

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER Hermitage Healthcare (the)		STREET ADDRESS, CITY, STATE, ZIP CODE 383 Mill Street Worcester, MA 01602	

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 0557</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 be treated with respect and dignity and to retain and use personal possessions.</p> <p>Based on observation, interview, and record review, the facility failed to ensure that one Resident (#10) out of a total sample of 20 residents was treated with respect and dignity during dining experiences when the Resident was identified as being dependent on staff assistance for meals. Specifically, for Resident #10, the facility failed to:-provide the Resident with appropriate eating utensils, when the Resident was observed utilizing a comb for eating during a lunch meal.-provide the Resident with the required supervision and intervene as needed when the Resident was left alone in his/her bedroom during breakfast and lunch meals and was observed spilling food items on their person, the meal tray, the tray table and the floor while trying to eat during the meals. Findings include:</p> <p>Review of the facility policy titled Resident Rights, revised January 2024 included but was not limited the following:</p> <ul style="list-style-type: none"> -Federal and State laws guarantee certain basic rights to all residents of this facility. These rights include .the residents right to dignity. <p>Resident #10 was admitted to the facility in February 2017 with diagnoses including Unspecified Dementia - severe with anxiety and bilateral cataracts.</p> <p>Review of Minimum Data Set (MDS) Assessment, dated 6/9/25, indicated Resident #10:</p> <ul style="list-style-type: none"> -has unclear speech and was rarely or never understood by others and sometimes able to understand others. -has severely impaired decision-making regarding tasks of daily living (which included eating). -demonstrated continuous inattention (difficulty focusing attention, for example being easily distractible, or having difficulty keeping track of what was being said). -required supervision/touching assistance for eating. <p>Review of Resident #10's Person Centered Care Plan included but was not limited to the following:</p> <ul style="list-style-type: none"> -Highly impaired vision, revised 6/11/25, with an intervention that included: <p>>Tell the Resident where their items had been placed.</p> <p>(continued on next page)</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER Hermitage Healthcare (the)		STREET ADDRESS, CITY, STATE, ZIP CODE 383 Mill Street Worcester, MA 01602	
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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-ADL self-care deficits as evidenced by the Resident's inability to initiate or sequence task, highly impaired vision, cognition and anxiety, revised 6/18/25, with interventions that included:</p> <p>&gt;Required assistance with care that fluctuated with mood and cognitive changes.</p> <p>On 8/14/25 from 12:10 P.M. through 12:30 P.M., the surveyor observed the following during the lunch meal:</p> <p>-Resident #10 was seated in a bedside chair, alone in his/her room with a meal tray positioned in front of him/her.</p> <p>-Resident #10 was holding a black comb and a fork together in his/her right hand.</p> <p>-Resident #10 was observed to stab at half of a grilled cheese sandwich with the comb and the fork.</p> <p>-Resident #10 stopped stabbing at the grill cheese sandwich and then used the comb and fork to take two bites of the vanilla ice cream. The vanilla ice cream was observed to drip through the fork and comb and fell on the Resident's chest and lap before the fork and comb made it to his/her mouth. The Resident then bit down on the empty fork and comb.</p> <p>-Resident #10 then returned to stabbing at the grilled cheese sandwich with the fork and comb in his/her right hand. Half of the grilled cheese sandwich stuck to the fork for a moment and then fell to the floor.</p> <p>-Resident #10 then stabbed at pieces of chicken that were on the plate, a piece of chicken stuck to the fork for a moment and then fell on the tray table. Resident #10 was observed repeatedly stabbing three separate pieces of chicken three times with the fork from his/her plate and having the pieces of chicken fall on the tray table. Resident #10 then used his/her fingers of the left hand, retrieved a piece of the chicken that had fallen to the tray table and placed it into his/her mouth. The surveyor observed after a brief time of chewing the piece of chicken, the Resident removed the chicken out of his/her mouth and placed it into the vanilla ice cream cup.</p> <p>-Resident #10 then picked up the vanilla ice cream cup with his/her left hand and began to feed him/herself the ice cream using the comb and fork. The bite of ice cream was observed to contain the piece of chicken which the Resident had previously removed from his/her mouth and placed into the ice cream cup. The vanilla ice cream again dripped through the comb and fork onto the Resident's chest and lap.</p> <p>-Resident #10 then placed the vanilla ice cream cup back on the meal tray and removed the piece of chicken from his/her mouth using his/her left-hand fingers and placed the piece of chewed chicken on his/her meal plate.</p> <p>-the Activities Director (AD) entered the Resident's room during this time and said someone should be with the Resident because he/she always gets help at mealtimes. The AD was observed to locate the Resident's spoon which was in the plate cover, under two plastic lids, a piece of tinfoil and the Resident's meal tray slip.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER Hermitage Healthcare (the)		STREET ADDRESS, CITY, STATE, ZIP CODE 383 Mill Street Worcester, MA 01602	
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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The AD was further observed to pick up the half of grilled cheese sandwich (which was on the floor) and throw it into the trash can.</p> <p>-The AD then removed the comb from the Resident's hand, provided him/her with the spoon, and said that she would locate a Certified Nurse Aide (CNA) to assist the Resident with the meal.</p> <p>During an interview at the time with CNA #2 and Nurse #4, CNA #2 said that she was the CNA assigned to Resident #10. CNA #2 said that she did not have a Resident Care Kardex (specific information about resident care needs) to follow for Resident #10. CNA #2 said she had been working at the facility for a long time and knew that Resident #10 could eat by him/herself and would sometimes require assistance from staff. Nurse #4 said that she was the Nurse assigned to Resident #10 and that there was a Resident Care Kardex for the staff to follow for Resident #10. The surveyor and Nurse #4 reviewed Resident #10's Care Kardex and Nurse #4 said that the Care Kardex indicated Resident #10 could bring food to his/her mouth independently but required continuous supervision during meals in order to keep the Resident safe when eating due to his/her impaired vision and memory.</p> <p>On 8/15/25 at 7:55 A.M., the surveyor observed Resident #10 seated at the edge of his/her bed with a tray table positioned in front of the Resident. A breakfast tray was observed on the tray table with a meal consisting of toast, a bite sized omelet, a bowl of grits and a cup of milk. The surveyor observed that half of the grits were spilled on the breakfast tray. The surveyor did not observe any facility staff present in the Resident's room to supervise the meal as required.</p> <p>On 8/15/25 at 11:51 A.M., the surveyor observed Resident #10 eating lunch alone in his/her room, unsupervised by any facility staff. Resident #10 was observed to pick up an empty cup from his/her meal tray and a cup of milk and was attempting to pour the milk from one cup to another while spilling milk onto his/her clothing.</p> <p>During an interview on 8/19/25 at 1:43 P.M., the Director of Nursing (DON) said that spilling food on oneself, the meal tray, the tray table and the floor, as well as eating with a comb during a mealtime would be a dignity concern for any reasonable person. The DON said that Resident #10 should have been continually supervised at mealtime to provide for a dignified meal experience.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER Hermitage Healthcare (the)		STREET ADDRESS, CITY, STATE, ZIP CODE 383 Mill Street Worcester, MA 01602	
