STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225509	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Brookline	99 Park Street Brookline, MA 02146

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to maintain a dignified existence for four Residents (#4, #20, #116 and #6) out of a total sample of 25 residents. Specifically,For Residents #4 and #20 the facility failed to maintain a dignified experience during meals by leaving the tray in front of the Resident for an extended period of time before providing assistance and standing over the Resident while assisting with the meal.For Resident #116 the facility failed to ensure that the Resident's chest was not visible from the hallway.For Resident #6 the facility failed to ensure that the Resident's privacy was maintained when their brief was visible from the hallway.Findings include:Review of facility policy titled Dignity, dated as revised February 2021, indicated the following:-Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self- worth and self- esteem.-Residents are treated with dignity and respect at all times.-Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures 1a. Resident #4 was admitted to the facility in October 2025 with diagnoses that included osteomyelitis and dysphagia (difficulty swallowing). Review of Resident #4's most recent Minimum Data Set (MDS), dated [DATE], indicated that the Resident was not able to participate in the Brief Interview for Mental Status exam and was assessed by staff has exhibiting moderately impaired cognitive skills for daily decision making. The MDS further indicated that the Resident is dependent for eating. On 12/16/25 at 8:18 A.M., the surveyor observed the Resident in bed. A staff member assisting the Resident with breakfast. The staff member was standing next to the bed, over the Resident assisting with the meal. On 12/17/25 at 11:53 A.M., the surveyor observed the Resident in bed with his/her eyes closed. The lunch tray had been passed to the Resident prior to the surveyor's arrival, and was on the over bed table, out of reach of the Resident. On 12/17/25 at 12:00 P.M., the surveyor observed a Certified Nurses' Aide (CNA) enter the room and begin to assist the Resident with his/her lunch meal. The CNA stood next to the bed, standing over the Resident to assist with the meal. During a continuous observation on 12/18/25 from 7:55 A.M., to 8:07 A.M., the surveyor observed a staff member bring the breakfast tray into the Resident's room and leave it on the over bed table, out of reach of the Resident. The Resident was observed to be awake in bed. For the duration of this observation, no staff entered the room to assist the Resident with his/her breakfast. 1b. Resident #20 was admitted to the facility in October 2025 with diagnoses that included metabolic encephalopathy and dysphagia (difficulty swallowing) oral phase. Review of the Minimum Data Set (MDS) Assessment, dated 10/20/25, failed to indicate a cognitive status was assessed for Resident #20. The MDS further indicated that the Resident required partial/ moderate assistance for eating meals. Review of Resident #20's current Activities of Daily Living (ADL) care plan, dated 10/21/25, indicated the following:-ADL Self- care deficit related to physical limitations.-Interventions included: Assist of (Specify: 1person/2 person) with ADL's. On 12/16/25 at 8:08 A.M., the surveyor observed Resident #20 sitting up in bed. A staff member was assisting the Resident with eating the breakfast meal while standing next to the bed, over the Resident. The staff member stood with her hand on her hip while (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assisting the Resident. On 12/16/25 at 12:18 P.M., the surveyor observed Resident #20 in bed. The Resident's lunch tray was on the over bed table, covered and not set up. The meal had been brought into the Resident's room before the surveyor arrived on the unit. On 12/16/25 at 12:27 P.M., a staff member entered the Resident's room and began to assist the Resident with his/her meal. The staff member stood on the side of the Resident's bed, over the Resident and stood with her hand on her hip while she assisted the Resident with the meal. During an interview on 12/18/25 at 8:55 A.M., Nurse #3 said that staff should be assisting the residents immediately upon providing a meal tray to them. She said it should not be left in the room to get cold. She further said that staff should be sitting with residents while assisting them with their meals. She said staff should be at eye level and not standing over them. During an interview on 12/18/25 at 10:01 A.M., Certified Nurses' Aide (CNA) #1 said that staff should be sitting and at eye level with residents that they are assisting with meals and no one should be standing over a resident while assisting them. During an interview on 12/18/25 at 10:09 A.M., Director of Nurses #1 and Director of Nurses #2 said that staff should be sitting to assist residents with their meals. They said that staff should assist the resident slowly without rushing them. They further said that staff should not be bringing the meals into the residents until they are ready to sit and assist them as the meals could get cold. They said that they would expect that staff are providing a dignified dining experience. 