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	12/19/2025

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews for one of three sampled residents (Resident #2), whose Advanced Directives indicated he/she chose to be a Do Not Resuscitate (DNR, instructs healthcare providers not to do cardiopulmonary resuscitation (CPR) if patients breathing stops or their heart stops beating) the Facility failed to ensure nursing staff honored his/her right to self-determination, when after he/she became unresponsive, was not breathing, was found to be without a pulse, and nursing staff initiated CPR.Findings include:Review of the Facility Policy titled Resident's Rights Regarding Treatment and Advanced Directives, dated as last revised 09/2024, indicated that the Facility will support and facilitate a resident's right to request, refuse, and/or discontinue medical or surgical treatments and to formulate advanced directives.The Policy further indicated that upon admission, should the residents have an advanced directive, copies will be made and placed in the chart and communicated to staff, during the care plan process the Facility will identify, clarify, and review with the resident or legal representative whether they desire to make any changes related to advanced directives.Resident #2 was admitted to the Facility in June 2025 diagnoses include schizoaffective disorder, diabetes mellitus, a history of dysphagia (difficulty swallowing), and Gastrointestinal Reflux Disease (GERD).Review of Resident #2's Hospital Discharge Summaries, dated 06/18/25 and 07/02/25, indicated that his/her code status at time of discharge was Do Not Resuscitate (DNR), Do Not Intubate (DNI-No CPR/No Intubation).Review of Resident #2's Massachusetts Order for Life Sustaining Treatment (MOLST) Form, dated and signed 07/01/25, indicated he/she had chosen to be a DNR/DNI, Do Not Ventilate and Do Not use Non-Invasive Ventilation. Review of Resident #2's History and Physical, dated 07/05/25, indicated he/she was a DNR/DNI and that the physician had discussed the advanced directives with the Health Care Agent (HCA) and Resident.Review of Resident #2's Physician's Orders, dated 07/14/25, indicated his/her Health Care Proxy had been invoked.Review of the report submitted by the Facility via Health Care Facility Reporting System (HCFRS), dated 11/24/25, indicated that Resident #2 had a choking event, received the Heimlich Maneuver successfully, walked back to his/her room with the assistance of two nurses, quickly became unresponsive and CPR was initiated until the MOLST Form had been located and CPR ceased (by EMS) due to being a DNR.During an interview on 12/19/25 at 11:09 A.M., Nurse #1 said that on 11/24/25, Resident #2's had been on her assignment since 7:00 A.M. Nurse #1 said that around shift change (3:15 P.M.) Resident #2 came walking out towards the nurse's station and said she noticed he/she was grabbing at his/her neck and attempting to speak. Nurse #1 said it appeared that he/she was choking and she immediately initiated the Heimlich Maneuver, providing two thrusts, resulting in Resident #2 expelling a good amount of what looked to be chewed food from his/her mouth.Nurse #1 said that Resident #2 was able to and insisted on walking back to his/her room with the help of Nurse #2, Certified Nurse Aide (CNA) #1 and herself. Nurse #1 said that his/her color was grey, he/she began to lay back, and became unresponsive.Nurse #1 said that she left Nurse #2 and CNA #1 in Resident #2's room while she ran to check his/her code status. Nurse #1 said that she looked in Point Click Care (PCC, the Facility's Electronic Medical Record) at his/her face sheet and determined that he/she was a full code. Nurse #1 said she called a Code Blue, returned to Resident #2's room and initiated CPR with Nurse #2 until EMS arrived and took over lifesaving needs.Nurse #1 said that it was not until after the EMS took over that she noticed the Former Director of Nurses (DON) with a pink MOLST Form in her hands informing EMS that Resident #1 was not a Full Code, but a DNR/DNI.During a telephone interview on 12/30/25 at 12:29 A.M. , Nurse #2 said that she was the Nurse helping Nurse #1 with administering CPR to Resident #2.Nurse #2 said that when EMS arrived, she had gone to Resident #2's chart and located his/her MOLST Form indicating he/she was a DNR/DNI. Nurse #2 said she immediately handed it to the former DON and that was when EMS announced to stop CPR, that Resident #2 was a DNR/DNI.During an interview on 12/18/25 at 2:02 P.M., Certified Nurse Aide (CNA) #1 said that at 3:15 P.M., Resident #2 walked to the nurse's station from his/her room, and she noted that he/she was unsteady on his/her feet (which had been unusual). CNA #1 said that she, Nurse #1 and Nurse #2 walked Resident #2 back to his/her room and said they were trying to prevent him/her from laying down, but he/she laid down flat and almost instantly became unresponsive. CNA #1 said that one of the nurses said to call a code blue, everyone began arriving with the crash cart, Automatic Electronic Defibrillator, and she said she called Emergency Medical Services (EMS/911).During an interview on 12/19/25 at 8:40 A.M., the Director of Social Services said that she had missed Resident #2's