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>Based on observations, interviews, and record reviews, the facility failed to provide reasonable accommodations by ensuring appropriate access to the call system for one Resident (#8) out of a total sample size of 20 residents. Specifically, for Resident #8, the facility staff failed to place the call system within reach for the individualized use of the Resident, placing him/her at risk for unmet needs. Findings include:</p> <p>Review of the facility policy titled Answering Call Lights, established April 2018, and last revised January 2024, indicated:</p> <p>>The purpose of this procedure is to respond to the resident's requests and needs.</p> <ul style="list-style-type: none"> -Explain the call light to the new resident as needed. -Demonstrate the use of the call light as needed. -When the resident is in bed, provide the call light within easy reach of the resident. -Report all defective call lights to the nurse promptly. -Answer the resident's call as soon as possible. <p>Resident #8 was admitted to the facility in April 2021 with diagnoses including history of falling, muscle weakness, anxiety disorder and disorders of the muscle.</p> <p>Review of the Minimum Data Set (MDS) Assessment, dated 7/3/25, indicated Resident #8:</p> <ul style="list-style-type: none"> -was sometimes understood and understands others. -has adequate hearing, hearing aid used -has adequate vision and clear speech. -refused to participate in Quarterly Assessment and Brief Interview for Mental Status (BIMS) Assessment, dated 7/2/25. <p>Review of Resident #8's Comprehensive Person-Centered Care Plan, initiated 4/18/21 and revised 7/9/25, indicated the Resident was at risk for falls with the following interventions:</p> <ul style="list-style-type: none"> -have call light within reach and encourage the Resident to use it for assistance as needed. -The Resident needs prompt response to all requests for assistance. <p>On 8/13/25 at 1:02 P.M., the surveyor observed Resident #8 lying in bed in his/her bedroom. The surveyor also observed that the Resident's call system was hanging on the wall behind the headboard of the Resident's bed and was not accessible to the Resident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER Hermitage Healthcare (the)		STREET ADDRESS, CITY, STATE, ZIP CODE 383 Mill Street Worcester, MA 01602	

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/13/25 at 3:28 P.M., Resident #8 was observed sitting on his/her bed in his/her bedroom watching Television. The surveyor observed that the call system was hooked to the cord on the wall behind the Resident's head and was not within the Resident's reach. At this time, Nurse #3 was observed entering the Resident's room to assist Resident #8's roommate and then exited the room after assisting the roommate.</p> <p>On 8/13/25 at 3:45 P.M., the surveyor observed Resident #8's call system hanging on the wall behind the Resident and not within reach of the Resident.</p> <p>On 8/14/25 at 7:50 A.M., the surveyor observed Resident #8 sitting on his/her bed with the head of the bed elevated and a bedside table in front of the Resident. The surveyor observed the call system was hanging on the wall behind the Resident and not within reach. During an interview at the time, when the surveyor asked the Resident how he/she calls for staff assistance, Resident #8 said that he/she uses the call light to call for help but is unable to reach it. Resident #8 said that the call light was behind him/her hanging on the wall.</p> <p>During an interview on 8/14/25 at 7:55 A.M., the surveyor and Certified Nurse Aide (CNA) #1 observed Resident #8's call system hanging on the wall behind the Resident's head and not within reach and CNA #1 said that the call light should be within the Resident's reach to call staff for assistance when needed. CNA #1 said that the clip on the call light was broken and should be fixed so that it can be clipped to the Resident's bed. CNA #1 also said that without access to the call light, Resident #8 would be upset that he/she was unable to call for help and/or assistance from staff and would be yelling and screaming for staff.</p> <p>During an interview on 8/14/25 at 8:03 A.M., the Director of Nursing (DON) said that Resident #8 should have access to his/her call light at all times. The DON said staff should ensure that the Resident call light was within his/her reach so he/she can use it to call for staff assistance.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER Hermitage Healthcare (the)		STREET ADDRESS, CITY, STATE, ZIP CODE 383 Mill Street Worcester, MA 01602	
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 0628</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>Based on record review, and interview, the facility failed to provide written documentation related to transfer discharge notices, and bed-hold policy notice upon hospitalizations, and the Office of the State Long-Term Care Ombudsman notification for four Residents (#2, #3, #1 and #89) out of a total sample of 20 residents. Specifically, the facility failed to: for Resident #2, provide evidence of written documentation relative to hospital transfer notice, bed-hold policy notification upon hospitalization, and Ombudsman notification. for Resident #3, provide evidence of written documentation relative to hospital transfer notice, bed-hold policy notification upon hospitalization and Ombudsman notification. for Resident #1, provide evidence of Ombudsman notification upon hospitalization. for Resident #89, provide evidence of written documentation relative to hospital transfer notice, bed-hold policy notification upon hospitalization and Ombudsman notification. Findings include:</p> <p>Review of the facility policy titled Transfer or Discharge Notice, established 4/2018, and revised 11/2024, indicated:</p> <p>>Our facility shall provide a resident and/or the resident's representative with a thirty (30)-day written notice of an impending transfer or discharge.</p> <p>>Under the following circumstances, the notice will be given as soon as it is practicable but before the transfer or discharge:</p> <ul style="list-style-type: none"> -The transfer is necessary for the resident's welfare and the resident's needs cannot be met in the facility. <p>>The resident and/or representative will be notified in writing of the following information:</p> <ul style="list-style-type: none"> -The reason of the transfer or discharge. -The effective date of the transfer or discharge. -The location to which the resident is being transferred or discharged . <p>>A statement of the resident's rights to appeal the transfer or discharge, including:</p> <ul style="list-style-type: none"> -The name, address, email, and telephone number of the entity which receives such request; information about how to obtain, complete and submit an appeal form; and how to get assistance completing the appeal process. -The facility bed-hold policy. -The name, address, and telephone number of the Office of the State Long-Term Care Ombudsman. -A copy of the notice will be sent to the Office of the State Long-Term Care Ombudsman. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER Hermitage Healthcare (the)		STREET ADDRESS, CITY, STATE, ZIP CODE 383 Mill Street Worcester, MA 01602	
