

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225413	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2024
NAME OF PROVIDER OR SUPPLIER Advocate Healthcare of East Boston, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456</p> <p>Based on observations, record review and interview, the facility failed to maintain one Resident's (#94) dignity by ensuring his/her clothing covered sensitive body parts, out of a total sample of 38 residents.</p> <p>Findings include:</p> <p>Resident #94 was admitted to the facility in September 2021 with diagnoses including major depression and schizophrenia.</p> <p>Review of Resident #94's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 7 out of a possible 15, which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #94 required supervision with bathing and dressing tasks.</p> <p>On 6/4/24 from approximately 8:00 A.M., to 8:50 A.M., Resident #94 was observed walking up and down the hallway barefoot. The Resident was wearing black sweatpants, and the right side of the pants were ripped open, exposing the Resident's buttocks. During this time, the Resident walked past a nurse several times and stopped to speak with a Certified Nursing Assistant (CNA).</p> <p>Review of Resident #94's Activity of Daily Living (ADL) care plan last revised on 5/14/24, indicated the following intervention:</p> <p>-Dressing: maximal assistance</p> <p>Review of the CNA documentation for 6/4/24 indicated Resident #94 required substantial assistance from staff for lower body dressing on 6/4/24.</p> <p>During an interview on 6/4/24 at 2:36 P.M., the Director of Nursing (DON) said staff should have observed the Resident's ripped pants and encouraged him/her to put pants on that covered his/her buttocks. The DON said Resident #94 will often put on clothes that staff have changed him/her out of but she would still expect staff to encourage the Resident to change his/her clothes.</p> <p>The ADL care plan was updated to add an intervention regarding Resident #94 making poor choices in clothing after the interview with the DON.</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46339</p> <p>Based on observation and interview, the facility failed to provide a homelike environment, specifically, the facility failed to address a chirping fire alarm.</p> <p>Findings Include:</p> <p>During an observation on 6/4/24 at 11:13 A.M., the surveyor observed a fire alarm in room [ROOM NUMBER] chirping repeatedly.</p> <p>During an observation on 6/5/24 at 6:50 A.M., the surveyor observed a fire alarm in room [ROOM NUMBER] chirping repeatedly.</p> <p>During an observation on 6/6/24 at 7:00 A.M., the surveyor observed a fire alarm in room [ROOM NUMBER] chirping repeatedly.</p> <p>During an interview on 6/6/24 at 9:56 A.M., the Maintenance Director said that he is usually told about any issues in the building via maintenance logbooks that are kept on all nursing units or staff call his direct phone line for any issues. The Maintenance Director said he was not aware or told of the chirping fire alarm in room [ROOM NUMBER].</p>

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876</p> <p>Based on record review and interview, the facility failed to ensure staff followed their abuse/neglect policy related to resident to resident abuse for one Resident (#37) out of a total of 38 sampled residents.</p> <p>Findings include:</p> <p>Review of the facility's Abuse, Neglect and Exploitation policy dated February 2023 indicated:</p> <p>Definitions: Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Verbal abuse means the use of oral, written or gestured communications or sounds that willfully includes disparaging and derogatory terms to residents or their families or within hearing distance regardless of their age, ability to comprehend or disability.</p> <p>Investigation of alleged abuse, neglect and exploitation: An immediate investigation is warranted when suspicion of abuse, neglect or exploitation or reports of abuse, neglect or exploitation occur.</p> <p>Reporting/Response: The facility will have written procedures that include: reporting of all alleged violations to the Administrator, state agency, adult protective services and all other required agencies within specified timeframes; immediately, but not later than two hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury. The Administrator will follow up with government agencies during business hours to confirm the initial report was received and to report the results of the investigation when final within 5 working days of the incident as required by state agencies.</p> <p>Resident #37 was admitted to the facility in September 2023 with diagnoses including traumatic brain injury, schizophrenia and traumatic hemorrhage of the cerebrum.</p> <p>Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #37 scored 6 out of a possible 15 on the Brief Interview for Mental Status Exam, indicating he/she is severely cognitively impaired.</p> <p>Review of of the nurse progress note dated 1/22/2024 at 1:04 P.M., indicated: Pt (patient) sent out 911, section 12 (involuntary hospitalization). Made homicidal comments, social worker & psych NP (nurse practitioner) made aware. Facilitated section, police arrived, pt resisted, restrained on stretcher.</p> <p>Review of the Psychiatric NP note dated 1/22/24 indicated Resident #37 had become agitated and shouted when she attempted to meet with Resident #37's roommate. Resident #37 threatened to hurt someone like a dog.</p> <p>Review of the hospital paperwork, dated 1/30/24, indicated: [Resident #37] threatened to strangle his/her roommate like a dog while he/she is sleeping.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the state agency's reporting system failed to indicate the facility reported the incident per their policy.</p> <p>During an interview on 6/10/24 at 9:40 A.M., the Director of Nursing (DON) said she thought the incident was reported to the state agency and was unaware it had not been.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876</p> <p>Based on record review and interview, the facility failed to ensure staff reported a resident to resident altercations for one Resident (#37) out of a total of 38 sampled residents.</p> <p>Findings include:</p> <p>Review of the facility's Abuse, Neglect and Exploitation policy dated February 2023 indicated:</p> <p>Definitions: Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Verbal abuse means the use of oral, written or gestured communications or sounds that willfully includes disparaging and derogatory terms to residents or their families or within hearing distance regardless of their age, ability to comprehend or disability.</p> <p>Investigation of alleged abuse, neglect and exploitation: An immediate investigation is warranted when suspicion of abuse, neglect or exploitation or reports of abuse, neglect or exploitation occur.</p> <p>Reporting/Response: The facility will have written procedures that include: reporting of all alleged violations to the Administrator, state agency, adult protective services and all other required agencies within specified timeframes; immediately, but not later than two hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury. The Administrator will follow up with government agencies during business hours to confirm the initial report was received and to report the results of the investigation when final within 5 working days of the incident as required by state agencies.</p> <p>Resident #37 was admitted to the facility in September 2023 with diagnoses including traumatic brain injury, schizophrenia and traumatic hemorrhage of the cerebrum.</p> <p>Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #37 scored 6 out of a possible 15 on the Brief Interview for Mental Status Exam, indicating he/she is severely cognitively impaired.</p> <p>Review of of the nurse progress note dated 1/22/2024 1:04 P.M., indicated: Pt (patient) sent out 911, section 12. Made homicidal comments, social worker & psych NP (nurse practitioner) made aware. Facilitated section, police arrived, pt resisted, restrained on stretcher.</p> <p>Review of the Psychiatric NP note dated 1/22/24 indicated Resident #37 had become agitated and shouting when she attempted to meet with Resident #37's roommate. Resident #37 threatened to hurt someone like a dog.</p> <p>Review of the hospital paperwork, dated 1/30/24, indicated: [Resident #37] threatened to strangle his/her roommate like a dog while he/she is sleeping.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the state agency's reporting system failed to indicate the facility reported the incident as required.</p> <p>During an interview on 6/10/24 at 9:40 A.M., the Director of Nursing (DON) said she thought that the incident was reported to the state agency and was unaware it had not been.</p>

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019</p> <p>Based on record review and interview, the facility failed to obtain an updated Pre-Admission Screening and Resident Review (PASARR) for one Resident (#192) out of a total sample of 38 residents.</p> <p>Findings include:</p> <p>Resident #192 was admitted in December 2023 with diagnoses including bipolar disorder, depression, schizoaffective disorder, and generalized anxiety. Review of the admission Minimum Data Set (MDS), dated [DATE], indicated Resident #192 scored a 10 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment.</p> <p>Review of the clinical record indicated Resident #192 received a PASARR Level II (a screening for individuals with serious mental illness, intellectual disability, developmental disability, or other related condition requiring specialized services). The PASRR indicated the following:</p> <p>- Your PASARR level II has been completed. It has been determined that you are appropriate for a Provisional Emergency admission to a Nursing Facility that cannot exceed 7-calendar days. Should the length of your stay in the nursing facility need to exceed the 7-calendar day approval of the Provisional Emergency, the nursing facility must submit a request on your behalf for an additional Level II Resident Review by the 2nd calendar day after your admission.</p> <p>The facility failed to provide evidence that an additional PASRR Level II was completed for Resident #192, whose stay exceeded 7-calendar days.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019</p> <p>Based on observation, record review, and interview, the facility failed to develop and implement the plan of care for 2 Residents (#192 and #62) out of a total sample of 38 residents. Specifically, the facility failed to 1. develop a suicidal ideation care plan and 2. develop a care plan for a behavior of chewing on any items in his/her hands which puts him/her at risk for choking.</p> <p>Findings include:</p> <p>Review of the facility policy titled Comprehensive Care Plans, revised 2/2023, indicated:</p> <ul style="list-style-type: none"> - It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident. - The physician, other practitioner, or professional will inform the resident and/or resident representative of the risks and benefits of proposed care, of treatment, and treatment alternatives/options. The facility will attempt alternate methods for refusal of treatment and services and document such attempts in the clinical record, including discussions with the resident and/or resident representative. <p>1. Resident #192 was admitted in December 2023 with diagnoses including bipolar disorder, depression, schizoaffective disorder, and generalized anxiety. Review of the admission Minimum Data Set (MDS), dated [DATE], indicated Resident #192 scored a 10 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment.</p> <p>Review of the hospital discharge paperwork indicated Resident #192 reported suicidal ideation (SI) during his/her hospital stay, stating if I did have access to firearms, I would kill myself and I have nothing to live for.</p> <p>On 1/8/24, review of the progress notes indicated Resident #192 expressed wanting to die.</p> <p>On 1/31/24, Resident #192 was readmitted to the facility after a planned hospitalization with suicidal ideation that was stated in the hospital. Resident #192 was placed on a section 12 in the hospital and cleared to come back.</p> <p>Review of the record failed to indicate that a care plan was developed for suicidal ideation after admission with a known history of suicidal ideation, verbalization on 1/8/24, and after re-admission to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/10/24 at 8:31 A.M., Social Services Assistant #1 said that Resident #192 had some cognitive issues, but engaged the best that he/she could. Social Services Assistant #1 said that there was an adjustment period that he/she struggled with slightly due to his/her family and brother. Social Services Assistant #1 said that if a Resident verbalizes a recent suicidal ideation, then that Resident should be followed on a regular basis and seen daily or once a shift to make sure they are feeling safe. Social Services Assistant #1 said that the care plan should be updated and supportive care in place.</p> <p>During an interview on 6/6/24 at 10:38 A.M., the psych NP said that if a Resident is expressing suicidal ideation then certain safety measures should be put in place and a care plan should be developed to keep the Resident safe.</p> <p>During an interview on 6/6/24 at 11:15 A.M., the Director of Nursing said when a resident is admitted with a history of suicidal ideation, a care plan should be developed with interventions to keep the Resident safe and supportive services would be put in place, including psych and social services.</p> <p>48990</p> <p>2.) Resident #62 was admitted to the facility in September 2023 with diagnoses including a stroke with left-sided hemiparesis (weakness on one side of the body).</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 3/6/2024, indicated that Resident #62 was rarely/never understood and had severely impaired cognition. This MDS also indicated Resident #62 required assistance that ranged from substantial/maximal to totally dependent with all activities of daily livings.</p> <p>Review of Resident #62's progress note, dated 3/4/24, indicated:</p> <p>- Pt (patient) always biting his/her hands if he/she does not have his/her mouth toy. Pt bites really hard. pt chewed away his/her last toy. Pt does not express pain. PRN (as needed) given and a new toy was brought in by the family.</p> <p>Review of Resident #62's progress note, dated 3/6/24, indicated:</p> <p>- Was behavioral yesterday and kept spitting out his/her meds no matter what this nurse tried. PRN given but pt spit it out and tried to bite the nurse multiple times. Gave him/her a new chew item yet cant [sic] not find it now. Pt bites his/her hand constantly really hard making indents and discoloration.</p> <p>On 6/10/24 at 10:03 A.M., the surveyor observed Resident #62 with a palm guard in his/her left hand and he/she was holding a blue chewing stick, which he/she was chewing on, in his/her right hand. CNA #7 said Resident #62 has a palm guard for his/her left hand and uses a chewing stick.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #62's comprehensive care plan, physician orders, and kardex failed to indicate the presence of chewing behaviors, presence of the risk of choking on items in his/her hands, or any interventions used for the chewing behavior to prevent choking.</p> <p>Review of Resident #62's plan of care related to risk for aspiration (when food, liquid, or saliva that's intended to be swallowed enters the trachea, airway or lungs), dated 6/7/24, indicated he/she was a risk for aspiration, however, failed to indicate his/her behaviors of chewing non-food items and risk for choking on those items.</p> <p>During an interview on 6/10/24 at 11:16 A.M., Unit Manager #2 said Resident #62 has a behavior of near constant chewing of any item in his/her hands which puts him/her at risk for choking. Unit Manager #2 says Resident #62 uses a chewing stick to decrease the risk of choking on other items. Unit Manager #2 said Resident #62 should not have a palm guard because he/she would try to eat it and they fear he/she will choke on it, but the agency nurse must have seen one in his/her room and applied without knowing. Unit Manager #2 said he would expect something to be in the care plan or orders indicating interventions to prevent the risk of choking, such as the chewing stick, and why the palm guard, or other items, should not be within reach.</p> <p>During an interview on 6/10/24 at 11:52 A.M., the Director of Rehab said Resident #62 used to have a palm guard, but it was discontinued because he/she kept trying to chew it and was at risk for choking on it.</p> <p>During an interview on 6/10/24 at 12:55 P.M., the Regional Nurse said she would expect interventions that are used to prevent the risk for Resident #62 choking, such as the chewing stick and not using a palm guard, to be documented in the care plan or the orders.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019</p> <p>Based on observation, record review, and interview, the facility failed to revise the behavioral health care plan for one Resident (#192) after a comprehensive assessment and suicidal ideation.</p> <p>Findings include:</p> <p>1. Resident #192 was admitted in December 2023 with diagnoses including bipolar disorder, depression, schizoaffective disorder, and generalized anxiety. Review of the admission Minimum Data Set (MDS), dated [DATE], indicated Resident #192 scored a 10 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment.</p> <p>Review of the hospital discharge paperwork indicated Resident #192 reported suicidal ideation (SI) during his/her hospital stay, stating if I did have access to firearms, I would kill myself and I have nothing to live for.</p> <p>At time of admission, a psychosocial well-being care plan was developed for Resident #192 and indicated the following:</p> <p>Focus: This resident is at risk for altered psychosocial well-being related to Adjustment to new environment/rehab setting, decline in functional/medical status, dx Schizoaffective d/o Bipolar 1, anxiety/panic d/o, depression, FTT (failure to thrive) in adult (initiated 12/2/23)</p> <p>Interventions:</p> <ul style="list-style-type: none"> - Activities to meet with this resident to develop and activity plan (initiated 12/2/23) - Behavioral health services as ordered and needed (initiated 12/2/23) - Encourage family members/residents representatives to be involved as allowed by resident to also participate in this plan to be able to provide direct support (initiated 12/2/23) - Encourage the resident to make their own decisions when able (initiated 12/2/23) - Encourage the resident to see a positive view of themselves (initiated 12/2/23) - Following up with responses to concerns brought up (initiated 12/2/23) - Medications as ordered to help manage their mood and behaviors (initiated 12/2/23) - Monitor and document mood and behaviors (12/2/23) - Provide 1:1 to allow this resident to verbal feeling/concerns (12/2/23) - Provide the resident praise for all their efforts made (initiated 12/2/23) <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Remind this resident of their goals and reassure them on progress made (12/2/23)</p> <p>Review of Resident #192's other comprehensive care plans failed to indicate a care plan was developed for the Resident's history of suicidal ideation (SI).</p> <p>On 1/8/24, review of the progress notes indicated Resident #192 expressed wanting to die.</p> <p>On 1/31/24, Resident #192 was readmitted to the facility after a planned hospitalization with suicidal ideation that was stated in the hospital. Resident #192 was placed on a section 12 in the hospital and cleared to come back.</p> <p>Review of the record failed to indicate Resident #192's care plan was revised or reviewed after re-admission to the facility and with a verbalization of suicidal ideation.</p> <p>During an interview on 6/10/24 at 8:31 A.M., Social Services Assistant #1 said that Resident #192 had some cognitive issues, but engaged the best that he/she could. Social Services Assistant #1 said that there was an adjustment period that he/she struggled with slightly due to his/her family and brother. Social Services Assistant #1 said that if a Resident verbalizes a recent SI, then that Resident should be followed on a regular basis and seen daily or once a shift to make sure they are feeling safe. Social Services Assistant #1 said that the care plan should be updated and supportive care in place.</p> <p>During an interview on 6/6/24 at 10:38 A.M., the psych NP said that if a Resident is expressing suicidal ideation then certain safety measures should be put in place and a care plan should be developed to keep the Resident safe.</p> <p>During an interview on 6/6/24 at 11:15 A.M., the Director of Nursing said when a resident is admitted with a history of suicidal ideation, a care plan should be developed with interventions to keep the Resident safe and supportive services would be put in place, including psych and social services.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46339</p> <p>Based on observations, record reviews and interviews, the facility failed to specifically provide required assistance with activity of daily living for one Resident (#287) out of a total sample of 38 residents.</p> <p>Findings include:</p> <p>Review of facility policy titled 'Activities of Daily Living (ADLs), reviewed February 2023 indicated the following but not limited to:</p> <p>-A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Resident #287 was admitted to the facility in May 2024 with diagnoses including, bipolar disorder and depression.</p> <p>Review of Resident #287's Minimum Data Set assessment dated [DATE] indicated he/she did not participate in a Brief Interview of Mental Status Exam.</p> <p>On 6/4/24 at 9:19 A.M., Resident #287 was observed sitting in his/her room, the Resident was observed with long thick bushy chin hairs. The Resident said he/she would like assistance with removing the facial hair.</p> <p>On 6/5/24 at 11:43 A.M., Resident #287 was observed in his/her room, the Resident had long thick bushy chin hair. Resident #287 said no one had offered to clean his/her facial hair.</p> <p>Review of Resident #287 medical record indicated the following:</p> <p>A care plan initiated 5/19/24 for ADLs require assistance: indicated the following interventions personal hygiene extensive assist.</p> <p>Further review of medical record failed to indicate that Resident #287 refused care.</p> <p>During an interview on 6/5/24 at 11:44 A.M., Certified Nursing Assistant (CNA) #1 said she did not offer Resident #287 to remove facial hair.</p> <p>During an interview on 6/5/24 at 11:48 A.M., Certified Nursing Assistant (CNA) #2 said the CNA's are to offer facial removal when providing ADL care.</p> <p>During an interview on 6/5/24 at 12:05 P.M., Nurse #2 said the Resident was recently admitted to the facility and has not shown any behaviors of refusing care.</p> <p>During an interview on 6/6/24 at 9:27 A.M., the Director of Nursing said chin hair removal is part of the ADL care, and if a resident refused it would be documented and care planned.</p>		

