STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225770	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brighton Rehabilitation and Nursing Center	170 Corey Road Brighton, MA 02135

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 49880 Based on record review and interviews, the facility failed to identify and complete a Significant Change in Status (SCSA) Minimum Data Set assessment (MDS) for one Resident (#16), out of a total sample of 17 residents, when the Resident was discharged from hospice services. Findings include: Review of the MDS 3.0 Resident Assessment Instrument (RAI) Manual, dated October 2023, indicated: - A Significant Change in Status Assessment (SCSA) is required to be performed when a resident is receiving hospice services and then decides to discontinue those services (known as revoking of hospice care). The ARD (assessment reference date) must be within 14 days from the effective date of the hospice election revocation. Resident #16 was admitted to the facility in November 2021 with diagnoses that include dementia and history of Covid-19. Review of the most recent Minimum Data Set Assessment, (MDS) Assessment, dated 9/6/24 indicated that the Resident could not participate in a Brief Interview for Mental Status exam, but was assessed by staff to have severe cognitive impairment. The MDS further indicated that the resident was not receiving hospice services. Review of the quarterly MDS Assessment, dated 3/6/24, indicated that Resident #16 was receiving hospice services. Review of the quarterly MDS Assessment, dated 6/6/24, indicated that Resident #16 was not receiving hospice services. Review of Resident #16's medical record indicated a form for revocation of hospice services indicating the hospice disenrollment date of 4/19/24. Review of the medical record failed to indicate a Significant Change in Status Assessment was completed upon disenrollment of hospice services. (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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/30/24 at 8:55 A.M., Unit Manager #1 said that Resident #16 was receiving hospice services but was doing well and gaining weight so he/she was taken off hospice services. Unit Manager #1 said she was unaware of whether a Significant Change in Status Assessment should have been completed when hospice services ended. During an interview on 10/30/24 at 9:34 A.M., the Regional MDS coordinator said that for a change in status, such as stopping hospice services, a Significant Change in Status Assessment should have been completed, but it was not. During an interview on 10/30/24 at 10:15 A.M. with the Director of Nurses and the Infection Preventionist they said a Significant Change in Status Assessment should have been completed for Resident #16.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36797 Based on observations, record review and interview the facility failed to accurately complete a Minimum Data Set (MDS) assessment for four Residents (#61, #41, #59, and #32) out of a total sample of 17 residents. Specifically, 1. For Resident #61 the facility inaccurately coded no significant weight gain when there was one. 2. For Resident #41 and Resident #59, the facility inaccurately coded their ability to be understood. 3. For Resident #32, the facility inaccurately coded that the Resident was in a comatose state. Findings Include: 1. Resident #61 was admitted to the facility in November 2023 with diagnoses including stroke, heart disease, asthma and diabetes. Review of the medical record indicated the following weights: 2/27/2024 15:14 146.2 Lbs. (pounds) 3/5/2024 13:51 151.4 Lbs. 3/12/2024 12:11 147.0 Lbs. 3/19/2024 14:24 147.0 Lbs. 3/26/2024 16:26 149.0 Lbs. 4/2/2024 08:34 148.0 Lbs. 4/10/2024 13:10 146.3 Lbs. 4/17/2024 12:06 148.0 Lbs. 4/23/2024 15:06 148.7 Lbs. 4/30/2024 07:50 147.0 Lbs. 5/7/2024 14:18 148.0 Lbs. 6/4/2024 13:55 154.2 Lbs. 6/21/2024 11:48 157.2 Lbs. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/25/2024 14:55 157.4 Lbs. 7/2/2024 15:51 172.8 Lbs. 7/24/2024 15:17 172.6 Lbs. 7/29/2024 07:57 174.0 Lbs. 8/8/2024 12:56 176.2 Lbs. 8/16/2024 15:14 173.8 Lbs. 8/22/2024 08:22 175.4 Lbs. 8/28/2024 13:28 178.8 Lbs. Further review of the recorded weights indicated that Resident #61 had experienced a significant weight gain of 22.30% of his/her total body weight in 6 months. Review of the MDS dated [DATE], indicated that Resident #61 did not have a significant weight gain. During an interview on 10/30/24 at 09:33 A.M. the Regional MDS nurse said that the MDS was coded in error and should indicate a significant weight gain. 36876 2a. Resident #41 was admitted to the facility in December 2022 with diagnoses including Parkinson's disease and cognitive communication deficit. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #41's primary language was Spanish and he/she wants/needs an interpreter. Additional review of the MDS indicated in section C that the Brief Interview for Mental Status Exam (BIMS) should not be completed as Resident #41 was rarely/never understood. Review of the MDS' dated 3/3/24 and 6/3/24 also indicated Resident #41 was rarely/never understood and staff did complete the BIMS. During interviews on 10/30/24 at 9:01 A.M., and 9:34 A.M., the MDS Coordinator said that indicating Residents are rarely/never understood on the MDS was not related to their ability to speak English, but related to their cognitive status. Review of Resident #41's Patient Health Questionnaire (PHQ) - 9 completed with psych services and dated 8/28/24 indicated Resident #41 was able to participate in the interview process. During an interview on 10/30/24 at 10:13 A.M., the Psychiatric Nurse said that when she meets with Resident #41 she utilizes a language line to facilitate communication. The Psychiatric Nurse said that Resident #41 was able to converse and communicate. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2b. Resident #59 was admitted to the facility in April 2024 with diagnoses including cognitive communication deficit and dysphagia. Review of Resident #59's Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #59's primary language was Cantonese and he/she required an interpreter. Additional review of the MDS indicated that Resident #59 was rarely/never understood and staff did not complete the Brief Interview for Mental Status exam (BIMS). Review of the Psychiatric Evaluation and Consultant note dated 8/28/24 indicated: Pt (patient) was alert and cooperative with assessment. No agitation or aggression noted. No acute MH (mental health) concerns noted today. Review of Resident #59's Occupational Therapy Evaluation dated 10/17/24 indicated: Interpreter: Present. PT (patient) present able to communicate with patient in Cantonese. During interviews on 10/30/24 at 9:01 A.M., and 9:34 A.M., the MDS Coordinator said that indicating Residents are rarely/never understood on the MDS is not related to their ability to speak English, but related to their cognitive status. During an interview on 10/30/24 at 11:06 A.M., the Psychiatric Nurse said that Resident #59 was confused, but he/she was able to communicate with him/her through the use of the interpreter line. 49880 3. Review of the MDS 3.0 Resident Assessment Instrument (RAI) Manual, dated October 2023, indicated: -Comatose is defined as a pathological state in which neither arousal (wakefulness, alertness) nor awareness exists. The person is unresponsive and cannot be aroused; they do not open their eyes, do not speak and do not move their extremities on command or in response to noxious stimuli (e.g., pain). -To code yes to comatose if the record indicates that a physician, nurse practitioner or clinical nurse specialist has documented a diagnosis of coma or persistent vegetative state that is applicable during the 7-day look-back period. Resident #32 was admitted to the facility in April 2021 with diagnoses that include pneumonia and acute respiratory failure with hypoxia. Review of the most recent Minimum Data Set (MDS) Assessment, dated 7/22/24, indicated that Resident #32 was comatose and could not participate in cognitive testing. On 10/29/24 at 7:58 A.M., the surveyor observed Resident #32 in bed awake with his/her eyes open. On 10/30/29 at 9:26 A.M., the surveyor observed Resident #32 in bed awake with his/her eyes open. Resident #32 did not respond verbally to the surveyor but looked at the surveyor when spoken to. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #32's medical record failed to indicate a diagnosis of coma or persistent vegetative state. During an interview on 10/30/24 at 8:51 A.M., Nurse #2 said that Resident #32 was not comatose. Nurse #2 said that the Resident was awake and alert at times and opens his/her eyes when their spouse was visiting. During an interview on 10/30/24 at 8:42 A.M., Unit Manager #1 said that Resident #32 was not comatose and responded by opening his/her eyes especially when family was visiting, talking to, or touching him/her. During an interview on 10/30/24 at 9:34 A.M., the Regional MDS coordinator said that if Resident #32 opened his/her eyes and was awake and alert, then the Resident would not be considered comatose. During an interview on 10/30/24 at 10:17 A.M., the Director of Nurses and Infection Preventionist said that Resident #32 was not comatose and this would be a coding error on the MDS.

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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. 36797 Based on observation, policy review and interview the facility failed to store medications in a safe manner, store medications in accordance with currently accepted professional principles and failed to follow manufacturer's instructions for storage. Specifically the facility failed to: 1. Store medication in secured (locked) locations, accessible only to designated staff in two medication carts on one of two units. 2. Store and label medications in accordance with currently accepted professional principles in one medication cart on one of two units. 3. Maintain temperatures in accordance with manufacturer specifications on one of two units Findings include: Review of the facility policy titled Medication Management-Medication Storage and dated reviewed 9/24 indicated that the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Further review indicated that medications requiring refrigeration must be stored and monitored in a refrigerator located in the drug room at the nurse's station or other secured location. 1. On 10/29/24 at 7: A.M., the surveyor observed two medication carts on the first floor unit, open and not within sight of the nurse sitting at the nurse's station. The surveyor also observed three residents and several staff members in the hall with potential access to the medication carts. 2. On 10/29/24 at 2:56 P.M., the surveyor observed a medication cup with applesauce and crushed medications in the top drawer of the medication cart on the first floor unit. The surveyor observed that the medication cup was not labeled with the medications it contained or the name of the resident they belonged to. During an interview on 10/29/24 at 2:56 P.M., Nurse #1 said that she had placed the unlabeled medication cup with a resident's medication in the top drawer of the medication cart and she should not have. 3. On 10/29/24 at 3:07 P.M., the surveyor observed a warm, unopened, Levemir Flex Pen (insulin), in the top drawer of the medication cart on the second floor unit. Review of the manufacturer's directions indicated that the Levemir Flex Pen is to be kept refrigerated until opened. During an interview on 10/29/24 at 3:07 P.M., Nurse #2 said that she didn't know when the unopened Levemir Flex Pen had been put in the medication cart but that it should remain in the refrigerator until opened.