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 0628</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>1. Resident #2 was admitted to the facility in April 2024 with diagnoses including Age Related Cognitive Decline, Mild Cognitive Impairment of Uncertain or Unknown Etiology, unspecified psychosis not due to a substance or known physiological condition.</p> <p>Review of Resident #2's clinical record included but was not limited to the following:</p> <ul style="list-style-type: none"> -Resident #2 had a Guardianship (a legally appointed person who makes decisions for someone that is unable to do so themselves) in place, effective 4/12/24. -Resident #2 was transferred to the hospital on 3/15/25 and returned to the facility on 3/17/25. <p>Further review of Resident #2's clinical record failed to indicate whether a transfer notice and bed-hold notice was issued to the Guardian, and that the Ombudsman's office was notified of the hospital transfer.</p> <p>During an interview on 8/14/25 at 2:23 P.M., the Social Worker (SW #1) said she was the person responsible for hospital transfer notifications. SW #1 said the facility did not have a specific policy for bed-hold, transfer and Ombudsman notification but that the Federal regulation should be followed for written notification to the responsible party and Resident. SW #1 said that she was unable to provide evidence that Resident #2 had the appropriate notifications sent to their Guardian or the Ombudsman office.</p> <p>2. Resident #3 was admitted to the facility in January 2023 with diagnoses including Dementia, severe with agitation.</p> <p>Review of Resident #3's clinical record included but was not limited to the following:</p> <ul style="list-style-type: none"> -Resident #3 was rarely understood by others and sometimes understood others. -Resident #3 had an invoked Health Care Proxy (HCP- appointed person that is able to make decisions for a person when they are unable to do so themselves), effective 2/22/22. -Resident #3 was transferred to the hospital on 7/17/25. <p>Further review of the Resident's clinical record failed to indicate that a transfer notice and bed-hold notice was sent in writing to the HCP, and that the Ombudsman's Office was notified of the hospital transfer.</p> <p>During an interview on 8/14/25 at 2:23 P.M., SW #1 said that she was unable to provide evidence that Resident #3 had the appropriate transfer and bed-hold notifications sent to the HCP or the Ombudsman office.</p> <p>3. Resident #1 was admitted to the facility in April 2023 with diagnoses including localized swelling, mass and lump lower limb and peripheral autonomic neuropathy.</p> <p>Review of the Medical Record indicated:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER Hermitage Healthcare (the)		STREET ADDRESS, CITY, STATE, ZIP CODE 383 Mill Street Worcester, MA 01602	
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 0628</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>-Nurse Progress Note dated 3/30/25, that indicated Resident #1 was having worsening lower extremity edema and having difficulty walking.</p> <p>-An order was obtained on 3/30/25 from the Nurse Practitioner (NP) to send Resident #1 to the hospital for evaluation and treatment.</p> <p>-No evidence that the Ombudsman's office was notified of Resident #1's transfer to the hospital.</p> <p>During an interview on 8/18/25 at 12:31 P.M., SW #1 said she was unable to provide evidence that the Ombudsman had been notified that Resident #1 was transferred to the hospital on 3/30/25. SW #1 said the Ombudsman should have been notified of Resident #1's transfer to the hospital.</p> <p>4. Resident #89 was admitted to the facility in March 2024, with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Dysuria, Type 2 Diabetes Mellitus, Major Depressive Disorder, anxiety disorder and paroxysmal Atrial Fibrillation.</p> <p>Review of the Resident #89's Minimum Data Set (MDS) Assessment, dated 7/24/25, indicated that the Resident was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of six out of possible score of 15.</p> <p>Review of Resident #89's clinical record included the following:</p> <p>-Nursing Progress Notes dated 7/11/25 which indicated Resident #89 was alert and oriented to self with a new onset of confusion and change of speech noted. Nurse Practitioner (NP) ordered to send Resident out to the emergency room (ER) for further evaluation and treatment.</p> <p>-MDS Assessment, dated 7/11/25, indicated that the Resident was discharged from the facility, with return anticipated.</p> <p>-Resident #89 returned to the facility on 7/13/25.</p> <p>Further review of Resident #89's clinical record failed to indicate any evidence that transfer, and bed-hold notification were provided to the Resident or that the Ombudsman was notified when the Resident was transferred to the hospital on 7/11/25.</p> <p>During an interview on 8/15/25 at 2:57 P.M., SW #1 said that she was unable to provide evidence that the bed-hold policy, notice of intent to transfer, and the Ombudsman notification were sent when Resident #89 was sent to the hospital on 7/11/25. SW #1 said that the regulation should be followed regardless of whether the Resident returned to the facility shortly after being sent out to the hospital.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER Hermitage Healthcare (the)		STREET ADDRESS, CITY, STATE, ZIP CODE 383 Mill Street Worcester, MA 01602	
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 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to accurately code a Minimum Data Set (MDS) Assessment for one Resident (#8), out of a total sample of 20 residents. Specifically, the facility failed to:-For Resident #8, accurately code for the use of corrective lenses (eyeglasses) during the MDS observation period. Findings include:Review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual version 1.19.1 dated October 2024, indicated the following:Hearing, Speech and Vision: Document whether the resident is comatose, the resident's ability to hear, understand, and communicate with others and the resident's ability to see objects nearby in their environment.Corrective Lenses:- &gt;Decreased ability to see can limit the enjoyment of everyday activities and can contribute to social isolation and mood and behavior disorders.- &gt;Many residents who do not have corrective lenses could benefit from them, and others have corrective lenses that are not sufficient. Resident #8 was admitted to the facility April 2021 with diagnoses including Hypertensive Chronic Kidney Disease, Essential Primary Hypertension, and History of Falling. Review of Resident #8's Optometry Evaluation, dated 3/25/25, indicated:-Resident was alert, oriented to person and place.-Resident has Cataract, mixed L&gt;R Severe-Hyperopia and Presbyopia; Both eyes&gt;Spectacle (Eyeglasses) Prescription-Right eye: +1.75, Add +2.50, DIST-Left eye: +1.75, Add +2.50, NEAR Review of Resident #8 Cataract Surgery Consultation/Referral Form dated 7/9/25, indicated:-Cataract surgery planned for both eyes, will do left eye and right eye second-Cataract both eyes, left eye &gt; right eye-Cataract both eyes. Left eye more than right eye Review of the MDS assessment dated [DATE], indicated Resident #8:-refused to participate in Quarterly Assessment and Brief Interview for Mental Status (BIMS) dated 7/2/25.-had adequate vision.-did not use corrective lenses (contacts, glasses, or magnifying glass). On 8/13/25 at 10:17 A.M., Resident #8 said that he/she wears eyeglasses. Resident #8 said that he/she had seen an eye doctor and the eye doctor said that he/she would need cataract surgery to correct his /her vision. On 8/14/25 at 7:50 A. M., the surveyor observed Resident #8 sitting on his/her bed in his/her bedroom and a bedside table in front of the Resident. The surveyor further observed eyeglasses on the Resident's bedside table. During an interview at the time, Resident #8 said they were his/her eyeglasses. During an interview on 8/14/25 at 3:28 P.M., the MDS Nurse said the MDS assessment dated [DATE], was coded in error for corrective lenses used and the MDS should be coded as corrective lenses used to reflect that the Resident uses eyeglasses. During an interview on 8/14/25 at 4:08 P.M., the MDS Nurse said that her float (staff) was the person who completed the MDS assessment dated [DATE]. The MDS Nurse said that she knows that Resident #8 has cataracts and wears eyeglasses and the MDS Assessment should be coded to reflect that the Resident uses eyeglasses. The MDS Nurse said that Resident #8 has cataracts and without his/her glasses, Resident #8 cannot see.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER Hermitage Healthcare (the)		STREET ADDRESS, CITY, STATE, ZIP CODE 383 Mill Street Worcester, MA 01602	
