike environment. -The staff and management develop room of the day schedule for terminal cleaning of rooms to assure rooms are clean, sanitary, comfortable . -Strip bed and remove linen. -Clean all furniture. -Sweep/mop floors. -Remove curtains, clean above windowsills, light fixtures, fans, etcetera. Resident #56 was admitted to the facility in May 2024 with diagnoses including Alzheimer's Disease. Review of Resident #56's Minimum Data Set (MDS) assessment dated [DATE], included but was not limited to the following:-severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of a total possible 15 points. On 7/25/25 at 1:39 P.M., Resident #56's Resident Representative (RR #1) requested to meet with surveyor #1 in the Resident's room. During an interview at the time, RR #1 said that he/she was concerned that the staff did not dust or clean the resident rooms. RR #1 was observed to swipe his/her hand across the top of Resident #56's television, with resulting thick dark gray dust accumulated on his/her fingertips. RR #1 further said that he/she had spoken with the facility administration about Resident #56's room cleaning concerns. During an interview on 7/29/25 at 9:01 A.M., surveyor #2 and the Director of Housekeeping discussed that each day the housekeeping staff should complete the room of the day cleaning according to the established facility schedule. The Director of Housekeeping said that the room of the day cleaning was a special deep cleaning procedure which included removal of privacy curtains for washing, resident furniture to be pulled to the center of the room, all surfaces get cleaned and disinfected, floors get swept and washed, and all high dusting zones should be dusted including the over the bed light fixtures. At this time, surveyor #2 and the Director of Housekeeping observed the Room of The Day cleaning schedule for July 2025 which indicated the following rooms and dates the rooms were cleaned: -room [ROOM NUMBER] and room [ROOM NUMBER]: on 7/14/25 -room [ROOM NUMBER] and room [ROOM NUMBER]: on 7/28/25 -room [ROOM NUMBER] and room [ROOM NUMBER]: on 7/16/25 -room [ROOM NUMBER]: on 7/15/25 -room [ROOM NUMBER]: on 7/24/25 -room [ROOM NUMBER]: on 7/21/25 -room [ROOM NUMBER]: on 7/23/25 -room [ROOM NUMBER]: on 7/11/25 -room [ROOM NUMBER]: on 7/27/25 -room [ROOM NUMBER]: on 7/18/25 -room [ROOM NUMBER]: on 7/22/25 -room [ROOM NUMBER]: on 7/25/25On 7/29/25 at 11:47 A.M., surveyor #2, the Director of Housekeeping, the Director of Nursing (DON), and the Infection Preventionist (IP) observed the following 15 rooms for cleanliness: Rooms 201, 202, 203, 204, 206, 207, 208, 209, 212, 215, 216, 220, 221, 223 and 224. The following 12 rooms: Rooms 201, 202, 204, 206, 207, 208, 209, 212, 215, 216, 221, and 224 were observed to have thick fibrous coating of dust on the overbed light fixtures. The Director of Housekeeping, DON and IP said that the light fixtures were dusty. The Director of Housekeeping said that the 12 rooms had not been terminally cleaned according to The Room of The Day schedule for July 2025 for various reasons. The Director of Housekeeping said that he was unable to provide evidence of when these 12 rooms had last been terminally cleaned. The DON and IP said that there was no process in place for monitoring the cleanliness of the facility's environment but that there probably should be. During an interview on 7/29/25 at 2:00 P.M., the Administrator said he was unaware that Rooms 201, 202, 204, 206, 207, 208, 209, 212, 215, 216, 221, and 224 had not been terminally cleaned according to the facility's established schedule. The Administrator said that he should have been informed by the Director of Housekeeping when rooms had been skipped during morning report or via text message the following day. The Administrator said that skipped rooms should be terminally cleaned the following day when skipped. The Administrator said that he was unaware of ongoing concerns related to resident room cleanliness. During an interview on 7/30/25 at 8:39 A.M., the DON said that there was a family member a long time ago that had expressed concerns related to high dusting zone areas, and she had reported it to the Administrator. The DON said she was unable to recall which family member had the dusting zone concerns or exactly when the concerns had been brought forward

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225483	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Rehabilitation and Healthcare Center	11 Pontiac Avenue Webster, MA 01570

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record reviews, and interviews, the facility failed to ensure that two Residents (#11 and #56) of five applicable residents, out of a total sample of 19 residents were free from unnecessary psychotropic medications. Specifically:For Resident #11, the facility failed to ensure a Physican order for PRN antipsychotic medications was limited to 14 days.For Resident #56, the facility failed to ensure a Gradual Dose Reduction (GDR) was attempted related to antidepressant medication use or provide supporting evidence that a GDR attempt was contraindicated. Findings include: 1. Review of the facility policy titled Antipsychotic Medication Use, revised July 2022, indicated the following: -PRN (as needed) orders for antipsychotic medications will not be renewed beyond 14 days unless the heath care practitioner has evaluated the resident for appropriateness of that medication and documented the rationale for continued use. -The duration of the PRN order will be indicated in the order. Resident #11 was admitted to the facility in March 2025, with diagnoses including Vascular Dementia with Mood Disturbances. Review of Resident #11's July 2025 Physician's orders included the following: -Haloperidol Lactate (Haldol - antipsychotic medication) 2 milligram/milliliter (ml), give 0.5 ml by mouth every 6 hours as needed (PRN) for agitation, effective 5/14/25. -Further review of the Physician's orders failed to indicate a limit or duration of use for the PRN Haldol medication. Review of Resident #11's Medication Administration Records (MAR's) for May 2025 through July 2025 indicated Resident #11 was administered the PRN dose of Haldol on the following days: -5/21/25 -7/18/25 Review of Resident #11's Medical Record failed to indicate limited use of PRN Haldol medication to 14 days as required. During an interview on 7/28/25 at 3:52 P.M., the Director of Nursing (DON) said that Resident #11 did not have the required 14-day limit included in the antipsychotic PRN order for his/her Haloperidol Lactate (Haldol). The DON said that the PRN antipsychotic medication prescribed to Resident #11 should have had a 14-day duration, unless otherwise specified by a Provider. The DON said Resident #11 did not have supporting documentation by a Provider for the extended use of the Haloperidol Lactate (Haldol). 2. Review of the facility policy titled Psychotropic Medication Use, dated July 2022, included but was not limited to the following: -Residents on Psychotropic medications receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue these medications. Resident #56 was admitted to the facility in May 2024 with diagnoses including Depression. Review of Resident #56's July 2025 Physician's orders included the following: -Mirtazapine (antidepressant medication) 30 milligrams (mg) by mouth two times a day, initiated 5/30/24. -Wellbutrin (antidepressant medication) 150 mg by mouth once a day in the morning, initiated 5/31/24. Review of Resident #56's Minimum Data Set (MDS) Assessment, dated 6/10/25, indicated: -The Resident was taking an Antidepressant medication. -No GDR had been attempted. -No contraindications for GDR had been documented by a Physician. Further review of Resident #56's medical record failed to indicate any evidence that a GDR of the Psychotropic medication had been attempted or that a GDR was contraindicated when the Resident had received psychotropic medications at the same dosage for over one year. During an interview on 7/29/25 at 10:30 A.M., the Director of Nursing (DON) said that Resident #56 was receiving psychotropic medications, and no GDR had been attempted. The DON said that she was unable to provide evidence that GDR of the psychotropic medications were attempted or contraindicated. The DON said a GDR should be attempted at least quarterly for Residents receiving psychotropic medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225483	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Rehabilitation and Healthcare Center	11 Pontiac Avenue Webster, MA 01570

