STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225173	A. Building B. Wing	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jewish Healthcare Center	629 Salisbury Street Worcester, MA 01609

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for one of three sampled residents (Resident #1), whose physician's orders included to administer an anti-anxiety medication three times per day, the facility failed to ensure professional standards of practice were maintained when nursing changed the order for the medication to be administered only twice a day, without consulting a physician, in accordance with nursing best practice and facility policy.Findings include:Review of the facility's policy, titled Medication Reconciliation, with a review date of 6/06/25 indicated the following:-It is the policy of the [facility] to accurately and completely reconcile medications across the continuum of care. The process of medication reconciliation involves comparing a patient's/resident's medication orders to all the medications that the patient has been taking to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions. On admission all medications taken by the resident prior to admission (prior setting and home) will be reviewed with current orders and reconciled.-On admission, a licensed nurse will review and compare the discharge medication list from the prior setting to the facility admission orders. Any changes, variations, and/or discrepancies identified will be clarified.-On all new admissions, the nurse will review the current medication orders with the patient/resident or family member/responsible person and obtain a history of medications taken at home.-A second licensed nurse will perform a medication reconciliation, comparing both the discharge summary with the orders that have been entered into the electronic health record to ensure no errors have been made.-The admission medication reconciliation process will ensure there are no medications taken at home that were unintentionally omitted and that the patient and/or responsible party have knowledge of the reconciliation process.Resident #1 was admitted to the facility in January 2026, diagnoses included anxiety disorder and Down Syndrome.Resident #1's Hospital Discharge summary, dated [DATE], included a medication order listed under modified medication which included the following:-Clonazepam 1 milligram (mg) tablet, take one tablet by mouth twice daily.Further review of the Summary indicated Resident #1 had been prescribed and administered Clonazepam 1 mg by mouth three times daily during his/her hospitalization, until the morning dose on 01/23/26 when the medication frequency was modified.During an interview on 04/07/26 at 3:23 P.M., Nurse Practitioner (NP) #1 said that the day Resident #1 was admitted to the facility, a nurse came to her and said that Resident #1's family member said Resident #1 had been taking Clonazepam 1 mg three times per day since before, and during, his/her hospitalization. NP #1 said she wrote Resident #1's prescription order for Clonazepam 1 mg three times a day.Review of Resident #1's Medication Administration Record (MAR) for the month of January 2026, indicated that he/she had a physician's order, dated 01/23/26, for Clonazepam was for 1 mg by mouth three times daily. During a telephone interview on 04/03/26 at 10:28 A.M., Family Member #1 said she had visited Resident #1 at the facility on 01/26/26 and 01/27/26 and he/she was more angry. Family Member #1 said Resident #1 presented that way when he/she did not take the prescribed Clonazepam. Family Member #1 said she voiced her concerns to the nursing staff and was told Resident #1 had only been receiving Clonazepam 1 mg by mouth only twice a day.Further review of the MAR indicated Resident #1's order for Clonazepam had been changed on 01/24/26 by nursing, to be administered only twice a day.The (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MAR indicated Resident #1 was administered Clonazepam 1 mg by mouth twice a day from 01/24/26 through 01/26/26.During a telephone interview on 04/08/26 at 7:30 A.M., Nurse #1 said that part of her duty was to double-check the reconciliation of medications. Nurse #1 said when she reconciled Resident #1's admission medications, she noticed that his/her Hospital Discharge Summary indicated he/she had an order for Clonazepam 1 mg twice daily, and the order that had been entered into the facility's Electronic Medical Record (EMR) was for Clonazepam 1 mg three times a day.Nurse #1 said she thought nursing had entered the Clonazepam order in error and changed it back to be given twice daily, without consulting a practitioner.Nurse Practitioner #1 said she was very upset when she found out nursing had changed the frequency of Resident #1's Clonazepam order without consulting her or the Physician. NP #1 said Resident #1 should have been given Clonazepam 1 mg three times a day during his/her stay at the facility. Review of the Facility's Medication/Treatment Incident Report, dated 01/27/26, indicated Resident #1's order for Clonazepam was changed by nursing, from three times a day to twice a day, without calling a practitioner for clarification.During an interview on 04/07/26 at 3:50 P.M., the Director of Nurses (DON) said she signed off on Resident #1's Medication/Treatment Incident Report on 01/29/26 and said the investigation concluded that there was a breakdown in communication regarding Resident #1's Clonazepam order, which resulted in the error.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for one of three sampled residents (Resident #1), the facility failed to ensure they maintained a complete and accurate medical record related to meal percentage intakes for five out of 14 applicable meals.Findings include:Resident #1 was admitted to the facility in January 2026, diagnosis included status post small bowel resection.Review of Resident #1's Hospital Discharge summary, dated [DATE], indicated he/she had received total parenteral nutrition (TPN- all essential nutrients are delivered intravenously) during his/her hospitalization due to significant malnutrition. The Summary indicated his/her TPN was discontinued on 01/20/26.Review of Resident #1's Certified Nurse Aide (CNA) Flow Sheets, for the month of January 2026, indicated that under the box to record his/her meal intake percentage, the following days/meals were left blank:-01/25/26-dinner-01/26/26- breakfast-01/26/26- lunch -01/27/26- breakfast-01/27/26- lunch The Facility was unable to provide the surveyor with Resident #1's Certified Nurse Aide assignments during his/her stay at the facility.During an interview on 04/07/26 at 1:03 P.M., Certified Nurse Aide (CNA) #1 said the CNAs are responsible to document meal percentage intakes for each resident at each meal.During an interview on 04/07/26 at 1:35 P.M., Unit Manager #1 said documenting the residents' meal intake percentage at each meal was part of the CNAs routine documentation.During an interview on 04/07/26 at 3:50 P.M., the Director of Nurses (DON) said they do not have a policy related to medical record accuracy and documentation because it was a standard of care. The DON said the CNAs were expected to document all of Resident #1's meal intake percentages.