STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225545	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Courtyard-Medford	200 Governors Avenue Medford, MA 02155

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 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. 37330 Based on records reviewed and interviews for one of three sampled residents (Resident #1), who had new physician's orders on 3/05/25, for a STAT (without delay, immediately) chest X-ray (two views) due to onset of acute respiratory congestion, the Facility failed to ensure Resident #1 was provided with radiology services consistent with his/her Physician's Orders, when the Radiology Provider was not contacted by nursing on 3/05/25 to order the STAT X-ray, the order was not followed-up on by nursing and as a result, the chest X-ray was not obtained, as ordered. Findings Include: The Facility Policy titled, Labs and Diagnostic, dated as revised 04/2022, indicated the Physician will identify, order diagnostic and lab testing, based on diagnostic and monitoring needs. The Policy indicated the staff will process test requisitions and arrange for tests. The Policy indicated a Nurse will identify the urgency of communicating with the Attending Physician based on the Physician request, the seriousness of any abnormality, and the individual's current condition. Resident #1 was admitted to the Facility in March 2025, diagnoses included Chronic Pulmonary Disease (a group of lung diseases that blocks airflow and make it difficult to breathe), Bipolar (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), Emphysema (chronic lung disease that permanently damages the lungs' air sacs, making it difficult to breathe), Chronic Kidney Disease Stage III (the kidneys have mild to moderate damage and are less able to filter waste and fluid out of the body), Anxiety (a feeling of fear, dread, and uneasiness), Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), Dementia (a loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), Depression (a serious mental illness that can impact how you think, feel act, and perceive the world), Hypertension (high blood pressure), Left Bundle Branch Block (a delay or blockage of electrical impulses to the left side of the heart), and Neoplasm of Bronchus and Lung (bronchogenic carcinoma or lung cancer). Review of Resident #1's Medication Administration Recorded, dated 03/05/25, indicated Resident #1 had new Physician's Orders (Prescriber Entered) for Diagnostic Management as follows: - Chest X-ray (2 views) STAT (without delay, immediately) for respiratory congestion. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/03/25 at 4:06 P.M., Nurse #1 said on 03/05/25, he worked the 7:00 A.M. to 3:00 P. M. shift and received a change of shift Nurse Report, around 7:00 A.M. Nurse #1 said he was told that Resident #1 was not feeling well and was coughing. Nurse #1 said he informed the Nurse Practitioner (NP), who assessed Resident #1 and provided new orders. Nurse #1 said he was aware there were new orders for the Flu and COVID swabs, but was unaware that the NP wrote orders for a STAT chest X-ray. Nurse #1 said if he had seen the STAT chest X-ray Order, he would have called the Clinical Services (Radiology Company), faxed over the paperwork and then ensure the company was aware it was a STAT Chest X-ray Order. Nurse #1 said if the Radiology Company was unable to obtain the STAT chest X-ray and there would have been a delay, he would have called the Nurse Practitioner to notify her to obtain new orders. Review of Resident #1's Nurse Practitioner's Progress Note, dated 03/05/25 indicated Resident #1 presented with acute cough symptoms, sinus congestion and evidence of chills upon assessment. The Note indicated an Order was provided (written) for Nursing to obtain a Stat Chest X-ray (2 views) on Resident #1. During an interview on 04/03/25 at 2:49 P.M., The Nurse Practitioner (NP) said she had assessed Resident #1 on 03/05/25, that he/she had sinus congestion, was shivering, and had an increased cough with a hoarse voice. The NP said Resident #1 had a history of Lung Cancer, and she was concerned about him/her having the Flu since other residents in the Facility had developed the Flu during this time, so she Ordered a STAT chest X-ray (2 views) for Resident #1. The NP said she did not receive an update from nursing staff regarding Resident #1's STAT chest X-ray and that she would have expected to be informed if the Radiology Company was unable to perform a STAT chest X-ray. The NP said she would have developed an alternate plan to ensure Resident #1 had a STAT chest X-ray completed. During an interview on 04/03/25 at 1:16 P.M., The Unit Manager said she was unaware Resident #1 had a STAT (urgent) Order for a chest X-ray that the Nurse Practitioner (NP) entered into the Electronic Medical Record on 03/05/25. The Unit Manager (during the interview) reviewed Resident #1's Medication Administration Record and said the Provider (NP) wrote an order on 03/05/25, for Resident #1, to have a STAT chest X-ray for his/her respiratory congestion. The Unit Manager said if a Provider orders a STAT X-ray, this indicates it is urgent, that nursing staff need to notify the Radiology Company of the STAT Order, because it can take two to three days for a non-STAT, non-emergent X-ray to be completed. During a telephone interview on 04/14/25 at 8:53 A.M., Nurse #2 said she worked the 3:00 P.M. to 11:00 P.M. , shift on 03/05/25, and was unaware of Resident #1's STAT chest X-ray Order until the end of shift when she completed her documentation in Resident #1's medical record, and read that he/she had been seen by the NP earlier in the day, who had ordered labs and a STAT chest X- ray. (continued on next page)

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse #2 said it was late in the shift when she became aware of the STAT X-ray order and that she did not follow-up to see if the STAT chest X-ray had been ordered or obtained. Nurse #2 said a STAT X-ray indicates the X-ray needs to be done right away and if they were unable to get the X-ray, the Nurse Practitioner would need to be informed. Review of Resident #1's Medical Record indicated there was no documentation to support Resident #1's STAT chest X-ray had been obtained and completed as ordered by the Nurse Practitioner on 03/05/25. There was no documentation to support nursing followed up with the Radiology Company (X-ray Department) regarding Resident #1's STAT chest X-ray Order, and no documentation to support nursing staff informed the NP that the STAT chest X-ray had not been completed. During a telephone interview on 04/14/25 at 9:30 A.M., the Supervisor Coordinator of the Radiology Company said they did not receive a call on 03/05/25 from the Facility regarding a STAT chest X-ray for Resident #1. The Coordinator said according to their records, there was no order placed with them by the Facility, for a STAT chest X-ray for Resident #1. During an interview on 04/03/25 at 6:17 P.M., the Director of Nurses (DON) said Resident #1's Nurse Practitioner placed his/her STAT chest-X ray in the Facility's Point Click Care System (an Electronic Health Record) and his expectations was that nursing call the Radiology Company, notify the Company of the STAT chest X-ray Order, inquire about their availability, and if there was going to be any delays in obtaining it, for nursing to inform the Nurse Practitioner to obtain new orders. The DON said the Radiology Company arrived at the Facility on 03/09/25, to obtain Resident #1's STAT chest X-ray, however Resident #1 was no longer at the Facility. The DON said he was unaware when Resident #1's order for the STAT Chest-X-ray was placed, or by whom. The DON said the Radiology Company's documentation indicated Resident #1's chest X-ray did not indicate it was a STAT Order and the X-ray was canceled on 03/09/25 by the facility because Resident #1 was no longer at the Facility.