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<p>F 0688</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456</p> <p>Based on observations, record review, policy review and interviews, the facility failed to 1) prevent a worsening of range of motion with new contracture development for one Resident (#125) and 2) failed to implement interventions for contracture management for one Resident (#16) out of a total sample of 38 residents.</p> <p>Findings include:</p> <p>Review of the facility policy titled, Prevention of Decline in Range of Motion, dated 2/2024 indicated the following:</p> <ul style="list-style-type: none"> -Residents who enter the facility without limited range of motion will not experience a reduction in range of motion unless the resident's clinical condition demonstrated that a reduction in range of motion is unavoidable. -The facility in collaboration with the medical director, director of nurses and as appropriate, physical/occupational consultant shall establish and utilize a systemic approach for prevention of decline in range of motion, including the assessment, appropriate care planning, and preventative care. -Licensed nurses will assess resident's range of motion (such as current extent of movement of his/her joints and identification of limitations) on admission/readmission, quarterly, and upon a significant change. -Residents who exhibit limitations and range of motion, initially and thereafter, will be referred to the therapy department for a focused assessment of range of motion. -Staff will be educated on the risk factors for a decline in range of motion. These include but are not limited to: limbs or digits immobilized because of injury or surgical procedures, immobilization (e.g. Bed rest), deformities arising out of neurological deficits, pain, spasms, and immobility associated with arthritis, late stage Alzheimer's disease or other conditions. <p>1. Resident #125 was admitted to the facility in December 2023 with diagnoses including dementia and diabetes.</p> <p>Review of Resident #125's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident was unable to complete the Brief Interview for Mental Status exam and staff had assessed him/her to have severe cognitive impairment. The MDS also indicated Resident #125 was dependent on staff for all functional tasks. Section GG of the MDS indicated the Resident did not have any impairments in range of motion.</p> <p>On 6/4/24 at 8:31 A.M., Resident #125 was observed lying in bed with both hands in a fist position. When asked, the Resident was unable to open his/her hands.</p> <p>(continued on next page)</p>

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<p>F 0688</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/7/24 at 11:30 A.M., Resident #125 was observed lying in bed with both hands in a fist position. When asked, the Resident was unable to open his/her hands.</p> <p>Review of Resident #125's full list of medical diagnoses failed to indicate a neurological diagnosis that would lead to a contracture.</p> <p>Review of the discharge summary from the hospital prior to admission indicated Resident #125 had bilateral lower extremity contractures but failed to indicate contractures of the Resident's upper extremities were present upon admission. The hospital paperwork also recommended staff complete ROM (range of motion) exercises with the resident.</p> <p>Review of Resident #125's admission nursing assessment dated [DATE], failed to indicate the Resident had an impairment of range of motion to his/her upper extremities.</p> <p>Review of the Occupational Therapy evaluation dated 12/27/23 indicated Resident #125's muscle tone was normal and failed to indicate the Resident had an upper extremity contracture.</p> <p>Review of the Nursing assessment dated [DATE] indicated Resident #125 had an impairment in range of motion to both upper extremities, a change from the assessment 3 months prior. Review of Resident #125's medical record failed to indicate a referral was made to rehabilitation at this time as a change in range of motion is first noted.</p> <p>During an interview on 6/7/24 at 11:35 A.M., Certified Nursing Assistant (CNA) #3 said she was unaware if Resident #125 had a decline in range of motion of his/her hands. CNA #3 entered Resident #125's room and attempted to open the Resident's hands. On both hands, CNA #3 was only able to straighten the Resident's first two fingers but the third, fourth and fifth fingers were bent in a fist position and CNA #3 could not straighten these fingers. As CNA #3 was attempting to straighten Resident #125's fingers, the Resident pulled his/her arms away wincing in pain.</p> <p>During an interview on 6/7/24 at 11:37 A.M., Nurse #3 said she was never told about a decline in Resident #125's range of motion.</p> <p>During an interview on 6/7/24 at 11:46 A.M., Unit Manager #2 said he was unaware of a decline in range of motion to Resident #125's hands. Unit Manager #2 then entered the Resident's room and attempted to straighten the fingers on both of Resident #125's hands. Unit Manager #2 could straighten the first two fingers on both hands but was unable to straighten the third, fourth and fifth fingers of each hand. As Unit Manager #2 was attempting to straighten the Resident's fingers, the Resident winced in pain and pulled his/her arm back. Unit Manager #2 said Resident #125 definitely had contractures of both hands. Unit Manager #2 said staff should be doing basic range of motion exercises during basic care and report any changes in range of motion to him so he could make a referral to the therapy department.</p> <p>During an interview on 6/7/24 at 12:03 P.M., the Director of Nursing (DON) said staff should be able to identify changes in range of motion and would be expected to report any changes to the nurse. The DON said the nurse would need to communicate any changes in range of motion to the therapy department so an evaluation could be completed. The DON said she was unaware Resident #125 had bilateral hand contractures.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/10/24 at 8:14 A.M., the Director of Rehabilitation (DOR) said all residents in the facility are screened quarterly to see if there have been any changes to the Resident's functional status. The DOR said a potential decline in range of motion is also looked at during the screening process. The DOR said she would also expect a referral from the nursing department if the nursing staff noticed a decline in range of motion for any of the residents in the facility. The DOR and surveyor looked through the screening logbook and the nursing referral book together. Both books failed to indicate a quarterly screen had been completed for Resident #125 since admission or that a referral was made to the therapy department in March 2024 when the decline in range of motion was indicated in the nursing assessment. The DOR said she was unaware Resident #125 had two new hand contractures and that the positioning of Resident #125's hands were a change and it would be appropriate for the Resident to have an occupational therapy evaluation.</p> <p>48990</p> <p>2.) For Resident #16, the facility failed to implement a physician's order for a left hand resting splint.</p> <p>Review of the facility policy titled 'Prevention of Decline in Range of Motion', revised 2/2024, indicated:</p> <p>-The facility will provide treatment and care in accordance with professional standards of practice. This includes, but is not limited to:</p> <p>ii. Appropriate equipment (braces or splints).</p> <p>Resident #16 was admitted to the facility in March 2014 with diagnoses including with a left hand contracture and a history of traumatic brain injury.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 4/24/2024, indicated that Resident #16 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 4 out of 15. This MDS also indicated Resident #16 was dependent on staff for dressing, transfers, and mobility.</p> <p>Review of the physician's order, dated 10/30/23, indicated:</p> <p>- Patient to wear resting hand splint on left hand in am and removed at bed, every day and evening shift *-*** kept in bedside drawer*****</p> <p>Review of the plan of care related to need for assistance with ADLS, dated 5/16/24, indicated</p> <p>- (L) resting hand sprint on in AM, off in PM.</p> <p>On 6/4/24 at 8:33 A.M., the surveyor observed Resident #16 in bed eating breakfast. Resident #16 did not have a resting hand splint on his/her left hand.</p> <p>On 6/4/24 at 12:10 P.M., the surveyor observed Resident #16 in bed eating lunch. Resident #16 did not have a resting hand splint on his/her left hand. Resident said staff need to help put it on his/her left hand, but when he/she asks staff says they can't do it.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The surveyor also made the following observations of Resident #16 without his/her left resting hand splint:</p> <ul style="list-style-type: none"> - On 6/4/24 at 2:38 P.M., Resident #16 said staff had not offered the resting hand splint today. - On 6/5/24 at 8:12 A.M. - On 6/6/24 at 10:01 A.M., Resident #16 said staff had not offered the resting hand splint today and asked surveyor to put it on. <p>On 6/6/24 at 10:07 A.M., Certified Nurse Assistant (CNA) #10 said Resident #16 is supposed to have a carrot (a device used for hand contractures) in his/her left hand but that sometimes staff can't find it, but that he/she does not refuse it. CNA #10 took a carrot out of Resident #16's drawer and applied it to Resident #16's left hand.</p> <p>During an interview on 6/7/24 at 11:30 A.M., Unit Manager #2 said Resident #16 should be wearing a left resting hand splint. Unit Manager #2 said Resident #16 should not be wearing a carrot because it is not a replacement for a left resting hand splint. Unit Manager #2 entered Resident #16's room and located a left resting hand splint and asked Resident #16 if he/she would like it on, and the Resident said yes.</p> <p>During an interview on 6/7/24 at 12:09 P.M., the Director of Nursing (DON) said Resident #16 should be wearing a left resting hand splint and that a carrot is not a replacement for this device. The DON said if Resident #16 had refused to wear the left resting hand splint that it should be documented in the Treatment Administration Record (TAR) or progress notes.</p> <p>Review of TAR and progress notes failed to indicate Resident #16 had refused to wear the left resting hand splint.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876</p> <p>Based on record review and interview, the facility failed to ensure the environment was free of hazards for one Resident (#37) out of a total of 38 sampled residents. Specifically, the facility failed to develop and implement interventions addressing Resident #37's behaviors of hoarding hazardous items, such as razors.</p> <p>Findings include:</p> <p>Resident #37 was admitted to the facility in September 2023 with diagnoses including traumatic brain injury, schizophrenia and traumatic hemorrhage of the cerebrum.</p> <p>Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #37 scored 6 out of a possible 15 on the Brief Interview for Mental Status Exam, indicating he/she is severely cognitively impaired.</p> <p>Review of Resident #37's clinical nurse progress notes indicated:</p> <p>On 1/22/2024 at 1:04 P.M., Pt (patient] sent out 911, section 12 (an emergent hospital transfer to keep a Resident safe from self-harm or harm to others). Made homicidal comments, social worker & psych NP (Nurse Practitioner) made aware. Facilitated section, police arrived, pt resisted, restrained on stretcher.</p> <p>On 1/22/2024 at 12:00 P.M., Pt was found having belongings (sic) that weren't [his/hers] hidden in [his/her] closet and draw (sic) in [his/her] room. Pt had about 20 razors, shaving cream, [and] other various supplies stashed in [his/her] room. Pt stole another patients belongings and cell phone, hid under a blanket in closet. These items were found while the pt was out on a MLOA (medical leave of absence).</p> <p>Review of Resident #37's care plans and physicians orders from January 2024 through April 15, 2024 failed to indicate interventions were implemented upon his/her return to the facility to monitor his/her behaviors of hazardous items including razors.</p> <p>Additional review of the nursing progress notes indicated:</p> <p>On 4/15/2024 at 2:18 P.M., This RN (registered nurse) obtained new wanderguard band and re-applied to pts R ankle. Pt cut old wanderguard band and fastened it together with string from a surgical mask. Pt verbally upset when this RN put new band on. Attending aide translated that pt stated [he/she] was going to cut it off Staff reminded pt that wanderguard was for safety. This RN looked in pt's room for scissors. While looking, 2 previous wanderguard devices were found, nail clippers and a plastic bag full of metal silverware. Items removed from room.</p> <p>Review of Resident #37's physicians orders indicated: 4/16/24; Safety check daily in [his/her] room for hoarding utensils (knives, forks, scissors, nail clippers, etc) call staff for assistance every day shift for hoarding and cutting safety bracelet.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/10/24 at 8:00 A.M., Nurse # 13 said that Resident #37 is behavioral and can escalate easily. Nurse #13 said that there is a physician's order for nurse staff check his/her room daily for razors and other hazardous items.</p> <p>During an interview on 6/10/25 at 9:40 A.M., the Director of Nursing (DON) said that after the incident where Resident #37 had threatened to kill his/her roommate, staff started routine searches of his/her rooms. The Director of Nursing was not aware that the searches were not initiated or completed until 4/16/24; after he/she was noted to be cutting off his/her wander guard.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>48990</p> <p>Based on observation, record review, policy review, and interview, the facility failed maintain professional standards in the managing and care for urinary catheter devices for one Resident (#27), out of a total sample of 38 residents. Specifically, the facility failed to ensure the urinary catheter drainage bag and tubing were not placed directly on the floor.</p> <p>Findings include:</p> <p>Resident #27 was admitted to the facility in January 2024 with diagnoses including obstructive uropathy and chronic kidney disease.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 4/24/24, indicated Resident #27 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 7 out of 15. This MDS also indicated Resident #27 was dependent on staff for assistance with toileting hygiene and had an indwelling urinary catheter.</p> <p>Review of Resident #27's physician's order, dated 5/16/24, indicated:</p> <p>- Indwelling Three way Foley Catheter 22 Fr (french units) with a 10cc (cubic centimeters) balloon to CD (catheter drainage) bag or leg bag in place check patency.</p> <p>Review of the plan of care related to indwelling foley catheter, revised 5/18/24, indicated Resident #27 was at risk for infection related to the presence of an indwelling foley catheter.</p> <p>On 6/4/24 at 8:14 A.M., the surveyor observed Resident #27 in bed asleep with his/her bed with his/her urinary catheter drainage bag attached to the bed frame. The urinary catheter drainage bag and tubing was directly touching the floor.</p> <p>The surveyor made the following additional observations of Resident #27 in bed:</p> <p>-On 6/4/24 at 12:07 P.M., Resident #27's urinary catheter drainage bag attached to the bed frame and was directly touching the floor.</p> <p>-On 6/5/24 at 6:11 A.M., Resident #27's urinary catheter drainage bag attached to the bed frame and was directly touching the floor.</p> <p>- On 6/6/24 at 7:25 A.M., Resident #27's urinary catheter drainage bag not attached to the bed frame. The urinary catheter drainage bag and tubing are lying flat on the floor.</p> <p>During an interview on 6/6/24 at 7:35 A.M., Certified Nurse Assistant (CNA) #6 said Resident #27 is totally dependent on staff for bed mobility and is unable to adjust the height of the bed himself/herself. CNA #6 visualized the urinary catheter drainage bag and tubing on the floor and said the urinary catheter drainage bag and tubing should never touch the floor.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/6/24 at 8:08 A.M., Nurse Supervisor #1 said urinary catheter drainage bags and tubing should never be on the floor. Nurse Supervisor #1 said Resident #27 had a history of throwing his/her urinary catheter drainage bag if it is near him/her, but said that was not the case if it was attached to the bedframe. Nurse Supervisor #1 said Resident #27 is unable to adjust the height of the bed, and staff must lower the bed for him/her.</p> <p>During an interview on 6/6/24 at 2:45 P.M., the Director of Nursing (DON) said urinary catheter drainage bags and tubing should not touch the floor. The DON said if the Resident's bed was lowered she would expect staff to put a barrier between the urinary catheter drainage bag and tubing and the floor to prevent them from touching the floor to prevent infection.</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>46339</p> <p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>Based on record review, policy review and interview, the facility failed to provide care and services consistent with professional standards for one Resident (#55) who required renal dialysis (a life sustaining treatment that helps your body remove extra fluid and waste products from your blood when the kidneys are not able to) out of a total sample of 38 residents. Specifically, the facility failed to ensure that clamps exchanging blood between a patient and a hemodialysis machine were at the bedside.</p> <p>Findings include:</p> <p>Review of the facility policy titled 'Hemodialysis' reviewed February 2023, indicated the following but not limited to:</p> <p>-This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical nursing, mental, and psychosocial needs of residents receiving hemodialysis.</p> <p>1. Resident #287 was admitted to the facility in May 2024 with diagnoses including acute kidney failure, type 2 diabetes mellitus with diabetic chronic kidney disease.</p> <p>Review of Resident #287's medical record indicated the following orders:</p> <p>-Clamps at bedside as all times for emergency use every shift.</p> <p>-If bleeding coming from the central venous catheter for dialysis (CVCD) use the clamps (kept and bedside) to clamp the line and call 911 as needed.</p> <p>Review of care plan date initiated 5/19/24 for hemodialysis had the following intervention: If bleeding coming from the CVCD use the clamps (kept at the bedside) to clamp the line and call 911 as needed.</p> <p>On 6/4/24 at 9:19 A.M., the surveyor observed Resident #287 lying in his/her bed. The surveyor did not locate emergency clamps or pressure dressing by Resident's bedside.</p> <p>On 6/5/24 at 6:52 A.M., the surveyor observed Resident #287 lying in his/her bed. The surveyor did not locate emergency clamps or pressure dressing by Resident's bedside.</p> <p>During an interview on 6/5/24 at 11:36 A.M., Unit Manager #1 said the Resident should have clamps and pressure dressing by bedside.</p> <p>During an interview on 6/5/24 at 11:39 A.M., Nurse #2 said the emergency clamp and pressure dressing should be in the Resident's room.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/6/24 at 9:38 A.M., the Director of Nursing said emergency clamp and pressure dressing should be kept by patient bedside.</p>

