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	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Center at Advocate	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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43963 Based on records reviewed and interviews, for three of five sampled resident (Resident #2, #4, and #5), the Facility failed to ensure that the resident and/or his/her family member or legal representative participated in the development and implementation of their person-center care plans, when the residents and/or their legal representatives were not invited to attend an interdisciplinary care plan meeting following the completion of their Comprehensive Minimum Data Set (MDS) Assessment. Findings include: Review of the Facility Policy titled, Comprehensive Care Plans, dated as last revised 11/01/24, indicated that comprehensive care plan will be reviewed and revised by the IDT after each comprehensive and quarterly Minimum Date Set (MDS) Assessment. The Policy further indicated that the IDT includes, however, not limited to; -The Attending Physician; -A Registered Nurse; -A Certified Nurse Aide; -A member of the food and nutrition services staff; -The Resident and the resident's representative, to the extent practicable; and -And other appropriate staff or professionals in disciplines as determined by the resident's needs. 1) Resident #2 was admitted to the Facility in November 2024, diagnoses include status post multiple back surgery, diabetes mellitus, bipolar disorder, and acute on chronic pain. Review of Resident #2's Quarterly Minimum Data Set (MDS) dated , 02/17/25, indicated that he/she was alert, oriented and had a Brief Interview of Mental Status (BIMS) score of 15 (score of 13-15 indicated cognitively intact). (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/22/25 at 3:27 P.M., Resident #2 said he/she has never attended a comprehensive care plan meeting. Resident #2 and said that the staff has not invited him/her to attend a care plan meeting with the team to talk about his/her goals and interventions since he/she has been admitted . Review of Resident #2's Medical Record indicated that there was no documentation to support that the facility scheduled and conducted a comprehensive care plan meeting after the completion of his/her admission and/or quarterly MDS. 2) Resident #4 was admitted to the Facility in March 2024, diagnoses included atrial fibrillation, neurocognitive disorder, peripheral vascular disease and depression. Review of Resident #4's Annual MDS, dated [DATE], indicated that he/she was alert and had a BIMS score of 7/15 (score or 8-12 indicates moderate cognitive impairment). Review of Resident #4's Medical Record indicated that there was no documentation to support he/she had been invited or attended a comprehensive care plan meeting after completion of his/her latest annual MDS. 3) Resident #5 was admitted to the Facility in March 2025, diagnoses included anemia, cirrhosis, diabetes mellitus, and a history of falls. Review of Resident #5's Admission MDS, dated [DATE] indicated that he/she was alert and had a BIMS score of 11/15 (score of 8-12 indicates moderate cognitive impairment). Review of Resident # 5's Medical Record indicated that there was no documentation to support that the facility scheduled, conducted and invited him/her to the care plan meeting. During an interview on 04/22/25 at 1:17 P.M., the Director of Social Services said that the MDS Nurse generates the Care Plan Meeting Schedules, and that the Receptionist is responsible for sending out invitations to the resident and/or their responsible party. The Director of Social Services said she had not invited Resident #2 to the latest care plan review and said that she did not see a care plan note for his/her latest comprehensive care plan meeting. During an interview on 04/23/25 at 10:00 A.M., the MDS Nurse said that the receptionist was responsible for inviting the Resident and/or the Resident Representative to attend the comprehensive Care Plan Meetings. The MDS Nurse said that each resident has the right to attend their own care plan meetings. During a telephone interview on 04/28/25 at 12:06 P.M., the Support MDS Nurse said that she reviews the new admissions every morning and puts the resident on a MDS and care plan schedule for the building. The MDS Nurse said that she does not know how Resident # 5 was missed and said that it is expected that all residents and their representatives are invited to attend all comprehensive care plan meetings. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/23/25 at 12:24 P.M., the Director of Nurses said that it is the Facility's expectation that all residents and families are to be invited to the care plan meetings, that the care plan meetings are completed in a timely manner and in accordance with the completion of a residents' MDS.