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	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brighton Post Acute Care	170 Corey Road Brighton, MA 02135

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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 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure physician visits were completed as required for three Residents (#32, #4 and #15) out of a total of 22 sampled residents. Findings include: 1. Resident #32 was admitted to the facility in December 2024 with diagnoses including heart failure, asthma and respiratory failure. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #32 was cognitively intact evidenced by a score of 13 out of a possible 15 on the Brief interview for Mental Status Exam (BIMS). Review of Resident #32's clinical record indicated he/she had been seen by the Physician on 12/28/24 and 9/2/25 and by the Nurse Practitioner (NP) on 1/3/25, 1/4/25, 1/7/25, 3/28/25, 4/15/25, 5/20/25, 6/8/25, 7/9/25, 7/27/25, 8/1/25 and 8/8/25. Resident #32 was not seen in February 2025 as required and the Physician did not alternate visits with the NP, as required. During an interview on 9/26/25 at 11:03 A.M., the Medical Director (Resident #32's attending physician) said that he usually sees new admissions within the first 48 hours and they are seen every month for the first three months. The Medical Director said he usually sees residents every four months and the NP also visits every couple months. During an interview on 9/26/2025 at 12:18 P.M., the Director of Nursing said that the expectation is for the physician and nurse practitioner to alternate visits and complete visits every 30 days for acute patients and every 60 days for long term residents. 2. Resident #4 was admitted to the facility in July 2024 with diagnosis of aphasia and coronary artery disease. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #4 was severely cognitively impaired and dependent on staff for all activities of daily living. Review of Resident #4's clinical record indicated that he/she had been seen by the Physician on 9/11/24, 9/21/24, 9/23/25 and had been seen by the Nurse Practitioner (NP) on 9/10/24, 9/15/24, 9/19/24, 6/4/25, and 7/27/25. The Physician did not alternate visits with the NP as required. During an interview on 9/26/25 at 11:03 A.M., the Medical Director (Resident #4's attending physician) said that he usually sees residents every four months and the NP also visits every couple months. During an interview on 9/26/25 at 12:18 P.M., the Director of Nursing said that the expectation is for the physician and nurse practitioner to alternate visits and complete visits every 30 days for acute patients and every 60 days for long term residents. 3. Resident #15 was admitted to the facility in January 2023 with diagnoses including stroke and cognitive communication disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #15 is cognitively intact as evidenced by a score of 15 out of a possible 15 on the Brief Interview for Mental Status exam and is dependent on staff for all activities of daily living. Review of Resident #15's clinical record indicated he/she had been seen by the physician on 7/12/24, 9/16/25 and 9/19/25 and was seen by the Nurse Practitioner (NP) on 10/3/24, 10/7/24, 10/8/24, 10/29/24, 11/11/24, 11/19/24, 1/30/25 and 6/6/25. The Physician did not alternate visits with the NP as required. During an interview on 9/26/25 at 11:03 A.M., the Medical Director (Resident #15's attending physician) said that he usually sees residents every four months and the NP also visits every couple months. During an interview on 9/26/25 at 12:18 P.M., the Director of Nursing said that the expectation is for the physician and nurse practitioner to alternate visits and complete visits every 30 days for acute patients and every 60 days for long term residents.

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
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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 - Some	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 medical records in accordance with accepted professional standards and practices that are complete and readily accessible for facility staff for four Residents (#8, #44, #32 and #42) out of a total sample of 22 residents. Specifically:1. For Resident #44 and #8, the facility failed to ensure the Physician and other licensed professionals' progress notes were documented in the Electronic Health Record (EHR).2. For Resident #42, the facility failed to ensure nursing staff accurately documented the administration of lidocaine pain patches.3. For Resident #32, the facility failed to accurately document the cleaning of an oxygen concentrator filter. Findings include: 1. Resident #44 was admitted to the facility in March 2022 with diagnoses including end stage renal disease, acute kidney failure, dependence on renal dialysis, shortness of breath atherosclerotic heart disease, essential primary hypertension, chronic atrial fibrillation, polyneuropathy, cardiomegaly, and tachycardia and dependence on supplemental oxygen. Review of Resident #44's Minimum Data Set (MDS) assessment, dated 9/29/25, indicated the Resident scored 7 out of a possible 15 on the Brief Interview for Mental Status (BIMS) exam indicating he/she had severe cognitive impairment. Review of Resident #44's Electronic Health Record (EHR) indicated that a Nurse Practitioner (NP) examined the Resident on 2/20/25 at 11:59 P.M. Further review of the EHR indicated a Physician (MD) examined the Resident on 12/27/24. Review of the EHR failed to indicate the Nurse Practitioner or Physician visited Resident #44 after 2/20/25, there were no documented notes in the medical record after 2/20/25. On 9/26/25 at 9:00 A.M., the surveyor requested the facility to provide any NP/MD progress notes dated after 2/20/25. Staff said there were no NP/MD documented visits after 2/20/25 in the EHR or hard copy medical record. During an interview on 9/26/25 at 11:03 A.M., the Medical Director said that he rounds on residents every four months and the NP rounds on residents every couple of months, unless there is a need for a resident to be seen sooner. The Medical Director said the progress notes are supposed to be uploaded to the electronic health record faster than they have been though they are usually uploaded within the month. Furthermore, the Medical