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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, and interviews, the facility failed to complete Comprehensive Minimum Data Set (MDS) Assessments that accurately reflected the status of three Residents (#11, #45, and #54) out of a total sample of 19 residents, for care planning and care delivery. Specifically, 1. For Resident #11, the facility failed to accurately code diuretic medications when the Resident was prescribed and received diuretic medication. 2. For Resident #45, the facility failed to accurately code the MDS Assessment relative to the use of anticoagulant medication when anticoagulant medication had not been ordered and administered to the Resident.3. For Resident #11, the facility failed to accurately complete the MDS assessment relative to the use of tobacco products, when the Resident was an identified smoker.4. For Resident #54, the facility staff failed to accurately code for Therapeutic Diet when Resident #54 was prescribed and received Therapeutic Diet on two consecutive MDS assessments. Findings include: 1. Review of the CMS Resident Assessment Instrument (RAI) Manual 3.0, located at CMS.gov included but was not limited to: -The RAI process has multiple regulatory requirements which require the assessment accurately reflects the resident's status. Resident #11 was admitted to the facility in March 2025, with diagnoses including Vascular Dementia with Mood Disturbance and Congestive Heart Failure (CHF). Review of Resident #11's July 2025 Physician's orders indicated the following: -Torsemide (diuretic medication) oral tablet 100 mg tablet by mouth in the morning for diuretic [sic], effective 3/17/25. Review of Resident #11’s Medication Administration Records (MAR’s) for May 2025 and June 2025 indicated the Resident was administered the following: -Torsemide daily, as ordered from 5/14/25 though 6/30/25 Review of Resident #11's most recent MDS with an assessment reference date of 6/27/25, failed to indicate that the Resident was administered a diuretic medication. During an interview on 7/28/25 at 11:40 A.M., MDS Nurse #1 said that the facility did not have a policy for coding MDS’s but should follow the RAI Manual guidelines. MDS Nurse #1 said the most recent MDS dated [DATE], failed to indicate that Resident #11 was taking diuretic medications. MDS Nurse #1 said that Resident #11 had taken diuretic medications during the MDS look back period which should have been coded but were not. MDS Nurse #1 said that MDS coding should be done accurately to reflect the resident's current status. 2. Review of the Centers for Medicare and Medicaid Services (CMS) Long- Term Care Facility Resident Assessment Instrument (RAI) 3.0 User’s Manual, Version 1.19.1 dated October 2024, retrieved at Minimum Data Set 3.0 Resident Assessment Instrument User’s Manual v1.19.1 indicated the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225483	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Rehabilitation and Healthcare Center	11 Pontiac Avenue Webster, MA 01570

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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	-Check if the resident received any anticoagulant (medication used to slow the formation of blood clots) medication during a seven day look back period and indicate yes/no. -Check to see if the resident received any antiplatelet (medication used to prevent blood clots by preventing platelets from sticking together) medication during a seven-day look back period and indicate yes/no. -Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel as Anticoagulant. Resident # 45 was admitted to the facility in October of 2022 with diagnoses including Chronic Diastolic (Congestive) Heart Failure, Morbid (Severe) Obesity due to excess calories, Type 2 Diabetes Mellitus without complications, and Hypertension (HTN). Review of the MDS assessment dated [DATE] indicated that Resident #45 was taking anticoagulant medication and antiplatelet medication. Review of Resident #45's Physician orders for April 2025 and May 2025 included: -Aspirin (antiplatelet medication) Oral Tablet Chewable, give 81 milligrams (mg) by mouth one time per day for blood thin[sic] related to Type 2 Diabetes Mellitus, effective 1/19/25. -Plavix (Clopidogrel Bisulfate: antiplatelet medication) Oral tablet 75 mg, give 75 mg by mouth one time a day related to Morbid (Severe) Obesity due to excess calories, effective 1/19/25. Further review of Resident #45’s April 2025 and May 2025 Physician orders failed to indicate that any anticoagulant medication was ordered to be administered to the Resident during the look back period. Review of Resident #45’s Anticoagulant Care Plan, initiated 1/20/25 and revised 5/20/25, indicated: -The Resident was on anticoagulant therapy related to Morbid Obesity. -The anticoagulant used was Plavix. During an interview on 7/29/25 at 2:00 P.M., the MDS Nurse said that Resident #45’s MDS assessment dated [DATE], was coded inaccurately for anticoagulant use. The MDS Nurse said Aspirin was an antiplatelet and that she assumed Plavix was an anticoagulant medication, so she coded anticoagulant and antiplatelet use on the MDS. 3. Review of the Centers for Medicare and Medicaid Services (CMS) Long -Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, Version 1.19.1 dated October 2024, indicated the following: -The negative effects of smoking can shorten life expectancy and create health problems that interfere with daily activities and adversely affect quality of life. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225483	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Rehabilitation and Healthcare Center	11 Pontiac Avenue Webster, MA 01570