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46339</p> <p>Based on observation, record review and interview, the facility failed to ensure a plan of care was developed for trauma-informed care for one Resident (#101), who was admitted to the facility with a diagnosis of post-traumatic stress disorder (PTSD), out of a total sample of 38 residents.</p> <p>Findings include:</p> <p>Review of the facility policy titled 'Trauma Informed Care' reviewed February 2023, indicated the following, but not limited to:</p> <ul style="list-style-type: none"> -It is the policy of this facility to provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and /or re-traumatization. -Collaboration - an emphasis on partnering between residents and/or his or her representative, and all staff and disciplines involved in the resident's care in developing the plan of care. -Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety. These interventions will also recognize the survivors' need to be respected, informed, connected, and hopefully regarding their own recovery. <p>Resident #101 was admitted to the facility in June 2021 with diagnoses including post-traumatic stress disorder.</p> <p>Review of Resident #101's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident scored a 3 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was severely cognitively impaired. The MDS further indicated the Resident had an active diagnosis of PTSD.</p> <p>Review of Resident #101 medical record failed to indicate a care plan for PTSD had been developed or implemented.</p> <p>During an interview on 6/6/24 at 9:26 A.M., the Director of Nursing said social services are responsible for creating and implementing the PTSD care plans and any resident with a diagnosis of PTSD should have a PTSD care plan.</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>48990</p> <p>Based on interviews, record review and policy review, the facility failed to ensure agency nursing staff were provided with an orientation to the facility's day-to-day operations including medication administration procedure.</p> <p>Findings include:</p> <p>Review of the facility policy titled Orientation, revised 2/2023, indicated, but was not limited to:</p> <ul style="list-style-type: none"> - It is the policy of this facility to develop, implement, and maintain an effective orientation process for all individuals providing services under a contractual arrangement consistent with their expected roles. - General orientation must be completed prior to the employee's formal contact with facility residents. <p>Review of the facility assessment, dated 12/13/22, indicated, but was not limited to:</p> <ul style="list-style-type: none"> - Are agency staff sufficiently trained to address needs of resident population? <p>Review of the facility assessment, dated 12/13/22, failed to indicate how the facility ensures agency staff are sufficiently trained to address needs of the resident population.</p> <p>On 6/6/24 at 9:05 A.M., the surveyor observed Nurse #14 prepare medication for a resident and attempted to administer an incorrect medication and the incorrect dose of another medication. Nurse #14 said it was his first day at this facility and did not receive an orientation, including orientation to their medication administration software, medication administration process, process of how/where to obtain missing medications, or general tour of the unit. Nurse #14 said he walked in and was given keys and a log-in and started administering medications.</p> <p>During an interview 06/6/24 at 9:52 A.M., Nurse #14 said he was presented with an orientation checklist after the surveyor notified the facility of the medication error. Nurse #14 said if they had gone over this orientation checklist, which included the medication administration process, before medication administration he would have been better prepared and not made the errors.</p> <p>During an interview on 6/6/24 at 10:00 A.M., the Staff Development Nurse said each agency nurse should receive an orientation checklist the first time they enter the building before they are given keys to a medication cart. She said agency nurses should receive a general orientation including emergency code process, location of emergency code carts, and medication administration process, but that it may not be happening because she only works two days a week and she is not sure who is responsible for it when she is not working.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/6/24 at 10:20 A.M., the Director of Nursing (DON) she expects every agency nurse to receive a general orientation and receive and sign the orientation checklist. The DON said there was a breakdown in the process this morning and Nurse #14 did not receive the orientation checklist or receive a general orientation, but should have.</p> <p>Review of a sample of six agency nurse orientation checklists that were completed indicated five out of six agency orientation checklists were not completed fully and were missing either signatures of the agency nurse, signatures of the preceptor, or had competencies not signed off as reviewed with the agency nurse.</p> <p>During an interview on 6/7/24 at 9:47 A.M., the DON said the expectation is for orientation checklists to be completed with a preceptor and signed by agency nurses and the preceptor. The DON said it is the expectation that the orientation checklist be complete and that the facility keep the signed copies of agency orientation checklists readily available.</p> <p>Review of the agency nurse orientation checklists indicated that four of six agency nurses, who worked on 6/4/24 and/or 6/5/24, did not have an orientation checklist on file with the facility at the time they worked on 6/4/24 or 6/5/24.</p> <p>During an interview on 6/7/24 at 9:47 A.M., the DON said they had no record of an orientation being completed for the four agency nurses who worked on 6/4/24 and 6/5/24.</p>

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>41456</p> <p>Based on employee personnel record review and interview, the facility failed to complete annual reviews for five out of five employees reviewed.</p> <p>Findings include:</p> <p>On 6/5/24 at 12:30 P.M., the surveyor reviewed five employee personnel records. All records failed to indicate an annual review was completed for any of the five employees in 2023.</p> <p>During an interview on 6/5/24 at 1:49 P.M., the Director of Nursing said she is responsible for annual reviews being completed for the employees at the facility and said no annual reviews were completed this past year.</p>

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019</p> <p>Based on record review and interview, the facility failed to provide behavioral health services for four Resident's (#192, #91 #64, and #73) with a history of suicidal ideation (SI) and/or depression, out of a total universe of 67 residents. Specifically, 1. Resident #192 expressed suicidal ideation and the facility failed to provide the appropriate services, which resulted in staff finding Resident #192 with a tightly tied plastic bag around his/her head during an attempted suicide, 2. the facility failed to provide behavioral health services timely for Resident #91, 3. failed to provide behavioral health services after an increase in depression scores for Resident #64 and #73.</p> <p>Findings include:</p> <p>Review of the facility policy titled Suicide Prevention, dated 8/1/23, indicated the following:</p> <ul style="list-style-type: none"> - Suicidal Ideation is defined as self-reported thoughts about engaging in suicide-related behaviors. - All staff members will immediately report any suicidal ideation to the resident's charge nurse and facility social worker. - Immediately notify the resident's physician if the resident presents with suicidal ideation, even if he or she isn't specific about a plan or intent. - Objectively and thoroughly document the resident's mood and behaviors, as well as actions taken, in the medical record. - All staff will be trained annually on risk factors and warning signs of suicide, as well as how to respond to a resident with suicidal ideation. <p>Review of the facility policy titled Suicide Assessment, revised February 2023, indicated the following:</p> <ul style="list-style-type: none"> - Residents will be assessed for suicide risk upon admission and as indicated. The facility social worker or designee will conduct and medical record review and then interview the resident regarding any risk factors that have been identified. Protective factors will be explored with the resident as well. - Risk factors include, but are not limited to: <ul style="list-style-type: none"> * History of prior suicide attempts or self-injurious behavior * Current or past psychiatric disorders and/or recent change in psychiatric treatment * Symptoms such as hopelessness, helplessness, anxiety/panic, and impulsivity <p>(continued on next page)</p>