Director said he was aware of the issue and will be working on fixing it. The Medical Director said progress notes are written in a different system and said staff do not have access to visit notes until they are uploaded into the residents' electronic medical records. Further review of the EHR indicated that a late entry physician progress note, dated 4/8/25 at 8:30 A.M., was entered into the EHR on 9/26/25 at 8:31 A.M. In addition, a physician progress note dated 8/12/25 at 9:19 A.M., was entered into the EHR on 9/26/25 at 9:19 A.M. These progress notes were added after the surveyor requested progress notes. During an interview on 9/26/25 at 12:18 P.M., the Director of Nursing said acute residents should be seen every 30 days and long-term residents every 60 days. She furthermore said she was aware of the issues with the providers uploading the progress notes and said staff do not have access to provider notes if they are not entered into the electronic health record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #8 was admitted to the facility in June 2022 with diagnoses including chronic obstructive pulmonary disease (COPD) and schizophrenia. Review of the most recent Minimum Data Set (MDS) assessment, dated 6/27/25, indicated Resident #8 was cognitively intact as evidence by a Brief Interview for Mental Status (BIMS) score of 15 out of a possible score of 15. Review of Resident #8's Electronic Health Record (EHR) indicated that the last nurse practitioner progress note was documented on 7/24/25 at 2:10 P.M. Further review of the EHR indicated that the last (late entry) physician progress note was documented on 4/29/25 at 10:46 A.M. On 9/26/25 at 9:00 A.M., the surveyor requested the facility staff to provide any nurse practitioner progress notes for Resident #8 completed after 7/24/25, and any physician progress notes completed after 4/29/25. Further review of the EHR indicated that one of the requested physician progress notes, dated 8/12/25 at 9:39 A.M., was documented as a late entry on 9/26/25 at 9:40 A.M., by the physician. During an interview on 9/26/25 at 11:03 A.M., the Medical Director said that he rounds on residents every four months and the NP rounds on residents every couple of months, unless there is a need for a resident to be seen sooner. The Medical Director said the progress notes are supposed to be uploaded to the EHR faster than they have been and are usually put in within the month. The Medical Director said he was aware of the issue. During an interview on 9/26/25 at 12:18 P.M., the Director of Nursing said acute residents should be seen every 30 days and long-term residents every 60 days. She furthermore said she was aware of the issues with the providers uploading the progress notes. 3. Resident #42 was admitted to the facility in September 2025 and has diagnoses that include status-post left knee surgery and arthritis. Review of Resident #42's most recent Minimum Data Set assessment dated [DATE] indicated a Brief Interview for Mental Status score of 15 out of a possible 15, indicating intact cognition. On 9/24/25 at 10:07 A.M., the surveyor observed Resident #42 awake in bed. The Resident had two surgical dressings covering the left knee and two lidocaine patches, one located on the medial side of the left knee, and the other on the left shin. The patch on the medial side of the knee was dated 9/21 and the patch on the shin was undated. During an interview with Resident #42, he/she said a nurse applied both patches to his/her left leg on 9/21/25 and had not changed them since that date. Review of Resident #42's physician order dated 9/17/25 indicated: Lidocaine External Patch 4% (Lidocaine). Apply skin topically one time a day for pain and removed per schedule. (Lidocaine is an externally applied topical anesthetic used for the temporary relief of minor pain.) Review of Resident #42's September MAR indicated nursing staff applied a patch on 9/21/25 at 8:00 A.M., and then removed it on 9/22/25 at 7:59 A.M. The MAR indicated patches were removed and applied on 9/22/25 and 9/23/25, contrary to the surveyor's observation made on 9/24/25 of the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	patch dated 9/21/25. During an interview on 9/24/25 at 2:16 P.M., Unit Manager #1 said she thought she had removed and applied a new patch for Resident #42 on the medial side of the left knee on 9/22/25 but may have accidentally dated the patch 9/21/25. Unit Manager #1 said she did not understand why the patch was still dated 9/21 as of 9/24/25. During an interview with the Director of Nurses (DON) and Regional Nurse #2 on 9/25/25 at 8:03 A.M., they said Unit Manager #1 applied two lidocaine patches to Resident #42 on 9/22/25 but accidentally wrote a date of 9/21 on the patch located on left knee and forgot to date the patch located on the shin. They said the nurse who was responsible for removing and applying Resident #42's lidocaine patch on 9/23/25 did not do the treatment and in error documented in the MAR the patch was changed on this date. 4. Resident #32 was admitted to the facility in May 2025 and had diagnoses which included respiratory failure and heart failure. Review of Resident #32's most recent Minimum Data Set (MDS) assessment dated [DATE], indicated a Brief Interview for Mental Status score of 13 out of a possible 15, indicating intact cognition. Resident #32 received oxygen therapy. On 9/24/25 at 8:52 A.M. the surveyor observed Resident #32 sitting in a wheelchair. The Resident wore a nasal cannula, and an oxygen concentrator was located next to his/her bed and running at 2 liters per minute. The surveyor observed that the surface of the oxygen concentrator filter was covered in a thick, white layer of dust. Review of Resident #32's physician orders indicated: Change Oxygen tubing, change O2 humidification bottle as applicable and clean filter (wash, rinse and pat dry filter) and change storage bag every week. Every nightshift every Sunday, dated 5/25/25. Review of Resident #32's September 2025 Treatment Administration Record (TAR) indicated staff last changed the oxygen concentrator air filter on 9/21/25. During an interview with Clinical Nurse Consultant #2 on 9/25/25 at 9:24 A.M., she said it did not appear that the filter was changed or cleaned on 9/21/25, as indicated on Resident #32's September TAR. Clinical Nurse Consultant said it was the facility's policy to change, or clean, oxygen concentrator filters one time per week to remove dust build up. Review of the facility policy Use of Oxygen dated September 2024 did not reference the oxygen concentrator filter or cleaning.