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to provide care and services according to accepted standards of clinical practice for two Resident's (#7 and #1) out of a total sample of 20 residents. Specifically, the facility failed to: 1.For Resident #7, implement recommendations from the Wound Consultant for the use of a wound cleansing solution for the treatment of a right heel arterial ulcer.2.For Resident #1, ensure that Physician's orders relative to the correct size of the Resident's indwelling urinary catheter were obtained when the urinary catheter size was changed during a Urology Consult visit. Findings include:</p> <p>1.Review of the facility policy titled Dressing, Dry/Clean, established 4/2018, and last revised 11/2024, indicated:</p> <p>&gt;The purpose of this procedure is to provide guidelines for the application of dry, clean dressings.</p> <p>-Verify that there is a physician's order for this procedure.</p> <p>-Review the resident's current orders, and diagnoses to determine if there are special resident needs.</p> <p>-Assemble the equipment and supplies needed.</p> <p>&gt;The following equipment and supplies will be necessary when performing this procedure.</p> <p>-Treatments supplies as indicated</p> <p>-Cleaning solution, as ordered</p> <p>Resident #7 was admitted to the facility in January 2020 with diagnoses including Atherosclerosis of native arteries of extremities bilateral legs, Hypertension, Peripheral Vascular Disease (PVD) and Generalized Anxiety Disorder.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #7:</p> <p>-was moderately cognitively impaired as evident by the Brief Interview for Mental Status (BIMS) score of eleven out of a total possible score of 15.</p> <p>-was at risk for Pressure Ulcers.</p> <p>-had an unstageable Pressure Ulcer that was not present on admission.</p> <p>-had Pressure ulcer/injury care.</p> <p>-total number of venous and arterial ulcers present - one</p> <p>Review of Resident #7's August 2025 Physician's orders indicated:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER Hermitage Healthcare (the)		STREET ADDRESS, CITY, STATE, ZIP CODE 383 Mill Street Worcester, MA 01602	
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Iodosorb (Cadexomer Iodine) External Gel 0.9% (antimicrobial wound dressing used to clean and heal chronic, wet wounds such as venous stasis ulcers). Apply to right heel topically every day shift (7:00 A.M - 3:00 P.M.) for wound dressing: Wash wound on right heel with Vashe (hypochlorous acid wound cleanser used to clean, moisten, and debride wound by removing microorganisms and disrupting biofilms), pat dry, apply Iodosorb gel to wound bed, cover with dry protective dressing (DPD) (4x4 gauze) gentle kling wrap, no foam dressing, initiated 6/10/25.</p> <p>Further review of Resident #7's July 2025 and August 2025 Treatment Administration Record (TAR) indicated pressure wound treatments had been completed as ordered by License Nursing staff.</p> <p>Review of Resident #7's Comprehensive Person-Centered Care Plan, initiated 3/27/25 and revised 5/21/25, indicated the Resident had actual impairment to skin integrity related to arterial ulcer located on the right with the following interventions:</p> <p>-Follow facility protocols for treatment of injury.</p> <p>-Provide treatment as ordered.</p> <p>Review of Resident #7's Wound Care Specialist Notes for June 2025, July 2025, and August 2025 indicated wound treatment plan as follows:</p> <p>-wound - arterial ulcer (full thickness wound) is located on the right heel. Wound size: 2.5 cm length by (x) 3.0 cm width x non-measurable depth.</p> <p>-Wound dressing: Vashe (or similar antibacterial wound cleanser), Iodosorb, DPD (4x4 gauze), and gentle kling to the right heel wound, change daily and as needed (PRN).</p> <p>On 8/13/25 at 3:35 P.M., Resident #7 was observed lying on his/her bed reading. During an interview at the time, Resident #7 said that he/she had a wound on his/her right heel and thought the wound on his/her right heel was healed but the Nurses changed the dressing today and the wound is still open.</p> <p>On 8/14/25 at 12:30 P.M., the surveyor observed Nurse #1 complete wound dressing changes to Resident #7 right heel, and the following observations were made:</p> <p>-Nurse #1 gathered supplies for the pressure ulcer wound dressing, that included normal saline (sodium chloride solution in water), Iodosorb External Gel 0.9%, 4x4 gauze, kling wrap and paper tape.</p> <p>-Nurse #1 donned (put on) personal protective equipment (PPE: items such as gowns and gloves worn to prevent the spread of infection) prior to the wound treatment.</p> <p>-Nurse #1 used clean scissors to remove the old dressing wrapped on Resident #7's right heel and dispose of the soiled dressing in a trash container next to the Resident's bed.</p> <p>-Nurse #1 doffed (removed) her gloves, used an alcohol-based hand sanitizer and donned a clean pair of gloves.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER Hermitage Healthcare (the)		STREET ADDRESS, CITY, STATE, ZIP CODE 383 Mill Street Worcester, MA 01602	
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Nurse #1 opened the normal saline solution, applied the solution to a 4x4 gauze, and cleansed the wound bed with the normal saline.</p> <p>-When the surveyor asked Nurse #1 what was being used to clean the wound, Nurse #1 said normal saline which was new as she had just opened the bottle to use for the wound.</p> <p>-Nurse #1 disposed of the 4x4 gauze, doffed her gloves, used alcohol hand base sanitizer and doffed a clean pair of gloves. Nurse #1 then pat dry the wound and applied Iodosorb External Gel 0.9% to a 4x4 gauze and applied to the wound bed.</p> <p>-Nurse #1 then wrapped the Resident's right foot with kling and secured the kling with paper tape.</p> <p>During an interview on 8/14/25 at 1:54 P.M., the surveyor and Nurse #1 reviewed Resident #7's Physician orders for the wound dressing changes. Nurse #1 said that the Physician order indicated that Vashe solution should be used to clean the right heel wound. Nurse #1 said that Vashe was an antibacterial wound cleanser that should be used to clean the wound. Nurse #1 said Resident #7's wound should have been cleaned with Vashe as recommended by the Wound Doctor and not the normal saline that she used to clean the wound. Nurse #1 said that normal saline was not an antibacterial agent and using it on Resident #7's wound would lead to infection of the wound and other wound complications.</p> <p>During an interview on 8/14/25 at 1:58 P.M., the Assistant Director of Nurses (ADON) said that Resident #7 was followed by the wound team for wound healing. The ADON said that the expectation for nursing staff performing wound dressing changes was that staff should follow the Wound Doctor's recommendations of treatment supplies needed to clean the wound to prevent wound complications.</p> <p>2. Review of the facility's policy titled Foley Catheter Insertion, [Gender] Resident, dated 4/2018 and last revised 3/2025, indicated:</p> <p>-Verify that there is a physician's order for this procedure.</p> <p>-Review the resident's care plan to assess any special needs of the resident.</p> <p>-Equipment needed Foley catheter tray (size specified in order).</p> <p>-no indication of a facility policy pertaining urinary catheter care.</p> <p>Resident #1 was admitted to the facility in April 2023 with diagnoses including BPH without Lower Urinary Tract Symptoms and Retention of Urine Unspecified.</p> <p>Review of Resident #1's medical record indicated:</p> <p>-Resident #1 returned to the facility from an open treatment fracture, shaft of humerus with intramedullary implant (right) on 6/23/25.</p> <p>-The discharge summary from the hospital indicated the Resident returned with a urethral catheter Coude 18 French (Fr), please keep catheter in place until a follow up with Urology.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER Hermitage Healthcare (the)		STREET ADDRESS, CITY, STATE, ZIP CODE 383 Mill Street Worcester, MA 01602	