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>* Triggering events that lead to despair such as the loss of a relationship, health decline, chronic pain, death of a loved one, family turmoil/chaos .etc.</p> <p>- If the assessment indicates the resident is having suicidal thoughts, specific discussions about thoughts, plans, behaviors, and intent will occur.</p> <p>Review of the facility policy titled Behavioral Health Services, revised February 2023, indicated the following:</p> <p>- It is the policy of this facility to ensure all residents receive the necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning.</p> <p>- Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders, psychosocial difficulty, and trauma or post-traumatic stress disorders.</p> <p>- The facility will ensure that necessary behavioral health care services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety.</p> <p>- The facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care . Staff will:</p> <ul style="list-style-type: none"> * Complete PASARR (pre-admission screening and resident review) * Obtain history from medical records, the resident, and as appropriate the resident's family and friends * Monitor the resident closely for expressions or indications of distress * Assess and develop a person-centered care plan for concerns identified in the resident's assessment. <p>- Facility staff will implement person-centered care approaches designed to meet the individual goals and needs of each resident, which includes non-pharmacological interventions.</p> <p>- The Social Services Director shall serve as the facility's contact person for questions regarding behavioral health services provided by the facility and outside sources such as physician, psychiatrist, or neurologist.</p> <p>Review of the facility assessment, revised 3/19/24, indicated the facility is able to manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnoses, intellectual or developmental disabilities. On average, the facility manages about 50 residents with behavioral health needs at a time.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Resident #192 was admitted in December 2023 with diagnoses including bipolar disorder, depression, schizoaffective disorder, and generalized anxiety. Review of the admission Minimum Data Set (MDS), dated [DATE], indicated Resident #192 scored a 10 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment.</p> <p>Review of the Resident's hospital discharge paperwork given to the facility upon admission and dated 12/1/23, indicated the following note from the psych team:</p> <p>- Pt now endorsing SI. Told Case Mgmt that he/she wants to end his/her life. I spoke with patient and he/she states that he/she has thought about suicide for a while and wishes he/she could end his/her life, but states 'he/she is not allowed'. Denies prior suicide attempts or access to firearms, but states if I did have access to firearms, I would kill myself and states I have nothing to live for. Endorses multiple prior psychiatric hospitalizations. Will place on Section 12, consult APS (Acute Psychiatric Stay). Per review of prior records, did note this during his/her prior hospital admission as well.</p> <p>Review of the PASARR Unit for Department of Mental Health, dated 11/29/23, indicated that Resident #192 had a PASARR Level II completed and was appropriate for a provisional emergency admission to a nursing facility that cannot exceed 7-calendar days.</p> <p>The PASARR (Pre-admission screening and resident review) evaluation indicated the following:</p> <p>- Upon admission to a nursing facility, it is the responsibility of the nursing facility to contact the PASARR authority in the event of a significant change in resident status, including:</p> <p>* Improvement or decline in condition, or</p> <p>* If the nursing facility newly identifies a condition that may impact the individual's PASARR disability status, appropriateness of nursing facility placement and/or specialized services, to determine whether a new PASARR evaluation is needed.</p> <p>At time of admission, a psychosocial well-being care plan was developed for Resident #192 and indicated the following:</p> <p>Focus: This resident is at risk for altered psychosocial well-being related to Adjustment to new environment/rehab setting, decline in functional/medical status, dx Schizoaffective d/o Bipolar 1, anxiety/panic d/o, depression, FTT (failure to thrive) in adult (initiated 12/2/23)</p> <p>Interventions:</p> <p>- Activities to meet with this resident to develop and activity plan (initiated 12/2/23)</p> <p>- Behavioral health services as ordered and needed (initiated 12/2/23)</p> <p>- Encourage family members/residents representatives to be involved as allowed by resident to also participate in this plan to be able to provide direct support (initiated 12/2/23)</p> <p>- Encourage the resident to make their own decisions when able (initiated 12/2/23)</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - Encourage the resident to see a positive view of themselves (initiated 12/2/23) - Following up with responses to concerns brought up (initiated 12/2/23) - Medications as ordered to help manage their mood and behaviors (initiated 12/2/23) - Monitor and document mood and behaviors (12/2/23) - Provide 1:1 to allow this resident to verbal feeling/concerns (12/2/23) - Provide the resident praise for all their efforts made (initiated 12/2/23) - Remind this resident of their goals and reassure them on progress made (12/2/23) <p>Review of Resident #192's other comprehensive care plans failed to indicate a care plan was developed for the Resident's history of suicidal ideation (SI).</p> <p>Review of the Psychiatric Evaluation and Consultation note, dated 12/4/23, indicated Resident #192 has felt depressed since childhood and has had multiple hospitalizations related to SI. The note also indicated: Resident was admitted to unit with SI, aware of resident's verbalizing SI. The note indicated that Resident #192 was on an established medication regimen to manage his/her mood, depression, and anxiety. The psychiatric consultation note recommendations indicated the following: Monitor resident for safety, provide medications as prescribed, encourage resident to participate in unit activities. Continue to monitor acute changes in behaviors, nutrition status, and sleep patterns. Redirect when possible, maintain adequate safety precautions, appropriately use diversionary activities on the unit, and provide positive encouragement. Patient would benefit from continued treatment to promote mental wellness and emotional stability.</p> <p>Review of the Patient Health Questionnaire-9 (PHQ-9) (an assessment of depression), dated 12/4/23, indicated Resident #192 scored a 23 out of a possible 27 points, indicating severe depression.</p> <p>During an interview on 6/7/24 at 9:26 A.M., Certified Nursing Assistant CNA #4 said that if a resident had changes in their mood or behaviors, staff would document the changes on the behavior sheets. CNA #4 remembered Resident #192. CNA #4 said that Resident #192 could be mean to staff, but did not say that he/she refused care.</p> <p>Review of the progress notes, behavior monitoring sheets, and medication administration record (MAR) failed to indicate that the facility was monitoring for any change in Resident #192's daily mood and depression.</p> <p>Review of the progress note, dated 1/8/24, indicated the following: Resident stated that he/she wanted to die. Social Worker (SW) went to talk to Resident #192. Resident #192 stated he/she was afraid of a woman and that she will kill him/her. SW asked to describe the woman. Resident stated she worked here and gave the description of the CNA that is working with him/her. SW informed unit manager and DON (Director of Nursing).</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the psych progress note, dated 1/8/24, indicated Resident #192 denied SI, but reported low mood. The progress note indicated that Resident #192 was on an established medication regimen with moderately severe depression.</p> <p>Review of the clinical record failed to indicate any changes had been made to Resident #192's plan of care, care plan, or that notification to the physician had occurred after the Resident had expressed suicide ideation.</p> <p>Review of the physician note, dated 1/9/24, did not indicate that the physician addressed Resident #192's suicidal ideation.</p> <p>During an interview on 6/7/24 at 9:29 A.M., Nurse #4 said that if a resident had changes in their mood or behavior, nursing staff would document the changes in the clinical record and leave a note for the Nurse Practitioner.</p> <p>Review of the clinical record indicated on 1/24/24, Resident #192 was sent to the hospital for a planned procedure. Resident #192 returned to the facility on [DATE].</p> <p>Review of the hospital discharge paperwork, dated 1/31/24, indicated Resident #192 reported suicidal ideation in the hospital and was provided a one on one sitter and was placed on a section 12 (an involuntary hospitalization if assessed to be a danger to self or others).</p> <p>During an interview on 6/10/24 at 8:52 A.M., the Director of Nursing said that the hospital discharge paperwork is reviewed by the clinical liaison team and the admitting nurse will review any discharge paperwork. The Director of Nursing said that the next day the whole team reviews discharge paperwork.</p> <p>During an interview on 6/10/24 at 9:24 A.M., the Director of Nursing said she wasn't notified of the section 12 that took place in the hospital. The Director of Nursing said that hospital discharge paperwork is reviewed by a clinical liaison team and the admitting nurse and then the full discharge summary is reviewed the next morning by the clinical team, which she is a part of.</p> <p>Review of the clinical record failed to indicate that, upon readmission to the facility, Resident #192's plan of care was reviewed or updated, despite Resident #192's vocalization of suicidal ideation in the hospital and a section 12.</p> <p>Review of the PHQ-9, dated 2/2/24, indicated Resident #192 scored a 19 out of 27, indicating moderately severe depression.</p> <p>There was no indication that Resident #192 was evaluated or seen by psych services, social services, or any behavioral health interventions were updated between 2/2/24 - 2/16/24.</p> <p>Review of the progress notes, behavior monitoring sheets, and medication administration record (MAR) failed to indicate that the facility was monitoring for any change in Resident #192's daily mood and depression.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the communication log from January 2024 through February 2024 for the 2nd floor unit failed to indicate any information related to Resident #192 or changes in his/her mood or behavior were communicated to psych services.</p> <p>Review of the progress note, dated 2/16/24, indicated the following:</p> <ul style="list-style-type: none"> - Resident section 12'd 2:20 pm after acting oddly this morning refusing to talk and refusing therapy which continued after lunch. Resident was covering his/her face with his/her hands and refusing to speak but did eat lunch. Call placed to nurse practitioner to report and was given order to send to ED. When this nurse went back in to resident room he/she was found with a clear plastic bag tied around his/her head full of condensation. Bag [sic] removed and resident was attempting to take plastic bag from nurse. Awake, alert but still refusing to speak. Resident taken to nurses station for 1:1 monitoring and psych in the building section 12'd him/her. EMS notified and resident transferred to hospital [sic] for psych eval. <p>Review of the psych note, dated 2/15/24, indicated the following:</p> <ul style="list-style-type: none"> - Resident is AOx3 (alert and oriented), he/she was found by nursing staff with a plastic bag over his/her head. Resident has an extensive hx of SI but with no past activity. Resident section 12A to hospital d/t safety concern, further evaluation. <p>Review of the hospital paperwork, dated 2/19/24, indicated the following:</p> <ul style="list-style-type: none"> - Presents from his/her SNF(Skilled Nursing Facility) after staff there reportedly found him/her with a plastic bag over head in an attempt to self-harm. At that time he/she stated he/she felt like he/she 'wasn't being listened to' there and has made passive SI statement since then without much other detail . <p>During an interview on 6/7/24 at 9:31 A.M., Nurse #5 said that Resident #192 was quiet and did not complain. She said that Resident #192 did not have a lot of issues and that he/she did not want to be here at the facility.</p> <p>During an interview on 6/7/24 at 8:38 A.M., the Activities Director said that Resident #192 was quiet and kept to himself/herself. The Activities Director said that Resident #192 was encouraged to leave his/her room but he/she declined and would not participate in activities. The Activities Director said that Resident #192 was upset because he/she did not want to be in the facility and felt that his/her family had left him/her here.</p> <p>During an interview on 6/6/24 at 9:36 A.M., the Social Services Assistant said that he is not a social worker or licensed for social work or counseling services. He said that the facility had a contract company that has since closed. He said that if a Resident expressed SI then he would contact the LICSW (Licensed Social Worker) from the company to do an evaluation via telehealth.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Advocate Healthcare of East Boston, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Orient Avenue East Boston, MA 02128	
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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/10/24 at 8:31 A.M., Social Services Assistant #1 said that Resident #192 had some cognitive issues, but engaged the best that he/she could. Social Services Assistant #1 said that there was an adjustment period that he/she struggled with slightly due to his/her family and brother. Social Services Assistant #1 said that if a Resident verbalizes a recent SI, then that Resident should be followed on a regular basis and seen daily or once a shift to make sure they are feeling safe. Social Services Assistant #1 said that the care plan should be updated and supportive care in place</p> <p>During an interview on 6/6/24 at 10:38 A.M., the Psychiatric Nurse Practitioner (Psych NP) said she reviews all of the referrals for behavioral health given by the nurses. She said the referrals are either given verbally or kept in a folder on the floors. The Psych NP said she provides medication management and will briefly talk to the residents if necessary, but said she does not provide talk therapy. The Psych NP said that when a Resident expresses suicidal ideation, she would section 12 the Resident if they were actively suicidal. The psych NP said that she would consider SI was active if there was a plan behind the statement. The psych NP said that Resident #192 has an extensive and complex history and that he/she was supposed to be in the facility on respite. She said she didn't want to change the Resident's medications because he/she was supposed to be in the facility short-term. The psych NP said that even if Resident #192 made a passive statement of SI, she would expect something to be put in place like 15-minute checks or moving his/her room closer to the nurses station for monitoring. The psych NP said that Resident #192 was alert and oriented and knew everything that was going on and felt like his/her brother was keeping him/her in the facility. The psych NP said that Resident #192 would have benefited from ongoing supportive talk therapy services because of his/her history, but that those services are provided by another provider.</p> <p>During an interview on 6/6/24 at 11:15 A.M., the Director of Nursing (DON) said that anyone with a history of SI should have a care plan developed and implemented and that the interventions are related to the safety of the Resident. The DON said the Psych NP does medication management and the facility has social services and emotional therapy support would be provided by a psychiatric provider. She said there is a psychologist that comes into the building and said if there was a recent expression of SI from a resident, she would expect all available options of behavioral health services to be involved. The DON said that Residents with depression should have behavioral monitoring that would pick up a change in status like not engaging, or not attending activities, more isolation, etc. The DON said that she would want those residents to have therapy beyond medications.</p> <p>During an interview on 6/7/24 at 7:36 A.M., Physician #1 said that he believes that Residents would benefit from counseling services and non-pharmacological interventions, but that he feels the facility needs more support to provide those services.</p> <p>During an interview on 6/10/24 at 11:47 A.M., the psych NP said that she was not made aware of Resident #192's suicidal ideation during his/her hospital stay and would have seen him/her upon return to the facility.</p> <p>During an interview on 6/10/24 at 11:47 A.M., the Director of Nursing said that the facility was never made aware of the Resident's suicidal ideation expressed during the most recent hospital stay on 1/31/24 and, if she had known, the facility wouldn't have taken Resident #192 back to the facility.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>2. Resident #91 was admitted in December 2023 with diagnoses including major depressive disorder, schizoaffective disorder, and dementia. Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #91 scored a 4 out of a possible 15, indicating severe cognitive impairment.</p> <p>Review of the progress note, dated 12/28/2023, indicated the following:</p> <p>Note Text: This nurse was notified by speech, that pt voiced to her that he/she was depressed and mentioned SI. This nurse went to speak with pt voiced he/she hated his/her sister for putting him/her here, that there is no need for him/her to be here. Pt went on to say more about living with his/her sister, getting a job but his/her sister dropped him/her off here Resident said he/she was going to take care of the situation by killing him/her self, asked pt if he/she had a plan, he/she stated yes he/she did. Asked him/her what it was, he/she said he/she was just going to do it and isn't telling me how. Asked pt if he/she felt suicidal now, he/she stated yes because he/she is so upset and hates his/her sister. DON notified. Safety maintained.</p> <p>Review of the clinical record failed to indicate that Resident #91's suicidal ideation was addressed by psych or social services.</p> <p>Review of the care plan for Resident #91 indicated the following:</p> <p>Focus: The resident exhibits behaviors putting themselves, by making suicidal statements and/or others at risk for potential injury R/T choosing to not participate or allow care to be completed. History of physical abuse toward others, History of withdrawal from usual daily activities (group or independent), refusal of care (initiated 12/28/23).</p> <p>Interventions:</p> <ul style="list-style-type: none"> - Administer medication as ordered (initiated 12/28/23) - Behavioral health services as ordered and treat as indicated (initiated 12/28/23) - Encourage attendance to activities (initiated 12/28/23) - Identify and implement nonpharmacological interventions (identify what these are for this resident): _____ (initiated 12/28/23) - Keep resident representative informed of changes or continued behaviors impacting the residents care (initiated 12/28/23) - Monitor and document behaviors for further review (initiated 12/28/23) - Social worker to provide routine visits and provide support as needed (initiated 12/28/23) <p>Review of the care plan failed to indicate that a suicidal ideation care plan was developed with appropriate interventions for the Resident's safety.</p> <p>Review of the care plan failed to indicate that any interventions were carried out after Resident #91 verbalized suicidal ideation.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the psych Nurse Practitioner note, dated 1/8/24, 11 days after the initial suicidal ideation, indicated Resident #91 presented with low mood and was upset about his/her sister not visiting while at the facility. The progress note did not mention Resident #91's suicidal ideation.</p> <p>During an interview on 6/10/24 at 11:47 A.M., the psych NP said that she is aware of Resident #91's suicidal ideation expressions and that his/her story changes because of memory issues. The psych NP said that Zolof (a medication used to treat depression) was started on 12/29/23, but it takes 2 weeks for that medication to take effect. The psych NP could not say if she assessed Resident #91.</p> <p>41456</p> <p>3a. Resident #64 was admitted to the facility in February 2024 with diagnoses including major depression.</p> <p>Review of Resident #64's most recent Minimum Data Set (MDS) dated [DATE], indicated Resident #64 had a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15, which indicated he/she was cognitively intact. The MDS also indicated Resident #64 was independent with daily functional tasks.</p> <p>Review of Resident #64's record indicated he/she completed the PHQ-9 (an assessment of depression) upon admission and scored a 0, which indicated he/she was displaying no symptoms of depression.</p> <p>Review of the Psychiatric Nurse Practitioner note on 4/4/24 indicated the following:</p> <ul style="list-style-type: none"> - Resident is very withdrawn, limited interaction with peers, upon assessment resident with limited communication ability, (he/she) uses one word response, unable to express (him/herself). Present with flat affect. <p>Review of Resident #64's record indicated he/she completed the PHQ-9 (an assessment of depression) again on 5/10/24 and scored a 12, which indicated he/she was displaying symptoms of moderate depression.</p> <p>Review of the Psychiatric Nurse Practitioner note on 5/10/24 indicated the following:</p> <ul style="list-style-type: none"> - Resident reports; Little interest in doing things for several days. Feeling depressed for more than half the days. Having trouble falling and staying asleep for more than half the days. Having little energy for more than half the days. Denies having poor appetite/overeating. Feeling bad about (him/herself) for several days. Trouble with concentration for several days. Moving slowly nearly every day. Denies any thoughts/plans of hurting (him/herself)/or others. PHQ-9 score 12-moderate depression. <p>Review of Resident #64's mood care plan last revised 5/9/24, indicated the following intervention:</p> <ul style="list-style-type: none"> -Behavioral Health Services as ordered and treat as indicated. <p>Review of Resident #64's medical record failed to indicate the Resident received any additional behavioral health services after the PHQ-9 indicated an increasing level of depression.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/6/24 at 9:36 A.M., the Social Services Assistant said that he is not a social worker or licensed for social work or counseling services. He said that the facility had a contract company that has since closed. He said that if a Resident expressed an increase in depression the facility would make a referral to support services and the social worker would check in with these residents.</p> <p>During an interview on 6/6/24 at 10:38 A.M., the Psychiatric Nurse Practitioner (Psych NP) said she reviews all of the referrals for behavioral health given by the nurses. She said the referrals are either given verbally or kept in a folder on the floors. The Psych NP said she provides medication management and will briefly talk to the residents, if necessary, but said she does not provide talk therapy.</p> <p>During an interview on 6/6/24 at 11:15 A.M., the Director of Nursing (DON) said the Psych NP does medication management and the facility has social services and emotional therapy support would be provided by a psychiatric provider. She said there is a psychologist that comes into the building, and she would expect all available options of behavioral health services to be involved with anyone expressing increased levels of depression. The DON said that Resident's with depression should have behavioral monitoring that would pick up a change in status like not engaging, or not attending activities, more isolation, etc. The DON said that she would want those residents to have therapy beyond medications.</p> <p>During an interview on 6/7/24 at 7:36 A.M., Physician #1 said that he believes that Residents would benefit from counseling services and non-pharmacological interventions, but that he feels the facility needs more support to provide those services.</p> <p>3b. Resident #73 was admitted to the facility in February 2024 with diagnoses including depression.</p> <p>Review of Resident #73's most recent Minimum Data Set (MDS) dated [DATE], indicated Resident #73 had a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15, which indicated he/she was cognitively intact. The MDS also indicated Resident #73 required substantial assistance with daily functional tasks.</p> <p>Review of Resident #73's record indicated he/she completed the PHQ-9 (an assessment of depression) on 2/16/24 and scored a 14, which indicated he/she was displaying symptoms of moderate depression.</p> <p>Review of the Psychiatric Nurse Practitioner note on 4/4/24 indicated the following:</p> <p>- Resident is very withdrawn, limited interaction with peers, upon assessment resident with limited communication ability, (he/she) uses one word response, unable to express (him/herself). Present with flat affect.</p> <p>Review of Resident #73's record indicated he/she completed the PHQ-9 (an assessment of depression) again on 5/13/24 and scored a 15, which indicated he/she was displaying symptoms of moderately severe depression, an increase from the previous PHQ-9.</p> <p>Review of the Psychiatric Nurse Practitioner note dated 4/8/24 indicated Resident #73 was at risk for worsening mood and behavior.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the Psychiatric Nurse Practitioner note dated 5/10/24 indicated the following:</p> <ul style="list-style-type: none"> - Resident reports; little interest in doing things for more than half the days. Feeling depressed nearly every day. Having trouble falling and staying asleep for more than half the days. Having little energy for more than half the days. Poor appetite for more than half the days. Feeling bad about (him/herself) for several days. Denies having trouble with concentration. Moving slowly nearly every day. Denies any thoughts plans of hurting (him/herself)/others. PHQ-9 score 15 - moderately severe depression. <p>Review of the Psychiatric Nurse Practitioner note dated 5/13/24 indicated the following:</p> <ul style="list-style-type: none"> - Resident reports having poor sleep in the past weeks. (He/she) reports (he/she) can't sleep more than 2 hours straight, (he/she) has poor sleep and depressed mood. -Resident #73's anti-depressant was increased at this time. <p>Review of Resident #73's psychotropic medication care plan last revised 5/28/24, indicated the following intervention:</p> <ul style="list-style-type: none"> -Behavioral Health Services PRN (as needed). <p>Review of Resident #73's medical record failed to indicate the Resident received any additional behavioral health services after the PHQ-9 indicated an increasing level of depression.</p> <p>During an interview on 6/6/24 at 9:36 A.M., the Social Services Assistant said that he is not a social worker or licensed for social work or counseling services. He said that the facility had a contract company that has since closed. He said that if a Resident expressed an increase in depression the facility would make a referral to support services and the social worker would check in with these residents.</p> <p>During an interview on 6/6/24 at 10:38 A.M., the Psychiatric Nurse Practitioner (Psych NP) said she reviews all of the referrals for behavioral health given by the nurses. She said the referrals are either given verbally or kept in a folder on the floors. The Psych NP said she provides medication management and will briefly talk to the residents, if necessary, but said she does not provide talk therapy.</p> <p>During an interview on 6/6/24 at 11:15 A.M., the Director of Nursing (DON) said the Psych NP does medication management and the facility has social services and emotional therapy support would be provided by a psychiatric provider. She said there is a psychologist that comes into the building, and she would expect all available options of behavioral health services to be involved with anyone expressing increased levels of depression. The DON said that Resident's with depression should have behavioral monitoring that would pick up a change in status like not engaging, or not attending activities, more isolation, etc. The DON said that she would want those residents to have therapy beyond medications.</p> <p>During an interview on 6/7/24 at 7:36 A.M., Physician #1 said that he believes that Residents would benefit from counseling services and non-pharmacological interventions, but that he feels the facility needs more support to provide those services.</p>		