2. Resident #116 was admitted to the facility in December 2025 with diagnoses that included history of falling and muscle weakness. There is no Minimum Data Set (MDS) information for Resident #116. Review of the medical record failed to indicate any behaviors were present or monitored for Resident #116. Review of Resident #116's active care plan failed to indicate any behaviors that were present or being monitored by staff. On 12/16/25 at 9:07 A.M., the surveyor observed Resident #116 sleeping in bed without clothing, with a sheet only up to his/her waist. The Resident's chest was visible from hallway. On 12/17/25 at 8:41 A.M., the surveyor observed the Resident sitting up in bed awake. The Resident only had a brief on and had removed his/her johnny. The Resident's chest was visible from the hallway. The Resident's breakfast tray was set up in front of him/her. Resident #116 is unable to participate in an interview. During an interview on 12/18/25 at 8:55 A.M., Nurse #3 said that a resident's chest should not be visible to people from the hallway, as that would not be dignified for the resident. During an interview on 12/18/25 at 10:01 A.M., CNA #1 said that residents should not be visible from the hallway if they are exposed in any way. She said a curtain should be pulled to maintain dignity. During an interview on 12/18/25 at 10:09 A.M., Director of Nurses #1 and Director of Nurses #2 said that a resident's chest visible to people in the hallway would not be dignified for a resident and if it is a behavior then it should be addressed by the staff. 3. Resident #6 was admitted to the facility in October 2025 with diagnoses that included adult failure to thrive and major depressive disorder. Review of Resident #6's most recent Minimum Data Set (MDS) Assessment, dated 12/7/25, indicated a Brief Interview for Mental Status score of 14 out of 15, indicating intact cognition. Review of Resident #6's active Activities of Daily Living (ADL) care plan indicated the following:-Assist of 1 staff with daily hygiene, grooming, dressing, oral care and eating, dated 12/2/25. Further Review of the Resident's care plan failed to indicate any behaviors exhibited by the Resident. On 12/16/25 at 8:58 A.M., the surveyor observed from the hallway the resident lying awake in bed. The Resident was wearing a t-shirt and a brief only, which was visible from the hallway. On 12/16/25 at 9:55 A.M., the surveyor observed from the hallway the Resident sitting on the side of the bed wearing only a brief that was visible from the hallway. The Resident had a basin of water on his/her bedside table. On 12/17/25 at 6:56 A.M., the surveyor observed the Resident lying in bed, uncovered, wearing a johnny and a brief. The Resident was uncovered, and his/her brief was visible from the hallway. On 12/17/25 at 9:24 A.M., the surveyor observed the Resident lying in bed, uncovered, wearing a johnny and a brief. The Resident was uncovered, and his/her brief was visible from the hallway On 12/18/25 at 10:46 A.M., Resident #6 was sleeping and unavailable at this time for an interview. During an interview on 12/18/25 at 8:55 A.M., Nurse #3 said that a resident wearing a brief should not be visible from the hallway, and the brief should not be (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	exposed for others to see. She said the resident's privacy and dignity should be maintained. During an interview on 12/18/25 at 10:01 A.M., CNA #1 said that residents should not be visible from the hallway if they are exposed in any way, including when they are utilizing a brief that could be visible to others and privacy should be maintained. During an interview on 12/18/25 at 10:09 A.M., Director of Nurses #1 and Director of Nurses #2 said that a resident utilizing a brief should be covered to maintain privacy with either clothing or a sheet or blanket. They said that Resident #6 does not like to have his/her privacy curtain pulled, but a sheet should be provided for privacy and dignity, and a resident's brief should not be visualized from the hallway.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interviews, and record review, the facility failed to ensure that respiratory care and services, consistent with professional standards of practice, were provided for three Residents (#88, #68 and #14) out of sample of 25 residents. Specifically,For Resident #88 the facility failed to properly label and store respiratory supplies and failed to administered oxygen as per the physician's orders.For Resident #68 and Resident #14 the facility failed to properly label and store respiratory supplies.Findings include:Review of facility policy titled Oxygen Administration, dated as revised October 2010, indicated the following: -Verify that there is a physician's order for this procedure. Review the physician's orders for facility protocol for oxygen administration. 