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure a call light was able to be utilized for one Resident (#15), out of a total of 22 sampled residents. Findings include: Review of the facility policy titled, Call Bell Procedure, dated as reviewed September 2024, indicated: Purpose: The purpose of this procedure is to respond to the resident's requests and needs. 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. Resident #15 was admitted to the facility in January 2023 with diagnoses including stroke and cognitive communication disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #15 is cognitively intact as evidenced by a score of 15 out of a possible 15 on the Brief Interview for Mental Status exam and is dependent on staff for all activities of daily living. During an interview on 9/24/25 at 8:29 A.M., Resident #15 asked the surveyor to pick up his/her television remote control off the floor. When asked if he/she has a functioning call light Resident #15 said no. The surveyor observed a red call bell string tied to the upper corner on his/her left bedrail. Resident #15 demonstrated he/she could reach it, but due to the way it was tied to the bedrail, he/she could not pull the cord down fully to activate the call light system. Review of Resident #15's fall care plan indicated: The resident is at risk for fall r/t deconditioning, gait/balance problems, paralysis, poor communication/comprehension, CVA (stroke) R-(right) side weakness 2022 and 2008, 1/12/23. Interventions: be sure resident's call light is within reach and encourage the resident to use it for assistance as needed, 1/12/23. On 9/25/25 at 7:27 A.M., the surveyor observed Resident #15 in bed. The red call light cord was still tied to the left side bedrail and Resident #15 said he/she could not use his/her call light. During an interview on 9/25/25 at 8:50 A.M., CNA #1 said that Resident #15 does not use a call light and staff check on him/her regularly. On 9/25/25 at 8:55 A.M., the surveyor observed Nurse #3 deliver Resident #15's breakfast tray. Nurse #3 observed Resident #15's call light and the surveyor attempted to pull the cord but could not pull the cord down completely to activate the call light system. Resident #15 said he/she could not pull his/her call light. Nurse #3 said that the call light should not be tied in that manner and should be closer to the Resident. During an interview on 9/25/25 at 9:43 A.M., Unit Manager #1 said that Resident #15 used to have a tap call light when he/she was in his/her previous room. Review of Resident #15's clinical record indicated he/she had changed rooms on 3/18/25.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure attending care plan meetings was offered to one Resident (#44) out of a total of 22 sampled Residents. Specifically, the facility failed to ensure the Resident was notified of the care plan meetings or was offered to attend. Findings include: Resident #44 was admitted to the facility in March 2022 with diagnoses including end stage renal disease and major depressive disorder. A diagnosis of dependence on supplemental oxygen was added to his/her record on 9/12/24. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #44 is severely cognitively impaired as evidenced by a score of seven out of a possible 15 on the Brief Interview for Mental Status exam. During multiple interviews throughout the survey, Resident #44 was able to engage in discussions about his/her healthcare related to his/her use of oxygen, attendance at dialysis and pain levels. Review of Resident #44's clinical record indicated his/her health care proxy was not activated (indicating Resident #44 is his/her own decision maker) and his/her most recent care plan meeting was held on 6/28/25; but failed to indicate who was in attendance at the meeting. During an interview on 9/29/25 at 10:39 A.M., Social Worker #1 said that Resident #44 has an activated health care proxy, but she was not sure who it was. Social Worker #1 said she is not responsible for inviting residents or family members to care plan meetings and she is not sure who is responsible for inviting residents or families to care plan meetings. Social Worker #1 said Resident #44 and his/her family do not attend his/her care plan meetings and she is not sure if they had ever been offered to attend. Review of the electronic and paper clinical record failed to indicate any attendance records for any care plan meetings for Resident #44. During a follow up interview on 9/29/25 at 12:50 P.M., Social Worker #1 also looked through Resident #44's paper record and was not able to locate copies of attendance sheets. Social Worker #1 said she was not aware that Resident #44 did not have an activated healthcare proxy and said that residents who are their own person have the right to attend care plan meetings. During an interview on 9/29/25 at 1:04 P.M., the Director of Nursing (DON) said that the receptionist is responsible for sending out care plan invitations to residents and their families, but there has been changes in staffing in reception services. The DON said residents who are their own person have the right to be invited and attend their own care plan meetings.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and records reviewed, the facility failed to meet professional standards of practice for two Residents (#44, and #35) out of a total of 22 sampled residents. Specifically:1. For Resident #44, the facility failed to implement physician orders for fluid restrictions.2. For Resident # 35, the facility failed to implement physician's orders for fluid restrictions.Findings include: Review of facility policy titled Encouraging and Restricting Fluids dated September 2024, indicated: - The purpose of this procedure is to provide the resident with the amount of fluids necessary to maintain optimum health. This may include encouraging or restricting fluids. - Verify there is a physician's order for this procedure. - Review the residents care plan and or your daily assignment sheet to assess for any special needs of the resident. - Follow specific instructions concerning fluid intake or restrictions. - Record the amount of fluids consumed on the intake side of the intake and output record fluid intake in mLs. (milliliters). Documentation - Following information should be recorded in the resident's medical record: 1. The date and time the procedure was performed. 