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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	-This item opens the door to negotiation of a plan of care with the resident that includes support for smoking cessation. -If cessation is declined, a care plan that allows safe and environmental accommodation of resident preferences is needed. -If the resident states that they used tobacco during the 7-day look-back period, code 1, yes. Resident #11 was admitted to the facility in March 2025, with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Chronic Respiratory failure with hypoxia, Vascular Dementia, and dependence of supplemental oxygen. Review of the Smoking Safety Evaluation, dated 3/7/25, indicated Resident #11: -wished to smoke. -was able to follow and understand the smoking policy. -may smoke safely with supervision. Review of the Comprehensive Smoking Care Plan, created 3/13/25, indicated Resident #11: -smoked 6 cigarettes per day. -would follow the smoking policy. -needed assistance to get to the smoking area. -required minimal supervision. Review of the Comprehensive Minimum Data Set (MDS) dated [DATE], indicated Resident #11: -was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 15 out of 15. -did not currently use tobacco. During an interview on 7/29/25 at 8:24 A.M., Resident #11 was observed seated in a wheelchair and said he/she was waiting for staff to bring him/her out for a cigarette. Resident #11 said he/she has smoked cigarettes for as long as could be remembered, and staff assisted him/her to the smoking area throughout the day. During an interview on 7/29/25 at 2:28 P.M., the MDS Nurse said that Resident #11’s Comprehensive MDS was coded incorrectly and should have reflected that the Resident smoked tobacco, which it did not. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225483	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Rehabilitation and Healthcare Center	11 Pontiac Avenue Webster, MA 01570

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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	4. Resident #54 was admitted to the facility in September 2023 with diagnoses including End Stage Renal Failure, Cognitive Communication Deficit, Hypoxemia, Major Depressive Disorder, Anxiety and dependence on dialysis. Review of the MDS assessment dated [DATE], indicated Resident #54: -was cognitively intact as evidenced by a BIMS score of 15 out of a total of 15. -was receiving dialysis. -was not receiving a therapeutic diet. Review of Resident #54's July 2025 Physician's orders indicated the following: -Carbohydrate Control-CCHO diet Regular texture, thin consistency, double protein for fluid restriction daily. Effective 12/2/24. Review of Resident #54's MDS with an assessment reference date (ARD) of 2/13/25, failed to indicate that the Resident was provided with a Therapeutic Diet. Review of Resident #54's most recent MDS with an ARD of 5/6/25, failed to indicate that the Resident was provided with a Therapeutic Diet. During an interview on 7/28/25 at 11:40 A.M., MDS Nurse #1 said the MDS Assessments dated 2/13/25 and 5/6/25, failed to indicate that Resident #54 was provided with a Therapeutic Diet. MDS Nurse #1 said that Resident #54 had been provided with a Therapeutic Diet during the MDS look back period which should have been coded but were not. MDS Nurse #1 said that MDS coding should be done accurately to reflect the Resident's status.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225483	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Rehabilitation and Healthcare Center	11 Pontiac Avenue Webster, MA 01570

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide appropriate treatment and services relative to an indwelling urinary catheter (a thin, flexible tube inserted into the bladder to drain urine outside the body) for one Resident (#56) out of a total sample of 19 residents.Specifically, for Resident #56, the facility staff failed to follow the Physician order's relative to the Foley (type of indwelling urinary catheter) catheter size, increasing the Resident's risk for indwelling urinary catheter complications. Findings include: Review of the facility policy titled Catheterization Foley, dated April 2018, indicated:-Indwelling urinary catheters are used only when there is valid medical justification.-the Foley catheter will be changed only when needed, unless otherwise specified by the Physician, Nurse Practitioner (NP) or Physician Assistant (PA).-Foley catheters should be changed when:>urinary tract infection is suspected>clogged or unable to irrigate>displaced (balloon [retention balloon - a tiny balloon at the end of the indwelling urinary catheter that is inflated with water to prevent the indwelling urinary catheter from sliding out of the body] suspected to be in urethra)>resident discomfort>MD (Medical Doctor/Physician) order Resident #56 was admitted to the facility in May 2024 with diagnoses including urinary retention and obstructive and reflux uropathy. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #56:-was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 5 out of 15. -had an indwelling urinary catheter-was dependent on staff for activities of daily living (ADL's - basic skills such as bathing, dressing, eating, etc.). Review of Resident #56's July 2025 Physician orders indicated:-Foley catheter 16 French [Fr - size measurement]/10 milliliter (ml) balloon, change PRN (as needed) for signs and symptoms of infection, one time a day, starting on the 10th every month, related to retention of urine, initiated 4/10/25. On 7/25/25 at 10:31 A.M., the surveyor and Nurse #5 observed Resident #56's Foley catheter and Nurse #5 said the size of the Foley catheter was 14 Fr, and the balloon size was faded and unreadable. During an interview on 7/25/25 at 10:35 A.M., the surveyor and Nurse #5 reviewed Resident #56's Foley catheter orders and Nurse #5 said the Resident's Foley catheter order was for size 16 Fr and 10 ml balloon. The surveyor and Nurse #5 then reviewed the Resident's Treatment Administration Record (TAR). Nurse #5 said the TAR indicated that Resident #56's Foley catheter had been changed on 7/10/25 and signed off by a Nurse as size 16 French and 10 ml balloon but the Foley catheter was not changed.During an interview on 7/25/25 at 10:39 A.M., the Director of Nursing (DON) said Resident #56's Foley catheter did not reflect the current Physician's orders and that the Resident's Foley catheter had not been changed as ordered. Please Refer to F842

