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	01/21/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and records reviewed, the facility failed to ensure that one Resident (#110) out of a total sample of 26 residents was provided the right to participate in the care plan process.Specifically, the facility failed to ensure that Resident #110 was provided the opportunity to participate in his/her initial and quarterly care plan meetings and also failed to document in the medical record why the Resident could not or did not participate in the two care plan meetings. Findings include:Review of the facility Patient/Resident admission Agreement and Information Packet, last revised 1/1/19 indicated: -the Center will develop a Plan of Care which describes in writing the medical, nursing and psychosocial needs of the Patient/Resident and how such needs will be met, so that the Patient/Resident will attain or maintain his or her highest practical physical, mental and psychosocial well-being. -This Plan will be prepared with the participation, to the extent practical, of the Patient/Resident, Patient's/Resident's family, Responsible Party or Legal Representative, and the Center's Team. Review of the facility policy titles Family and Interdisciplinary Team Meetings, last revised 12/10/25, indicated:-It is the policy of the facility to hold interdisciplinary team meetings with the resident, responsible party, or next of kin and interdisciplinary team to include but not limited to nursing, recreational therapy, social service, rehab service and clinical practitioner.-Team meetings will be scheduled after admission, quarterly thereafter as needed for any change in resident condition or discharge disposition.-Social Service department is responsible for scheduling meetings and contacting family/responsible party based on resident's preference. -All disciplines attending will report Resident's status, any changes in condition, and all care plans will be reviewed with all attendees.>Care plans will be individualized based on the information provided by the interdisciplinary team as well as residents and family. Resident #110 was admitted to the facility in September 2025, with diagnoses including anxiety, muscle weakness, and Dementia. Review of the MDS (Minimum Data Set) assessment dated [DATE], indicated that Resident #110:-was cognitively impaired as evidenced by a Brief Interview of Mental Status (BIMS) score of 4 out of 15. -was English speaking.-makes himself/herself understood and usually understands others. During an interview on 1/15/26 at 9:05 A.M., Resident #110 said that he/she was unaware of what a care plan meeting was. During an interview on 1/20/26 at 7:58 A.M., Resident #110 said that he/she had never been invited to a care plan meeting, but that he/she would definitely like to go to one. Review of Resident #110's clinical record failed to indicate any evidence that the Resident participated in the care planning process with the interdisciplinary team (IDT) during the Resident's care plan meeting reviews held on 10/30/25 and 1/2/26. Further review of the clinical record failed to indicate the rationale as to why the Resident did not or could not participate in any care plan meetings, or refusals to participate in the meetings on 10/30/25 and 1/2/26. During an interview on 1/20/26 at 8:55 A.M., Unit Manager (UM) #2 said that the facility invites residents to care plan meetings, unless they have determined that it would be detrimental to invite them and cause the residents' emotional upset. During an interview on 1/21/26 at 8:44 A.M., the Social Worker (SW) said that all residents should be invited to their care plan meetings, that Resident #110's Healthcare Proxy (HCP) had been invited to attend Resident (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#110's care plan meeting and that Resident #110 was not invited to attend either meeting because his/her HCP had been invoked. The SW also said that she did not have documented evidence in the Resident's record as to why the Resident had not been invited to attend either of his/her care plan meetings, as required. During an interview on 1/21/26 at 9:07 A.M., the Director of Nursing (DON) and Clinical Services said that being invited to care plans meetings is a resident's right.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to provide respiratory care and services consistent with professional standards of practice relative to the care and maintenance of oxygen equipment for one Resident (#84) out of a total sample of 26 residents.Specifically, for Resident #84, the facility failed to ensure that an oxygen concentrator filter was maintained in a clean and sanitary manner. Resident #84 was admitted to the facility in October 2024 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD). Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #84 was cognitively intact as evidenced by a Brief Interview for Mental Status score of 15 out of a total possible score of 15. On 1/15/26 at 10:24 A.M., the surveyor observed Resident #84 seated in a wheelchair next to his/her bed with a nasal cannula in his/her nose and the oxygen tubing connected to an oxygen concentrator. The oxygen concentrator was observed to be running and set to deliver 1.5 liters per minute (LPM) of oxygen to the Resident. The surveyor also observed that the filter located on the left side of the oxygen concentrator was covered entirely with thick grey dust. Review of Resident #84's January 2026 Physician's orders included:-Humidified Oxygen:1 - 4 liters per minute, may titrate to keep sats (oxygen saturation) greater than 90% every shift for SOB (shortness of breath). Review of the Resident's Medical Record failed to include any indication that staff cleaned the filter located on the left side of the oxygen concentrator. Review of the facility policy titled Oxygen Maintenance, last revised 10/15/25, indicated:-The Center shall maintain all oxygen concentrators in a clean, safe and functional condition.-Weekly cleaning of oxygen concentrator filters and weekly oxygen tubing changes are mandatory. Review of the Resident's medical record failed to provide any evidence that staff had cleaned the filter on the oxygen concentrator. On 1/20/26 at 1:18 P.M., the surveyor and Unit Manager (UM) #1 observed that Resident #84 was receiving oxygen therapy and the filter on the oxygen concentrator remained covered entirely with thick grey dust. During an interview at the time, UM #1 said that the filter was covered with dust and that it should not have been covered in dust. UM #1 said that she was not sure who was responsible for cleaning and maintaining the filter on the oxygen concentrator but that she would find out. During an interview on 1/21/26 at 8:02 A.M., the Director of Clinical Services said that she had been made aware of the issue with Resident #84's oxygen concentrator filter and that UM #1 had told her that the filter was dirty. The Director of Clinical Services said the 11:00 P.M. - 7:00 A.M. (night shift) staff were responsible for cleaning the filters on the oxygen concentrators. The Director of Clinical Services said the filters on the oxygen concentrators should be cleaned every Wednesday.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, record review, and interview, the facility failed to ensure that the medication error rate was not five percent (5%) or greater when one Nurse (#1) out of three Nurses observed during the medication pass procedure, made two errors in 26 total opportunities, for a medication error rate of 7.69%, impacting one Resident (#119) of six residents observed, out of a total sample of 26 residents. Specifically, for Resident #119, the facility failed to: ensure that Nurse #1 followed the Physician orders for Losartan Potassium (blood pressure medication used to treat hypertension) to be held when Resident #119's systolic blood pressure (the top/upper number for blood pressure measurement) reading was less than 130 mmHg (millimeters of mercury). ensure that Nurse #1 administered the correct Calcium medication when Calcium/ Vitamin D 600 mg (milligrams) /10 mcg (micrograms) was administered to Resident #119 and Calcium 1200 mg was ordered by the Physician.Findings include: Review of the facility policy titled Physician Orders, revised 9/5/25, included but not limited to:The facility shall ensure that all resident care, treatment, medications, and services are provided only upon valid physician or authorized practitioner orders. Orders must be clear, complete, properly documented, promptly carried out, and authenticated. >Orders are carried out promptly and safely.Resident #119 was admitted to the facility in November 2021, with diagnoses including Cardiomegaly Nonrheumatic Mitral (Valve) Insufficiency, Chronic Kidney Disease Stage 2, Hypertensive Heart and Chronic Kidney Disease with Heart Failure, Multiple Sclerosis and age-related Osteoporosis. Review of Resident #119's Physician orders dated 1/16/26, indicated the following:-Losartan Potassium Oral Tablet 100 mg (Losartan Potassium). Give 1 tablet by mouth one time a day related to Hypertensive Heart and Chronic Kidney Disease with Heart Failure and Stage 1 through Stage 4 chronic kidney disease, or unspecified chronic disease. Hold for SBP (systolic blood pressure) less than 130, initiated 4/4/23, discontinued 1/16/26.-Calcium 600 Oral Tablet. Give 1200 milligrams (mg) by mouth, one time a day for Calcium supplement, initiated 12/24/25. On 1/16/26 at 9:00 A.M., during medication administration, the surveyor observed Nurse #1 assess Resident #119's blood pressure and administer the following medication:-Losartan Potassium Oral Tablet 100 mg one tablet by mouth. -Calcium/Vitamin D 600 mg/ 10 micrograms (mcg) two tablets by mouth.