2. The name and title of the individual who performed the procedure. 3. Any changes in the resident's condition. 4. Any problems or complaints made by the resident related to the procedure. 5. Any evidence of dehydration such as weight loss, confusion, drowsiness, dry skin, etc. 6. The amount (in mls.) of fluids or the amount of fluids if outside the parameter. 1. Resident #44 was admitted to the facility in March 2022 with diagnoses including end stage renal disease, dependence on renal dialysis, shortness of breath, atherosclerotic heart disease, tachycardia and dependence on supplemental oxygen. Review of Resident #44's Minimum Data Set (MDS) assessment, dated 9/29/25, indicated the Resident scored 7 out of a possible 15 on the Brief Interview for Mental Status (BIMS) exam indicating he/she had severe cognitive impairment. The MDS further indicated Resident #44 is frequently incontinent of urine and is dependent on staff for toileting. On 9/24/25 at 8:41 A.M., the surveyor observed Resident #44 resting in bed. There was one cup of coffee and one cup of juice on the Resident's overbed table. On 9/25/25 at 6:48 A.M., the surveyor observed Resident #44 resting in bed. There was one cup of (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	water on the Resident's overbed table. On 9/25/25 at 8:48 A.M., the surveyor observed Resident #44 resting in bed. There was one cup of coffee and one cup of cranberry juice on the Resident's overbed table. On 9/26/25 at 9:50 A.M., the surveyor observed Resident #44 resting in bed. There was one cup of coffee and one cup of cranberry juice on the Resident's overbed table. On 9/29/25 at 8:25 A.M., the surveyor observed Resident #44 resting in bed. There was one cup of coffee and one cup of juice on the Resident's overbed table. Review of Resident #44's active physician orders indicated the following: - Fluid restriction to 1000 ml/24 hours Nursing (360 ML/24 hours) Dietary (640 ML/24 hours) 7-3pm allowance: Nursing 120 cc Dietary 390 cc Total= 510cc 3-11pm allowance: Nursing 120cc Dietary 250cc Total = 370cc 11-7am allowance: 120 Nursing (120cc) Dietary (0) Total=120cc every shift. Start Date 8/10/23. Review of Resident #44's Medication Administration Record (MAR) for September 2025 failed to include daily fluid intake and output (I&O's) for each nursing shift indicating no fluid intake or output was measured. Further review of the medical record failed to indicate intake and output was measured or documented in the medical record. Review of the CNA documentation survey report for the month of September 2025 did not include I&O values. During an interview on 9/25/25 at 8:47 A.M., Nurse #4 said Resident #44 is on a fluid restriction and needs I&O's monitored because he/she is a dialysis patient and needs monitoring for fluid overload. Nurse #4 said CNA's track the I&O levels and document it in the medical record or tell the nurses so we can put it in the medical record. During an interview on 9/25/25 at 9:01 A.M., Unit Manager #2 said Resident #44 is on a fluid restriction because he/she is on dialysis and has a history of fluid overload. Unit Manager #2 said urinary output is measured and fluid intake is tracked by the CNA's and reported to the nursing staff to document values in the electronic medical record. Unit Manager #2 said nurses must follow the physician orders and care plan to care for the Resident. The surveyor along with Unit Manager #2 reviewed Resident #44's electronic medical record. Unit Manager #2 said the order for fluid restrictions is in place, but I&O values are not being documented in the medical record and said she expects them to be documented to monitor his/her fluid status. During an interview on 9/26/25 at 11:56 A.M., Regional Clinical Consultant #1 said Resident #44 has an order in place for fluid restrictions that need to be followed, and I&O should be documented each shift to monitor the resident's status as he/she is a dialysis patient and requires close monitoring. During an interview on 9/29/25 at approximately 8:19 A.M., the surveyor observed Nurse #6 in Resident #44's room and said she does not know if Resident #44 is on a fluid restriction. Nurse #6 then left a cup of water with the Resident before exiting the room. During an interview on 9/29/25 at 1:05 P.M., the Director of Nursing said residents on fluid restrictions must have intake and output values measured and documented as ordered and said she expects staff to be aware of the resident's fluid restrictions. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #35 was admitted to the facility in August 2025 with diagnoses including sepsis, heart failure and cognitive communication deficit. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #35 was moderately cognitively impaired evidenced by a score of 12 out of a possible 15 on the Brief Interview for Mental Status Exam (BIMS). The MDS also indicated Resident #12 is frequently incontinent of urine. During an interview on 9/24/25 at 8:45 A.M., the surveyor observed boxes of nutritional supplement drinks on Resident #35's dresser. Resident #35 said his/her family brought them in for him/her. Resident #35 then pointed to an open container of a chocolate flavored nutritional supplement on his/her overbed table and said he/she drinks them daily. Review of Resident #35's physician orders indicated the following: MD Orders: Fluid restriction to 1500 ml/24 hours. Nursing 500 ML/24 hours Dietary 1000 ML/24 hours). 