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<p>F 0742</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019</p> <p>Based on record review and interview, the facility failed to provide the appropriate treatment and services for one Resident (#192), with a known history of mental disorders, suicidal ideation, and adjustment difficulty. Specifically, the facility failed to develop, implement, and update the plan of care, resulting in an attempted suicide after the vocalization of suicidal ideation.</p> <p>Findings include:</p> <p>Review of the facility policy titled Suicide Prevention, dated 8/1/23, indicated the following:</p> <ul style="list-style-type: none"> - Suicidal Ideation is defined as self-reported thoughts about engaging in suicide-related behaviors. - All staff members will immediately report any suicidal ideation to the resident's charge nurse and facility social worker. - Immediately notify the resident's physician if the resident presents with suicidal ideation, even if he or she isn't specific about a plan or intent. - Objectively and thoroughly document the resident's mood and behaviors, as well as actions taken, in the medical record. - All staff will be trained annually on risk factors and warning signs of suicide, as well as how to respond to a resident with suicidal ideation. <p>Review of the facility policy titled Suicide Assessment, revised February 2023, indicated the following:</p> <ul style="list-style-type: none"> - Residents will be assessed for suicide risk upon admission and as indicated. The facility social worker or designee will conduct and medical record review and then interview the resident regarding any risk factors that have been identified. Protective factors will be explored with the resident as well. - Risk factors include, but are not limited to: <ul style="list-style-type: none"> * History of prior suicide attempts or self-injurious behavior * Current or past psychiatric disorders and/or recent change in psychiatric treatment * Symptoms such as hopelessness, helplessness, anxiety/panic, and impulsivity * Triggering events that lead to despair such as the loss of a relationship, health decline, chronic pain, death of a loved one, family turmoil/chaos .etc. <p>(continued on next page)</p>

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<p>F 0742</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>- If the assessment indicates the resident is having suicidal thoughts, specific discussions about thoughts, plans, behaviors, and intent will occur.</p> <p>Review of the facility policy titled Behavioral Health Services, revised February 2023, indicated the following:</p> <p>- It is the policy of this facility to ensure all residents receive the necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning.</p> <p>- Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders, psychosocial difficulty, and trauma or post-traumatic stress disorders.</p> <p>- The facility will ensure that necessary behavioral health care services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety.</p> <p>- The facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care . Staff will:</p> <ul style="list-style-type: none"> * Complete PASARR screening * Obtain history from medical records, the resident, and as appropriate the resident's family and friends * Monitor the resident closely for expressions or indications of distress * Assess and develop a person-centered care plan for concerns identified in the resident's assessment. <p>- Facility staff will implement person-centered care approaches designed to meet the individual goals and needs of each resident, which includes non-pharmalogical interventions.</p> <p>- The Social Services Director shall serve as the facility's contact person for questions regarding behavioral health services provided by the facility and outside sources such as physician, psychiatrist, or neurologist.</p> <p>Review of the facility assessment, revised 3/19/24, indicated the facility is able to manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnoses, intellectual or developmental disabilities. On average, the facility manages about 50 residents with behavioral health needs.</p> <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Resident #192 was admitted in December 2023 with diagnoses including bipolar disorder, depression, schizoaffective disorder, and generalized anxiety. Review of the admission Minimum Data Set (MDS), dated [DATE], indicated Resident #192 scored a 10 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment.</p> <p>Review of the Resident's hospital discharge paperwork given to the facility upon admission and dated 12/1/23, indicated the following note from the psych team:</p> <p>- Pt now endorsing SI. Told Case Mgmt that he/she wants to end his/her life. I spoke with patient and he/she states that he/she has thought about suicide for a while and wishes he/she could end his/her life, but states 'he/she is not allowed'. Denies prior suicide attempts or access to firearms, but states if I did have access to firearms, I would kill myself and states I have nothing to live for. Endorses multiple prior psychiatric hospitalization s. Will place on Section 12, consult APS (Acute Psychiatric Service). Per review of prior records, did note this during his/her prior hospital admission as well.</p> <p>At time of admission, a psychosocial well-being care plan was developed for Resident #192 and indicated the following:</p> <p>Focus: This resident is at risk for altered psychosocial well-being related to Adjustment to new environment/rehab setting, decline in functional/medical status, dx Schizoaffective d/o Bipolar 1, anxiety/panic d/o, depression, FTT (failure to thrive) in adult (initiated 12/2/23)</p> <p>Interventions:</p> <ul style="list-style-type: none"> - Activities to meet with this resident to develop and activity plan (initiated 12/2/23) - Behavioral health services as ordered and needed (initiated 12/2/23) - Encourage family members/residents representatives to be involved as allowed by resident to also participate in this plan to be able to provide direct support (initiated 12/2/23) - Encourage the resident to make their own decisions when able (initiated 12/2/23) - Encourage the resident to see a positive view of themselves (initiated 12/2/23) - Following up with responses to concerns brought up (initiated 12/2/23) - Medications as ordered to help manage their mood and behaviors (initiated 12/2/23) - Monitor and document mood and behaviors (12/2/23) - Provide 1:1 to allow this resident to verbal feeling/concerns (12/2/23) - Provide the resident praise for all their efforts made (initiated 12/2/23) - Remind this resident of their goals and reassure them on progress made (12/2/23) <p>(continued on next page)</p>		

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<p>F 0742</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #192's other comprehensive care plans failed to indicate a care plan was developed for the Resident's history of suicidal ideation (SI) or any interventions related to the safety of Resident #192.</p> <p>Review of the progress note, dated 1/8/24, indicated the following: Resident stated that he/she wanted to die. Social Worker (SW) went to talk to Resident #192. Resident #192 stated he/she was afraid of a woman and that she will kill him/her. SW asked to describe the woman. Resident stated she worked here and gave the description of the CNA that is working with him/her. SW informed unit manager and DON.</p> <p>Review of the psych progress note, dated 1/8/24, indicated Resident #192 denied SI, but reported low mood. The progress note indicated that Resident #192 was on an established medication regimen with moderately severe depression.</p> <p>Review of the clinical record failed to indicate any changes had been made to Resident #192's plan of care, care plan, or that notification to the physician had occurred after the Resident had expressed suicide ideation.</p> <p>Review of the clinical record indicated on 1/24/24, Resident #192 was sent to the hospital for a planned procedure. Resident #192 returned to the facility on [DATE].</p> <p>Review of the hospital discharge paperwork, dated 1/31/24, indicated Resident #192 reported suicidal ideation in the hospital and was provided a one on one sitter and was placed on a section 12 (an involuntary hospitalization if assessed to be a danger to self or others).</p> <p>During an interview on 6/10/24 at 8:52 A.M., the Director of Nursing said that the hospital discharge paperwork is reviewed by the clinical liaison team and the admitting nurse will review any discharge paperwork from the hospital. The Director of Nursing said that the next day, when she is in the facility, the whole interdisciplinary team, including her, reviews the discharge paperwork.</p> <p>During an interview on 6/10/24 at 9:24 A.M., the Director of Nursing said she wasn't notified of the section 12 that took place in the hospital. The Director of Nursing said that hospital discharge paperwork is reviewed by a clinical liaison team and the admitting nurse and then the full discharge summary is reviewed the next morning by the clinical team.</p> <p>Review of the clinical record failed to indicate that, upon readmission to the facility, Resident #192's plan of care was reviewed or updated, despite Resident #192's vocalization of suicidal ideation in the hospital and a section 12.</p> <p>Review of the progress note, dated 2/16/24, indicated the following:</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225413	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2024
NAME OF PROVIDER OR SUPPLIER Advocate Healthcare of East Boston, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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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<p>F 0742</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>- Resident section 12'd 2:20 pm after acting oddly this morning refusing to talk and refusing therapy which continued after lunch. Resident was covering his/her face with his/her hands and refusing to speak but did eat lunch. Call placed to nurse practitioner to report and was given order to send to ED. When this nurse went back in to resident room he/she was found with a clear plastic bag tied around his/her head full of condensation. Bag [sic] removed and resident was attempting to take plastic bag from nurse. Awake, alert but still refusing to speak. Resident taken to nurses station for 1:1 monitoring and psych in the building section 12'd him/her. EMS notified and resident transferred to hospital [sic] for psych eval.</p> <p>Review of the psych note, dated 2/15/24, indicated the following:</p> <p>- Resident is AOx3 (alert and oriented), he/she was found by nursing staff with a plastic bag over his/her head. Resident has an extensive hx of SI but with no past activity. Resident section 12A to hospital d/t safety concern, further evaluation.</p> <p>Review of the hospital paperwork, dated 2/19/24, indicated the following:</p> <p>- Presents from his/her SNF(Skilled Nursing Facility) after staff there reportedly found him/her with a plastic bag over head in an attempt to self-harm. At that time he/she stated he/she felt like he/she 'wasn't being listened to' there and has made passive SI statement since then without much other detail .</p> <p>During an interview on 6/6/24 at 11:15 A.M., the Director of Nursing said when a resident is admitted with a history of suicidal ideation, a care plan should be developed with interventions to keep the Resident safe and supportive services would be put in place, including psych and social services.</p> <p>During an interview on 6/6/24 at 10:38 A.M., the Psych Nurse Practitioner said she would consider someone with a history of SI who has recently expressed SI to be put on 15 minute checks or moved closer to the nursing station. The Psych NP said she was not notified of Resident #192's return from the hospital with a verbalization of SI. The psych NP said that Resident #192 had some issues with being at the nursing facility and with his/her brother placing him/her here.</p> <p>During an interview on 6/6/24 at 9:36 A.M., the Social Services Assistant (SSA) #1 said that he is not a social worker, but at the time Resident #192 was admitted , an outside contract service provided social worker support as needed. SSA #1 said he would expect a care plan to be developed for suicidal ideation and if a Resident expressed suicidal ideation then the Resident should be seen immediately.</p> <p>During an interview on 6/10/24 at 8:30 A.M., SSA #1 said that if a resident expressed SI then that Resident should be checked in on daily from social services to make sure they are safe. SSA #1 said that Resident #192 was having a difficult time adjusting to the facility and his/her brothers decision to keep him/her at the facility.</p> <p>Review of the clinical record did not indicate that any interventions were put in place or updated after return from the hospital, between 1/31/24 - 2/16/24, for Resident #192 with a known history of suicidal ideation and adjustment difficulty.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0745</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019</p> <p>Based on record review and interview, the facility failed to assure sufficient social services were provided to meet the needs of one Resident (#192), out of a total sample of 38 residents. Specifically, Resident #192 did not receive social support after verbalizing suicidal ideation (SI), resulting in an attempted suicide.</p> <p>Findings include:</p> <p>Review of the facility policy titled Social Services, revised February 2023, indicated the following:</p> <ul style="list-style-type: none"> - The facility, regardless of size, will provide medically-related social services to each resident, to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. - Any need for medically-related social services will be documented in the medical record. - Services to meet the resident's needs may include: <ul style="list-style-type: none"> * Assisting residents in voicing and obtaining resolution to grievances about treatment, living conditions, visitation rights and accommodation of needs. * Making referrals and obtaining needed services from outside entities * Providing or arranging for needed mental and psychosocial counseling services * Identifying and seeking ways to support residents' individual needs through the assessment and care planning process. * Identifying and promoting individualized, non-pharmacological approaches to care that meet the mental and psychosocial needs of each resident. * Meeting the needs of residents who are grieving from losses and coping with stressful events. <p>- The facility should provide social services or obtain services from outside entities during situations that include:</p> <ul style="list-style-type: none"> * Expressions or indications of distress that affect the resident's mental and psychosocial well-being, resulting from depression * Difficulty coping with change or loss * Need for emotional support <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>- The resident's plan of care will reflect any ongoing medically-related social service needs, and how those needs are being addressed.</p> <p>- The Social Worker, or social services designee, will monitor the resident's progress in improving physical, mental, and psychosocial functioning.</p> <p>Review of the facility assessment tool, dated 3/19/24, indicates the facility provides psycho/social/spiritual support including supporting emotional and mental well-being and helpful coping mechanisms.</p> <p>Resident #192 was admitted in December 2023 with diagnoses including bipolar disorder, depression, schizoaffective disorder, and generalized anxiety. Review of the admission Minimum Data Set (MDS), dated [DATE], indicated Resident #192 scored a 10 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment.</p> <p>Review of the Resident's hospital discharge paperwork given to the facility upon admission and dated 12/1/23, indicated the following note from the psych team:</p> <p>- Pt now endorsing SI. Told Case Mgmt that he/she wants to end his/her life. I spoke with patient and he/she states that he/she has thought about suicide for a while and wishes he/she could end his/her life, but states 'he/she is not allowed'. Denies prior suicide attempts or access to firearms, but states if I did have access to firearms, I would kill myself and states I have nothing to live for. Endorses multiple prior psychiatric hospitalizations. Will place on Section 12, consult APS. Per review of prior records, did note this during his/her prior hospital admission as well.</p> <p>At time of admission, a psychosocial well-being care plan was developed for Resident #192 and indicated the following:</p> <p>Focus: This resident is at risk for altered psychosocial well-being related to Adjustment to new environment/rehab setting, decline in functional/medical status, dx Schizoaffective d/o Bipolar 1, anxiety/panic d/o, depression, FTT (failure to thrive) in adult (initiated 12/2/23)</p> <p>Interventions:</p> <ul style="list-style-type: none"> - Activities to meet with this resident to develop and activity plan (initiated 12/2/23) - Behavioral health services as ordered and needed (initiated 12/2/23) - Encourage family members/residents representatives to be involved as allowed by resident to also participate in this plan to be able to provide direct support (initiated 12/2/23) - Encourage the resident to make their own decisions when able (initiated 12/2/23) - Encourage the resident to see a positive view of themselves (initiated 12/2/23) - Following up with responses to concerns brought up (initiated 12/2/23) - Medications as ordered to help manage their mood and behaviors (initiated 12/2/23) <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - Monitor and document mood and behaviors (12/2/23) - Provide 1:1 to allow this resident to verbal feeling/concerns (12/2/23) - Provide the resident praise for all their efforts made (initiated 12/2/23) - Remind this resident of their goals and reassure them on progress made (12/2/23) <p>Review of Resident #192's other comprehensive care plans failed to indicate a care plan was developed for the Resident's history of suicidal ideation (SI).</p> <p>Review of the Patient Health Questionnaire-9 (PHQ-9) (an assessment of depression), dated 12/4/23, indicated Resident #192 scored a 23 out of a possible 27 points, indicating severe depression.</p> <p>Review of the Psychiatric Evaluation and Consultation note, dated 12/4/23, indicated Resident #192 has felt depressed since childhood and has had multiple hospitalizations related to SI. The note also indicated: Resident was admitted to unit with SI, aware of resident's verbalizing SI. The note indicated that Resident #192 was on an established medication regimen to manage his/her mood, depression, and anxiety. The psychiatric consultation note recommendations indicated the following: Monitor resident for safety, provide medications as prescribed, encourage resident to participate in unit activities. Continue to monitor acute changes in behaviors, nutrition status, and sleep patterns. Redirect when possible, maintain adequate safety precautions, appropriately use diversionary activities on the unit, and provide positive encouragement. Patient would benefit from continued treatment to promote mental wellness and emotional stability.</p> <p>Review of the clinical record did not indicate that social services were provided for Resident #192 between his/her admitted and 1/8/24.</p> <p>Review of the Social Worker progress note, dated 1/8/24, indicated the following: Resident stated that he/she wanted to die. Social Worker (SW) went to talk to Resident #192. Resident #192 stated he/she was afraid of a woman and that she will kill him/her. SW asked to describe the woman. Resident stated she worked here and gave the description of the CNA that is working with him/her. SW informed unit manager and DON.</p> <p>Review of the clinical record indicated on 1/24/24, Resident #192 was sent to the hospital for a planned procedure. Resident #192 returned to the facility on [DATE].</p> <p>Review of the hospital discharge paperwork, dated 1/31/24, indicated Resident #192 reported suicidal ideation in the hospital and was provided a one on one sitter and was placed on a section 12 (an involuntary hospitalization if assessed to be a danger to self or others).</p> <p>Review of the clinical record did not indicate that social services were provided for Resident #192 between 1/31/24 and 2/16/24.</p> <p>Review of the clinical progress note, dated 2/16/24, indicated Resident #192 was found with a plastic bag tied around his/her neck in an attempted suicide and was sent to the hospital for evaluation.</p> <p>(continued on next page)</p>

