STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225413	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Center at Advocate	111 Orient Avenue East Boston, MA 02128

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review the facility failed to ensure grievances were filed and resolved in a timely manner for one Resident (#48) out of a total sample of 30 residents. Findings include: Review of the facility policy titled Resident and Family Grievances, dated as revised 2/2023, indicated the following: -Policy: It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal. -Definitions: Prompt efforts to resolve include facility acknowledgment of a complaint/grievance and actively working toward resolution of that complaint/grievance. Resident #48 was admitted to the facility in March 2024 and has diagnoses that include major depressive disorder and mild neurocognitive disorder without behavioral disturbance. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/26/25, indicated that on the Brief Interview for Mental Status exam Resident #48 scored a 7 out of a possible 15, indicating severely impaired cognition. During an interview on 6/3/25 at 9:00 A.M., Resident #48 stated that his/her roommate constantly blares the television at night when he/she is trying to sleep and that even though he/she complains about it to staff, no one does anything. Review of Resident #48's clinical progress notes indicates the following notes written by Nurse #2: -5/7/25: Resident expressing to writer that roommate TV is too loud not able to sleep especially at night, and that would like intervention, its just annoying. Writer requested roommate to try accommodate his/her peer however stated that that doesn't concern him/her whatsoever. (sic) -5/10/25: c/o (complain of) not wanting to be in the same room with roommate because roommate has his/her TV on all night and that makes him/her can't sleep, patient wants to be in a different room and will speak to the Unit Manager. (sic) (continued on next page)

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

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's grievance log book failed to indicate that a grievance was filed regarding Resident #48's complaint on 5/7/25 or 5/10/25. During an interview on 6/4/25 at 12:22 P.M., with Nurse #2 he said that when Resident #48 complained about the roommates TV blaring at night he took the following action: -he spoke to the roommate; and -he did not file a grievance but rather reported the complaint to the Unit Manager and she took it from there. Nurse #2 said that he thinks that the situation has improved and was not aware that the Resident continued to have concerns regarding the roommates television. The Unit Manager was not available during the survey. During an interview on 6/4/25 at 1:13 P.M., with the Nursing Home Administrator (NHA) she said that anyone can file a grievance and that when they do the facility will try to fix the problem immediately. The NHA said that they will write up both the complaint and the resolution to the grievance on the grievance form. The NHA could not say why a grievance, that included a resolution to Resident #48's ongoing concern, was not completed. The NHA said that if the Resident were offered a room change it would be documented in Resident's medical record.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interviews, the facility failed to ensure a comprehensive resident centered care plan was developed for one Resident (#118) out of a total sample of 30 Residents. Specifically, the facility failed to develop an individualized comprehensive resident centered care plan related to the monitoring and care of a pacemaker. Findings include: Review of the facility policy title Use of Pacemaker, undated, indicated the following: -All residents with a pacemaker will be monitored according to standard protocol and plan of care. -All documentation about the pacemaker will be placed in the residents' chart and part of their permanent record. Resident #118 was admitted to the facility in February 2025 with diagnoses including bradycardia and presence of a pacemaker. Review of Resident #118's most recent Minimum Data Set (MDS) assessment, dated 5/15/25, indicated the Resident scored a 5 out of a possible 15 on the Brief Interview for Mental Status exam, indicating severe cognitive impairment Review of the care plan, dated as initiated 2/26/25, indicated the following: Resident has a pacemaker related to cardiac dysrhythmia and is at risk for activity intolerance, pacemaker failure and altered cardiac output. Intervention: Monitor vital signs as ordered or per facility protocol and record. Notify physician of significant abnormalities from baseline values. Review of Resident #118's current physician orders failed to indicate a pacemaker setting rate, serial number and cardiologist information. During an interview on 6/5/25 at 9:00 A.M., Nurse #4 said the pacemaker setting should be in the physician orders and that the nurses check the Resident's heart rate and would report any abnormal rate. During an interview on 6/5/25 at 9:18 A.M., Nurse #3 said the pacemaker setting should be in the physician orders. The setting would guide the nurses to know how low or high the pacemaker is set to. During an interview on 6/5/25 at 10:47 A.M., the Director of Nursing said the physician orders should have the pacemaker setting and all the details in regards to the pacemaker.