7-3pm allowance: 690. Nursing (210mL) Dietary (480mL) 3-11pm allowance:690 Nursing (210mL) Dietary (480mL) 11-7am allowance:120. Nursing (120mL) Dietary (0mL), 8/20/25. Review of Resident #35's Medication Administration Record for September 2025 indicated three sections for nursing staff to document Resident #35's daily fluid intake and output for each nursing shift. Review of the 7:00 A.M. - 3:00 P.M., documentation indicated output N/A (not applicable) on 9/3/25, 9/9/25, 9/11/25 -9/16/25, and 9/20/25. Additionally, 9/10/25 was left blank; indicating no fluid intake or output was measured. Review of the 3:00 P.M. - 7:00 A.M. documentation indicated output N/A on 9/9/25-9/14/25, 9/17/25, 9/20/25 and 9/26/25. Review of the 11:00 P.M. - 7:00 A.M. documentation indicated output N/A on 9/4/25, 9/9/25, 9/11/25, 9/13/25, 9/15/25, 9/22/25, 9/24/25 and 9/25/25. Additionally, 9/2/25-9/3/25, 9/5/25-9/6/25, 9/8/25, 9/12/25, 9/14/25, 9/17/25, 9/21/25 and 9/23/25 were left blank; indicating no fluid intake or output was measured. During an interview on 9/29/25 at 10:55 A.M., Nurse #4 said that Resident #35 is on a fluid restriction and he/she doesn't like to drink a lot. Nurse #4 said that nursing staff will check his/her urinal to measure Resident #35's output. Nurse #4 said that Certified Nursing Aids (CNA's) are aware and that he/she is on a fluid restriction and will report to the nursing staff his/her fluid intake as well. During an interview on 9/29/25 at approximately 11:00 A.M., the surveyor observed CNA #1 in Resident #35's room and said she was about to provide care. CNA #1 said that she did not think Resident #35 is on a fluid restriction and that staff give him/her water, juice and ginger ale. During an interview on 9/29/25 at approximately 11:05 A.M., Unit Manager #1 said that Resident #35 is on a fluid restriction but would have to check if there was an order to monitor his/her output. Unit Manager #1 said that she was not aware that CNA staff did not know Resident #35 was on a fluid restriction. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brighton Post Acute Care	170 Corey Road Brighton, MA 02135

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/29/25 at 1:05 P.M., the Director of Nursing said that for residents on fluid restrictions, intake and output should be measured and documented as ordered.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to provide supervision with meals for one Resident (#44) out of a total sample of 22 residents. Findings include:Review of the facility policy titled Activities of Daily Living (ADL) Supporting, dated as revised September 2024, indicated: - Residents will be provided with care, treatment and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable. ADLs are provided in according with resident preference and needs. - Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: Dining (meals and snacks). - Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice. Findings include: Resident #44 was admitted to the facility in March 2022 with diagnoses including aphasia (communication disorder), other lack of coordination, end stage renal disease, and shortness of breath. Review of Resident #44's Minimum Data Set (MDS) assessment, dated 9/29/25, indicated the Resident scored 7 out of a possible 15 on the Brief Interview for Mental Status (BIMS) exam indicating he/she had severe cognitive impairment. On 9/24/2025 at 8:12 A.M., the surveyor observed Resident #44 in bed, with his/her breakfast attempting to eat the meal. The Resident had eggs on his/her clothing and bed linen. The Resident was not visible from the hallway; no staff were present in the room throughout the breakfast meal.On 9/25/25 at 8:41 A.M., the surveyor observed Resident #44 in bed, with his/her breakfast attempting to eat the meal. The Resident had eggs on his/her clothing and floor. The Resident was not visible from the hallway; no staff were present in the room throughout the breakfast meal.On 9/26/25 at 6:48 A.M., the surveyor observed Resident #44 in bed, with his/her breakfast attempting to eat the meal. The Resident had food on his/her clothing. The Resident was not visible from the hallway; no staff were present in the room throughout the breakfast meal.Review of Resident #44's Risk for Aspiration Care Plan, dated 2/28/23, indicated but was not limited to:- Resident to eat only with supervision.- Check mouth after meal for pocketed food and debris. Report to nurse. Provide oral care to remove debris.- Encourage resident to eat in an upright position, to eat slowly, and to chew each bite thoroughly.- Keep head of bed elevated 45 degrees during meal and thirty minutes afterwards - Monitor for shortness of breath, choking, labored respirations, lung congestion.- All staff to be informed of resident's special dietary and safety needs.Review of Resident #44's nutritional assessment dated [DATE], failed to indicate dining ability and was left blank. Review of Resident #44's current September 2025 Kardex (form indicating level of care needs) indicated the following: Eating/Nutrition- Resident to eat only with supervision.- Keep head of bed elevated 45 degrees during meal and thirty minutes afterwards. - Encourage resident to eat in an upright position, to eat slowly, and to chew each bit thoroughly.- Check mouth after meal for pocketed food and debris. Report to nurse. Provide oral care to remove debris.Resident Care: - All staff to be informed of resident's special dietary and safety needs.Review of the Speech Discharge summary dated [DATE], indicated:- Assistance to be provided: A.M., assistance/caregiver available, P.M., assistance/caregiver available.- To facilitate safety and efficiency, it is recommended that patient use the following strategies during oral intake: alteration of liquids/solids, bolus size modifications, cyclic ingestion technique, ratio modification, hard throat clear/swallow and general swallow techniques/precautions, along with the following maneuvers: upright posture during meals and upright posture for >30 minutes after meals. During an interview on 9/25/25 at 9:22 A.M., Certified Nursing Assistant (CNA) #2 said Resident #44 eats in his/her room and requires set up and said staff check on him/her during the meal but he/she does not need to be supervised.During an interview on 9/25/25 at 9:59 A.M., Nurse #4 said Resident #44 does not require supervision with (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	meals and prefers to eat in his/her room. During an interview on 9/25/25 at 10:08 A.M., Unit Manager #2 said Resident #44 needs supervision during meals and said the care plan and Kardex must be followed. Unit Manager #2 said staff should stay with the Resident during meals because he/she eats in his/her room and must be monitored.During an interview on 9/26/25 at 11:38 A.M., the Director of Nursing (DON) said she expects the Kardex and care plan to be followed and said residents who need supervision during meals should not be left alone while eating. The DON said she was not aware that Resident #44 required supervision due to aspiration risks and said he/she should not be left unattended during meals.