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 43963 Based on record review and interviews, for one of five sampled residents (Resident #1) who had requested bed rails be placed on his/her bed for repositioning and safety reasons, the Facility failed to ensure his/her request was adequately addressed when bed rails were not provided and was told he/she did not need them. Findings include: Review of the Facility Policy titled Resident Rights, dated 11/01/24, indicated that each resident has the right to a dignified existence, self-determination, and communication with the access to people and services inside and outside the facility. The Policy further indicated that the resident has the right to be informed of, participate in his or her treatment. Resident #1 was admitted to the Facility in February 2025, diagnoses included but not limited to Peripheral Artery Disease (PAD) with bilateral foot gangrene, diabetic neuropathy, Acute Lymphoblastic Leukemia (ALL) in remission, chronic pain and chronic urinary retention with an indwelling catheter in place. Review of Resident #1's Admission Minimum Data Set (MDS) Assessment, dated 02/21/25, indicated he/she was alert, oriented, was his/her own decision maker, and had scored a 15/15 on his/her Brief Interview for Mental Status (BIMS) Assessment (0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired cognition, and 12-15 suggests a resident is cognitively intact). Review of Resident #1's Physician's Order, for February 2025, indicated he/she had a new Physician's Order dated 2/14/25, to place two (2) quarter (1/4) bed rails on his/her bed. Review of Resident #1's Admission Bed Rail Assessment, dated 02/14/25, indicated that he/she had not been consulted regarding the use of the bed rails. During a telephone interview on 04/22/25 at 12:02 P.M., Family Member #1 said that on 02/21/25, he told Nurse #7 that he was worried about Resident #1's safety because he/she did not have bed rails on his/her bed. Family Member #1 said that Resident #1 had bed rails on his/her hospital bed both at home and while in the Hospital and said he/she (Resident #1) felt more comfortable and safer with the bed rails on the bed. During a telephone interview on 04/23/25 at 2:52 P.M., Resident #1 said that no one at the facility ever asked if he/she wanted bed rails on his/her bed. Resident #1 said that he/she had requested them, but was only told that he/she did not need them. Resident #1 said bed rails were not put on his/her bed during his/her stay at the facility. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 04/23/25 at 3:24 P.M., Nurse #2 said that she does not remember doing Resident #1's bed rail assessment upon admission. Nurse #2 said that residents sign a bed rail consent form upon admission and then nursing informs maintenance department staff when they need to place bed rails on the residents' bed. During an interview on 04/22/25 at 12:50 P.M., the Nurse Manager said that she was not aware that the staff had not consulted with Resident #1 regarding the use of bed rails. During an interview on 04/22/25 at 1:39 P/M., the Director of Rehabilitation (DOR) said that she did not remember talking about Resident #1 being able to utilize bed rails for mobility and said he/she was not assessed by the rehabilitation department for the use of bed rails. During an interview on 04/22/25 at 12:34 P.M., the Director of Nurses (DON) said that she was not aware that Resident #1 was not consulted on the use of bed rails. The DON said that the Facility's expectation to assess each resident for bed rails upon admission, obtain consent, and then have maintenance install the side rails to the bed if the Resident requests them for safety and security.

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 43963 Based on records reviewed and interviews for one of five sampled residents (Resident #1), who was totally dependent on staff for bed mobility, which included turning, repositioning and incontinence care, the Facility failed to ensure his/her was provided with the necessary level of staff supervision and/or assistance, when on 03/02/25, Resident #1 was positioned onto his/her side during care, the staff member left the room to get supplies, leaving him/her unattended and when staff member returned he/she was found on the floor after falling out of bed. Resident #1 was transferred to the Hospital Emergency Department (ED) where he/she was diagnosed with multiple bone fractures and was admitted for care. Findings include: Review of the Facility Policy titled Incidents and Accidents, dated as last revised 11/01/24, indicated that an accident refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident. The Policy further indicated that the purpose of incident reporting can include the following; -Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent reoccurrences and improve the management of the resident's care; -Conducting root cause analysis to ascertain causative/contributing factors as part of the Quality Assurance Performance Improvement (QAPI) to avoid further occurrences; and -Alert risk management and/or administration of occurrences that could result in claims of further reporting requirements. Review of the report submitted by the Facility via Health Care Facility Reporting System (HCFRS), dated 03/10/25, indicated that Resident #1 was found on the floor and sent to the