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's June 2025 Physician's orders indicated:</p> <p>>Foley Catheter 16 Fr/10 milliliter (ML), drainage bag every shift, initiated 6/23/25.</p> <p>>Foley Catheter care every shift, initiated 6/23/25.</p> <p>Review of the June 2025, July 2025, and August 2025, Treatment Administration Records (TARs) indicated Resident #1 had the 16 Fr/10 ML catheter in place from 6/23/25 - 8/18/25, and catheter care was completed daily by the licensed nursing staff as ordered by the Physician.</p> <p>Review of Resident #1's Foley Catheter Care Plan, initiated 8/6/25 indicated:</p> <p>>Resident has a Foley catheter in place related to urinary retention postoperatively.</p> <p>>Interventions included, Resident has 16 Fr/10 ML catheter</p> <p>Review of the medical record indicated Resident #1 attended a Urology Consult on 8/5/25 and returned with a Urology Progress Note which indicated:</p> <p>-the Foley catheter was exchanged, and the size was 18 Fr Coude/ 10 cc (cubic centimeters, same measurement as milliliters).</p> <p>-return to the Urology clinic in 4 weeks.</p> <p>During an interview on 8/18/25 at 11:34 A.M., Nurse #8 said for urinary catheter care, the Nurse would monitor if the urinary catheter was draining, flush the catheter if needed, look for any skin changes or irritations and that the catheter tubing was labeled correctly and was functioning. Nurse #8 said she didn't usually take care of Resident #1 and did not know what size urinary catheter he/she currently had in place. The surveyor and Nurse #8 observed Resident #1's urinary catheter and Nurse #8 said the Resident's current urinary catheter size was size 18 Fr/10 ML. Nurse #8 reviewed Resident #1's Physician's orders relative to the catheter and said the urinary catheter orders indicated the Resident's catheter size was 16 Fr/10 ML. Nurse #8 said the size of the urinary catheter inserted into the Resident and the size indicated on the Physician's orders should be the same, but they were not.</p> <p>During an interview on 8/18/25 at 12:07 P.M., Nurse #5 said as far she was aware the urinary catheter had not been replaced with a different size since the Resident went out to a Urology appointment on 8/5/25. Nurse #5 said the Physician's orders in the chart should match the size of the urinary catheter the Resident had inserted. Nurse #5 said if she had to change Resident #1's urinary catheter, she would check the Physician's orders to see what size catheter she should use. Nurse #5 said when a Resident returns from a Consultation, the Nurse should call the Physician and the Director of Nursing (DON) with the results of the Consult and get new orders if needed based on the results of the Consult. Nurse #5 said Resident #1's Physician's orders should have been updated with the correct size urinary catheter when the Resident returned from his/her Urology appointment on 8/5/25.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER Hermitage Healthcare (the)		STREET ADDRESS, CITY, STATE, ZIP CODE 383 Mill Street Worcester, MA 01602	
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/18/25 at 12:13 P.M., the DON said Resident #1's order should have been updated to reflect the change in urinary catheter size during the Resident's Urology Consultation on 8/5/25. The DON said when a Resident returns from a Consultation the Nurse should be reading the results of the Consultation, and the orders should be updated as needed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER Hermitage Healthcare (the)		STREET ADDRESS, CITY, STATE, ZIP CODE 383 Mill Street Worcester, MA 01602	

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 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>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER Hermitage Healthcare (the)		STREET ADDRESS, CITY, STATE, ZIP CODE 383 Mill Street Worcester, MA 01602	
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide assistance while eating for one Resident (#10) out of a total sample of 20 residents, when the Resident was identified to be dependent on staff assistance to eat. Specifically, the facility failed to provide constant supervision and one-person assistance while eating when Resident #10 was known to lack the ability to initiate or sequence tasks and had impaired vision. Findings include: Review of the facility policy titled, Activities of Daily Living (ADLs)-Supporting, last revised 11/2024 included but was not limited to the following: -Resident's who are unable to carry out activities of daily living independently will receive the services necessary for ADLs. -Appropriate care and services will be provided .and in accordance with the resident's plan of care. Including: Dining (meals and snacks). Resident #10 was admitted to the facility in February 2017 with diagnoses including Unspecified Dementia - severe with anxiety and bilateral cataracts. Review of Minimum Data Set (MDS) assessment dated [DATE], indicated the following relative to Resident #10: -has unclear speech and was rarely or never understood by others and sometimes able to understand others. -has severely impaired decision-making regarding tasks of daily living (which included eating). -demonstrated continuous inattention (difficulty focusing attention, for example being easily distractible, or having difficulty keeping track of what was being said). -require supervision/touching assistance for eating. Review of Resident #10's Person Centered Care Plan included but was not limited to the following: -Highly impaired vision, last revised 6/11/25, with an intervention that included: &gt;Tell the Resident where their items had been placed. -ADL self care deficits as evidenced by the Resident's inability to initiate or sequence task, highly impaired vision, cognition and anxiety, last revised 6/18/25, with interventions that included: &gt;Required assistance with care that fluctuated with mood and cognitive changes. &gt;Eating: Independent to supervision, one assist as needed. On 8/14/25 from 12:10 P.M. through 12:30 P.M., the surveyor observed the following: -Resident #10 was seated in a bedside chair alone in his/her room. -A tray table was positioned in front of the Resident at arm's length distance and the Resident's legs were extended straight forward and both feet were resting on the lower tray table bar. The Resident was observed holding a black comb and a fork together in his/her right hand. -A meal tray was observed on the tray table and contained a blue lipped plate with bite sized pieces of chicken, a grill cheese sandwich which was cut in half, coleslaw and baked beans. On the left side of the Resident's meal tray was a cup of chocolate pudding and one cup of vanilla ice cream. -Resident #10 made a long reach forward to his/her meal tray with his/her fingertips of the left-hand making contact in the baked beans and then in the coleslaw, with the black comb and fork remaining held in his/her right hand. -Resident #10 was observed to stab at half of the grilled cheese sandwich with the comb and the fork and at the same time used his/her left hand to put the full vanilla ice cream cup into the full chocolate pudding cup. -Resident #10 stopped stabbing at the grill cheese sandwich and then used the comb and fork to take two bites of the vanilla ice cream that was sitting in the chocolate pudding cup. The vanilla ice cream dripped through the fork and comb and fell onto the Resident's chest and lap before the fork and comb made it to his/her mouth. The Resident then bit down on the empty fork and comb. -Resident #10 returned to stabbing at the grilled cheese sandwich with the fork and comb in his/her right hand. Half of the grilled cheese sandwich stuck to the fork for a moment and then fell to the floor. -Resident #10 began to stab at the chicken pieces on the plate, the chicken stuck to the fork for a moment and then fell on the tray table, with the Resident repeating this action three times. -Resident #10 then used his/her fingers of the left hand and put a piece of the chicken that had fallen to the table into his/her mouth. After a brief time of chewing the piece of chicken, the Resident removed the chicken from his/her mouth and placed it into the vanilla ice cream cup. -Resident #10 then picked up the chocolate pudding cup which contained the vanilla ice cream cup with his/her left hand and began to feed him/herself the ice cream using the comb and fork. The bite of ice cream was observed to contain the piece of chicken which the Resident had previously removed from his/her mouth and placed into the ice cream cup. The vanilla ice cream again dripped through the comb and fork onto the Resident's chest and lap. -Resident #10 placed the chocolate pudding cup (containing the vanilla ice cream cup) back on the tray and removed the piece of chicken from his/her mouth using his/her left-hand fingers and then placed the piece of chewed chicken on his/her meal plate. During an interview at the time, the Activities Director (AD) said to the surveyor someone should be with the Resident because he/she always gets help at mealtimes. The AD was observed to move the Resident's tray table closer to him/her and located the Resident's spoon</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER Hermitage Healthcare (the)		STREET ADDRESS, CITY, STATE, ZIP CODE 383 Mill Street Worcester, MA 01602	