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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, 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 (#44, #1, and #32) out of sample of 22 residents. Specifically:For Resident #44, the facility failed to obtain physician orders for oxygen use prior to administration.For Resident #1, the facility failed to obtain physician orders for oxygen use prior to administration.For Resident #32, the facility failed to clean the oxygen concentrator filter, resulting in a thick build-up of dust. Findings include:Review of facility policy titled Resident Care and Treatment- Use of Oxygen dated as reviewed September 2024, indicated the following but not limited to- Nursing personnel administer oxygen as prescribed by policy and ensure compliance with all Life Safety Codes.- Adjust the oxygen delivery device so that it is comfortable for the Resident and the proper flow of oxygen is being administered. Resident #44 was admitted to the facility in March 2022 with diagnoses including end stage renal disease, dependence on renal dialysis, shortness of breath, atherosclerotic heart disease, tachycardia and dependence on supplemental oxygen. Review of Resident #44's Minimum Data Set (MDS) assessment, dated 9/29/25, indicated the Resident scored 7 out of a possible 15 on the Brief Interview for Mental Status (BIMS) exam indicating he/she had severe cognitive impairment. The MDS further indicated that the Resident was on oxygen therapy. On 9/24/25 at 8:41 A.M., the surveyor observed Resident #44 resting in bed. The Resident was receiving oxygen at 2 liters via nasal cannula. On 9/25/25 at 6:48 A.M., the surveyor observed Resident #44 resting in bed. The Resident was receiving oxygen at 2 liters via nasal cannula. On 9/25/25 at 8:48 A.M., the surveyor observed Resident #44 resting in bed. The Resident was receiving oxygen at 2 liters via nasal cannula. On 9/26/25 at 9:50 A.M., the surveyor observed Resident #44 resting in bed. The Resident was receiving oxygen at 2 liters via nasal cannula. On 9/29/25 at 8:25 A.M., the surveyor observed Resident #44 resting in bed. The Resident was receiving oxygen at 2.5 liters via nasal cannula. Review of Resident #44's active physician orders indicated the following: Review of the medical record failed to indicate a physician order for oxygen therapy was active. Further review of the medical record indicated the following physician order: May administer oxygen at 2 liters/min via nasal cannula as needed for Shortness of Breath. Start Date 6/3/25 and discontinued on 8/7/25. Review of Resident #44's Medication Administration Record (MAR) and Treatment Administration Record (TAR) from June 2025 through September 2025 was left blank and did not contain documented administration of oxygen therapy at 2L. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/25/25 at 8:47 A.M., Nurse #4 said Resident #44 needs oxygen because his/her oxygenation levels drop and said the Resident is always on oxygen. During an interview on 9/25/25 at 9:01 A.M., Unit Manager #2 said Resident #44 is oxygen because he/she has a hard time breathing without it. Unit Manager #2 said nurses must follow the physician orders and care plan to care for the Resident and said Resident #44 should have an order in place for continuous oxygen at 2L because his/her oxygen levels will drop without it. The surveyor along with Unit Manager #2 reviewed Resident #44's electronic medical record and Unit Manager #2 said she is not sure why the order for 2L oxygen was discontinued on 8/7/25. Unit Manager #2 said the Resident needs oxygen continuously and does not remove it. During an interview on 9/26/25 at 11:56 A.M., Regional Clinical Consultant #1 said Resident #44 should have orders in place when receiving oxygen. During an interview on 9/29/25 at approximately 8:19 A.M., the surveyor observed Nurse #6 in Resident #44's room. Nurse #6 said Resident #44 requires oxygen because he/she can't breathe without it. During an interview on 9/29/25 at 1:05 P.M., the Director of Nursing said she expects orders to be in place and documented in the medical record for oxygen therapy. 2. Resident #1 was admitted to the facility in June 2024 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), asthma and obstructive sleep apnea. Review of the most recent Minimum Data Set (MDS) assessment, dated 8/22/25, indicated Resident #1 was cognitively intact as evidence by a Brief Interview for Mental Status (BIMS) score of 15 out of a possible score of 15. Further view of the MDS indicated that Resident #1 was documented as receiving oxygen. Review of Resident #1's active physician orders failed to indicate orders for either continuous or as needed [PRN] oxygen. Review of Resident #1's care plan, included but not limited to: -Focus: Resident has altered respiratory status/difficulty breathing with O2 use at 2 l/min (liters/minute) continuously r/t (related to) COPD, asthma. NP (an advanced practice registered nurse)/MD (Doctor of Medicine) to evaluate for weaning of oxygen and plan of care will be updated as indicated, initiated 1/7/25. -Interventions: Administer oxygen per ordered, initiated 9/25/25. On 9/24/25 at 9:32 A.M., the Surveyor observed Resident #1 lying in bed with a nasal cannula (a device that gives additional oxygen through the nose) in nostril. The oxygen tubing was connected to an oxygen concentrator set at 1.5 liters per minute (LPM). On 9/25/25 at 9:00 A.M., the Surveyor observed Resident #1 lying in bed with a nasal cannula (a device that gives additional oxygen through the nose) in nostril. The oxygen tubing was connected to an oxygen concentrator set at 1.5 liters per minute (LPM). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/25/25 at 11:41 A.M., Nurse #1 said when a resident requires oxygen, an order is received from the physician. The physician provides orders for the nurse that includes how many liters of oxygen should be administered. Review of Resident #1's active physician orders with Nurse #1 indicated that a physician order was documented in the Electronic Health Record (EHR) on 9/25/25 at 9:32 A.M., indicating the following: -Administer oxygen at 2 L/min (LPM) via nasal canula. During a follow up interview on 9/25/25 at 11:50 A.M., Nurse #1 said that the oxygen should not have been administered without a physician order. During an interview on 9/25/25 at 12:41 P.M., the Director of Nursing (DON) said, residents should have a physician order to receive oxygen with the number of liters per minute to be administered transcribed within the order. 3. Resident #32 was admitted to the facility in May 2025 and had diagnoses which included respiratory failure and heart failure. Review of Resident #32's most recent Minimum Data Set (MDS) assessment dated [DATE], indicated a Brief Interview for Mental Status score of 13 out of a possible 15, indicating intact cognition. Resident #32 received oxygen therapy. On 9/24/25 at 8:52 A.M. the surveyor observed Resident #32 sitting in a wheelchair. The Resident wore a nasal cannula, and an oxygen concentrator was located next to his/her bed and running at 2 liters per minute. The surveyor observed that the surface of the oxygen concentrator filter was covered in a thick, white layer of dust. Review of Resident #32's physician orders indicated: Change Oxygen tubing, change O2 humidification bottle as applicable and clean filter (wash, rinse and pat dry filter) and change storage bag every week. Every nightshift every Sunday, dated 5/25/25. Review of Resident #32's September 2025 Treatment Administration Record (TAR) indicated staff last changed the oxygen concentrator air filter on 9/21/25. During an interview with Clinical Nurse Consultant #2 on 9/25/25 at 9:24 A.M., she said it was the facility's policy to change, or clean, oxygen concentrator filters one time per week to remove dust build up. She said dust has the potential of increasing the risk of infection and decreasing the efficiency of the concentrator. The Clinical Nurse Consultant said it did not appear that the filter was changed or cleaned on 9/21/25, as indicated on the September TAR. Review of the facility policy Use of Oxygen dated September 2024 did not reference the oxygen concentrator filter or cleaning.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed for one Resident (#42) of 22 sampled residents, to provide adequate pain relief. Specifically, did not remove the used patch and replace it with a new patch for two days, which resulted in the Resident experiencing mild pain, and the potential for the body to absorb excessive amounts of lidocaine. In addition, facility staff applied two patches when there was an order for only one patch, which also contributed to the potential for the body to absorb excessive amounts of lidocaine. Findings include:Review of the facility policy Pain Management Guidelines dated September 2024 indicated it did not reference the use of Lidocaine patches, specifically.Lidocaine is an externally applied topical anesthetic used for the temporary relief of minor pain.Review of the Federal Drug Administration guidance for the use of lidocaine 4% patches indicated:- - Do not use more than one patch on your body at a time or with other topical analgesics at the same time.- - Patch may be used for up to 24 hours.- - Use of the same lidocaine patch for over 24 hours can lead to increased absorption, overdose risk, systemic toxicity and skin reactions.Resident #42 was admitted to the facility in September 2025 and has the following diagnoses: Status-post left knee surgery and arthritis.Review of Resident #42's most recent Minimum Data Set assessment dated [DATE] indicated a Brief Interview for Mental Status score of 15, signifying intact cognition.On 9/24/25 at 10:07 A.M., the surveyor observed Resident #42 awake in bed. The Resident had two surgical dressings covering the left knee and two lidocaine patches, one located on the medial side of the left knee, and the other on the left shin. The patch on the medial side of the knee was dated 9/21 and the patch on the shin was undated.During an interview with Resident #42, he/she said a nurse applied both patches to his/her left leg on 9/21/25 and had not changed them since that date. Resident #42 said he/she experienced mild pain but expected that a nurse would be giving him/her more pain medication this morning.Review of Resident #42's physician order dated 9/17/25 indicated: Lidocaine External Patch 4% (Lidocaine). Apply skin topically one time a day for pain and removed per schedule.Resident #42's physician order did not indicate the placement location for the patch and did not indicate more than one patch was to be applied.Review of Resident #42's September 2025 Medication Administration Record (MAR) indicated the lidocaine patch was scheduled to be applied at 8:00 A.M. and removed the next day at 7:59 A.M.Review of Resident #42's September MAR indicated nursing staff applied a patch on 9/21/25 at 8:00 A.M., and then removed it on 9/22/25 at 7:59 A.M. The MAR indicated patches were removed and applied on 9/22/25 and 9/23/25, contrary to the surveyor's observation made on 9/24/25 of the patch dated 9/21/25.Review of Resident #42's pain assessments dated 9/21/25, 9/22/25 and 9/23/25 indicated he/she did not complain of