Hospital Emergency Department for evaluation. The Report further indicated that at approximately 12:25 A.M., Resident #1 put his/her call light on, Nurse #1 responded and that Resident #1 asked to be changed. Nurse #1 said that she informed Certified Nurse Aide (CNA) #1, who went to Resident #1's room to provide care. The Report indicated that CNA #1 went into Resident #1's room, asked him/her what was needed and stepped out of the room to get supplies to change Resident #1. The Report indicated that when CNA #1 returned to Resident #1's room, he/she was found on the floor. Review of Resident #1's Hospital ED report, dated 03/02/25, indicated he/she suffered a left scalp abrasion, left superior and inferior pubic ramus (part of the pelvic bone) fracture, left scapular (shoulder blade) fracture and a left clavicle (collar bone) fracture. The Report indicated Resident #1 was admitted and remained in the Hospital for six days. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Resident #1 was admitted to the Facility in February 2025, diagnoses included but was not limited to Peripheral Artery Disease (PAD) with bilateral foot gangrene, diabetic neuropathy, Acute Lymphoblastic Leukemia (ALL) in remission, chronic pain and chronic urinary retention with an indwelling catheter in place. Review of Resident #1's Physical Therapy Evaluation, dated 02/17/25, indicated he/she was totally dependent for bed mobility and does not attempt to initiate. Review of Resident #1's Care Plan, titled ADL-Self-Care deficit, dated 02/18/25, indicated he/she was totally dependent on staff for all ADL's, including all transfers (mechanical lift required), repositioning, and toileting/incontinent care. Review of Resident #1's Admission Minimum Data Set (MDS) Assessment, dated 02/21/25, indicated that Resident #1 required total physical assistance from staff members for toileting needs, bed mobility and repositioning. Review of Resident #1's Occupational Therapy (OT) Note, dated 02/26/25, indicated that OT was working on bed mobility exercises to increase functional skills. The Note indicated Resident #1 required maximum assistance to position self towards the center of the bed due to severe right lateral lean when in bed. During a telephone interview on 04/23/25 at 2:52 P.M., Resident #1 said that on 03/02/25 at approximately 12:30 A.M., he/she put his/her call light on and told Nurse #1 that he/she needed to be changed. Resident #1 said two male CNA's (exact names unknown) came into the room to change him/her, turned and rolled him/her onto his/her side toward the window, left him/her on the bed like that and then they both walked away to go get some supplies for incontinent care. Resident #1 said he/she then rolled right off the bed and landed on concrete ledge on the floor that was below his/her window. Resident #1 said there was no bed rail on his/her bed to grab onto to help him/herself hold on. During a telephone interview on 04/24/25 at 9:27 A.M., Nurse #1 said she answered Resident #1's call light early in the morning on 03/02/25, toward the beginning of the night shift and he/she asked to be changed. Nurse #1 said she told CNA #1 that Resident #1 needed to be changed. Nurse #1 said she did not see how many CNA's entered Resident #1's room to provide him/her care. Nurse #1 said she went to go do something and CNA #1 came back to her and said Resident #1 was on the floor. Nurse #1 said that when she entered the room, Resident #1 was lying up against the concrete ledge that extended out from the floor under the window and they had to move the bed away from the window in order for her to assess Resident #1 for potential injuries. Nurse #1 said that Resident #1 was transferred to the Hospital Emergency Department (ED) for evaluation once she saw his/her face begin to bruise. During an interview on 04/28/25 at 12:06 P.M., CNA #1 said that around 12:15 A.M., Nurse #1 informed him that Resident #1 was wet and needed to be assisted with incontinent care. CNA #1 said he went to Resident #1's room, asked him/her what he/she needed and said Resident #1 told him that he/she needed to be changed. CNA #1 said he did not touch (reposition) Resident #1 to start care, but left the room to go get supplies first, that were needed to assist with care. CNA #1 said when he returned to the room approximately 2-3 minutes later, Resident #1 was on the floor. CNA #1 said there was no other CNA in the room helping him that night. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 04/22/25 at 1:07 P.M., the Certified Occupational Therapist Assistant (COTA) said that Resident #1 was bed bound and could use his/her hands to some extent, for example grasping his/her drink and he/she was working on self-feeding. During an interview on 04/22/25 at 1:39 P.M., the Director of Rehabilitation (DOR) said that she did not remember talking about Resident #1 being able to utilize side rails for mobility and said he/she was not assessed by the rehabilitation department for the use of side rails. The DOR said that Resident #1 was totally dependant for bed mobility, positioning, and incontinent care and said she was not certain who decides how many staff, one versus two should be providing a resident's care. During an interview on 04/22/25 at 4:16 P.M., CNA #5 said Resident #1 was difficult to reposition if the staff were unaware of his/her abilities. CNA #5 said Resident #1's body would slip (tilt) to one side and if he/she was not positioned correctly, he/she could have an accident. During an interview on 04/23/25 at 12:34 P.M., the Director of Nurse (DON) said that she does not know how Resident #1 ended up being found on the floor. The DON said that the Facility's expectation is to provide a safe environment for all residents and provide the necessary service and care needs that each resident requires. During an interview on 04/23/25 at 11:51 A.M., the Administrator said in the morning of 03/02/25 is when she learned of Resident #1 being found on the floor after requesting to be cleaned and changed earlier in the shift. The Administrator said she only knew the circumstances as they were reported to her.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 43963 Based on records reviewed, interviews, and observation for three of five sampled residents (Resident #3, #4 and #5), who had all been assessed as being their own person, the Facility failed to ensure that 1) Resident #3 was assessed for the use of bed rails and that his/her physicians order was for bed rails, and 2) after Resident #4 and #5 underwent a room change, that the bed rails were provided on their new beds, per their physicians orders. Findings include: Review of the Facility Policy titled Proper Use of Bed Rails, dated as last revised 11/01/24, indicated that the facility is to utilize a person-centered approach when determining the use of bed rails. The Policy further indicated that a proper assessment, informed consent, and a physician's order must be obtained prior to utilizing bed rails. 1) Resident #3 was admitted to the Facility in April 2025, diagnoses include status post left total knee replacement, bipolar disorder, Chronic Obstructive Pulmonary Disease (COPD) and obesity. Review of Resident #3's Informed Consent for Use of Bed Rails, dated 04/18/25, indicated he/she had consented to the use of bilateral quarter bed rails. Review of Resident #3's Physician's Order, dated 04/18/25, indicated to provide two grab bars (not bed rails) for bed mobility and positioning. Review of Resident #3's Admission Bed Rail Assessment, dated 04/18/25, indicated the form was blank, and that a bed rail assessment had not been completed upon admission or by the date of survey. During an observation on 04/22/25 at 2:00 P.M., the Surveyor observed bilateral quarter bed rails attached to his/her bed. 2) Resident #4 was admitted to the Facility in March 2024, diagnoses included atrial fibrillation, neurocognitive disorder, peripheral vascular disease, and depression. Review of Resident #4's Informed Consent for Use of Bed Rails, dated 03/02/24, indicated that he/she consented to the use of bed rails. Review of Resident #4's Quarterly Bed Rail Assessment, dated 02/28/25, indicated the use of two quarter bed rails may be used on his/her bed. During an observation on 04/22/25 at 4:44 P.M., the Surveyor observed Resident #4's bed, however there were no bed rails installed on it. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/22/25 at 4:44 P.M., Resident #4 said that he/she did not know why there were no bed rails on his/her bed and said that he/she used to have them on his/her bed before he/she changed rooms. Resident #4 said that he/she used the bed rails to help move him/herself in bed. Review of the Facility Room Change Summary Report, dated 04/23/25, indicated that on 03/04/25, Resident #4 had undergone a room change. 3) Resident #5 was admitted to the Facility in March 2025, diagnoses included anemia, cirrhosis, diabetes mellitus, and a history of falling. Review of Resident #5's Informed Consent for Use of Bed Rails, dated 03/24/25, indicated that he/she consented to the use of Bed Rails. Review of Resident #5's Admission Bed Rail Assessment, dated 03/24/25, indicated the use of bed rails had been assessed to be used on his/her bed. Review of Resident #5's Physician's Order, dated 03/24/25, indicated to provide two quarter grab bars for bed mobility and positioning. During an observation on 04/23/25 at 10:00 A.M., the Surveyor observed Resident #5's bed, however there were no bed rails installed on it. Review of the Facility Room Change Summary Report, dated 04/23/25, indicated that on 03/27/25, Resident #5 had undergone a room change. During an interview on 04/23/25 at 10:44 A.M., the Director of Maintenance said that he was not aware that two residents (#4 and #5, who had orders for and previously had bed rails in place on the beds), had their rooms changed, and therefore was not aware that bed rails needed to be installed on their new beds. The Director said nursing staff will inform the maintenance department when bed rails are to be installed or removed from a bed and if a resident moves to a different room nursing must inform them if the bed rails need to be removed from the residents original bed and