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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. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews for two of three sampled residents (Resident #1 and #3) who received wound care services by either an Out-Patient Clinic or Facility Contracted Provider, the Facility failed to ensure nursing staff provided care and services that met professional standards of quality related to A) notifying the attending physician of recommendations made by their wound care clinicians and B) adequate monitoring and assessment of the residents wounds by nursing to determine if areas were improving or deteriorating. Findings include:Review of the Facility Policy titled Consulting Physician/Practitioners Orders, dated as last revised 09/2024, indicated that the attending physician shall authenticate orders for the care and treatment of assigned residents.The Policy further indicated that consulting physician/practitioner orders are those orders provided to the facility by a physician/practitioner other than the residents' attending physician who is acting on behalf of the attending physician, including a Wound Clinic Physician or Nurse Practitioner, clinical nurse specialist, or physician's assistant to the Wound Physician. Review of the Facility Policy titled Pressure Injury Prevention Guidelines, dated as last revised 09/2024, indicated the goal is to prevent formation of avoidable pressure injuries and to promote healing of existing pressure injuries, it is the policy of this facility to implement evidence-based interventions for all residents who are assessed at risk or who have a pressure injury present. The Policy indicated that the compliance with interventions will be documented in the medical record;-For at-risk residents: treatment or medication administration records.-For residents who have a pressure injury present: treatment or medication administration records; weekly wound summary and charting.The Policy further indicated that the effectiveness of interventions will be monitored through ongoing assessment of the resident and/or wound. Considerations for needed modifications include:-Development of a new pressure injury; and-Lack of progression towards healing or changes in wound characteristics.1) Resident #1 was admitted to the Facility in February 2024, diagnoses include schizophrenia, bipolar disorder, diabetes mellitus with neuropathy, and a non-healing left hip surgical wound that developed into a Stage IV (full thickness tissue loss where skin damage extends down to exposed muscle, tendon, or bone) pressure injury.A) During a telephone interview on 12/15/25 at 3:30 P.M., Family Member #1 said that he escorts Resident #1 to his/her outpatient clinic wound appointments monthly. Family Member #1 said that the Facility does not follow the recommendations made by Resident #1's Wound Care Provider and said that he was concerned that by not following the recommendations, that it may be hindering his/her recovery.Review of Resident #1's Hospital Discharge summary, dated [DATE], indicated he/she Stage IV (pressure injury to his/her left hip.Review of Resident #1's Out-Patient Clinic's Wound Care Summary, dated 08/06/25, indicated he/she had a Stage IV pressure injury to his/her left hip and a new wound to his/her left buttocks.The Clinic's Summary further indicated a treatment order for his/her left buttocks wound; -Clean Wound with saline, pat dry 2 times a day and each diaper change; and-Apply Moisture Barrier cream to the wound.Review of Resident #1's Medical Record indicated that there was no documentation to support a treatment order had been obtained from his/her physician for his/her left buttocks wound. Review of Resident #1's Out-Patient Clinic's Wound Care Summary, dated 11/06/25, indicated he/she had a Stage IV pressure injury to his/her left hip (increased in size) and a new Stage IV sacral pressure injury, debrided of a large amount of necrotic (dead) tissue.The Clinic's Summary further indicated that the Wound Physician's treatment recommendations were as follows;-Initiate an external catheter for management of incontinence (if successful, stop using adult briefs);-Place Resident #1 on a full air mattress (not an overlay);-Resident #1 is to be bedbound except for physical therapy (must be returned to bed when physical therapy is done);-Turn to a 30-degree lateral side lying position, use wedge pillows to keep in positions, and do not place wedge or pillow under the