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<p>F 0745</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the hospital paperwork, dated 2/19/24, indicated the following:</p> <p>Presents from his/her SNF(Skilled Nursing Facility) after staff there reportedly found him/her with a plastic bag over head in an attempt to self-harm. At that time he/she stated he/she felt like he/she 'wasn't being listened to' there and has made passive SI statement since then without much other detail .</p> <p>During an interview on 6/10/24 at 8:31 A.M., Social Services Assistant (SSA) #1 said that Resident #192 had some cognitive issues, but engaged the best that he/she could. Social Services Assistant #1 said that there was an adjustment period that he/she struggled with slightly due to his/her family and brother. Social Services Assistant #1 said that if a Resident verbalizes a recent SI, then that Resident should be followed on a regular basis and seen daily or once a shift to make sure they are feeling safe. Social Services Assistant #1 said that the care plan should be updated and supportive care in place</p> <p>During an interview on 6/6/24 at 9:36 A.M., the Social Services Assistant #1 said that he is not a social worker, but at the time Resident #192 was admitted , an outside contract service provided social worker support as needed. Social Services Assistant #1 said he would expect a care plan to be developed for suicidal ideation and if a Resident expressed suicidal ideation then the Resident should be seen immediately.</p> <p>During an interview on 6/10/24 at 8:30 A.M., Social Services Assistant #1 said that if a resident expressed SI then that Resident should be checked in on daily from social services to make sure they are safe. Social Services Assistance #1 said that Resident #192 was having a difficult time adjusting to the facility and his/her brothers decision to keep him/her at the facility.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>48990</p> <p>Based on observations, records reviewed, policy review, and interviews, the facility failed to ensure it was free from a medication error rate of greater than 5% when 2 out of 3 nurses observed made 4 errors out of 28 opportunities, resulting in a medication error rate of 14.29%. Those errors impacted two Residents (#87 and #91), out of four residents observed.</p> <p>Findings include:</p> <p>Review of the facility policy titled 'Medication Administration', revised 2/2023, indicated, but was not limited to:</p> <p>Policy: Medication are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician.</p> <p>10. Ensure that the six rights of medication administration are followed:</p> <p>b. Right drug</p> <p>c. Right dosage</p> <p>1.) For Resident #87, the nurse attempted to administer the incorrect dosage of a medication and the incorrect medication.</p> <p>Resident #87 was admitted to the facility in September 2021 with diagnoses including hypertension and venous ulcers.</p> <p>Review of Resident #87's physician's orders indicated:</p> <ul style="list-style-type: none"> - Metoprolol (a medication used to treat high blood pressure) 25 milligrams (mg) , Give 0.5 (12.5mg) tablet orally two times a day. - Tab-a-vite (a dietary supplement that is specially formulated for those on dialysis), Give 1 tablet orally one time a day. <p>On 6/6/24 at 8:38 A.M., the surveyor observed Nurse #14 began to prepare to administer medications to Resident #87 including:</p> <ul style="list-style-type: none"> - two metoprolol half tablets, 12.5 mg each. - one Rena Vite tablet. <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/6/24 at 9:05 A.M., Nurse #14 said he was going to administer the above medications and crossed the threshold into Resident #87's room. The surveyor intervened and requested Nurse #14 clarify the metoprolol order. Nurse #14 said he was going to administer two tablets of 12.5 mg half tablets of metoprolol because the resident needed a total dose of 25 mg twice a day. Nurse #14 said he was supposed to administer tab-a-vite, but since he did not have tab-a-vite in his cart, he was going to substitute it for Rena Vite. Nurse #14 said he had never worked in this facility before and was not oriented to the facility including where the correct dosage is listed in the medication administration software or the process for obtaining medications that were not available.</p> <p>On 6/6/24 at 9:07, Nurse #16 said she would clarify the orders for Nurse #14. Nurse #16 said the order clearly reads to administer one half tablet of a 25 mg metoprolol tablet because the dose is 12.5 mg, not two half tablets. Nurse #16 said she could get a bottle of tab-a-vite from the medication room and that Rena Vite should not be given as a substitute because it requires a different physician's order.</p> <p>During an interview on 6/6/24 at 2:35 P.M., The Director of Nursing (DON) said medications should be administered following the physician's order. The DON said Nurse #14 should have given one half tablet, which is 12.5 mg, not two half tablets. The DON said Rena Vite should not be given as a substitute because it requires a different physician's order.</p> <p>2.) For Resident #91, the nurse failed to administer the correct dosage of two medications.</p> <p>Resident #91 was admitted to the facility in December 2023 with diagnoses including dementia and depression.</p> <p>Review of Resident #91's physician's orders indicated:</p> <ul style="list-style-type: none"> - Olanzapine (an antipsychotic medication) 2.5 mg, Give 5 mg by mouth one time a day. - Zolof (an antidepressant medication) Oral Tablet, Give 100 mg by mouth on time a day. <p>On 6/06/24 at 9:37 A.M. the surveyor observed Nurse #15 prepare and administer medications to Resident #91 including:</p> <ul style="list-style-type: none"> - one olanzapine 2.5 mg tablet. - three zolof 25 mg tablets. <p>During an interview on 6/6/24, Nurse #15 said she gave the order based off what it said on the medication card, not the order in the computer. Nurse #15 checked the physician's order in the computer and said she should have administered 5 mg of olanzapine and 100 mg of zolof, and that was an error.</p> <p>During an interview on 6/6/24 at 2:35 P.M., The Director of Nursing (DON) said medications should be administered following the physician's order in computer, not on the medication card.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>48990</p> <p>Based on observations, interviews, and record review, the facility failed to ensure that one Resident (#87), was free from significant medication errors, out of a total sample of 38 residents. Specifically, the nurse prepared to administer double the prescribed dose of the medication metorolol (which is a medication that lowers blood pressure and heart rate).</p> <p>Findings include:</p> <p>Review of the facility policy titled 'Medication Administration', revised 2/2023, indicated, but was not limited to:</p> <p>Policy: Medication are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician.</p> <p>10. Ensure that the six rights of medication administration are followed:</p> <p>c. Right dosage.</p> <p>Resident #87 was admitted to the facility in September 2021 with diagnoses including hypertension.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 3/13/24, indicated that Resident #87 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15.</p> <p>Review of Resident #87's active physician's orders indicated:</p> <p>- Metoprolol (a medication used to treat high blood pressure) 25 milligrams (mg), Give 0.5 (12.5mg) tablet orally two times a day.</p> <p>On 6/6/24 at 8:38 A.M., the surveyor observed Nurse #14 began to prepare to administer medications to Resident #87 including:</p> <p>- two metoprolol half tablets, 12.5 mg each.</p> <p>On 6/6/24 at 9:05 A.M., Nurse #14 said he was going to administer the prepared medications and crossed the threshold into Resident #87's room. The surveyor intervened and requested Nurse #14 clarify the metoprolol order. Nurse #14 said he was going to administer two tablets of 12.5 mg half tablets of metoprolol because the resident needed a total dose of 25 mg twice a day. Nurse #14 said he had never worked in this facility before and was not oriented to the facility including where the correct dosage is listed in the medication administration software or the process for obtaining medications that were not available.</p> <p>On 6/6/24 at 9:07, Nurse #16 said she would clarify the orders for Nurse #14. Nurse #16 said the order clearly reads to administer one half tablet of a 25 mg metoprolol tablet because the dose is 12.5 mg, not two half tablets.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/6/24 at 2:35 P.M., The Director of Nursing (DON) said medications should be administered following the physician's order. The DON said Nurse #14 should have given one half tablet, which is 12.5 mg, not two half tablets.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>46339</p> <p>Based on observation, policy reviews and interviews, the facility failed to ensure medications with short expiration dates were dated when opened, failed to ensure medication carts, cabinets were securely locked when unattended and medications were securely locked, refrigerated medications were stored correctly.</p> <p>Findings include:</p> <p>Review of the facility policy titled 'Medication Storage' last revised in February 2023, indicated the following but not limited to:</p> <ul style="list-style-type: none"> -It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/ or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. -All drugs and biologicals will be stored in locked compartments, i.e. medication carts, cabinets, drawers, refrigerators, medication rooms, under proper temperature controls. -All medications requiring refrigeration are stored in refrigerators located in the pharmacy and at each medication room. -Unused medications the pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with our destruction of unused drugs policy. <p>On 6/5/24 at 6:40 A.M., the surveyor observed the following in the first-floor west medication cart:</p> <ul style="list-style-type: none"> -Two fluticasone propionate 50 mcg (microgram) opened and undated. -One ipratropium bromide nasal solution 0.03% opened and undated. -One box of refresh eye drops opened and undated. -One bottle of prostat (nutritional supplement) opened and undated. <p>During an interview on 6/5/24 at 6:45 A.M., Nurse #6 said medications with short expiration dates should be dated when opened.</p> <p>On 6/5/24 at 6:55 A.M., the surveyor observed the following in the second-floor west medication cart:</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Latanoprost 0.005% eye drop unopened on the packaging it indicated refrigerated.</p> <p>-One box gentel eye drops opened and undated</p> <p>-One box incuse ellipta 62.5 mcg opened and undated.</p> <p>-Fluticasone propionate and salmeterol inhalation powder 500/ 50 mcg opened and undated.</p> <p>-One box Advair diskus 250/50 mcg opened and undated.</p> <p>During an interview on 6/5/24 at 7:05 A.M., Nurse #7 said inhalers should be dated when opened, medications that require refrigeration should be kept in the refrigerator.</p> <p>On 6/5/24 at 7:13 A.M., the surveyor observed the following in the second-floor east medication cart:</p> <p>-Two fluticasone nasal sprays 50 mcg opened and undated.</p> <p>-One albuterol/budesonide 90/80 mcg opened and undated.</p> <p>-One Advair 250/50 mcg opened and undated.</p> <p>During an interview on 6/5/24 at 7:20 A.M., Nurse #8 said the inhalers should be dated when they first open them.</p> <p>On 6/5/24 at 7:30 A.M., the surveyor observed the following in third-floor medication cart:</p> <p>-Two incuse ellipta 62.5 mcg inhalers opened and undated.</p> <p>During an interview on 6/5/24 at 7:30 A.M., Nurse #9 said inhalers are dated when opened.</p> <p>On 6/5/24 at 12:10 P.M., the surveyor observed the medication cart on the first floor open unlocked and unattended.</p> <p>During an interview on 6/5/24 at 12:15 P.M., Nurse #2 said the medication cart should be locked while unattended.</p> <p>On 6/7/24 at 6:12 A.M., the surveyor observed a medication on the second-floor open and unattended, there was a resident walking by the medication cart. The nurse was in a resident room not within the view of the cart.</p> <p>During an interview on 6/7/24 at 6:15 A.M., Nurse #12 said medication carts should be locked when left unattended.</p> <p>On 6/7/24 at 11:46 A.M., the surveyor observed the medication cabinet behind the second-floor nurses station opened and unattended.</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/7/24 at 11:47 A.M., Unit Manager #3 said the medication cabinet should always be locked.</p> <p>During an interview on 6/6/24 at 9:31 A.m., the Director of Nursing said all medications with short expirations dates should be dated when opened, medications should be stored per the pharmacy directions, medications carts and medication cabinets should be locked when left unattended. Medication carts should be wiped down clean inside and outside.</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48671</p> <p>Based on observations, record review and interview, the facility failed to provide the correct ordered therapeutic diet for two Residents (#40 and #45) out of a total sample of 38 residents.</p> <p>Findings include:</p> <p>Review of the facility policy titled Therapeutic Diets, dated Reviewed / Revised 2/2023, indicated the following:</p> <ul style="list-style-type: none"> -Therapeutic Diets including mechanically altered diets where appropriate will be based on the residents' individual needs as determined by the resident assessment. -All diet orders are to be communicated to the dietary department in accordance with facility procedures-dietary and nursing staff are responsible for providing therapeutic diets in the appropriate form and or the appropriate nutritive content as prescribed. -Therapeutic diet is a diet ordered by a physician or delegated registered or licensed dietitian as part of treatment for a disease or clinical condition. -Mechanically altered diet is one in which the texture or consistency of food is altered to facilitate oral intake. Examples include soft foods, puree foods, ground meat, and thickened liquids. <p>1. Resident #40 was admitted to the facility in June 2021 with diagnoses including dysphagia, dementia, communication deficit, and muscle weakness.</p> <p>Review of Resident #40's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 3 out of a possible 15, indicating he/she has severe cognitive impairment. The MDS also indicated Resident #40 required a mechanically altered diet and required a change in texture of food or liquids.</p> <p>Review of Resident #40's physician orders indicated the following orders:</p> <ul style="list-style-type: none"> -Diet Order: Regular diet ground texture, regular consistency, plastic utensils all meals. Dated 11/1/23. <p>During an observation on 6/4/24 at 8:45 A.M. Resident #40 was observed sitting in bed eating breakfast. He/she had regular textured toast on his/her plate.</p> <p>During an observation on 6/4/24 at 12:41 P.M., Resident #40 was observed sitting on the edge of the bed eating lunch. He/she had a fruit cup containing whole grapes and chopped meat.</p> <p>During an observation on 6/6/24 at 8:42 A.M., Resident #40 was observed sitting up in bed and had regular textured toast on his/her plate.</p> <p>(continued on next page)</p>