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 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure one Resident (#22) out of a total sample of 21 residents, received an assistive device to maintain his/her hearing abilities. Specifically, the facility failed to follow-up with the audiology office to ensure Resident #22 received a hearing aid when the Resident had sensorineural hearing loss and a hearing aid was recommended for the Resident by the Audiologist, increasing the Resident's risk for hearing difficulties. Findings include: Review of the facility's policy titled Ancillary Physician Services, dated April 2018 and revised March 2025, indicated the following:-Routine . audiology services are available to meet the residents' health needs.- . audiologist will be available to provide follow-up care per resident's request.-Social services or nursing representatives will assist residents with appointments . Resident #22 was admitted to the facility in October 2022 with diagnoses including left ear hearing loss. Review of Resident #22's Request for Services Consent dated 10/7/22, indicated a signed consent for audiology services. Review of Resident #22's Communication Care Plan, initiated 10/10/22 and revised 1/2/25, indicated the Resident had impaired communication related to left ear deafness and cognitive communication deficit. Review of the Audiological Evaluation, dated 5/18/23, indicated Resident #22:-appeared to have no useable hearing in his/her left ear.-had mild to moderately severe sensorineural hearing loss in his/her right ear.-was a candidate for a hearing aid, which was discussed with the Resident.-The plan was to proceed with the process to obtain hearing aids. Review of Resident #22's Nursing Progress Note, dated 5/18/23, indicated:-The Resident went for an Audiology appointment.-No future appointment date had been scheduled.-A hearing aid had been ordered for the Resident.-Once the hearing aid arrived, the Audiology office would call the facility to schedule an appointment for the Resident. Review of the MDS assessment dated [DATE], indicated Resident #22:-was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of nine out of 15 total possible points.-had minimal difficulty with hearing.-did not have hearing aids. On 8/13/25 at 8:37 A.M., surveyor #1 observed Resident #22 seated on the side of his/her bed. During an interview at the time, Resident #22 said that he/she was very hard of hearing and that his/her hearing would come and go. Resident #22 said that he/she did not have any hearing aids and would like to see someone about his/her hearing. The surveyor observed that Resident #22 was not wearing any hearing aids, and the Resident used his/her hand to cup his/her right ear when the surveyor spoke to the Resident. During an interview on 8/15/25 at 3:59 P.M., Resident #22's Legal Guardian said the facility was going to request information in November 2023 relative to the recommendations made by Audiology for Resident #22. The Resident's Legal Guardian said it looked like the ball was dropped after the appointment relative to the recommendations from the Audiologist. The Resident's Legal Guardian said that he/she would have no problem with purchasing hearing aids if Resident #22 wanted them. During an interview on 8/15/25 at 5:06 P.M., the Unit Manager (UM) said that the facility had contacted the Audiology office on 5/18/23 and the Audiology office informed the facility hearing aids had been ordered for Resident #22. The UM said that the Audiology office was supposed to contact the facility to schedule an appointment for the Resident once the hearing aids arrived at the Audiology office. The UM said she did not know what happened relative to follow-up with the Audiology office after 5/18/23, and she thought the Resident's Legal Guardian would have been responsible to follow-up. During an interview on 8/19/25 at 10:42 A.M., between surveyor #2 and the UM, the UM said she contacted the Audiology office and hearing aids had not been ordered for Resident #22 in May 2023. The UM said the facility should have followed up with the Audiology office for the Resident, and that no further contact had been made with the Audiology office for Resident #22 after May 2023.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER Hermitage Healthcare (the)		STREET ADDRESS, CITY, STATE, ZIP CODE 383 Mill Street Worcester, MA 01602	
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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews, the facility failed to ensure that nursing staff possessed the competencies required to meet the needs of one Resident (#4) of one applicable resident with a laryngectomy (surgical procedure in which one's voice box [larynx] is removed, separating one's airway from their mouth, nose, and esophagus, allowing for breathing to occur only through and opening in the front of the neck and omitting the mouth and nose as a means of receiving oxygenation and ventilation) tube, out of a total sample of 20 residents. Specifically, for Resident #4, the facility failed to evaluate competencies that demonstrated the knowledge and skills required by the direct care nursing staff to implement proper care and services of the Resident's laryngectomy tube. Findings include: Review of the National Library of Medicine abstract titled Standardized Nurse Training Strategies to Improve Knowledge and Self-Efficacy with Tracheostomy and Laryngectomy Care published August 2016 indicated: -appropriate tracheostomy and laryngectomy care requires nurses maintain specific knowledge and a particular skillset, to endure safe and competent care. Resident #4 was admitted to the facility in July 2024 with diagnoses including Laryngectomy tube and Alzheimer's Dementia. Review of the Facility assessment dated [DATE] failed to indicate that the facility: -had any residents that required laryngectomy tube care. -had any staff training/education or competencies necessary to provide care for residents with laryngectomy tubes. During an interview on 8/19/25 at 8:50 A.M., Nurse #5 said Resident #4 had a tracheostomy (surgical opening through the neck and into the trachea to allow placement of a tracheostomy tube to assist with breathing) and she did not know if Resident #4 had a laryngectomy tube. Nurse #5 said she did not know the difference between a tracheostomy and laryngectomy. During an interview on 8/19/25 at 9:16 A.M., Nurse #7 said she regularly worked the overnight (11:00 P.M. - 7:00 A.M.) shift and was familiar with Resident #4. Nurse #7 said Resident #4 had a tracheostomy tube and that she did not know the difference between a tracheostomy and laryngectomy. Nurse #7 said she could not recall receiving any specific training from the facility relative to the Resident's tracheostomy or laryngectomy tube. Nurse #7 said it may be good to have refresher training once in a while. During an interview on 8/19/25 at 9:53 A.M., the Assistant Director of Nurses (ADON), who was also the facility's Staff Development Coordinator (SDC), said tracheostomy care training and competency skills assessments had been provided for licensed nursing staff in July 2024 but no training and competency skill set assessment had been provided relative to the care of residents with laryngeal tubes. The ADON/SDC said that no training relative to caring for residents with laryngeal tubes had been completed since Resident #4 was admitted to the facility in July 2024. The ADON/ SDC said that the facility does not have a policy for residents with laryngectomy. The ADON/SDC also said there is no competency for laryngectomy. The ADON/SDC said tracheostomy and laryngectomy are different because the tracheostomy is larger. The ADON/SDC said he would have to check on a laryngectomy, and that nursing care would not be much different between a tracheostomy and a laryngectomy. During an interview on 8/19/25 at 12:06 P.M., Nurse #6 said that she remembered the facility providing education and competency relative to tracheostomy care for nurses in July 2024 when Resident #4 was admitted to the facility. Nurse #6 said that she did not recall any education and competency assessments completed relative to laryngectomy tube care. During an interview on 8/20/25 at 11:34 A.M, Resident #4's Physician said he did not realize Resident #4 had a different stoma from tracheostomy. The Physician said he thought there would be a Respiratory Therapist (RT) assigned not just for the suctioning of secretions but ensuring proper equipment was in the facility and that education to the staff about the equipment had been done. The Physician said he would expect the facility staff to follow Advanced Cardiovascular Life Support (ACLS) protocol for a Resident in respiratory distress and ensure staff training and assessment were in place. Please refer to F835</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER Hermitage Healthcare (the)		STREET ADDRESS, CITY, STATE, ZIP CODE 383 Mill Street Worcester, MA 01602	