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225483	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Rehabilitation and Healthcare Center	11 Pontiac Avenue Webster, MA 01570

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225483	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Rehabilitation and Healthcare Center	11 Pontiac Avenue Webster, MA 01570

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, and interviews, the facility failed to provide adequate nutritional care and services for one Resident (#39), out of a total sample of 19 residents. Specifically, the facility failed to appropriately address a significant weight loss when Resident #39 was identified as having a greater than 5 percent (%) weight loss in one month and no re-weight was completed as required. Findings include: Review of the facility policy titled .Nursing Policy and Procedure Manual: Nutritional Services, last revised May 2024, indicated the following:-The facility will perform the following best practice guidelines to manage risk of unplanned weight change and ensure the nutritional needs are met for all residents.-Residents are weighed a minimum of monthly, by the 7th day of each month with more frequent weights obtained as ordered or deemed necessary.-Residents are weighed in a consistent manner, using the same scale, consistent time of day, and consistent clothing/devices at time of weight.-Weights are verified and documented in the medical record as they are obtained.-Check the previous monthly weight for any significant weight change. If there is a significant weight change of +/- 5% (percent) in 30 days, +/- 7.5% in 90 days or +/- 10% in 180 days, the Dietician will review nutritional needs and add or discontinue interventions as needed.-Nursing will re-weigh any resident with a +/- 5 pounds in a month within 24 hours. Resident #39 was admitted to the facility in June 2024 with diagnoses including Unspecified Nutritional Deficiency, Unspecified Severe Protein-Calorie Malnutrition, and schizoaffective disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #39 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a total possible score of 15. Review of the active Physician Orders, dated 7/29/25, indicated the following:-Regular Diet, Mechanical Soft texture, thin consistency, initiated 6/13/24. Review of Resident #39's medical record indicated the following weights:-5/1/25: 140 pounds (lbs.)-6/2/25: 138 lbs. (down 2 lbs. from 5/1/25)-7/6/25: 122 lbs. (down 16 lbs. from 6/2/25, and down 18 lbs. since 5/1/25) Further review of the weight record indicated Resident #39 experienced a sixteen-pound weight loss in thirty days duration from 6/2/25 to 7/6/25. Review of a Nurse Practitioner (NP) Progress Note dated 7/7/25, indicated:-Abnormal weight loss - Monthly weights reviewed, significant weight loss noted 138 pounds to 122 pounds.-Weight is likely inaccurate and should be attempted again. -PO (by mouth) intake is variable but typically around 50% of meals.-Patient is followed by the Dietician to ensure nutritional needs are being met. Review of Resident #39's Dietician Progress Note dated 7/9/25, indicated:-Weight Warning: weight change of 16 pounds, 11.6% weight loss in the last thirty days.-Recommend reweigh, this is a significant change from last month. Further review of the Resident's medical record failed to indicate that any further weight measurements were obtained for Resident #39 after the recorded weight of 122 lbs. on 7/6/25. During an interview on 7/28/25 at 1:24 P.M., with Certified Nurse Aide (CNA) #2, Nurse #3 and Nurse #2, CNA #2 said that everyone on the unit helps to obtain weights for the residents at the beginning of every month. CNA #2 said that the staff know the residents very well and if a weight measurement for any resident doesn't seem accurate, then staff reweigh the resident. Nurse #3 said that at the beginning of each month the Director of Nursing (DON) provides the nursing unit with a list of residents who require weight measurements. Nurse #3 said that all monthly weights are required to be completed by the sixth day of the month, and the DON will come to the nursing unit and let staff know if a resident requires a re-weight to be obtained. Nurse #3 further said that all weight measurements are documented in the electronic health record. Nurse #2 said that the Assistant Director of Nurses (ADON) or the DON will tell staff if a resident needs to be reweighed and all weights are documented in the electronic health record. During an interview on 7/28/25 at 2:50 P.M., the DON said at the beginning of every month she provides a weight sheet to each nursing unit indicating which residents require weight measurements for the month. The DON said that the weight sheet contained previous weight measurements for all residents so that staff can compare resident weights from month to month and obtain a re-weight for any resident who experienced a significant weight change. The DON said if a resident experienced significant weight change, then the resident should be re-weighed within a day or two and weight measurements documented in the electronic medical record (EMR). The DON said that Resident #39 experienced a significant weight change on 7/6/25 and staff should have re-weighed the Resident to confirm the significant weight change. The DON further said that she could not provide any evidence that Resident #39 had been re-weighed, but the Resident should have been re-weighed.During a telephone interview on 7/29/25 at 10:07 A.M., the Dietician said that that she works in the facility one day per week and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225483	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Rehabilitation and Healthcare Center	11 Pontiac Avenue Webster, MA 01570

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, interview, and record review, the facility failed to provide respiratory care and services in accordance with professional standards of practice for one Resident (#29), out of a total sample of 19 residents. Specifically, for Resident #29, the facility failed to ensure that Physician orders for oxygen use were in place when the Resident was being administered oxygen. Findings include: Review of the facility policy titled Oxygen Administration - Reservoir or Pendant Style Nasal Cannula/Oxymizer, adopted November 2017, indicated:-Policy: To deliver low flow oxygen rates and concentration, per the Physician's order via oxygen conserving devices that serve to reduce oxygen usage and nasal irritation. Resident #29 was admitted to the facility in June 2025 with diagnoses including Chronic Kidney Disease (CKD), Obstructive Sleep Apnea (OSA), Acute and Chronic Respiratory Failure with Hypoxia, and Chronic Obstructive Pulmonary Disease (COPD). Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #29 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a total possible score of 15. On 7/28/25 at 8:00 A.M., the surveyor observed Resident #29 seated on the edge of his/her bed with a nasal cannula in place connected to an oxygen concentrator set at 4 LPM (liters per minute) oxygen flow rate. During an interview at the time, Resident #29 said he/she always wears oxygen set at 4 LPM. Review of Resident #29's current Physician orders failed to indicate any Physician orders in place for the use of oxygen. During an interview on 7/28/25 at 10:42 A.M., Nurse #2 said that Resident #29 was receiving oxygen therapy at 4 LPM via nasal cannula. Nurse #2 said she thought Resident #29 should be administered oxygen therapy set at 4 LPM because the Resident had respiratory disease and was admitted to the facility with the oxygen set at 4 LPM in place. The surveyor and Nurse #2 reviewed Resident #29's Physician orders and Nurse #2 said that there were no Physician orders in place for the Resident's oxygen therapy but there should have been Physician orders in place. During an interview on 7/28/25 at 10:48 A.M., the Director of Nursing (DON) said that all medications and treatments require a Physician's order. The DON said that there were no Physician orders in place for Resident #29 to be administered oxygen therapy but there should have been an order in place.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225483	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Rehabilitation and Healthcare Center	11 Pontiac Avenue Webster, MA 01570