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 6/7/24 at 8:19 A.M., Resident #40 was observed sitting up in bed eating scrambled eggs, regular textured toast and had two sausage links broken into chunks on his/her plate.</p> <p>Review of Resident #40's nutritional care plan indicated the following:</p> <ul style="list-style-type: none"> - Difficulty chewing/swallowing, requires mechanically altered diet for maintenance. Revised 4/9/24. -Diet as ordered: regular, ground texture, thin liquids. No caffeine or MSG. Date Initiated: 11/29/2023. - Monitor texture tolerance Date Initiated: 11/29/23. - Supplements and enhanced foods as ordered: house supplement 8 oz PO (by mouth) QD (everyday). Date Initiated: 11/29/23. - Registered Dietician to consult on meal and texture. Date Initiated: 3/15/24 -SLP evaluation and treat as indicated. Date Initiated: 3/15/24 <p>Review of Resident #40's meal ticket for the days of the survey indicated the following: Diet Order: Ground, Regular Diet Regular Liquids.</p> <p>Review of Resident #40's dietary progress note dated 4/5/24, indicated, Regular diet, ground consistency, thin liquids.</p> <p>Review of the Speech Therapy Discharge summary dated 4/2/23, indicated the following: Minimal close supervision, mechanical soft/ground textures thin liquids.</p> <p>During an interview on 6/7/24 at 8:31 A.M., Certified Nursing Assistant (CNA) #8 said Resident #40 eats breakfast alone in his/her room and is on a regular diet.</p> <p>During an interview on 6/7/24 at 8:42 A.M., Nurse #11 said Resident #40 requires a ground diet and Nurse #11 reviewed the active dietary orders with the surveyor and said Resident #40 requires a ground diet due to dysphagia. Nurse #11 reviewed the diet slip located on the Residents breakfast tray and said Resident #40 should not cut up sausage links and requires a ground diet. Nurse #11 said Resident #40's diet slips should have been checked by staff.</p> <p>During an interview on 6/7/24 at 9:04 A.M., Supervisor #2 said Resident #40 does not have trouble swallowing and said Resident #40 can have sausages if they are chopped up. Supervisor #2 said Resident #40 is followed by speech services and has a diet order for ground foods.</p> <p>During an interview on 6/7/24 at 9:33 A.M., the Speech Language Pathologist (SLP) said Resident #40 should have ground foods with his/her meal. The (SLP) said Resident #40 is on a mechanical soft ground textured diet with thin liquids and he/she should not be eating whole grapes, whole toast, or cut up sausages as those foods are not part of a ground textured diet.</p> <p>(continued on next page)</p>

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/7/24 11:21 A.M., The Director of Nursing (DON) said all meal trays need to be checked by a nurse prior to giving it to a resident to ensure the correct textured diet is provided and said diet slips should match the diet order. The DON said dietary orders are expected to be followed and said Resident #40 requires a ground diet and should not be eating whole toast, whole grapes, or cut sausages on a mechanically altered diet.</p> <p>2. Resident #45 was admitted to the facility in October 2023 with diagnoses including dementia, alzheimers, and heart failure.</p> <p>Review of Resident #45's most recent Minimum Data Set (MDS) dated [DATE], indicated he/she had a Brief Interview for Mental Status (BIMS) score of 2 out of a possible 15, which indicated the Resident had severe cognitive impairment.</p> <p>During an observation on 6/4/24 at 8:45 A.M., Resident #45 was observed sitting in bed, eating breakfast alone in his/her room. He/she had regular textured toast on his/her plate, and a box of opened dry cereal.</p> <p>During an observation on 6/6/24 at 8:42 A.M., Resident #45 was observed sitting in bed eating breakfast alone in his/her room. He/she had regular textured toast on his/her plate, one whole blueberry muffin, and a box of opened dry cereal.</p> <p>During an observation on 6/7/24 at 8:19 A.M., Resident #45 was observed sitting in bed eating breakfast alone in his/her room. He/she had regular scrambled eggs, textured toast, and two whole sausage links, on his/her plate.</p> <p>Review of Resident #45's physician orders indicated the following order:</p> <ul style="list-style-type: none"> -Ground texture, Regular consistency, GROUND SOLIDS + NSP (Non-starch polysaccharides), dislikes coffee and milk. Dated 5/9/24. <p>Review of Resident #45's nutritional care plan indicated the following:</p> <ul style="list-style-type: none"> -Diet as ordered: HCC (House Consistent Carb) +NSP /ground/Thins. Revised on 6/7/24. -Monitor texture tolerance. Dated 11/27/23. -Registered Dietician consult as needed. Dated 11/27/23. -Speech Therapy Eval and Treat as indicated. Dated 1/4/24. <p>Review of Resident #45's meal ticket for the days of the survey indicated the following:</p> <ul style="list-style-type: none"> -Diet Order: Ground, HCC, Regular Liquids. Notes: NSP, No Dairy, Milk/Ice cream) Cut Up Pizza when served. -Standing Orders: 1/2 cup choice of cereal, 1 slice whole wheat toast-buttered. <p>Review of Resident #45's physician progress note dated 5/8/24 indicated the following:</p> <p>(continued on next page)</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Patient has been having difficulty swallowing medications. Eating with applesauce.</p> <p>Review of Resident #45's medical record indicated a nursing to therapy communication form dated 5/8/24, indicate the following:</p> <p>-Change has been noted in the following areas: Difficulty swallowing.</p> <p>-Evaluate swallowing and aspiration.</p> <p>Review of Resident #45's speech therapy evaluation and plan of treatment dated 5/9/24 indicated the following:</p> <p>-Resident referred by nursing for suspected swallowing difficulty.</p> <p>-Diet downgrade to ground solids for efficiency of oral phase.</p> <p>During an interview on 6/7/24 at 8:42 A.M., Nurse #11 said Resident #45 had difficulty swallowing foods and was placed on a ground diet after he/she was evaluated by speech therapy. Nurse #11 reviewed the active dietary orders with the surveyor and said Resident #45 has an order for a ground diet. Nurse #11 reviewed the diet slip located on the Residents breakfast tray and said Resident #45 should not be eating whole sausage links and requires a ground diet. Nurse #11 said Resident #40's diet slips should have been checked by staff.</p> <p>During an interview on 6/7/24 at 8:59 A.M., Supervisor #2 said Resident #45 was on a regular diet but was observed by speech therapist having difficulty swallowing so he/she was downgraded to a ground diet on 5/9/24. The supervisor said Resident #45 is followed by speech therapy and said the Resident is observed during lunch when the speech therapist sits with Resident #45 to monitor swallowing difficulties. The Supervisor said whole sausages are not part of a ground diet.</p> <p>During an interview on 6/7/24 at 9:19 A.M., the Speech Language Pathologist (SLP) said Resident #45 is not followed by speech therapy and she does not sit with Resident #45 during meals. The (SLP) said Resident #45 was evaluated and downgraded to a ground diet on 5/9/24 due to swallowing difficulties, should not be eating whole sausages, blueberry muffin, whole toast, and certain cereals depending on size. The (SLP) said Resident #45 requires distant supervision, and should not eat alone. The (SLP) said the diet slip and orders should reflect a ground diet.</p> <p>During an interview on 6/7/24 at 11:18 P.M., the Director of Nursing (DON) said all meal trays need to be checked by a nurse prior to giving it to a resident to ensure the correct textured diet is provided. The DON then observed Resident #45's diet order and said the Resident is supposed to have ground foods and said that he/she should not be eating whole sausages and foods not approved on a ground diet.</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41019</p> <p>Based on observations and interviews the facility failed to ensure it was administered in a manner that enabled the facility to use its resources effectively to attain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, the facility administration failed to ensure the appropriate behavioral health services were in place for one Resident (#192) who attempted suicide after verbalizing suicidal ideation.</p> <p>Findings Include:</p> <p>During the survey process it was identified that the Administration's failure to ensure adequate behavioral health services were provided for residents with mental health disorders.</p> <p>Out of a total universe of 67 residents identified with depression disorder, 7 residents were not provided the behavioral health services after an identification of decreased mood through the PHQ-9 (personal health questionnaire-9) (a tool used to measure depression).</p> <p>Review of the facility assessment, revised 3/19/24, indicated the facility is able to manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD (post traumatic stress disorder), other psychiatric diagnoses, intellectual or developmental disabilities. On average, the facility manages about 50 residents with behavioral health needs.</p> <p>Review of the Behavioral Health Service Agreement, dated December 2022, indicated the following services were provided to the facility:</p> <ul style="list-style-type: none"> - Provide psychiatric evaluations at the request of the attending physician for the purpose of assessing the specific needs of residents of the facility with psychiatric symptomology and recommending therapeutic interventions. - Perform psychopharmacological consults and monitoring; and psychotherapeutic services. - Act as a liaison for emergency situations in the event of a psychiatric crisis - Maintain certain that all residents that have a referral for behavioral health management services receive an evaluation within 10 days. <p>Resident #192 was admitted in December 2023 with diagnoses including bipolar disorder, depression, schizoaffective disorder, and generalized anxiety. Review of the admission Minimum Data Set (MDS), dated [DATE], indicated Resident #192 scored a 10 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the Resident's hospital discharge paperwork given to the facility upon admission and dated 12/1/23, indicated Resident #192 verbalized that he/she would kill him/herself if he/she had a gun in the hospital. The Resident was placed on a section 12 (an emergent mental health measure to prevent a patient from harming themselves) and cleared prior to admission.</p> <p>Review of the clinical record did not indicate that any SI (suicide ideation) care plan had been developed or any interventions for safety were put into place following admission.</p> <p>Review of the progress note, dated 1/8/24, indicated Resident #192 verbalized SI and was subsequently evaluated by the behavioral health services (Psychiatric Nurse Practitioner) for immediate safety. No changes were made to the Resident's plan of care.</p> <p>Review of the clinical record failed to indicate any changes had been made to Resident #192's plan of care, care plan, or that notification to the physician had occurred after the Resident had expressed suicide ideation.</p> <p>Review of the clinical record indicated on 1/24/24, Resident #192 was sent to the hospital for a planned procedure. Resident #192 returned to the facility on [DATE].</p> <p>Review of the hospital discharge paperwork, dated 1/31/24, indicated Resident #192 reported suicidal ideation in the hospital and was provided a one on one sitter and was placed on a section 12 hospitalization .</p> <p>Review of the clinical record failed to indicate that, upon readmission to the facility, Resident #192's plan of care was reviewed or updated, despite Resident #192's vocalization of suicidal ideation in the hospital and a section 12. There was no indication that Resident #192 was evaluated or seen by behavioral health services, social services, or any additional behavioral health interventions were updated between 2/2/24 - 2/16/24.</p> <p>Review of the record indicated, on 2/16/24, Resident #192 attempted suicide by placing a bag tightly over his/her head. Resident #192 was subsequently sent to the hospital and never returned to the facility.</p> <p>During an interview on 6/6/24 at 10:38 A.M., the psych NP said that she does not provide talk therapy to residents and that the other provider within her contract company should be utilized. The psych NP said she primarily focuses on medication management and checking in with residents. The psych NP said that Resident #192 would have benefited from talk therapy given everything that was going on with him/her. The psych NP also said that if a Resident is expressing suicidal ideation then certain safety measures should be put in place and a care plan should be developed to keep the Resident safe.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/7/24 at 9:21 A.M., the Administrator said that he brought supportive care services on board when the facility opened a behavioral health unit (around September 2023) to provide oversight and the Psychiatric NP is in a couple of times per week. The Administrator said that the psych NP is a consultant and sometimes meets with the residents to provide support and make recommendations to the doctor. He said he is unsure what she does when she sees them, but would assume she goes in to meet and talk with the residents. The Administrator said that social workers would be providing talk therapy to the residents, but that he doesn't differentiate the difference between talk therapy and when the psych NP goes to meet with residents. The Administrator said that if a Resident expresses suicidal ideation then the interdisciplinary team should be involved (department heads), as well as, psych services. The Administrator was not aware that the psych NP was not providing talk therapy services and just providing medication management.</p> <p>During an interview on 6/6/24 at 11:15 A.M., the Director of Nursing said emotional therapy and support would be provided by a contract provider that comes in (a psychologist), but could not say why Resident #192 had not been provided those services.</p> <p>During an interview on 6/10/24 at 11:54 A.M., the Director of Nursing said that she came on board last year and the social services department needs some work. She said she was never made aware of Resident #192's SI in the hospital and would not have taken him/her back if she knew.</p> <p>During an interview on 6/7/24 at 7:36 A.M., Physician #1 said that he believes that Residents would benefit from counseling services and non-pharmalogical interventions, but that he feels the facility needs more support to provide those services.</p> <p>The Administrator or Director of Nursing were unable to provide evidence throughout survey that the behavioral contract services were meeting the facilities expectations for behavioral health services provided to residents.</p>		

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.</p> <p>41019</p> <p>Based on interviews and review of the facility assessment, the facility failed to accurately evaluate their resident population and identify the resources needed to provide the necessary care and services of the resident population related to behavioral health services.</p> <p>Findings include:</p> <p>Review of the facility assessment, revised 3/19/24, indicated the facility is able to manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnoses, intellectual or developmental disabilities. On average, the facility manages about 50 residents with behavioral health needs.</p> <p>It was determined during survey that out of a total universe of 68 residents identified with depression disorder, 6 residents were not provided the behavioral health services after an identification of decreased mood through the PHQ-9 (personal health questionnaire-9) (a tool used to measure depression).</p>		