installed on the resident's bed in the new room. The Director said each time before bed rails are installed to a bed, the maintenance worker will complete an entrapment assessment to ensure proper placement. During an interview on 04/23/25 at 11:05 A.M., the Assistant Director of Nurses (ADON) said that when a resident is admitted , the nurse doing the admission needs to complete the Admission Bed Rail Assessment, obtain informed consent from the Resident, obtain a physician's order, and inform maintenance that they need to install bed rails to the bed. During an interview on 04/23/25 at 12:34 P.M., the Director of Nurses (DON) said that it is the Facility's expectation that upon admission nursing completes a bed rail assessment, obtain informed consent from the resident and/or representative if being used, obtain a physician's order, and inform maintenance to install or remove bed rails after the appropriate steps have been taken for the use of bed rails.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 43963 Based on records reviewed and interviews, for one of five sampled residents (Resident #2) whose Physician's Orders included the administration of a narcotic medication for pain, the Facility failed to ensure the resident was free from a significant medication error due to omission, when Resident #2 missed two consecutive doses of scheduled pain medication because nursing staff could not gain access to the facility's Emergency Medication Dispensing System (EMDS, electronic kiosk system that requires a security code to be entered by nursing staff in order to access and dispense stored medications). Finding include: Review of the Facility Policy titled Medication Errors, dated as last revised 11/01/24, indicated that the Facility is to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors. The Policy further indicated that all medications shall be administered as follows; -According to a Physician's Order, including medication omissions; -Per Manufacturer's specifications regarding the preparation, and administration of the drug or biological; and -In accordance with the accepted standards and principles which apply to professionals providing services. Resident #2 was admitted to the Facility in November 2024, diagnoses included status post multiple back surgery, diabetes mellitus, bipolar disorder, and acute on chronic pain. Review of Resident #2's Physician's Orders, dated 01/23/25, indicated to administer Hydromorphone (Dilaudid, narcotic/pain medication) 2 milligrams (mg), give 2 tablets every four hours for pain, hold for sedation. Review of Resident #2's Medication Administration Record (MAR), dated 03/28/25, indicated he/she was not administered his/her scheduled doses of Dilaudid at 6:00 P.M. and 10:00 P.M. During an interview on 04/22/25 at 3:27 P.M., Resident #2 said that he/she was unable to get two doses of his/her pain medication because the medications were not ordered in a timely manner to be delivered from the pharmacy and was told by nursing that only the Director of Nurses (DON) could override the Emergency Medication Dispensing System (EMDS) to retrieve the pain medication from their emergency supply. During an interview on 04/22/25 at 2:20 P.M., Nurse #3 said that Nurse #4 (who was assigned to Resident #2 on 03/28/25) was an agency nurse and did not have security code access to the EMDS, so she was tried to help obtain Resident #2's medication from the EMDS for her. (continued on next page)

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	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Center at Advocate	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.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse #3 said when she went to obtain the 6:00 P.M. dose for Nurse #4 to administer to Resident #2, the EMDS displayed a error code, stating that there was not enough medication to fill the request and the EMDS would not unlock for them. Nurse #3 said that the only person who could unlock the EMDS was the DON and she (DON) was not able to come into the Facility to unlock the EMDS and release the medication. During a telephone interview on 05/01/25 at 1:43 P.M., Nurse #4 said that she was Resident #2's nurse on the evening (3:00 P.M.-11:00 P.M.) shift on 03/28/25 when the medication error of omission occurred. Nurse #4 said that she did not have access to the Facility's EMDS and Nurse #3 tried to help her obtain the medication for Resident #2, however, the EMDS had an error code and would not dispense the medication. Nurse #4 said that she was told only the Director of Nurses (DON) could override the error code in the EMDS and was unable to get to the Facility to do so. Nurse #4 said that the omission of the two doses of pain medication was considered a medication error. During a telephone interview on 05/01/25 at 1:22 P.M., the Pharmacy Representative for the Facility said that both the DON and Assistant Director of Nurses (ADON) have administrative access and were able to override error message issues in the EMDS. The Pharmacy Representative said that there was a miss count earlier in the day with the EMDS, so when the