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations, interviews, and record review, the facility to ensure that services provided met professional standards for one Resident (#10), out of a total sample of 30 residents. Specifically, the facility failed to complete a physician order for weekly skin check and failed to identify bruises for three days. Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated the following: - Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize errors. Review of the facility policy titled Skin Assessment, undated, indicated the following: -A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, daily for three days, and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury. -Documentation of skin assessment-document if resident refused assessment and why. Resident #10 was admitted to the facility in April 2025 with diagnoses including dementia and chronic long-term use of anticoagulants (medications used for thinning blood). Review of Resident #10's most recent Minimum Data Set (MDS) assessment, dated 5/14/25, indicated the Resident scored 3 out of a possible 15 on the Brief Interview for Mental Status exam, indicating severe cognitive impairment. The MDS further indicated that Resident #10 is dependent for all activities of daily living (ADLs). On 6/3/25 at 9:03 A.M., the surveyor observed Resident #10 lying in his/her bed. Resident #10's right arm was on top of the covers with a deep purplish yellowish fading bruise on the back and forearm. On 6/4/25 at 7:24 A.M., the surveyor observed Resident #10 lying in his/her bed. Resident #10's right arm had purplish/yellowish bruising to the back and forearm. On 6/5/25 at 7:31 A.M., the surveyor observed Resident #10 lying in his/her bed. Resident #10's right arm had purplish/yellowish bruising to the back and forearm. Review of Resident #10's current physician orders indicated the following: -Skin check weekly on Wednesday 3-11 shift I=intact, O=open, and complete skin assessment on Universal Design for Assessment (UDA) every shift every Wednesday for skin check. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #10's anticoagulant care plan, dated as initiated 5/1/25, indicated: -Resident is currently taking an anticoagulant related to Atrial Fibrillation. Interventions: -Daily skin inspection report abnormalities to the nurse. -Monitor/document /report to medical doctor (MD) as needed, signs and symptoms of anticoagulant complications: blood tinged or frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs. Review of Resident #10's weekly skin evaluations dated 5/7/25, 5/14/25, 5/21/25, and 5/28/25 failed to indicate bruising to the right arm. Review of Resident #10's medical record failed to indicate a weekly skin evaluation was completed on 6/4/25 as ordered. Review of Resident #10's nursing progress notes failed to indicate bruising to right hand/forearm had been identified. During an interview on 6/5/25 at 7:33 A.M., Certified Nursing Assistant (CNA) #1 said she saw the bruise on the Resident's right arm on Tuesday (6/3/25) but did not tell the nurse about it. She said when giving care, if a bruise is identified, the CNAs are supposed to report it to the nurse immediately. During an interview on 6/5/25 at 7:38 A.M., Nurse #5 said skin checks are completed weekly and should identify any bruises, skin tears and pressure injuries. She said the CNAs are responsible for reporting to the nurses immediately if they observe any skin alterations. Nurse #5 further said any bruises on a resident should be documented in the progress notes. During an interview on 6/5/25 at 9:20 A.M., Nurse #3 said skin checks should be completed weekly, and any skin alterations are documented in the progress notes and the weekly skin evaluation. Nurse #3 further said a skin check should have been completed yesterday as per the orders. During an interview on 6/5/25 at 10:47 A.M., the Director of Nursing said skin checks should be completed weekly per the physician orders, daily with care and any bruises should be documented in the medical record.