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 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>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER Hermitage Healthcare (the)		STREET ADDRESS, CITY, STATE, ZIP CODE 383 Mill Street Worcester, MA 01602	
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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview and record review, the facility failed to maintain a medication administration error rate of less than five percent (%) for two Residents (#14 and #54), out of two applicable residents, out of 27 medication pass opportunities. The medication error rate was calculated to be 11%. Specifically, 1. For Resident #14, the Resident was administered the wrong medication doses when one puff of Budesonide-Formoterol Fumarate (an inhaled combination medication used to manage asthma and chronic obstructive pulmonary disease) 160-4.5 micrograms per actuation (mcg/act) Inhalation and one puff of Spiriva Respimat (an inhaled medication used to manage chronic obstructive pulmonary disease) 1.25 mcg/act Inhalation were administered, and two puffs of Budesonide-Formoterol Fumarate 160-4.5 mcg/act and two puffs of Spiriva Respimat 1.25 mcg/act Inhalation were ordered by the Physician. 2. For Resident #54, the Resident was administered the wrong dose of Omeprazole Delayed Release (DR) when 20 milligrams (mg) of Omeprazole DR was administered, and 40 mg of Omeprazole DR was ordered by the Physician. Findings include: Review of the facility's policy titled Administering Medications, effective February 2020 and revised in September 2024, indicated but was not limited to the following:-Policy: Medications are administered in a safe and timely manner and as prescribed.-The individual administering the medication checks the label to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. 1. Resident #14 was admitted to the facility in May 2025, with diagnoses including asthma. Review of Resident #14's Order Summary Report indicating active orders as of 8/14/25, indicated the following:-Budesonide-Formoterol Fumarate Inhalation Aerosol 160-4.5 mcg/act two puffs inhale orally two times a day related to unspecified asthma. Rinse mouth with water after use. (Start: 5/8/25)-Spiriva Respimat Inhalation Aerosol 1.25 mcg/act (Tiotropium Bromide Monohydrate) two puffs inhale orally one time a day for shortness of breath or wheezing related to unspecified asthma. (Start: 7/8/25)On 8/14/25 at 8:24 A.M., during a medication administration pass, the surveyor observed Nurse #1 provide the following medications to Resident #14:- Budesonide-Formoterol Fumarate Inhalation Aerosol 160-4.5 mcg/act. Resident self-administered one puff. Nurse #1 did not encourage the Resident to self-administer two puffs of the medication, as was ordered by the Physician.-Spiriva Respimat Inhalation Aerosol 1.25 mcg/act. Resident self-administered one puff. Nurse #1 did not encourage the Resident to self-administer two puffs of the medication, as was ordered by the Physician.Review of Resident #14's Medication Administration Record (MAR), dated August 2025, indicated the following:- Nurse #1 electronically signed that she had administered Budesonide-Formoterol Fumarate 160-4.5 mcg/act Inhalation two puffs at 8:00 A.M. on 8/14/25.- Nurse #1 electronically signed that she had administered Spiriva Respimat 1.25 mcg/act Inhalation two puffs at 8:00 A.M. on 8/14/25.During an interview on 8/14/25 at 1:19 P.M., Nurse #1 said Resident #14 was ordered to receive two puffs of Budesonide-Formoterol Fumarate Inhalation and two puffs of Spiriva Respimat Inhalation. Nurse #1 said that there was a potential risk that the inhaled medications would not be as effective as they should have been when a lower dose of inhaled medications was administered than was ordered.During an interview on 8/14/25 at 1:34 P.M., the Director of Nurses (DON) said that the expectation was that all medications were administered according to the Physician's orders. 2. Resident #54 was admitted to the facility in December 2024 with diagnoses including dysphagia (difficulty swallowing), and gastro-esophageal reflux disease (a condition that causes heartburn or acid indigestion). Review of Resident #54's Order Summary Report indicating active orders as of 8/15/25, indicated the following:Omeprazole oral capsule Delayed Release 20 mg. Give two capsules by mouth one time a day related to gastro-esophageal reflux disease without esophagitis. (Start: 10/18/24) On 8/15/25 at 8:44 A.M., during a medication administration pass, the surveyor observed Nurse #9 prepare and administer Omeprazole DR 20 mg to Resident #54.Review of Resident #54's MAR, dated August 2025, indicated the following:Nurse #9 electronically signed that she had administered two capsules of Omeprazole DR 20 mg at 8:00 A.M. on 8/15/25.During an interview on 8/15/25 at 10:04 A.M., Nurse #9 said Resident #54's physician's order indicated to administer two capsules of Omeprazole DR 20 mg, and that she had administered one capsule of Omeprazole DR 20 mg. Nurse #9 said that she should have administered what the physician ordered.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER Hermitage Healthcare (the)		STREET ADDRESS, CITY, STATE, ZIP CODE 383 Mill Street Worcester, MA 01602	

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER Hermitage Healthcare (the)		STREET ADDRESS, CITY, STATE, ZIP CODE 383 Mill Street Worcester, MA 01602	
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 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and records reviewed, the facility failed to provide effective administration related to necessary care and services for one Resident (#4), out of a total sample of 20 residents when the facility reviewed Resident #4's clinical status of a laryngectomy (surgical procedure in which one's voice box is removed, separating one's airway from the mouth, nose, and esophagus, resulting in the ability to breathe only through an opening in the front of the neck) tube prior to the Resident's admission to the facility and accepted and admitted Resident #4, with a laryngeal tube in place, to the facility. Specifically, the facility administration failed to:-Develop policies and procedures relative to necessary care and services for residents with laryngeal tubes, placing the Resident at risk for ineffective respiratory care.-Identify staff competency levels for providing necessary care to residents with laryngeal tubes, placing the Resident at risk for ineffective respiratory care and airway management in the event of cardiopulmonary compromise.-Identify and obtain necessary emergency medical equipment required to effectively manage the Resident's airway in the event of cardiopulmonary compromise, which would result in the inability to appropriately ventilate the Resident. Findings include:Resident #4 was admitted to the facility in July 2024 with a diagnosis of Dementia and with a laryngectomy tube. Review of Resident #4's Hospital Discharge summary, dated [DATE], indicated the following:-The Resident's problem list included tracheostomy in place and difficult airway.-The Resident had a laryngectomy.-The Resident's advanced care planning was for full code. Review of the Facility Assessment, updated 7/28/25, indicated the following relative to decisions regarding caring for residents with conditions not listed under common diagnoses/conditions:-When the facility is not familiar with or have not previously provided care for a diagnosis of a potential admission, the interdisciplinary team (IDT) consisting of the Director of Nurses (DON) . along with the Physician or designee will review the details of the patient's requirements for care prior to admission if appropriate.-The review will consist of the education level/clinical skills of licensed staff .-Educational opportunities will be identified and training with validation will be provided to staff based on educational needs review.-Support will be provided by the DON and Assistant DON (ADON) to ensure clinical needs of the resident are being met.