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225483	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Rehabilitation and Healthcare Center	11 Pontiac Avenue Webster, MA 01570

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, interviews, and record reviews, the facility failed to provide care and services consistent with professional standards of practice for one Resident (#54), out of one applicable resident receiving dialysis (process that filters waste and fluids from the blood when the kidneys are unable to work adequately) services, out of a total sample of 19 residents.Specifically, for Resident #54, the facility failed to ensure:-Timely medication administration on the Resident's scheduled dialysis days (Tuesdays, Thursdays, and Saturdays), when scheduled morning medication administration was delayed until after the Resident's return to the facility in the early afternoon on dialysis days.-That Eliquis (medication to prevent and treat blood clots), ordered to be administered twice daily by the Physician, was being administered at appropriate intervals on dialysis days placing the Resident at risk for complications related to bleeding.-Accurately monitor daily fluid intake, as ordered by the Physician, when the Resident was dependent on renal dialysis, placing the Resident at risk for complications related to fluid overload. Findings include: Review of Medscape Eliquis (apixaban) Professional Standards, retrieved from https://reference.medscape.com/drug/eliquis-apixaban-999805#91, indicated:-Take this medication by mouth with or without food as directed by your doctor, usually twice daily (every 12 hours). Review of the facility policy titled Hemodialysis, dated February 2018, indicated:-Purpose is to provide comprehensive care to resident/patients that receive hemodialysis treatments.-If Resident is placed on fluid restriction, monitor intake. Review of the facility policy titled Intake and Output Monitoring, dated February 2018, indicated:-Intake and Output will be monitored, as indicated by the resident's hydration status, risk for dehydration, and/or per physician's order.-Intake and Output is totaled daily by 3:00 P.M. to 11:00 P.M. shift nurse, and 24-hour totals are transcribed to the Medication Administration Record (MAR). Resident #54 was admitted to the facility in September 2023 with diagnoses of End Stage Renal Failure, Cognitive Communication Deficit, Hypoxemia, Major Depressive Disorder, Anxiety and dependent on dialysis. Review of the Minimum Data Set (MDS) Assessment, dated 5/6/25, indicated Resident #54:-was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a total of 15.-was receiving dialysis. Review Resident #54's Comprehensive Person-Centered Care Plan, revised 7/24/25, indicated the Resident was at risk for potential for fluid overload related to End Stage Renal Disease with need for Hemodialysis (HD). Further Review of the Care plan included interventions to monitor, document, and report to MD signs and symptoms of fluid overload, and fluid restriction as ordered with intake monitoring. Review of Resident #54's July 2025 Physician orders included:>Hemodialysis every Tuesday, Thursday, and Saturday, initiated 10/6/23.>Fluid Restriction 32 ounces (oz) per day, initiated 12/2/24:-12 to 16 oz with breakfast, 100 milliliters (ml) with medications-6 - 8 oz with lunch, 100 ml with medications-6 - 8 oz with supper, 100 ml with medications. >Intake and Output for dialysis/fluid management every shift for renal function, document at the end of the shift, initiated 12/2/24. >Apixaban (Eliquis) oral tablet 2.5 milligram (mg) give two tablets two times a day, initiated 11/4/24. Review of Resident #54's July 2025 Medication Administration Record (MAR) indicated:-Apixaban (Eliquis) 2.5 mg, give 2 tablets by mouth two times a day related to Paroxysmal Atrial Fibrillation, started 11/5/24, scheduled for 8:00 A.M. and 7:00 P.M. daily. During an interview on 7/24/25 at 11:20 A.M., Resident #54 said he or she was on dialysis and leaves the facility at 5:30 A.M. on Tuesdays, Thursday and Saturdays for dialysis treatment. Resident #54 said he/she received his/her morning medications including the Eliquis medication between the hours of 10:30 A.M. and 11:00 A.M., upon his/her return from dialysis. Resident #54 also said he/she was not on fluid restriction and that no staff member asks how much fluid he or she drank daily. During an interview on 7/24/25 at 11:45 A.M., Nurse #5 said she was an agency Nurse but worked regularly at the facility. Nurse #5 said Resident #54 had an order for a fluid restriction, but the Nurse had not monitored the Resident's fluid intake as the Resident was independent in his/her room. During an interview on 7/29/25 at 11:09 A.M., Nurse #1 said Resident #54 had an order for fluid restriction, but the Resident was independent in his/her room and that the Resident could monitor his/her own fluids. During an interview on 7/29/25 at 11:14 A.M., CNA #1 said Resident #54 was not on fluid restriction, and staff would document Resident #54's fluid intake on the Meal Percentage Documentation Sheet but would not report the Resident's fluid intake to the Nurses. During an interview on 7/29/25 at 2:55 P.M., the Director of Nursing Services (DNS) said she will get back to the surveyor after she had reviewed Resident #54's fluid intake documentation and medication orders. During an interview on 7/30/25 at 8:12 A.M., the DON said Resident #54 was on fluid restrictions, but the facility staff had not been consistent with monitoring the Resident's fluid

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225483	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Rehabilitation and Healthcare Center	11 Pontiac Avenue Webster, MA 01570