pain.During an interview on 9/24/25 at 2:16 P.M., Unit Manager #1 said she thought she had removed and applied a new patch for Resident #42 on the medial side of the left knee on 9/22/25 but may have accidentally dated the patch 9/21/25. Unit Manager #1 said she did not understand why the patch was still dated 9/21 as of 9/24/25. Unit Manager #1 said Resident #42's lidocaine pain patch should be changed every 12 hours. Unit Manager #1 said she did not know why there were two lidocaine patches on Resident #42's left leg when the physician's order only indicated one patch. Unit Manager #1 said she did not understand why the patch on the left shin was undated. Unit Manager #1 said the physician's order should have included the placement location and the admitting nurse should have called the provider to clarify the order. Unit Manager #1 said that keeping a lidocaine patch on the skin longer than 12 hours could result in the patch losing some of its pain control efficacy. During an interview with the Director of Nurses (DON) and Regional Nurse #2 on 9/25/25 at 8:03 A.M., they said Unit Manager #1 applied two lidocaine patches to Resident #42 on 9/22/25 but accidentally wrote a date of 9/21 on the patch located on left knee and forgot to date the patch located on the shin. They said the nurse who was responsible for removing and applying Resident #42's lidocaine patch on 9/23/25 did not do the treatment and in error documented in the MAR the patch was changed (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on this date. They said the physician's order should have included placement location. They said the physician's order only indicated one lidocaine patch and that staff should not have applied two patches.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure medications were stored as required for one Resident (#22), out of a total sample of 22 residents. Specifically, the facility failed to ensure that medications were not left at the bedside for Resident #22 while unsupervised by staff.Findings include: Review of the facility policy titled Medication Management-Medication Storage, dated and revised September 2024, indicated the following:-The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. -Drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received.Review of the facility policy titled Self-Administration of Medications, dated and revised September 2024, indicated the following:-It is the responsibility of the interdisciplinary team (IDT) to determine that it is safe for the resident to self-administer medications.-The decision that a resident has the ability to self-medicate is subject to periodic review based on changes in the resident's status. An assessment must be done at least annually. -Upon request, assess the resident's ability to meet criteria outlined above and document outcomes on the form Assessment for the Self-Administration of medication.-If determined that the resident is capable of self-administration medications, review with MD.-Document on the resident's care plan. Resident #22 was admitted to the facility in December 2022 with diagnoses including cerebral infarction (a condition where blood flow to the brain is interrupted, leading to brain cell damage or death), contracture of left hand and depression.Review of Resident #22's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #22 was cognitively intact as evidence by a Brief Interview for Mental Status (BIMS) score of 15 out of a possible score of 15. On 9/24/2025 at 8:19 A.M., the surveyor observed a medication cup on Resident #22's bedside table with 3 white pills inside. Resident #22 stated those were his/her morning pills and he/she just hadn't taken them yet.Review of Resident #22's physician orders and care plans failed to indicate that the Resident had met criteria to self-administer medications at his/her bedside.Review of the Self-Administration of Medication BC-V5 assessment dated [DATE] indicated that the Resident did not have medications he/she wants to keep at bedside or wishes to administer his/her own medication. Review of the Self-Administration of Medication BC-V5 assessment dated [DATE] at 9:34 A.M., indicated that the Self-Administration of Medication BC-V5 assessment was completed after the surveyor's observation.During an interview on 9/24/25 at 2:25 P.M., Nurse #2 said she was not aware of Resident #22's medications being left at the bedside. Nurse #2 said that when she investigated the medications it was noted these were Resident #22's scheduled 6:00 A.M. Tylenol that were left by the overnight nurse. Nurse #2 said that a Self-Administration assessment should have been completed prior to leaving the medications with the Resident. Review of Resident #22's physician order dated 10/31/24 indicated the following:-Tylenol Tablet 325 MG (Acetaminophen) Give 3 tablet by mouth three times a day for Pain TD (total dose) =975mg. Review of Resident #22's September Medication Administration Record indicated that Resident #22's scheduled 6:00 A.M. Tylenol was signed off as Resident receiving medication on 9/24/25. During an interview on 9/25/25 at 12:51 P.M., the Director of Nursing said when residents ask to self-administer medications, an assessment is performed at the bedside to observe the resident self-administer medications. After the assessment is completed and the resident was deemed to be appropriate to self-administer medications, the provider is contacted to receive an order before the resident is allowed to self-administer. The Director of Nursing said a Self-Administration assessment should have been completed prior to leaving the medications with Resident #22.