1. Resident #88 was admitted to the facility in October 2025 with diagnoses that included acute respiratory failure and chronic obstructive pulmonary disease.Review of Resident #88's most recent Minimum Data Set (MDS) Assessment, dated 12/11/25, indicated a Brief Interview for Mental Status score of 13 out of a possible 15, indicating intact cognition. The MDS further indicated the use of oxygen therapy.On 12/16/25 at 9:52 A.M., the surveyor observed the Resident sleeping in bed. The Resident was receiving oxygen via nasal cannula at 4.5 liters per minute (lpm). The oxygen tubing was not labeled with a date, and the nebulizer was not stored in a bag and was observed in the drawer of the bedside table with other belongings.On 12/17/25 at 6:50 A.M., the surveyor observed the Resident in bed, receiving oxygen via nasal cannula at 4.5 lpm. The nebulizer was not stored in a bag and was observed in the Resident's bed.On 12/18/25 at 6:52 A.M., the surveyor observed the Resident awake in bed, receiving oxygen via nasal cannula at 4.5 lpm. The concentrator was out of reach of the Resident.On 12/18/25 at 8:47 A.M., the surveyor observed the Resident awake in bed, receiving oxygen via nasal cannula at 4.5 lpm. The concentrator was out of reach of the Resident, and the Resident said he/she had not changed the setting on the concentrator.Review of Physician's orders indicated the following:-Oxygen at: 2 Liters/minute Via: Nasal Cannula, dated 12/6/25.-(Continuous/PRN) Oxygen Therapy Oxygen at: 2 Liters/minute Via: Via: Nasal Cannula, dated 12/6/25.-Change all disposable oxygen supplies every week and as needed. Label and date all supplies, every night shift, every Wednesday, dated 12/6/25.Review of nursing progress notes indicated the following:-A progress note dated 12/14/25, that indicated in part: Pt (patient) on 4L (liters) nasal cannula with SATs 97%.-A progress note dated 12/11/25, that indicated in part: Pt on 2L nasal cannula and O2 SATs 90-91%. Pt was then turned to 4L nasal cannula and is starting 95%. Vitals were WNL (within normal limits). But O2 was low and raised to 4L with positive refiled. [sic]Review of Resident #88's active respiratory care plan, dated 12/5/25, indicated the following:-Administer oxygen per physician's orders.During an interview on 12/18/25 at 8:51 A.M. Nurse #3 said that all respiratory supplies should be changed weekly and labeled with a date. She further said that any supplies not in use at any time should be stored in a plastic bag to prevent exposure to germs or the growth of bacteria. Nurse #3 said that any oxygen being administered should be administered per physician's orders. She said Resident #88 should be on 2 lpm as per physician's orders and receiving oxygen at 4 lpm places the Resident at risk for potential elevation in carbon dioxide levels. During an interview on 12/18/25 at 10:04 A.M., Director of Nurses #1 and Director of Nurses #2 said that when respiratory equipment is not in use it should be stored in a bag. They further said all disposable equipment should be changed and labeled weekly and as needed. They further said that oxygen should be administered as per the physician's orders and should not be turned to a higher flow rate without physician notification and obtaining a new order for administration. She said Resident #88 would not be able to change the concentrator flow rate him/herself.2a. Resident #68 was admitted to the facility in November 2025 with diagnoses that included chronic obstructive pulmonary disease and chronic respiratory failure.Review of Resident #68's most recent Minimum Data Set (MDS) Assessment, dated 12/5/25, indicated a Brief Interview for Mental Status score of 14 out of a possible 15, indicating intact cognition. Review of Resident #68's active physician's orders indicated the following:-Change (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and label nebulizer tubing every week and as needed, every night shift every Monday and as needed, dated 12/1/25.On 12/16/25 at 8:59 A.M., the surveyor observed the Resident's nebulizer machine on the over bed table. The tubing and pipe connected to the machine were not labeled with a date and the pipe was stored on the bedside table, not in a bag.On 12/17/25 at 6:54 A.M., the surveyor observed the nebulizer laying on the overbed table, not stored in a bag.During an interview on 12/17/25 at 6:54 A.M., Resident #68 said that staff changed the tubing and labeled it yesterday because it was not labeled and it was weak and kept popping off the top of the nebulizer machine. He/She said he/she wasn't sure when it was changed last before yesterday.On 12/18/2025 at 6:56 A.M., the surveyor observed the nebulizer laying on the overbed table, not stored in a bag. 2b. Resident #14 was admitted to the facility in November 2025 with diagnoses that included cerebral infarction, chronic respiratory failure and dysphagia.Review of the most recent Minimum Data Set (MDS) Assessment, dated 12/2/25, indicated the Resident could not participate in the Brief Interview for Mental Status (BIMS) exam and was assessed by staff as having severe cognitive impairment. The MDS further indicated the Resident required suctioning and tracheostomy care.On 12/16/25 at 8:04 A.M., the surveyor observed Resident #14 lying in bed sleeping. The Resident had a tracheostomy (a hole that surgeons make through the front of