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, and interviews, the facility failed to ensure proper sanitation and food storage practices to prevent the potential spread of foodborne illnesses on two kitchenettes ([NAME] Unit and [NAME] Unit) out of two kitchenettes observed. Specifically, the facility failed to ensure that the [NAME] Unit and [NAME] Unit kitchenette refrigerators: -had food items that were dated to ensure proper rotation by expiration dates.-were kept clean and sanitized on a scheduled basis.-had food/drink items that were not expired or past the perish dates. Findings include: Review of the Facility Policy titled Refrigerators and Freezers, revised December 2014, indicated: -All food shall be appropriately dated to ensure proper rotation by expiration dates. -Expiration dates on unopened food will be observed and use by dates indicated once food is opened. -Supervisors will be responsible for ensuring food items in pantry, refrigerators, and freezers are not expired or past perish dates. -Refrigerators and freezers will be kept clean, free of debris, and mopped with sanitizing solution on a scheduled basis and more often as necessary. On 7/30/25 at 10:27 A.M, the surveyor and the Food Service Director (FSD) observed the following in the [NAME] Unit kitchenette refrigerator: -A container of sour cream with an expiration date of 6/25/25. -A container of whole milk with an expiration date of 7/21/25 -2 containers of Instant Jello with expiration dates of 2/24/25 -Unlabeled and undated resident food items. -Spilled food items and debris on the refrigerator shelves. During an interview at the time, the FSD said that the Dietary Department does not maintain the kitchenette refrigerators on the [NAME] unit and the [NAME] unit and is not responsible for cleaning and maintaining the food in the refrigerators. The FSD said that the Dietary Department does not maintain a cleaning schedule for the kitchenettes because the housekeeping department is responsible for the cleaning of the refrigerators and making sure food items are not expired. On 7/30/25 at 10:30 A.M, the Housekeeping Director said he was employed by the facility two months ago, did not realize his department was responsible for kitchenette refrigerator cleaning and food items, and therefore did not have a cleaning schedule. On 7/30/25 at 10:37 A.M, the surveyor and the Housekeeping Director observed the following in the [NAME] Unit kitchenette refrigerator: -Resident food items including milk, yogurts, and juices, that were unlabeled and undated. -Boiled eggs in a paper cup that were undated, unlabeled, and uncovered. -Cut Lemons, ginger, and cucumbers, in a ziploc bag that were unlabeled and undated. -An open stick of butter, partially wrapped, that was undated and unlabeled. -An expired supermarket packaged Cobb salad with turkey and bacon, expired on 7/21/25, unlabeled. During an interview at the time, the Housekeeping Director said that the food items in the refrigerator appear to be some staff food and some resident foods, but he was unsure. The Housekeeping Director said that he was unaware that his department was responsible for the kitchenette refrigerator maintenance and food items. On 7/30/25 at 10:45 A.M., the Administrator said the Dietary Department should have been maintaining the refrigerator and checking daily for unlabeled or expired items in the [NAME] Unit kitchenette refrigerator, but this had not happened. The Administrator said that the [NAME] kitchenette refrigerator is for staff items only and should not contain resident items. The Administrator said the [NAME] kitchenette refrigerator should be maintained by nursing staff because the staff store food items there, but all food items should be dated and labeled, and no expired food items should ever be stored past the expiration dates. During an interview on 7/30/25 at 11:02 A.M the Administrator said having unlabeled, undated and expired items in the refrigerators puts residents at risk for foodborne illness.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225483	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Rehabilitation and Healthcare Center	11 Pontiac Avenue Webster, MA 01570

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to maintain clinical records in accordance with professional standards of practice relative to accurate documentation for two Residents (#45 and #56) out of a total sample of 19 residents.Specifically, the facility failed to: 1.For Resident #45, document the PRN (as needed) administration of Tramadol (opioid analgesic - controlled medication used to treat pain, having the potential for abuse and addiction), and its effectiveness, on the Resident's Medication Administration Record (MAR) when a PRN dose of Tramadol was administered to the Resident. 2. For Resident #56, the facility failed to complete accurate documentation relative to changing the Resident's Foley (type of indwelling urinary catheter) catheter size, increasing the Resident's risk for indwelling urinary catheter complications. Findings include: 1.Review of the facility's policy titled Medication Pass, dated April 2018, indicated the following: - Med (medical) record is initialed immediately after medication administration. - PRN (as needed) meds must state reason given, and the results on the MAR. Resident #45 was admitted to the facility in October 2022 with diagnoses including Chronic Pain Syndrome. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #45: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 total possible points. -reported pain presence as almost constantly. -reported his/her pain occasionally affected his/her sleep and day to day activities. -received opioid medication during the observation period for the MDS Assessment. During an interview on 7/24/25 at 11:41 A.M., Resident #45 said he/she had chronic pain and was able to request Tramadol on an as needed (PRN) basis to treat his/her pain. Review of Resident #45's July 2025 Physician orders indicated the following: -Tramadol HCl Oral Tablet 50 milligrams (mg) by mouth every 12 hours as needed for pain, initiated 3/17/25. Review of the [NAME] Unit Narcotic Book, page three, indicated PRN Tramadol was administered to Resident #45 in July 2025 as follows: -7/11/25 at 10:00 A.M. and again at 10:00 P.M. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225483	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Rehabilitation and Healthcare Center	11 Pontiac Avenue Webster, MA 01570