-The review will also include specialized equipment, ., and/or specialized needs of the patient to determine the facility's ability to meet those needs. -The acuity of the patient's medical condition will also be reviewed to determine if staffing adjustments need to be made to accommodate the patient's needs. Further review of the Facility Assessment did not list residents requiring laryngectomy tube care under common diagnoses/conditions and indicated:-The facility may submit recommendations and changes to policies and procedures to the Compliance and Quality Committee. -New, updated, modified policies and procedures are reviewed at QAPI.-Our nurse management team works closely with physicians and nurse practitioners . to review resident care needs .-This frequent communication ensures that all aspects of resident care are thoroughly addressed and coordinated, leading to more comprehensive and effective care.-Both the nurse practitioner (NP) and medical doctor (MD) are highly involved in the facility's operations . Review of Resident #4's Otolaryngology-Head and Neck Surgery Note, dated 8/13/25, indicated the Resident had undergone a total laryngectomy with tracheoesophageal prosthesis ([NAME]: device that is placed in the wall that separates the trachea and esophagus in order to enable a total laryngectomy patient to make voice) placement on 12/17/20. On 8/14/25 at 1:51 P.M., the surveyor observed Resident #4 lying in bed in his/her room. The surveyor observed the Resident to have a stoma (permanent opening) in his/her neck with a laryngectomy tube in place. During an interview on 8/19/25 at 8:50 A.M., Nurse #5 said Resident #4 had a tracheostomy and she did not know if the Resident had a laryngectomy. Nurse #5 then said she did not know the difference between a tracheostomy and laryngectomy. During an interview on 8/19/25 at 9:16 A.M., Nurse #7 said she normally worked the overnight (11:00 P.M.-7:00 A.M.) shift and was familiar with Resident #4. Nurse #7 said that Resident #7 had a tracheostomy and that she did not know the difference between a tracheostomy and laryngectomy. Nurse #7 said she could not recall receiving any specific training from the facility for the Resident relative to tracheostomy or laryngectomy tube care. Nurse #7 said it may be good to have a refresher training once in a while. During an interview on 8/19/25 at 9:53 A.M., the ADON, who was also the facility's Staff Development Coordinator (SDC), said tracheostomy care training and competency skills assessments had been provided for licensed nursing staff in July 2024 and that no training and competency skill set assessments had been provided relative to care of residents with laryngeal tubes. The SDC also said that no training relative to</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER Hermitage Healthcare (the)		STREET ADDRESS, CITY, STATE, ZIP CODE 383 Mill Street Worcester, MA 01602	
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 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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 (including nights and weekends) and emergencies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, the facility failed to update the Facility Assessment when the facility had a change in resident population not already identified in the Facility Assessment, increasing the risk for inadequate medical care. Specifically, the facility failed to re-evaluate its resident population and identify the resources needed to provide necessary care and services when Resident #4:-was admitted to the facility with a laryngectomy (surgical procedure in which one's voice box [larynx] is removed, separating one's airway from their mouth, nose, and esophagus, allowing for breathing to occur only through and opening in the front of the neck) tube.-required staff assistance for care of his/her laryngectomy tube.-required specialized equipment to manage his/her airway in the event of cardiopulmonary arrest. Findings include:Resident #4 was admitted to the facility in July 2024 with diagnoses including Dementia and with a laryngectomy tube. Review of Resident #4's Hospital Discharge summary, dated [DATE], indicated the following:-The Resident's problem list included tracheostomy in place and difficult airway.-The Resident had a laryngectomy.-The Resident's advanced care planning was for Full Code. Review of Resident #4's Nurse Practitioner Progress Note, dated 8/24/24 for a service date of 8/19/24, indicated the Resident had a [NAME] (laryngectomy) tube in place. Review of the Facility Assessment, updated 7/28/25, indicated the following:-The Administrator, Director of Nursing (DON), Governing Body, Medical Director, one direct care staff member, Assistant DON (ADON)/Staff Development Coordinator (SDC)/Infection Preventionist (IP) all participated in reviewing the Facility Assessment.-Common diagnoses/conditions for residents accepted to the facility indicated respiratory failure.-Special treatments and conditions indicated: -A range of 15-20 residents with Oxygen therapy. -A range of zero to one resident requiring suctioning, tracheostomy care, ventilator or respirator care, and BIPAP/CPAP. Further review of the Facility Assessment failed to indicate:-Any residents identified as requiring laryngectomy tube care.-Staff training/education and competencies necessary to provide necessary care for residents with laryngectomy tubes.-Specialized medical equipment needed to manage the airway of a resident with a laryngectomy tube in the event of respiratory arrest. During an interview on 8/20/25 at 10:20 A.M. with the Administrator and the Director of Clinical Operations, the Administrator said the Facility Assessment was reviewed annually and when a change in resident population occurred. The Administrator said the Facility Assessment was most recently reviewed and updated in July 2025 and did not include information relative to a resident population requiring care of a laryngectomy tube. The Administrator said the Facility Assessment probably should have been updated to reflect a resident population for laryngectomy tube care needs when Resident #4 was admitted to the facility in July 2024.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER Hermitage Healthcare (the)		STREET ADDRESS, CITY, STATE, ZIP CODE 383 Mill Street Worcester, MA 01602	
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 0942</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents.</p> <p>Based on interview and record review, the facility failed to ensure all staff received annual training on Resident's Rights. Specifically, 35 facility staff members were not in compliance for completion of their mandatory annual Resident's Rights education as of 8/20/25 evidenced by the Annual All Employee Course Completion History Report. Findings include: During an interview on 8/19/25 at 8:48 A.M., the Staff Development Coordinator (SDC) said he was responsible for all education to all facility staff employed by the facility. The SDC said that most mandatory education is available to the employees through a computerized education platform, or he could develop education if/when needed. The SDC said that Resident Rights education should be done upon hire and annually by all staff. The SDC said that he did not have a tracking system in place to monitor staff members that were not up to date with mandatory education. During an interview on 8/19/25 at 12:00 P.M., the Director of Nurses (DON) said that he did have a way to track education compliance for staff members in the facility. The DON reviewed the Annual All Employee Course Completion History Report from the computerized education platform and said that many staff were out of compliance with Residents Rights training and that Residents Rights training should be done annually by all staff. Review of the Annual All Employee Course Completion History Report from the computerized education platform indicated 35 facility staff members were beyond their annual due date for Residents Rights education compliance. During an interview on 8/20/25 at 3:00 P.M., the Administrator said the facility did not have a policy on mandatory education frequency. During an interview on 8/20/25 at 3:46 P.M., the DON said that mandatory Residents Rights education was important so that staff are educated on the needs and services for the residents in the facility and to ensure that the staff are properly trained to care for the residents.</p>		