STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225413	A. Building B. Wing	11/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advocate Healthcare of East Boston, LLC	111 Orient Avenue East Boston, MA 02128

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. 43963 Based on record reviews and interviews for one of three sampled residents (Resident #1), whose Hospital Discharge (DC) Summary indicated he/she had a scheduled appointment with a Urologist in the community for a consult, the Facility failed to ensure nursing provided care and services that met professional standards of quality, when Resident #1 missed the Urology Consult appointment because nursing overlooked the appointment when reviewing his/her Hospital DC Summary, and transportation was never booked. Findings include: Standard Reference: Standard of Practice Reference: Pursuant to Massachusetts General Law (M.G.L), chapter 112, individuals are given the designation of registered nurse and practical nurse which includes the responsibility to provide nursing care. Pursuant to the Code of Massachusetts Regulation (CMR) 244, Rules and Regulations 3.02 and 3.04 define the responsibilities and functions of a registered nurse and practical nurse respectively. The regulations stipulate that both the registered nurse and practical nurse bear full responsibility for systematically assessing health status and recording the related health data. They also stipulate that both the registered and practical nurse are incorporated into the plan of care and implement prescribed medical regimens. The rules and regulations 9.03 defined standards of Conduct for Nurses where it is stipulated that a nurse licensed by the Board shall engage in the practice of nursing in accordance with accepted standards of practice. Resident #1 was admitted to the Facility in March 2024, diagnoses included cognitive decline, chronic obstructive pulmonary disease, anxiety, depression, history of renal cancer, and urinary retention. Review of Resident #1's Hospital Discharge Summary, dated 03/19/24, indicated that he/she was to have an outpatient Urology Consult on 5/13/24 due to urinary retention. Review of Resident #1's Nurse Practitioner #1's Progress Notes, dated 4/10/24 through 8/18/24 (which included approximately 10 visits), indicated that he/she had a appointment for a Urology Consult scheduled for 5/13/24. Review of Resident #1's Nurse Progress Note, dated 04/18/24, indicated that he/she was having urinary retention and required to be straight catheterized (tube inserted into the bladder to drain urine, one-time or at intermittent intervals) and an indwelling catheter (tube that remains in the bladder for a period of time to drain urine). (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
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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Physician's Orders, dated 04/18/24, indicated to insert an indwelling catheter secondary to urinary retention. Review of the Resident Appointment book, dated 5/13/24, indicated that there was no scheduled appointments for Resident #1 with a community based provider. During an interview on 11/04/24 at 2:16 P.M., the Patient Coordinator/Medical Records Assistant said that she does not remember getting any information regarding Resident #1 needing transportation to a Urology Consult on 05/13/24. The Patient Coordinator said that when a new resident is admitted or readmitted , the nurse will give me or my coworker the hospital paperwork and let us know if there are any appointments to be scheduled or appointments that residents need to get to and then she scans the paperwork directly into the Resident's electronic medical record. During an interview on 11/04/24 at 2:52 P.M., Nurse #4 said that she had been the nurse that admitted Resident #1 and said that she was only the medication cart nurse and that administered his/her medications and completed his/her assessments. Nurse #4 said she was unaware that Resident #1 had a Urology Consult scheduled for 5/13/24. Nurse #4 said that the supervisor is the one that reads the discharge summary, looks for any appointments needed and will notify the Patient Coordinator to schedule an appointment or transportation as needed. During an interview on 11/12/24 at 11:05 A.M., Nurse Practitioner (NP) #1 said he recalled that Resident #1 was supposed to have an Urology Consult, after his/her admission to the Facility, however the NP said he was unaware that Resident #1 had never gone to the scheduled urology consult on 05/13/24. NP #1 said that he does not know how he missed that Resident # 1 had never gone to his/her appointment and said it had been an oversight. During an interview on 11/04/24 at 3:39 P.M., the Director of Nurses (DON) said that she was not aware that Resident #1 had a scheduled appointment on 05/13/24 for a Urology Consult and said Resident #1 missed the appointment. The DON said it is the Facility's expectation that when a resident is admitted or readmitted to the Facility, the Hospital DC Paperwork is to be reviewed by nursing staff and said if an appointment is scheduled or in need of scheduling the Patient Coordinator/Medical Records Staff will be promptly notified and arrangements will be made according to the physician's orders.