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-7/13/25 at 9:30 P.M. -7/16/25 at 10:30 P.M. -7/18/25 at 9:30 A.M. Review of Resident #45's July 2025 MAR indicated PRN Tramadol was administered to the Resident as follows: -7/11/25 at 10:00 A.M. and again at 10:00 P.M. for pain levels of 8/10 and was effective. -7/13/25 at 9:30 A.M. for a pain level of 8/10, and was effective -7/18/25 at 9:29 A.M. for a pain level of 8/10 and was effective. -No evidence PRN Tramadol was administered to the Resident on 7/16/25 at 10:30 P.M., as indicated in the Narcotic Book. Review of Resident #45's clinical record failed to indicate any evidence that one dose of PRN Tramadol medication was administered to the Resident at 10:30 P.M. on 7/16/25. During an interview on 7/29/24 at 10:47 A.M., Nurse #4 said she worked at the facility for the evening (3:00 P.M.-11:00 P.M.) shift on 7/16/25 and was assigned to provide care for Resident #45. Nurse #4 said she included one dose of PRN Tramadol in the Resident's regularly scheduled 10:00 P.M. medications because the Resident was having pain. Nurse #4 said she administered the medications to Resident #45 as ordered, and the Resident accepted the medication, including the PRN Tramadol. Nurse #4 said that she should have documented the PRN Tramadol administration on Resident #45's MAR when she administered the Tramadol to the Resident. Nurse #4 also said she should have documented whether the PRN Tramadol was effective for treating the Resident's pain. During an interview on 7/29/25 at 1:34 P.M., the Director of Nursing (DON) said Nurses were required to document administration of all medications on each Residents' MARs. The DON said Nurse #4 should have documented the dose of PRN Tramadol administered on 7/16/25 at 10:30 P.M. to Resident #45 on the Resident's MAR. The DON also said that Nurse #4 should also have documented whether the Tramadol was effective for treating the Resident's pain. The DON said documenting the administration and effectiveness of PRN pain medication was important to ensure the pain medication was effective for the Resident. 2.Review of the facility policy titled Catheterization Foley, dated April 2018, indicated: -Indwelling urinary catheters are used only when there is valid medical justification. -The Foley catheter will be changed only when needed, unless otherwise specified by the Physician, Nurse Practitioner (NP), or Physician Assistant (PA). -Foley catheters should be changed when: <urinary tract infection is suspected (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225483	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Rehabilitation and Healthcare Center	11 Pontiac Avenue Webster, MA 01570

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<clogged or unable to irrigate <displaced (balloon [retention balloon- a tiny balloon at the end of the indwelling urinary catheter that is inflated with water to prevent the indwelling urinary catheter from sliding out of the body] suspected to be in urethra) <resident discomfort <MD (Medical Doctor/Physician) order 2. Resident #56 was admitted to the facility in May 2024 with diagnoses including urinary retention and obstructive and reflux uropathy. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #56: -was cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of five out of 15. -had an indwelling urinary catheter. -was dependent on staff for activities of daily living (ADL's - basic skills such as bathing, dressing, eating, etc.). Review of Resident #56’s July 2025 Physician orders indicated: -Foley catheter 16 French [Fr]/10ml balloon, change PRN for signs and symptoms of infection, one time a day starting on the 10th every month related to retention of urine, initiated 4/10/25. On 7/25/25 at 10:31 A.M., the surveyor and Nurse #5 observed Resident #56’s foley catheter and Nurse #5 said the size of the Foley catheter was 14 Fr, and the balloon size label had faded and was unreadable. On 7/25/25 at 10:35 A.M., the surveyor and Nurse #5 reviewed Resident #56’s Foley catheter order and Nurse #5 said the Foley catheter ordered for Resident #56 was 16 Fr and 10 ml balloon. The surveyor and Nurse #5 reviewed the Treatment Administration Record (TAR) and Nurse #5 said the TAR indicated that Resident #56’s Foley catheter had been changed on 7/10/25 and signed off by a Nurse as size 16 Fr and 10 ml balloon. During an interview on 7/25/25 at 10:39 A.M., the Director of Nursing (DON) reviewed the TAR for May 2025, June 2025, and July 2025 and said that Nurses had signed off that Resident #56’s Foley catheter had been changed on 5/10/25, 6/10/25, and 7/10/25, to 16 Fr/10 ml balloon, but the Nurses had not provided the Foley catheter care but had signed off as care provided. During an interview on 7/29/25 at 8:59 A.M., Nurse #1 said she had signed off the TAR as having changed Resident #56’s Foley catheter to 16 Fr/10 ml balloon on 6/10/25 and 7/10/25, but she did not change the Foley catheter and the TAR record was inaccurate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225483	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Rehabilitation and Healthcare Center	11 Pontiac Avenue Webster, MA 01570

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, record and policy review, the facility failed to implement an infection control program designed to help prevent the potential transmission of communicable diseases and infections within the facility for one Resident (#6) out of a total sample of 19 residents. Specifically, the facility staff failed to disinfect a multi-use Glucometer (machine used to test a resident's blood for blood sugar levels) after use on a resident, prior to placing the same equipment back into the medication cart. Findings include: Review of the facility policy titled Infection Control, revised October 2018, indicated but was not limited to:-The facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections.-The objectives of our infection control policies and procedures are to:>prevent, detect, investigate, and control infections in the facility.>provide guidelines for the safe cleaning and reprocessing of reusable resident-care equipment. Review of the facility provided Operators Manual titled, Cleaning and Disinfecting your Evencare G2 Meter, undated, indicated but was not limited to:-The following products are validated for disinfecting the Evencare G2 Meter:>Dispatch Hospital Cleaner disinfectant towels with Bleach>Medline Micro-kill>Clorox Healthcare Bleach Germicidal and Disinfectant wipes>Medline Microkill Bleach Germicidal Bleach wipes Resident #6 was admitted to the facility in March 2015 with diagnoses including Chronic Respiratory Failure, Tracheostomy (surgical procedure that involves creating an opening in the neck to place a tube into a person's trachea, or windpipe to assist with breathing), Gastrostomy Tube Placement (G-tube), and Type 2 Diabetes. Review of the Resident #6's July 2025 Medication Administration Record (MAR) indicated:-Fingerstick blood sugar check weekly in the morning every 7 days related to Type 2 Diabetes Mellitus. On 7/29/25 at 8:29 A.M., the surveyor observed the following:-Nurse #1 removed the Glucometer machine from a case in the top drawer of her medication cart.-Nurse #1 performed hand hygiene and donned Personal Protective Equipment (PPE), including gown and gloves prior to entering Resident #6's room. -Nurse # 1 performed the finger stick on Resident #6 using the glucometer and then placed the glucometer on the Resident's bedside table. -Nurse #1 removed her gown and gloves, performed hand hygiene, and disposed of the lancet in the sharps disposal container.Nurse #1 removed Lysol wipes from the medication cart and wiped the glucometer device before placing it back in the case and in the top drawer of the medication cart. During an interview immediately following the observation, Nurse #1 said that she always uses the facility provided Lysol wipes to clean the glucometer and uses the same glucometer on multiple residents. Nurse #1 said that she was not aware of any other cleaning product that should be used on the glucometer device. During an interview on 7/29/25 at 10:16 A.M., with the Director of Nursing (DON) and Infection Preventionist (IP), the IP said Nurses should be using a bleach wipe to clean the glucometer immediately, allowing a 2-minute dry time, before placing it back in the medication cart. The DON said the facility started using a newer glucometer several months ago and should have been following the manufacturers guidelines that indicate a bleach product should be used to clean the glucometer. The DON said that the facility Policy and Procedure titled Glucometer Cleansing and Disinfecting Policy is outdated and was not updated when it should have been, and the facility was following the Evencare G2 Meter Operators Manual that indicated a bleach cleaner should be used to clean the glucometer. During an interview on 7/29/25 at 10:35 A.M., the IP said that Nurse #1 should have used bleach wipes for the glucometer to prevent the transmission of blood borne pathogens from one resident to another but used Lysol wipes which did not contain bleach.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225483	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Rehabilitation and Healthcare Center	11 Pontiac Avenue Webster, MA 01570

