STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225690	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brockton Post Acute Care	50 Christy Place Brockton, MA 02301

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (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
	225690	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brockton Post Acute Care	50 Christy Place Brockton, MA 02301

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record reviews and interviews for one of three sampled residents (Resident #1), the Facility failed to ensure nursing provided care and services that met professional standards of practice, when upon admission his/her medications were not reconciled accurately, and medications were administered at doses and intervals that were not consistent with Physicians Orders.Findings include:Review of the Facility Policy titled Reconciliation of Medication on Admission, dated as last revised 07/2017, indicated that the purpose of medication reconciliation is to ensure medication safety by accurately accounting for the resident's medications, routes and dosages upon admission or readmission to the Facility.The Policy indicated that all prescription medications, including those taken only as needed are obtained from all sources prior to reconciliation as well as dose, route, frequency and last doses taken.Resident #1 was admitted with Hospice Services from the community to the Facility in April 2025 for a five (5) day respite stay, diagnoses include Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), and dementia.Review of Resident #1's Physician's Orders, dated 04/30/25, indicated that his/her Health Care Proxy (HCP) had been invoked upon admission.During a telephone interview on 07/29/25 at 2:27 P.M., Resident #1's Family Member said that the Facility had administered a medication that was not on his/her list of scheduled medications and that his/her antipsychotic medication was administered by nursing at the wrong time of day for two (2) days. During a telephone interview on 08/06/25 at 11:52 A.M., the Director of Hospice Admissions said that on 04/28/25, the original clinical information, including the medication list for Resident #1 had been faxed to the Facility.The Director said that as of 04/29/25, certain medications, including his/her Scopolamine (anticholinergic used to treat motion sickness and to decrease saliva) Transdermal Patch, had been discontinued which was prior to being admitted to the Facility for a respite stay.The Director said that the call log between the Facility and Hospice, indicated that a nurse from the Facility called to obtain a current medication list for Resident #1 and it had been faxed to the Facility as requested.Review of Resident #1's Hospice Physician's Orders/Plan of Care, dated 04/14/25-06/12/25, indicated that on 04/28/25, Hospice faxed his/her referral to the Facility to see if they were able to accommodate his/her needs.The Hospice Physician's Orders indicated to administer;-Risperidone (antipsychotic) 0.25 milligrams (mg) one table by mouth every P.M. (evening) and-Scopolamine Transdermal Patch 72 hours one (1) mg per three (3) days, one patch every 72 hours.Review of Resident #1 Hospice Medication list (faxed upon request of the Facility), dated 04/30/25, indicated to administer;-Risperidone 0.25 mg one table by mouth every P.M. (evening). Further review of the Hospice Medication list indicated that there was no documentation to support he/she was to be administered scopolamine via transdermal patch.Review of Resident #1's Facility Physician's Orders, dated 04/30/25, indicated to administer;-Risperidone 0.25 mg one table by mouth every A.M. (morning) and-Scopolamine Transdermal Patch 72 hours 1 mg per 3 days, 1 patch every 72 hours.Review of Resident #1's Medication Administration Record, dated 05/01/25 and 05/02/25, indicated that he/she had been administered daily dose of Risperidone at 9:00 A.M. and a transdermal scopolamine patch had been placed behind his/her left ear on 05/01/25 at 9:00 A.M.During an interview on 07/30/25 at 12:07 P.M., Nurse #1 said that she had been the second nurse to review and cosign Resident #1's medication for reconciliation. Nurse #1 said she did see that there were 2 separate medications list but said she did not know which list the Unit Manager used to reconcile Resident #1's medication.Nurse #1 said that there was an error with the timing of Resident #1's Risperidone and the medication should have been administered at 9:00 P.M. instead of 9:00 A.M. per the medication list.During an interview on 07/30/25 at 12:25 P.M., the Unit Manager said that she remembered that someone from the Facility called Hospice for an updated medication list because Resident #1 was coming from home and under Hospice care.The Unit Manager said that she missed transcribing the correct time for Resident #1's Risperidone, that it had been scheduled to be administered at 9:00 A.M. dose instead of 9:00 P.M. The Unit Manager said that she does not know why there were 2 medication lists in Resident #1's record and said she used the original list dated 04/28/25 to reconcile his/her medications with the Physician.During an interview on 07/30/25 at 2:22 P.M., the Director of Nurses (DON) said she was unaware of the errors found in Resident #1's medication reconciliation upon admission and that there were two different medication lists for Resident #1.The DON said it is the Facility's expectation that nursing staff admitting a resident reconcile all medications with the Physician accurately and according to the Facility Policy.