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NAME OF PROVIDER OR SUPPLIER Advocate Healthcare of East Boston, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Orient Avenue East Boston, MA 02128	
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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>48990</p> <p>Based on observation, record review, and interview, the facility failed to maintain an accurate medical record for one Resident (#16), out of a total sample of 38 residents. Specifically, the nurses documented in the Treatment Administration Record (TAR) that they had applied a resting hand splint to Resident #16's left hand when they had not.</p> <p>Findings include:</p> <p>Resident #16 was admitted to the facility in March 2014 with diagnoses including with a left hand contracture and a history of traumatic brain injury.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 4/24/2024, indicated Resident #16 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 4 out of 15. This MDS also indicated Resident #16 was dependent on staff for dressing, transfers, and mobility.</p> <p>Review of the physician's order, dated 10/30/23, indicated:</p> <p>- Patient to wear resting hand splint on left hand in am and removed at bed, every day and evening shift *-*** kept in bedside drawer*****</p> <p>Review of the plan of care related to need for assistance with ADLS (activities of daily living), dated 5/16/24, indicated:</p> <p>- (L) resting hand sprint on in AM, off in PM.</p> <p>Review of Resident #16's Treatment Administration Record (TAR) indicated the order for Patient to wear resting hand splint on left hand in am and removed at bed, every day and evening shift *-*** kept in bedside drawer***** was documented as administered on 6/4/24, 6/5/24, and 6/6/24.</p> <p>On 6/4/24 at 8:33 A.M., the surveyor observed Resident #16 in bed eating breakfast. Resident #16 did not have a resting hand splint on his/her left hand.</p> <p>On 6/4/24 at 12:10 P.M., the surveyor observed Resident #16 in bed eating lunch. Resident #16 did not have a resting hand splint on his/her left hand. Resident said staff need to help put it on his/her left hand, but when he/she asks, staff says they can't do it.</p> <p>The surveyor also made the following observations:</p> <p>- On 6/4/24 at 2:38 P.M., Resident #16 in bed without his/her left resting hand splint. Resident #16 said staff had not offered the resting hand splint today.</p> <p>- On 6/5/24 at 8:12 A.M., Resident #16 in bed without his/her left resting hand splint.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- On 6/6/24 at 10:01 A.M., Resident #16 in bed without his/her left resting hand splint. Resident #16 said staff had not offered the resting hand splint today and asked surveyor to put it on.</p> <p>On 6/6/24 at 10:07 A.M., Certified Nurse Assistant (CNA) #10 said Resident #16 is supposed to have a carrot (a device used for hand contractures) in his/her left hand but that sometimes staff can't find it, but that he/she does not refuse it. CNA #10 gets a carrot out of Resident #16's drawer and applies it to Resident #16's left hand.</p> <p>During an interview on 6/7/24 at 11:30 A.M., Unit Manager #2 said Resident #16 should be wearing a left resting hand splint. Unit Manager #2 said Resident #16 should not be wearing a carrot because it is not a replacement for a left resting hand splint. Unit Manager #2 enters Resident #16's room and locates a left resting hand splint and asks Resident #16 if he/she would like it on, and the Resident says yes.</p> <p>During an interview on 6/7/24 at 12:09 P.M., the Director of Nursing said Resident #16 should be wearing a left resting hand splint and that a carrot is not a replacement for this device. The DON said if Resident #16 had refused to wear the left resting hand splint that it should be documented in the Treatment Administration Record (TAR) or progress notes.</p> <p>Review of TAR and progress notes failed to indicate Resident #16 had refused to wear the left resting hand splint.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456</p> <p>Based on observations, record review, policy review and interviews, the facility failed to 1.) maintain airborne precautions for one Resident (#94) who was diagnosed with chicken pox, 2.) conduct site-specific infection control surveillance and risk assessments including surveillance data and documentation of follow-up activity in response to active varicella outbreak that required airborne precautions to be implemented, and 3.) failed to report a communicable disease timely to the local and or state health department when a communicable disease was diagnosed on [DATE].</p> <p>Findings include:</p> <p>Review of the facility policy titled, Transmission Based (Isolation) Precautions, dated May 2024 indicated the following:</p> <ul style="list-style-type: none"> -it is our policy to take appropriate precautions to prevent transmission of pathogens, based on the pathogens' modes of transmission. -Airborne precautions refer to measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment. -Residents on transmission-based precautions should remain in their rooms except for medically necessary care. -an order for transmission-based precautions/isolation will specify the type of precaution and reason for the transmission-based precaution. The duration will depend upon the infectious agent or Organism involved. -The order for transmission-based precautions/isolation will specify the type of precaution and reason for the transmission-based precaution. The duration will depend upon the infectious agent or Organism involved. -Signage that includes instructions for the use of specific PPE (personal protective equipment) will be placed in a conspicuous area location outside of the resident's room, wing, or facility wide. Additionally, either the CDC category of transmission-based precautions (e.g. contact, droplet, or airborne) or instructions to see the nurse before entering will be included in the signage. -Airborne precautions- <p>*a. Airborne precautions prevent transmission of pathogens that remain infectious over long distances when suspended in air</p> <p>*b. The preferred placement for patients who require airborne precautions is in a airborne infection isolation room (AIIR).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*c. This facility does not have an airborne infection isolation room; Therefore, residents who have confirmed infection requiring airborne precautions will be transferred to an acute care hospital that has an available AIIR.</p> <p>*d. If unable to transfer resident to an AIIR room, as in the case of COVID-19 infection, the facility will follow CDC guidance as to cohorting, private room accommodations and or designated units and staff will wear a fit tested N-95 or higher-level respirator and other appropriate PPE while delivering care to the resident.</p> <p>Review of the Facility Assessment, updated and reviewed with QAPI Committee dated, March 2024, indicated the following:</p> <ul style="list-style-type: none"> -Special Treatments and Conditions: Isolation or Quarantine for Active Infectious Disease. -Resident support /care needs. General care infection prevention and control. Identification and containment of infections, prevention of infections, track and trend of infections, antibiotic stewardship. -Staff members, other health care professionals, and medical practitioners that are needed to provide support and care for residents: Infection Control and Preventionist. -Infection Control- hand hygiene, isolation, standard universal precautions. The facility identifies and implements precautions that are individualized dependent upon type of precaution and identified prior to entry. The facility utilizes the Center for Disease Control (CDC) for proper signage and use of Personal Protective Equipment (PPE). -The facility evaluates our infection prevention and control program on a routine basis and as needed. The interdisciplinary team includes but is not limited to SDC (Staff Development Coordinator), DNS (Director of Nursing Services), ADNS (Assistant Director of Nursing), Administrator, Medical Director and lab. Effective systems for this team ensure the facility is preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement, that follow accepted national standards and local standards. <p>1. Resident #94 was admitted to the facility in September 2021 with diagnoses including major depression and schizophrenia.</p> <p>Review of Resident #94's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 7 out of a possible 15, which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #94 required supervision with bathing and dressing tasks.</p> <p>Review of the nursing note dated 6/3/24, indicated the following:</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Resident found to have multiple raised blisters covering areas on (his/her) body. (He/she) denies pain or discomfort. Seen by N.P. (nurse practitioner) new order for (a medication used to treat the symptoms of chickenpox, shingles and herpes virus infections) 800 mg (milligram) by mouth 4 times daily for 5 days. calamine lotion every 6 hours PRN (as needed), Benadryl 25 mg tab twice daily for itching for 14 days. Isolation and contact precautions maintained.</p> <p>Review of the nurse practitioner note dated 6/3/24 indicated the following:</p> <p>-Varicella (a herpes virus that causes chicken pox) zoster infection on client with rashes over the body. Alert and responsive and in no acute distress. No sob/resp distress noted. Client will continue on precautions. Varicella without complication.</p> <p>Review of Resident #94's physician orders indicated the following order initiated on 6/3/24:</p> <p>-Isolation precautions: airborne and contact precautions, until resolved due to varicella (chickenpox) every shift.</p> <p>On 6/4/24 at approximately 8:00 A.M., a sign was observed outside of Resident #94's room that indicated Airborne Precautions. The Resident was not in his/her room and the door to the room was open.</p> <p>On 6/4/24 from approximately 8:00 A.M., to 8:50 A.M., Resident #94 was observed walking up and down the hallway barefoot. The Resident was wearing black sweatpants, and the right side of the pants were ripped open, exposing the Resident's buttocks. During this time, the Resident walked past a nurse several times and stopped to speak with a Certified Nursing Assistant (CNA). A significant rash was observed on Resident #94's buttocks and bilateral arms. At no point did the staff members encourage Resident #94 to return to his/her room.</p> <p>On 6/4/24 at approximately 8:56 A.M., Resident #94 was observed sitting in a chair in his/her room with the door open.</p> <p>On 6/4/24 at 1:29 P.M. Resident #94 was observed in his/her room with the door to the room wide open.</p> <p>On 6/5/24 at 7:05 A.M., the Maintenance Director was observed entering Resident #94's room without a N-95 or other PPE on. When observed leaving the room, he is not observed washing his hands. At 7:06 A.M. , the Maintenance Director told a CNA If you see (Resident #94) in the hall (he/she) has to go back. (Resident #94) is on precautions and is contagious.</p> <p>On 6/5/24 at 7:43 A.M., a CNA entered Resident #94's room without any PPE or N-95 mask.</p> <p>On 6/10/24 at 7:49 A.M., a staff member was observed leaving Resident #94's room wearing full PPE (gown, gloves, and mask) and began walking down hallway. The social service assistant stopped the aid in the hallway and told her the PPE cannot be worn in the hallway after being inside the room.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/4/24 at 1:32 P.M., Unit Manager #2 and Nursing Supervisor #1 said Resident #94 was diagnosed with the chickenpox on 6/3/24 and was immediately put on airborne and contact precautions. Both Unit Manager #2 and Nursing Supervisor #1 said staff had been educated on the necessary precautions and should be making all attempts to ensure the precautions are in place at all times. Unit Manager #2 said due to the Resident's cognition and behaviors, it will be difficult for him/her stay in his/her room, however, the staff are expected to encourage him/her to always follow the precautions and if he/she is seen in the hallway the staff should ask him/her to return to his/her room and close the door.</p> <p>During interviews on 6/4/24 at 1:47 P.M., and 2:36 P.M., the Director of Nursing (DON) said Resident #94 was diagnosed with chickenpox and was immediately put on airborne and contact precautions. The DON said these precautions meant that the Resident needed to be isolated in his/her room and the staff need to wear a N-95 mask, gown, and gloves when entering the Resident's room. The DON said all staff had been educated on these precautions and are expected to follow them and encourage the Resident to follow them as well. The DON said this would include the staff closing Resident #94's door if opened and encouraging the Resident to return to his/her room if observed outside of the room.</p> <p>48671</p> <p>2. The Facility failed to conduct site-specific infection control surveillance and risk assessments including provide surveillance data, documentation of follow-up activity in response to active varicella outbreak that required airborne precautions to be implemented.</p> <p>Review of the facility policy titled, Infection Surveillance undated, indicated the following:</p> <p>-A system of infection surveillance serves as a core activity of the facility's infection prevention and control program. Its purpose is to identify infections and to monitor adherence to recommended infection prevention and control practices in order to reduce infections and prevent the spread of infections.</p> <p>-Infection surveillance refers to an ongoing systemic collection analysis interpretation and dissemination of infection related data.</p> <p>-Outcome measure is a mechanism for evaluating outcomes or results such as tracking specific infection events.</p> <p>-Process measure is a mechanism for evaluating specific steps in a process that lead either positively or negatively to a particular outcome metric also known as performance monitoring a process measure is used to evaluate whether infection prevention and control practices are being followed.</p> <p>-Surveillance activities will be monitored facility wide and may be broken down by department or unit depending on the measure being observed a combination of process and outcome measures will be utilized.</p> <p>-The RN's (Registered Nurse) and (Licensed Practical Nurse) LPN's participate in surveillance through assessment of residents and reporting changes in condition to the resident's physicians and management staff, per protocol for notification of change and in- house reporting of communicable diseases and infections:</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>a. Resident develops signs and symptoms of infection.</p> <p>b. A resident is started on antibiotic</p> <p>c. A microbiology test is ordered</p> <p>d. A resident is placed on isolation precautions, whether empirically or by physician order.</p> <p>-An annual infection control risk assessment will be used to prioritize surveillance efforts, as documented in the facility's Infection Surveillance Action Plan. In turn, surveillance data will provide information for subsequent infection control risk assessments.</p> <p>- The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and report surveillance findings to the facility's Quality Assessment and Assurance Committee, and public health authorities when required.</p> <p>-All resident infection will be tracked. Separate, site-specific measures may be tracked as priorities from the infection control risk assessment. Outbreaks will be investigated.</p> <p>-Data to be used in the surveillance activities may include but are not limited to: Rounding observation data.</p> <p>Review of the infection control line listings for May 2024 and June 2024 did not include monitoring, tracking, analyzing of infections, surveillance activities or implementation of an outbreak investigation.</p> <p>During the course of the survey, the facility was unable to provide an infection control site specific risk assessment, documentation of follow-up activity in response to active varicella outbreak investigation documentation, or on-going surveillance plan that required airborne precautions to be implemented.</p> <p>Review of the infection control line listings during the month of May 2024 did not include surveillance data and documentation of follow-up activity in response to active Shingles virus (Shingles is a painful rash illness. People get shingles when the varicella-zoster virus (VZV), which causes chickenpox, reactivates in their bodies after they have already had chickenpox).</p> <p>Review of the infection control line listings during the month of June 2024 failed to include ongoing surveillance data and documentation of follow-up activity in response to active VZV outbreak that required airborne precautions to be implemented for one Resident.</p> <p>During an interview on 6/4/24 at 4:42 P.M., Supervisor #1 said Residents who test positive for Varicella-zoster virus must be placed on airborne precautions and wear full PPE and N95 mask because the virus is highly contagious. Supervisor #1 said he did not conduct any symptom surveillance on the unit, check for symptoms of other residents or review immunity of the other residents on the unit because there was no need to. Supervisor #1 said he didn't know what to do or what should be done or offered to other Residents.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/10/24 at 11:03 A.M., the Director of Nursing (DON) said she updated the monthly line listing, and that the facility did not conduct or implement any additional surveillance data or follow-up activity during the months of May 2024 or June 2024.</p> <p>During an interview on 6/10/24 at 1:04 P.M., the Regional Nurse said she was aware of the chickenpox diagnoses in the building and said she is the regional nurse for this facility but could not speak to the specific infection prevention program or surveillance of infections in the building.</p> <p>3. The Facility failed to report a communicable disease timely to the local and or state health department when a communicable disease, varicella-zoster virus, was diagnosed on [DATE].</p> <p>Review of the facility policy titled Infection Outbreak Response and Investigation dated as revised 2/2023, indicated the following:</p> <ul style="list-style-type: none"> -The facility promptly responds to outbreaks of infectious diseases within the facility to stop transmission of pathogens and prevent additional infections. -Prompt recognition of an outbreak: A single case of a rare or serious infection (i.e. invasive group A strep, foodborne pathogens, active TB (Tuberculosis), acute hepatitis, Legionella, chickenpox, measles, COVID-19. -An outbreak will be reported to the local and or state health department in accordance with the state's reportable disease website. <p>Review of the Health Care Facility Reporting System report, dated 6/3/23 to 6/10/24, failed to include documentation to support the facility reported the communicable disease to the state agency as required.</p> <p>During an interview on 6/4/24 at 4:47 P.M., Supervisor #2 said the DON is covering the infection control tasks in the building and that one Resident was placed on airborne precautions due to active chickenpox on 6/3/24 with open pustules all over his body. Supervisor #2 said airborne precautions are required and the Resident needs a negative pressure room, but the facility does not have one.</p> <p>During an interview on 6/4/24 at 2:13 P.M., the Administrator said he was not aware if the DON reported the chickenpox and said less than three cases is not an outbreak and does not need to be reported.</p> <p>During an interview on 6/4/24 01:47 P.M., the DON said one case of chicken pox does not need to be reported to the local board of health or state agency because it is not a cluster of three or more.</p> <p>Reference F882</p>		

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<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>48671</p> <p>Based on interviews and review of the Facility Assessment, the facility failed to designate one or more individuals as the infection preventionist who are responsible for the facility's infection prevention and control plan. Specifically, the facility failed to have a qualified infection preventionist with completed specialized training in infection prevention and control.</p> <p>Findings include:</p> <p>Review of the Facility Assessment, updated and reviewed with QAPI Committee, dated, March 2024 indicated the following:</p> <ul style="list-style-type: none"> -Facility resources need to provide competent support and care for our resident population every day and during emergencies. -Infection Control and Preventionist. -Staff training / education and competencies programs are reviewed and revised to ensure we provide the level and types of support and care needed for our resident population. Include staff certification requirements as applicable. -The facility evaluates our infection prevention and control program on a routine basis and as needed. The interdisciplinary team includes but is not limited to SDC (Staff Development Coordinator), DNS (Director of Nursing Services), ADNS (Assistant Director of Nursing), Administrator, Medical Director and lab. Effective systems for this team ensure the facility is preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement, that follow accepted national standards and local standards. <p>During an interview on 6/4/24 at 4:21 P.M., the Director of Nursing (DON) said she understands the importance of the infection prevention program and has been covering this role since the end of April 2024. The DON said she does not have the required infection control certification and the facility does not have an approved infection preventionist working in the facility.</p> <p>During an interview on 6/5/24 at 10:11 A.M., the Medical Director said he expects the facility to have an infection preventionist in the building managing the infection control program</p> <p>During an interview on 6/5/24 at 1:25 P.M., the Administrator said he was aware that the facility did not have an infection preventionist in the building.</p> <p>During an interview on 6/10/24 at 1:04 P.M., the Regional Nurse said she was the regional nurse for this facility but could not speak to the specific infection prevention program in the building. The Regional Nurse said they do not currently have an infection preventionist in the building.</p>		

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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.			
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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36876</p> <p>Based on observation, record review and interview, the facility failed to ensure the call light was accessible for one Resident (#79) out of a total of 38 sampled residents.</p> <p>Findings include:</p> <p>Review of the facility's Call lights: Accessibility and Timely Response policy, dated February 2023 indicated: Staff will ensure the call light is within reach of resident and secured as needed. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room.</p> <p>Resident #79 was admitted to the facility in December 2021 with diagnoses including dementia, cerebrovascular accident (stroke) and depression.</p> <p>Review of Resident #79's Minimum Data Set assessment dated [DATE] indicated he/she scored 15 out of 15 on the Brief Interview of Mental Status Exam indicating intact cognition. The MDS also indicated that Resident #79 requires assistance with bathing, dressing and transfers.</p> <p>On 6/4/24 at 8:52 A.M., the surveyor observed Resident #79 laying in bed with his/her call light inaccessible and out reach, on the floor behind his/her bed.</p> <p>On 6/4/24 at 12:19 P.M., and 1:36 P.M., the surveyor observed Resident #79 laying in bed with his/her call light inaccessible and out of reach on the floor behind his/her bed.</p> <p>On 6/6/24 at 2:02 P.M., the surveyor observed Resident #79 laying in bed. Resident #79 said he/she did not have a way to call out of help or assistance if he/she needed it. The surveyor observed Resident #79's call light inaccessible and out of reach on the floor behind his/her bed.</p> <p>Review of Resident #79's fall care plan, dated 3/15/24, indicated an intervention to be sure Resident #79's call light is within reach.</p> <p>During an interview on 6/6/24 at 2:05 P.M., Unit Manager #2 said call lights should be within reach and accessible for all residents.</p>		