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review and interview the facility failed to ensure nursing staff provided assistance with Activities of Daily Living (ADLs) for one dependent Resident (#111) out of a total sample of 30 residents. Specifically, for Resident #111 the facility failed to provide assistance with the removal of facial hair. Findings Include: Review of the facility policy titled Activities of Daily Living (ADL's), undated, indicated the following: Policy -The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADL's do not deteriorate unless deterioration is unavoidable. -Care and services will be provided for the following activities of daily living: bathing, dressing, grooming, and oral hygiene. Policy Explanation and Compliance Guidelines: -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. Resident #111 was admitted to the facility in March 2024 with diagnoses including displaced fracture of the greater trochanter of the right femur, fracture of T7-T8 vertebrae, malignant neoplasm of the upper lobe of the right lung, and contracture of right hand. Review of Resident #111's most recent Minimum Data Set (MDS) assessment, dated 5/13/25, indicated the Resident had a Brief Interview for Mental Status exam score of 13 out of a possible 15, indicating intact cognition. The MDS further indicated Resident #111 required substantial/maximal assistance for self-care activities. During an interview on 6/3/25 at 8:45 A.M., Resident #111 said he/she normally does not have facial hair and would like it removed but needs assistance. On 6/3/25 at 8:45 A.M., and 3:31 P.M., 6/4/25 at 7:41 A.M., 12:29 P.M., and 4:12 P.M., and 6/5/25 at 7:39 A.M., Resident #111 was observed with upper lip, chin, and neck hair. Review of Resident #111 personal hygiene care card (documentation indicating level of care provided for combing hair, shaving, applying make-up, and washing/drying face and hands), indicated Resident #111 required substantial/maximal assistance to complete personal hygiene. Review of Resident #111's nursing progress notes failed to indicate he/she refused ADL care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/5/25 at 8:10 A.M., Nurse #6 said the Certified Nursing Assistants (CNA's) normally shave residents during morning care with their permission. Nurse #6 said Resident #111 required assistance of one to two people for self-care, would only refuse care if he/she was in pain and it should be documented in the medical record if a resident refused care. During an interview on 6/5/25 at 8:35 A.M., CNA #2 said we shave residents with their permission, and if they refuse, we will try again later and if they continue to refuse, we notify the nurse. CNA #6 said she does not have Resident #111 today but does assist him/her with shaving when he/she is assigned to her. During an interview on 6/5/25 at 9:40 A.M., the Administrator said she would expect facial hair to be removed with the resident's permission during routine care and any refusals should be documented in the medical record.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observations, record reviews and interviews, the facility failed to ensure residents at risk for developing pressure ulcers received necessary treatment and services, consistent with professional standards of practice for two Residents (#2 and #61) out of a total sample of 30 residents. Specifically, the facility failed to follow physician orders for air mattress settings. Findings include: Review of the facility policy titled Use of Support Surfaces, undated, indicated the following: 7. For powered devices, or those requiring air, the licensed nurse will check each shift and prn (as needed) for proper functioning, and/or inflation. 1. Resident #2 was admitted to the facility in December 2000 with diagnoses including multiple sclerosis and diabetes. Review of Resident #2's most recent Minimum Data Set Assessment (MDS) assessment, dated 5/27/25, indicated the Resident scored a 15 out of possible 15 on the Brief Interview for Mental Status exam, indicating intact cognition. The MDS further indicated that Resident #2 required a pressure reducing device and was at risk of developing pressure ulcers/injuries. On 6/4/25 at 1:08 P.M., the surveyor observed Resident #2 lying in his/her bed with an air mattress setting at 125 lbs (pounds). On 6/5/25 at 7:08 A.M., the surveyor observed Resident #2 lying in his/her bed with an air mattress setting at 125 lbs. Review of the medical record indicated the following physician orders, dated 8/22/24: -Air mattress to bed setting at 150 (resident request) check setting and function q shift for wound prevention. -Right hip: clean with normal saline, cover with foam dressing change every three days for protection every day shift. Review of Resident #2's weekly skin evaluation, dated 6/1/25 indicated the following : -Blanchable area with no visible drainage noted to the right hip. Review of Resident #2's skin care plan, dated as revised on 5/27/25, indicated the following focus: -At risk for a pressure injury related to poor mobility, decreased range of motion, diagnosis of diabetes, bowel incontinence, left below the knee amputation, history of pressure areas, noncompliant with repositioning side to side and psoriasis. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Intervention: Air mattress to bed setting at 150 per resident request, check function and setting every shift. During an interview on 6/5/25 at 9:48 A.M., Certified Nursing Assistant (CNA) #3 said she adjusts Resident #2's air mattress setting to firm when she is performing activities of daily. During an interview on 6/5/25 at 10:00 A.M., Nurse #4 said nurses are responsible for checking air mattress settings. Nurse #4 further said air mattresses are checked every shift and settings are listed in the physician order. During an interview on 6/5/25 at 10:02 A.M., Nurse #3 said air mattresses are set by weight, nurses are responsible for checking air mattresses every shift, and that Resident #2's air mattress should be set to 150 pounds. During an interview on 6/5/25 at 10:50 A.M., the Director of Nursing said nurses should have checked the air mattress for the correct setting every shift and the expectation is to follow the physician order. 2. Resident #61 was admitted to the facility in August 2023 with diagnoses including multiple sclerosis and pressure ulcer of sacral region stage 3. Review of Resident 61's most recent Minimum Data Set Assessment (MDS) assessment, dated 4/18/25, indicated the Resident scored a 14 out of possible 15 on the Brief Interview for Mental Status exam, indicating intact cognition. The MDS further indicated that Resident #61 required a pressure-reducing device, had a pressure ulcer/injury and a non removable dressing/device. On 6/4/25 at 7:54 A.M., the surveyor observed Resident #61 lying in his/her bed, the air mattress was set at 340 Lbs (pounds). The resident also had a wound vacuum (a medical procedure that uses negative pressure to promote wound healing). On 6/4/25 at 1:11 P.M., the surveyor observed Resident #61 lying in his/her bed, the air mattress was set at 340 Lbs (pounds). On 6/5/25 at 7:11 A.M., the surveyor observed Resident #61 lying in his/her bed, the air mattress set at 340 Lbs (pounds). Review of the medical record indicated the following physician orders: -Air mattress to bed. Setting on 160. Check functioning of mattress every shift. Check for proper setting every shift, dated 8/21/24. -Continuous Negative Pressure wound Vacuum to sacrum, dated 6/3/25. Review of Resident #61's skin care plan revised on 4/30/25 indicated the following interventions: -Sacral wound pressure stage three. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Air mattress to bed. Setting on 160. Check functioning of mattress every shift. Check for proper setting every shift. -Evaluate need for alternating pressure mattress and adhere to manufacturer guidelines to ensure settings are correct, check function every shift of mattress when in place. During an interview on 6/5/25 at 9:48 A.M., Certified Nursing Assistant (CNA) #3 said she adjust the air mattress setting to firm when she is performing activities of daily. During an interview on 6/5/25 at 10:00 A.M., Nurse #4 said nurses are responsible for checking air mattress settings. Nurse #4 further said air mattresses are checked every shift and settings are listed in the physician order. During an interview on 6/5/25 at 10:02 A.M., Nurse #3 said air mattresses are set by weight, nurses are responsible for checking air mattresses every shift, and that Resident #61's air mattress should be set to 160 pounds. During an interview on 6/5/25 at 10:50 A.M., the Director of Nursing said nurses should have checked the air mattress for the correct setting and the expectation is to follow the physician order.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on record review, policy review and interview the facility failed to ensure a comprehensive plan of care was developed for Trauma Informed Care for one Resident (#78) out of a total sample of 30 residents. Specifically, for Resident #78, who had a history of trauma, the facility failed to develop a comprehensive trauma care plan, with individualized triggers. Findings Include: Review of the facility policy titled, Trauma Informed Care, undated, indicated the following: Policy Statement -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. Policy Explanation and Compliance Guidelines: -The facility will collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, the primary care physician, and other health care professionals (such as psychologists