the neck and into the windpipe, also known as the trachea). Respiratory supplies were stored in the open on the Resident's bedside table. There was a nebulizer with tubing that was not labeled with a date and was not stored in a bag but was out on the bedside table. Suction tubing and a Yankaur (a firm plastic suction tip with a large opening surrounded by a bulbous head and is designed to allow effective suction without damaging surrounding tissue. This tool is used to suction pharynx secretions in order to prevent aspiration) were unlabeled and not stored with any type of covering or protection.During an interview on 12/18/25 at 8:51 A.M. Nurse #3 said that all respiratory supplies should be changed weekly and labeled with a date. She further said that any supplies not in use at any time should be stored in a plastic bag to prevent exposure to germs or the growth of bacteria. During an interview on 12/18/25 at 10:04 A.M., Director of Nurses #1 and Director of Nurses #2 said that when respiratory equipment is not in use it should be stored in a bag. They further said all disposable equipment should be changed and labeled weekly and as needed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation and interview, the facility failed to ensure medications and biologicals were secured on two out of three Resident units. Specifically, medication carts were unlocked on the first floor and second floor. Findings include:Review of the facility policy titled Medication Labeling and Storage dated revised February 2023 indicated that compartments (including but not limited to, drawers, cabinets, rooms, refrigerators, carts and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others. 1. On 12/16/25 at 7:00 A.M., the surveyors observed two medication carts on the first-floor unit unlocked, and no nurses present within eyesight of the medication carts. 2. On 12/16/25 at 3:27 P.M., the surveyor observed an unlocked medication cart on the second-floor unit. The surveyor also observed other staff members and residents in the hall in close proximity to the unlocked medication cart. The surveyor then observed Nurse #1 enter the second-floor unit carrying a bag of takeout food and several drinks. During an interview on 12/16/25 at 3:27 P.M., Nurse #1 said that she had left the medication cart unlocked when she went down to the first floor to pick up the takeout food and drinks. Nurse #1 said that she should have locked the medication cart before leaving the floor. During an interview on 12/17/25 at 10:25 A.M., Corporate Nurse #1 said that medication carts are to be locked at all times, and the nurse should have locked the cart prior to leaving the unit.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observations and interviews, the facility failed to provide a homelike environment during dining on one of three Resident units. Specifically, on the second-floor unit, residents were observed eating meals on meal trays in the dining room.Findings include:Review of the facility policy titled Homelike Environment, dated revised February 2021, failed to indicate that meals are served in a homelike manner. On 12/16/25 at 8:45 A.M., the surveyor observed 4 out 4 residents in the second-floor dining room eating breakfast served on trays. On 12/16/25 at 1:10 P.M., the surveyor observed 3 out of 4 residents in the second-floor dining room eating lunch served on trays. On 12/17/25 at 8:55 A.M., the surveyor observed 4 out of 4 residents in the second-floor dining room eating breakfast served on trays. On 12/17/25 at 12:57 P.M., the surveyor observed 4 out of 4 residents in the second-floor dining room eating lunch served on trays. One resident was being assisted by staff On 12/18/25 at 8:47 A.M. the surveyor observed 3 out of 3 residents in the second-floor dining room eating breakfast served on trays. One resident was being assisted by staff.During an interview on 12/18/25 at 9:50 A.M., Director of Nursing #2 said that meals are not supposed to be served off of trays.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to implement a care plan for one Resident (#2) out of a total sample of 25 residents. Specifically, for Resident #2, the facility failed to implement a care plan for a knee immobilizer.Findings include:Review of the facility policy titled Care Plans, Comprehensive Person-Centered dated revised March 2022 indicated that the care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . Resident #2 was admitted to the facility in April 2025 with diagnoses including non-displaced fracture of the right tibial tuberosity, brain cancer and malnutrition. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #2 is severely cognitively impaired and totally dependent on staff for all activities of daily living. Review of the physician's orders dated December 2025 indicted an order dated to start 11/12/25 for Right Knee Immobilizer: Check skin integrity every shift. Review of the current care plan indicated a focus of; At risk for complications due to musculoskeletal problems related to fracture right tibial fracture related to fall. Date Initiated: 11/11/2025 Revision on: 11/13/2025 with an intervention of immobilizer as ordered. On 12/16/25 at 10:00 A.M., and 2:00 P.M., the surveyor observed Resident #2 lying in bed and the knee immobilizer on a stool, leaning on the wall, across the room. On 12/17/25 at 10:20 A.M., 12:30 P.M. and 2:45 P.M., the surveyor observed Resident #2 lying in bed and the knee immobilizer on a stool, leaning on the wall, across the room. Review of the progress notes dated December 2025 failed to indicate Resident #2 refused to wear the brace or that the physician was notified. During an interview on 12/18/25 at 7:25 A.M., Nurse #2 said that nurses are to follow physician orders and the knee immobilizer should have been placed on the Resident as ordered. Nurse #2 then said that if a resident were to refuse a physician's order, the nurse should document the refusal, write a progress note, and call the physician. During an interview on 12/18/25 at 7:27 A.M., Director of Nursing (DON) #1 said that nurses are to follow a physician's orders and the care plan at all times. DON #1 then said that should a resident refuse a physician's order, then the medical record should reflect the refusal and the physician notification.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to address recommendations from the dialysis center. Specifically, the facility failed to notify the physician of dialysis recommendations for one Resident #10 out of a sample of 25 Residents.Findings include: A review of the facility policy titled 'Hemodialysis Pre and Post Care' with a revision date of March 2010 indicated the following:-Residents will receive appropriate care and monitoring pre and post dialysis.-To assist the residents/patient in maintaining homeostasis pre and post hemodialysis.-Document all communications in the hemodialysis communication progress note or Dialysis center communication book.-Ensure ongoing communication with dialysis center staff.Resident #10 was admitted to the facility in July 2017 with diagnoses including end stage renal disease and dependence on renal dialysis.A review of the Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMs) score of 0/15 indicating severe cognitive impairment.A review of the dialysis progress notes filed in the dialysis communication book dated 12/16/25 indicated the following:30 day supply of sevemar carbonate (a medication used to control high blood phosphate levels) provided. Please make sure the resident gets the medication with each meal for phosphate control. Please call dialysis to acknowledge the reception of the medicine. [sic]A review of the medical record failed to indicate that that the physician had been contacted to approve or deny this recommendation.During an interview and record review on 12/18/25 at 8:37 A.M., Unit Manager # 1 and the Surveyor reviewed the medical record. The Unit manager said the dialysis recommendation to include sevemar carbonate in the Resident's current medications had not been addressed. The Unit Manager said the Nurse is supposed to review the dialysis communication book after the Resident returns from dialysis. The Unit Manager said the Nurse is then supposed to contact the physician immediately for approval or denial of any recommendations made in the dialysis communication book.During an interview on 12/18/25 at 9:00 A.M., Director of Nurses #1 and #2 said the dialysis book should be reviewed by Nurses after residents return from dialysis. DON #1 and #2 said the physician should have been contacted to approve or deny sevemar carbonate promptly, within 24 hours.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to maintain complete and accurate medical records for three Residents (#14, #10 and #2) out of a total sample of 25 Residents. Specifically,For Resident #14, the medical record failed to accurately indicate necessary care to be provided to a tracheostomy tube.For Resident #10, the facility failed to accurately document blood pressure taken.For Resident #2 the facility failed to a. document accurately for the application of a knee brace and, b. accurately document a treatment.Findings include: 1. Resident #14 was admitted to the facility in November 2025 with diagnoses that included cerebral infarction, chronic respiratory failure and dysphagia. Review of the most recent Minimum Data Set (MDS) Assessment, dated 12/2/25, indicated the Resident could not participate in the Brief Interview for Mental Status (BIMS) exam and was assessed by staff as having severe cognitive impairment. The MDS further indicated the resident required suctioning and tracheostomy care. Review of physician's orders indicated the following: -Trach care every shift (clean non-disposable inner cannula, around stoma and under flange of trach with sterile water, and change 4x4 gauze drainage sponge), every shift, dated 11/27/25. -If inner cannula is disposable, change every day and as needed, dated 11/27/25 Review of the December 2025 Treatment Administration Record (MAR) indicated the following: -Daily from 12/1 through 12/17 staff signed off changing the disposable cannula daily. -Every shift from 12/1 through 12/17 staff signed off trach care and cleaning of a non-disposable inner cannula. On 12/16/25 at 8:04 A.M., the surveyor observed Resident #14 sleeping in bed. A tracheostomy was in place. During an interview on 12/18/25 at 9:03 A.M., Nurse #4 said she regularly cares for Resident #14. She is not sure if the cannula is disposable or not for Resident #14's trach. She said she doesn't clean a cannula but just cleans around the outside of the trach and re applies a drain sponge around it. She said the orders are not clear. During an interview on 12/18/25 at 10:18 A.M., Director of Nurses #1 and Director of Nurses #2 said that the type of trach that Resident #14 has does not have an inner cannula at all. They said physician's orders should be more specific as to the care required for each resident. 