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225483	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Rehabilitation and Healthcare Center	11 Pontiac Avenue Webster, MA 01570

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to assess the Pneumococcal Vaccine status, and/or administer Pneumococcal vaccinations as consented to by two Residents (#11 and #9), of five applicable residents, out of a total sample of 19 residents.Specifically, 1. For Resident #11, the facility failed to assess for Pneumococcal consent or declination for the Resident and to provide education relative to Pneumococcal vaccination at the time of admission. 2. For Resident #9, the facility failed to obtain a Physician's order and administer PCV 20 (Pneumococcal Conjugate Vaccine/ Prevnar 20: vaccine used to protect against 20 types of pneumococcal bacteria that commonly cause serious infections) at the time of admission when the Resident consented to PCV20 vaccination. Findings include: Review of the facility's policy titled Pneumococcal Vaccination dated April 2018, indicated but was not limited to the following: -It is the policy of the facility that Pneumococcal Vaccine will be offered to every new resident admitted to this facility, and all new residents not previously immunized will be encouraged to receive the vaccination to help prevent the occurrence of Pneumococcal pneumonia and/or its complications. -Upon admission to this Center each new resident will be provided with a copy of the most recent Vaccine Information Sheet (VIS) . -The completed consent (form) and VIS . will be placed in the resident's record. -A Physican order will be obtained to administer the vaccination. -If the resident/responsible party is uncertain about previous vaccination status the vaccine should be administered. Additional doses are not detrimental. -The Infection Control Nurse .will record the following information on the residents Pneumonia Vaccine Log: resident name/consent form completed/acceptance or declination of vaccination/reason vaccine not administered/date vaccine administered. Review of the Centers for Disease Control (CDC) and Prevention Guidance on Pneumococcal Vaccine Timing for Adults, dated October 2024, included but was not limited to the following: For Adults [AGE] years old or older, vaccine recommendations are as follows: -Unvaccinated adults should receive: a) PCV20 (Prevnar 20) or PCV21 vaccine or b) PCV15 followed by PPSV23 at least one year later -Adults who have received PPSV23 vaccine only (at any age): a) PCV20 or PCV21 vaccine administered at least one year after PPSV23 was received -Adults who have received PCV13 vaccine at any age: a) PCV20 or PCV21 vaccine administered at least one year after PCV13 was received -Adults who have received PCV13 at any age and PPSV23 when younger than age [AGE]: a) PCV20 or PCV21 at least 5 years after PCV13 or PPSV20 vaccine was received 1.Resident #11 was admitted to the facility in March 2025, with diagnoses including Chronic Obstructive Pulmonary Disease (COPD) with Lower Respiratory Infection and Chronic Respiratory Failure. Review of the most recent Minimum Data Set (MDS) Assessment with a reference date of 3/17/25, indicated Resident #11: -was cognitively intact as indicated by a BIMS (Brief Interview of Mental Status) score of 15 out of a possible 15.-Pneumococcal vaccination status was not up to date. -the Pneumococcal vaccine had not been offered to the Resident by the facility. Review of Resident #11's medical record included but was not limited to: -A blank Pneumococcal Immunization Form signed by the Resident and dated 3/2/1959 [sic]. -Evidence of prior Pneumococcal vaccination with PCV13 in September 2017. During an interview on 7/28/25 at 1:30 P.M., the Director of Nursing (DON) said that she was responsible for completion of vaccine consent forms for Resident #11. The DON said that Resident #11 did not have evidence of Pneumococcal consent or declination in his/her medical record but should have. The DON said that the Resident had not yet been offered or educated on the Pneumococcal vaccination as required but should have been. 2. Resident #9 was admitted to the facility in March 2025 with diagnoses including COPD and Chronic Respiratory Failure. Review of the most recent MDS Assessment with a reference date of 6/17/25, indicated Resident #9's: -Pneumococcal vaccination status was not up to date. -Pneumococcal vaccine had not been offered by the facility. Review of Resident #9's medical record included but was not limited to: -A signed Pneumococcal Immunization consent form dated 3/13/25. -Evidence of prior vaccination with PCV13 in November 2016. -No evidence that the Pneumococcal Vaccine had been administered as requested or that a shared clinical decision had occurred relative to Pneumococcal vaccination for Resident #9. During an interview on 7/28/25 at 4:26 P.M., the DON said that she was unable to provide evidence that a shared clinical decision had occurred or that a Pneumococcal Vaccination had been provided as consented to by the Resident at the time of his/her admission. During an interview on 7/29/25 at 10:42 A.M., the DON said that Resident #9 should have had a shared clinical decision making on whether or not the PCV20 or PCV21 should have been given within one week of