wound; and -May sit up in bed on his back for 30 minutes for meals then must be returned to side lying position.Review of Resident #1's Medical Record indicated that there was no documentation to support that nursing staff reviewed the recommendations that had been suggested by the Outpatient Clinic or that they were brought to the attention of Resident #1's Attending Physician for approval or rejection.During an interview on 12/19/25 at 12:51 P.M., the Assistant Director of Nurses said that if a Nurse receives any recommendations from a provider, including an outpatient wound clinic, the recommendations must be reviewed with the resident's physician for either approval or denial immediately.B) Review of Resident #1's readmission Skin Assessment, dated 08/01/25, indicated he/she had an unspecified area to his/her left thigh However, there was no description of the area

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed, interviews, and observations for one of three sampled residents (Resident #3) who required Enhanced Barrier Precautions (EBP-an infection control intervention designed to reduce transmission of Multi-Drug-Resistant Organisms (MDRO) in nursing homes) related to wound care needs, the Facility failed to ensure nursing staff were aware of when to use and implement the necessary infection control practices during the provision of care. Findings include:Review of the Facility's Policy titled Enhanced Barrier Precautions (EBP) dated as last revised 09/2024, indicated that EBP's are utilized for the prevention of transmission of multi-drug-resistant organisms (MDRO's) to residents.The Policy further indicated that a physician's order for EBP's will be obtained for residents with any of the following:-Wounds (chronic wounds such as pressure injuries, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers); and/or-Indwelling medical devices (central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters) even if the resident is not known to be infected or colonized with a MDRO.-PPE for EBP's is only necessary when performing high-contact care activities (dressing, bathing, transferring, providing hygiene, changing linens, briefs, toileting, device care and wound care)Resident #3 was admitted to the Facility in 09/2025, diagnoses include dementia with behaviors, repeated falls, and depression.Review of Resident #3's, admission assessment dated [DATE], indicated that he/she was admitted with two (2) Stage 2 (partial thickness skin loss where the outer layer and part of the underlying dermis is damaged) pressure injuries, one to each of his/her heels.Review of Resident #3's admission Minimum Data Set (MDS) Assessment, dated 09/30/25, indicated he/she had two Stage 2 pressure injuries present on admission.During an interview on 12/31/25 at 1:32 P.M., the Infection Preventionist (IP) said that she was not aware that Resident #3 had two pressure injuries upon admission. The IP said that if a resident is admitted with or develops a pressure injury nursing staff must notify her and initiate EBP's (put a sign at their room door and provide PPE outside of the room) to help minimize the spread of any infection.Review of Resident #3's Physician's Orders, dated 12/19/25, indicated that there was no documentation to support that a Physician's Order had been obtained to maintain EBP's (until after being identified by the Surveyor during the survey).During an observation on 12/19/25 at 9:36 A.M., the Surveyor observed that there was no signage on Resident #3's room outside the doorway to indicate that he/she was on any kind of precautions and there was no Personal Protective Equipment (PPE- gowns, gloves, masks, eye protection) designated to his/her room. During the same observation the Surveyor observed two Certified Nurse Aides (CNA) in Resident #3's room providing direct care for him/her without wearing the appropriate PPE.During an interview on 12/19/25 at 10:05 A.M., CNA #2 said that Resident #3 was not on any precautions that she was aware of, that she had provided Resident #3 personal care in the morning and had not worn PPE other than gloves. During an interview on 12/19/25 at 10:16 A.M., Nurse #4 said that Resident #3 has a pressure injury to his/her left heel that was open and bleeding. Nurse #4 said that he/she should be on EBP's. Nurse #4 said she was not sure why there was no sign for EBP's outside of his/her room.During an interview of 12/19/25 at 1:24 P.M., the Director of Nurses (DON), said she did not know Resident #3 was not placed on EBP's and said he/she should have been secondary to his/her pressure injury, wound care needs.The DON said that it was the Facility's expectation that any resident with a history of an MDRO, indwelling device, and wounds, that they must be placed on EBP's immediately, and also be reported to her and the IP to ensure proper infection control procedures are being followed.