2. A review of the facility policy titled 'Hemodialysis Pre and Post Care' with a revision date on March 2010 indicated the following: -Do not use access arm for venipuncture or blood pressure. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225509	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Brookline	99 Park Street Brookline, MA 02146

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled 'Charting and Documentation' with a revision date of July 2017 indicated the following: -Documentation in the medical record will be objective, (not opinionated or speculative), complete, and accurate. Resident #10 was admitted to the facility in July 2017 with diagnoses including end stage renal disease and dependence on renal dialysis. A review of the Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMs) score of 0/15 indicating severe cognitive impairment. A review of Resident #10's December 2025 physician's orders indicated the following: -No BP (blood pressure) or draw on left arm. [sic] A review of Resident #10's blood pressure documentation indicated the following: -12/13/25 10:22 144/89 mmHg (millimeters of mercury) Lying l/arm. [sic] -12/13/25 10:25 144/89 mmHg (millimeters of mercury) Lying l/arm. [sic] During an interview and medical record review on 12/18/25 at 8:37 A.M., Unit Manger #1 and the Surveyor reviewed the medical record. The Unit Manager said Nurses should not be taking blood pressures on the Resident's left arm as per the physician's orders. The Unit Manager said the Nurses must have documented inaccurately. The Unit Manager said the Nurses should document accurately in the medical record. During an interview on 12/18/25 at 9:00 A.M., the Director of Nurses #1 and #2 said Nurses should not be taking blood pressure on the Resident's left arm. DON #2 said since the AV fistula (Arteriovenous Fistula) is still working well with no infections, she said she is sure the Nurses documented in the medical record inaccurately. DON #2 said Nurses should document accurately in the medical record. 3. Resident #2 was admitted to the facility in April 2025 with diagnoses including non-displaced fracture of the right tibial tuberosity, brain cancer and malnutrition. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #2 is severely cognitively impaired and totally dependent on staff for all activities of daily living. a. Review of the physician's orders dated December 2025 indicted an order dated to start 11/12/25 for Right Knee Immobilizer: Check skin integrity every shift. Review of the current care plan indicated a focus of; At risk for complications due to musculoskeletal problems related to fracture right tibial fracture related to fall. Date Initiated: 11/11/2025 Revision on: 11/13/2025 with an intervention of immobilizer as ordered. On 12/16/25 at 10:00 A.M., and 2:00 P.M., the surveyor observed Resident #2 lying in bed and the knee immobilizer on a stool, leaning on the wall, across the room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225509	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Brookline	99 Park Street Brookline, MA 02146

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/17/25 at 10:20 A.M., 12:30 P.M. and 2:45 P.M., the surveyor observed Resident #2 lying in bed and the knee immobilizer on a stool, leaning on the wall, across the room. Review of the progress notes dated December 2025 failed to indicate Resident #2 refused to wear the brace. Review of the Treatment Administration Record indicated that on 12/16/25 the nurses documented that the knee immobilizer was on, on all three shifts. Review of the Treatment Administration Record dated 12/17/25 indicated that the nurse documented that the knee immobilizer was on. b. On 12/17/25 at 10:55 A.M., the surveyor observed Nurse #5 perform a treatment to Resident #2's right leg. Review of the Medication Administration Record dated 12/17/25 at 8:21 A.M., indicated that nurse #5 had signed off that the treatment had been completed. During an interview on 12/18/25 at 7:25 A.M., Nurse #2 said that if a resident were to refuse a physician's order the nurse should document the refusal, write a progress note and call the physician. Nurse #2 said that a nurse should never document that a physician's order was completed when it was not. During an interview on 12/18/25 at 7:27 A.M., Director of Nursing (DON) #1 said that nurses are to accurately document in the medical record. DON #1 then said that a nurse should never document that a treatment was completed before the completion of the treatment.