nurse tried to re-access the medication it locked her out from obtaining that specific medication, and also said there had been alternative medications available. The Pharmacy Representative said that either the DON or ADON could have accessed the medication if needed and if there had not been enough doses, the original order should have been placed STAT, and a representative from the pharmacy could have delivered the doses needed. During an interview on 04/22/25 at 12:34 P.M., the DON said she was not aware if the nursing staff had called the pharmacy on 03/28/25 for help, but said if the staff had called the pharmacy to help override the error, that the pharmacy could have helped with the lock out issue. The DON said that it is the Facility's expectation is that all prescribed medications should be ordered timely. The DON said that if a medication is needed from the EMDS and an error occurs, the nurse must call the pharmacy for additional guidance to gain access to the appropriate medication to prevent a medication error. On 04/23/25, the Facility was found to be in Past Noncompliance and presented the Surveyor with a plan of correction (with an effective date of 03/29/25) that addressed the area(s) of concern as evidenced by: A) Resident #1 was administered all other pain medication as ordered, and was monitored for effectiveness. B) On 03/29/25, the DON investigated the incident with the pharmacy to resolve the override issues and lockouts. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C) On 03/29/25, the Director of Nurses (DON) educated the licensed nurses on ordering medications form the pharmacy, obtaining medications form the EMDS, and what actions to take if a medication is unavailable. D) On 03/29/25, the DON began an audit of controlled substance medications and ensured medications needed were on hand or ordered from the pharmacy. E) On 03/29/25, The DON educated all licensed nurses on obtaining a physician's order to hold a missed medication and possibly provide an asked for alternative medication until issues resolved. F) Results of all audits and observations will be brought to and reviewed at Quality Assurance and Performance Improvement (QAPI) meetings for the next three months or until compliance is achieved. G) The DON and or Designee are responsible for overall compliance.

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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	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** 43963 Based on records reviewed and interviews for one of five sampled residents, (Resident #1), the Facility failed to ensure they maintained complete and accurate medical/clinical records, when documentation on his/her Activities of Daily Living (ADL) Flow Sheets that were to be completed daily by Certified Nurse Aides (CNA's), was often left blank. Findings include: Review of the Facility Policy titled Documentation in the Medical Record, dated as last revised 11/01/24, indicated that each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. The Policy further indicated the following; -Licensed staff and Interdisciplinary Team Members (IDT) shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy; and -Documentation shall be completed at the time of service, but no later the shift in which the assessment, observation, or care service occurred. Resident #1 was admitted to the Facility in February 2025, diagnoses included but not limited to Peripheral Artery Disease (PAD) with bilateral foot gangrene, diabetic neuropathy, Acute Lymphoblastic Leukemia (ALL) in remission, chronic pain and chronic urinary retention with an indwelling catheter in place. Review of Resident #1's Admission Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #1 required total physical assistance from staff members to transfer (with a mechanical lift device), total physical assistance from staff members for toileting needs, bed mobility, and repositioning. Review of Resident #1's Care Plan, titled ADL-Self-Care deficit, dated 02/18/25, indicated he/she was totally dependent on staff for all ADL's, including all transfers (mechanical lift required), repositioning, and toileting/incontinent care. Review of Resident #1's ADL Flow Sheets, completed by CNA's, dated 02/14/25 through 02/28/25, indicated the for the following shifts, documentation on the flow sheets were incomplete. -7:00 A.M. to 3:00 P.M.- 10 days (out of 15) all ADL care areas were left blank. -3:00 P.M. to 11:00 P.M.- 11 days (out of 15) all ADL care areas were left blank. -11:00 P.M. to 7:00 A.M.- 13 days (out of 15) all ADL care areas were left blank. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/22/25 at 12:16 P.M., CNA #6 said that documentation for the resident's ADL's needed to be completed before the end of their shift. During an interview on 04/22/25 at 12:50 P.M., the Unit Manager said that all ADL documentation done by the CNA must be completed by the end of their shift. During an interview on 04/23/25 at 12:34 P.M., the Director of Nurses (DON) said that all CNA documentation on the residents ADL's must be completed accurately and in a timely manner.