and mental health professionals) to develop and implement individualized care plans and interventions. -The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident and will be added to the resident's care plan. -The facility will evaluate whether the interventions have been able to mitigate (or reduce) the impact of the identified triggers on the resident that may cause re-traumatization. The resident and/or his or her family or representative will be included in this evaluation to ensure clear and open discussion and better understand if interventions must be modified. -In situations where trauma survivors are reluctant to share their history, the facility will still try and identify triggers which may re-traumatize the resident and develop care plan interventions which minimize or eliminate the effect of the trigger on the resident. Resident #78 admitted to the facility in November 2023 with diagnoses that included Post-Traumatic Stress Disorder (PTSD), vascular dementia, and anxiety. Review of the most recent Minimum Data Set (MDS) assessment, dated 4/25/25, indicated the Resident was assessed by staff to have moderate cognitive impairment. The MDS further indicated Resident #78 has an active diagnosis of PTSD. Review of Resident #78's medical record failed to indicate a plan of care for PTSD with identified triggers. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/5/25 at 8:10 A.M., Nurse #6 said she believed the social workers complete the trauma assessments and develop the PTSD care plans, and she would expect triggers to be identified to better care for the residents. During an interview on 6/5/25 at 8:28 A.M., Unit Manager #1 said the entire team works together to develop the PTSD care plan and she would expect triggers to be identified so we know how to best care for the residents. During an interview on 6/5/25 at 9:35 A.M., the Administrator said the social worker would initiate the trauma informed assessment and psych services would be consulted. The Administrator said it was a team effort, and she would expect a PTSD care plan to be developed with identified triggers. The Social Worker was not availabe for interview.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to ensure staff stored all drugs and biologicals in accordance with accepted professional standards of practice. Specifically, the facility failed to properly secure a medication cart on 1 of 5 units (2 West). Findings include: On 6/4/25 at 9:02 A.M., on the 2 [NAME] unit the surveyor observed an unlocked and unattended medication cart. The surveyor was able to open and access the cart. During an interview on 6/4/25 at 9:04 A.M., Nurse #1 returned to her cart. She closed and locked the medication cart and said that the cart should be locked when unattended. During an interview on 6/5/25 at 10:46 A.M., with the Director of Nursing she said that it is the expectation that the medication cart be locked when not attended.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225413	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Center at Advocate	111 Orient Avenue East Boston, MA 02128

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 2. On 6/4/25 at 9:47 A.M., during the medication pass in the 3 [NAME] unit corridor, Nurse #9 left the medication cart to find medications in the medication room. Nurse #9 left the laptop computer screen open. While Nurse #9 was away, several staff and two residents passed the open screen, and they were able to see a resident's name and their Medication Administration Record. Nurse #9 then returned to the medication cart. During an interview on 6/4/25 at 9:51 A.M. Nurse #9 said she had forgotten to close the laptop screen before leaving for the medication room. Nurse #9 said the screen showing resident medical information should be closed when the laptop is unattended. Based on observation and interview the facility failed to maintain confidential resident information (medication administration information) on 2 of 5 resident units (2 [NAME] and 3 West). Findings include: 1. On 6/4/25 at 9:02 A.M., on the 2 [NAME] unit, the surveyor observed an unattended medication cart. The laptop computer on top of the cart was a open and displaying a resident's name and their Medication Administration Record. The laptop screen was visible to residents and staff in the corridor. During an interview on 6/4/25 at 9:04 A.M., Nurse #1 returned to the medication cart. She shut the laptop computer screen, said that it should not be open and should be in a private setting when the cart is unattended. During an interview on 6/5/25 at 10:46 A.M., with the Director of Nursing she said that it is the expectation that the laptop computer screen by covered or in a private setting when it is open to a resident's medical record.