

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225173	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER Jewish Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>45429</p> <p>Based on record and policy review, and interview, the facility failed to ensure a Preadmission Screening and Resident Review Level I (PASRR-screening that assesses for Serious Mental Illness or Developmental Disabilities [Level I screen (initial pre-screening completed prior to admission to a Nursing Facility)] was completed prior to admission for one Resident (#107) out of a total sample of 26 residents.</p> <p>Specifically, for Resident #107, the facility failed to ensure that a Level I screen was completed prior to the Resident's admission to the facility to assist in determining the level of services needed.</p> <p>Findings include:</p> <p>Review of the facility policy titled PASRR Screening for Admission/Readmission, last revised 7/29/24, indicated:</p> <p>-that prior to admission, the facility will complete a Level I PASRR to evaluate for the presence of a mental disorder or intellectual disability.</p> <p>Resident #107 was admitted to the facility in July 2024, with diagnoses including Post Traumatic Stress Disorder (PTSD- a mental health condition that is caused by an extremely stressful or terrifying event - either being part of it or witnessing it. Symptoms may include flashbacks, nightmares, severe anxiety and uncontrollable thoughts about the event).</p> <p>Review of Resident #107's medical record failed to indicate a Level I PASRR had been completed prior to admission to the facility.</p> <p>Further review of the medical record indicated that the Level I had been completed on 8/15/24, after the Resident's admission to the facility.</p> <p>During an interview on 10/8/24 at 3:46 P.M., the Director of Nursing (DON) said that Resident #107's Level I PASRR had been completed late and should have been completed prior to the Resident's admission to the facility.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>50563</p> <p>Based on observation, interview, record and policy review, the facility failed to adhere to infection control standards to prevent the potential transmission of communicable diseases and infections within the facility on one Unit (Fourth Floor) out of three total Units.</p> <p>Specifically, the facility failed to:</p> <p>1) clean and disinfect a glucometer (device used to test sugar level in the blood) after resident use to prevent potential contamination and potential transmission of blood-borne disease.</p> <p>2) ensure wound care supplies brought into a resident room were designated for use on that resident and stored in that resident's room to prevent potential cross-contamination.</p> <p>Findings include:</p> <p>1) Review of the facility policy titled Glucometer Cleaning, revised 5/2/24, indicated the following:</p> <p>-Blood glucose meters (glucometer) . must be cleaned and disinfected after each patient/resident use.</p> <p>-Per OSHA [Occupational Safety and Health Administration] and manufacturer's guidelines, and EPA [Environmental Protection Agency] approved disinfectant, effective against HBV (Hepatitis B Virus-a virus that can cause infection of and damage to the liver), HCV (Hepatitis C Virus- a virus that can cause infection of and damage to the liver, and HIV (Human Immunodeficiency Virus-a virus that can cause weakening of the bodies ability to fight infection and illness) is used on glucometers. PDI wipes (a specific brand of disinfectant wipes) meet this requirement.</p> <p>On 10/8/24 at 3:45 P.M., during a medication pass process on the Fourth Floor Unit, the surveyor observed Nurse #1 take a cloth glucometer storage bag containing a glucometer, lancets (device used to pierce skin to obtain blood sample for glucometer), alcohol prep pads (used to clean/disinfect the finger used for before lancet), and test strips (inserted to glucometer to obtain blood) and bring the items into a resident room. Nurse #1 was observed to set the storage bag on the resident's bed next to the resident. The surveyor then observed Nurse #1 take supplies out of the bag, perform the blood test, and then return the glucometer to the storage bag, zip the bag and return it to the medication cart. The surveyor did not observe Nurse #1 disinfect the glucometer before placing it into the storage bag.</p> <p>During an interview immediately following the observation, Nurse #1 said the glucometer was used for all residents on her assignment. Nurse #1 further said she should not have placed the cloth storage bag on the bed or placed the glucometer back into the bag without cleaning and disinfecting the glucometer with PDI wipes due to the risk for cross-contamination.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/9/24 at 12:41 P.M., the surveyor reviewed Nurse #1's observation with the Infection Control Preventionist (ICP). The ICP said the expectation would be that Nurse #1 should not have brought the cloth storage bag into the resident room or set it on the resident's bed to prevent cross-contamination. The ICP also said that Nurse #1 should have cleaned and disinfected the glucometer per facility policy before placing the glucometer back into the storage bag to prevent cross-contamination.</p> <p>2) Review of the facility policy titled Wound Care: Assessment and Documentation of Wounds, revised 7/1/24, indicated the following:</p> <ul style="list-style-type: none"> -any leftover supplies that have been brought into the room, should be labeled with open date and left in [the] room, -do not place [supplies] back into treatment cart. <p>On 10/9/24 at 10:08 A.M., during a wound care observation on the Fourth Floor Unit, the surveyor observed the Staff Development Coordinator (SDC)/Wound Nurse use a bottle of wound cleanser (a solution used to clean wounds) and then place the bottle of wound cleanser on the resident's bed. After completion of the wound care, the surveyor observed the SDC/Wound Nurse take the bottle of wound cleanser and place it into the treatment cart.</p> <p>During an interview immediately following the observation, the SDC/Wound Nurse said she should not have placed the bottle of wound cleanser on the resident's bed and then return it to the treatment cart due to concern for cross-contamination.</p> <p>During an interview on 10/9/24 at 12:38 P.M., the ICP said the expectation was that the SDC/Wound Nurse would not place a shared wound care supply onto the resident's bed. The ICP further said, if the wound care supply was placed in the resident's room and/or bed, that it should have been labeled and left in the resident's room per facility policy to prevent cross-contamination.</p>		