-Blood pressure reading of BP 113/65 mmHg was obtained. Review of Resident #119's January 2026 Medication Administration Record (MAR), indicated Nurse #1 had electronically signed that the following medications were administered on 1/16/26:-Losartan Potassium Oral Tablet 100 mg with the Resident's SBP documented as 113 mmHg. -Calcium Oral Tablet (Calcium) 1200 mg. Further review of Resident #119's January 2026 MAR indicated 100 mg Losartan Potassium Oral Tablet was electronically signed by Nursing staff as administered when the SBP was less than 130 on the following dates:-1/3/26: SBP reading of 128 mmHg-1/14/26: SBP reading of 123 mmHg Review of Resident #119's December 2025 MAR, indicated 100 mg Losartan Potassium Oral Tablet was electronically signed by Nursing staff as administered when the SBP was less than 130 on the following dates:-12/6/25: SBP reading of 125 mmHg-12/29/25: SBP reading of 122 mmHg During an interview on 1/16/26 at 11:57 A.M., the surveyor and Nurse #1 reviewed the Physician orders for Resident #119 and Nurse #1 said that the Physician orders indicated to hold Resident #119's Losartan Potassium when the SBP was less than 130 mmHg and he administered the medication when Resident #119's SBP was 113 mmHg. Nurse #1 also said that the Physician orders indicated to administer Calcium Carbonate 1200 mg, and he administered Calcium/ Vitamin D 600 mg/10 mcg. Nurse #1 said that he did not see the Physician orders indicating to hold the Losartan Potassium when the blood pressure was less than 130 mmHg. Nurse #1 further said that he should not have administered the 100 mg Losartan Potassium and the Calcium/ Vitamin D 600 mg/10 mcg medication to Resident #119, but he did. During an interview on 1/16/26 at 1:47 P.M., the Director of Nursing (DON) said that Nurse #1 should not have administered the 100 mg Losartan Potassium and Calcium/ Vitamin D 600 mg/10 mcg to Resident #119. The DON also said that Nurse #1 should follow the Physician orders to hold and not administer the blood pressure medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure that medication was stored in a safe and sanitary manner in the medication carts on one (Fifth-Floor North) out of four medication carts reviewed.Specifically, the facility failed to ensure that Nurse #2 stored medications in a safe and sanitary manner in the Fifth-Floor North medication cart when Nurse #2 was observed storing one pre-poured medication cup containing resident medications in the top drawer and a second medication cup containing pre-poured resident medications in the bottom drawer of the medication cart. Findings include:Review of the facility policy titled, Oral Medication Administration Procedure, revised 1/1/25, included but not limited to:It is the policy of the facility to administer resident medications in an organized and safe manner.>Meds are never pre-poured. Review of the facility policy titled, Medication Storage, revised 10/16/25, included but not limited to:It is the policy of the facility that all medications within the facility shall be stored, labeled, secured, and monitored in a manner that:>Maintains drug integrity and potency. On 1/16/26 at 10:24 A.M., the surveyor observed the following pertaining to Nurse #2 and the Fifth-Floor North medication cart:-Nurse #2 opened the medication cart and picked up an item from the bottom drawer of the medication cart and held the item behind her back. -When the surveyor asked Nurse #2 what she was holding behind her back, Nurse #2 showed the surveyor a medication cup with no name or label present, containing apple sauce mixed with white tablets and a blue and white capsule.-Nurse #2 then opened the top drawer of the medication cart and the surveyor observed an unlabeled plastic medication cup containing three white tablets and one white capsule. During an interview at the time, Nurse #2 said when she went to administer the medications to a resident, but the resident had refused the medications. Nurse #2 said she should have immediately destroyed the medications that were mixed in apple sauce when the resident refused the medications. Nurse #2 also said that she had placed the second medication cup containing medications for another resident in the bottom drawer because that resident had refused the medications earlier. During an interview on 1/16/26 at 1:45 P.M., the Director of Nursing (DON) said that the standard practice for nursing staff was to destroy medications immediately that were refused by residents. The DON also said that the medications should have been destroyed by Nurse #2.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to follow professional standards of practice for food safety relative to the use and preparation of unpasteurized eggs to prevent the potential of foodborne illness to residents who are at high risk. Specifically, the facility staff failed to utilize pasteurized eggs for the preparation of over easy (eggs fried on both sides with a runny yolk) eggs to safely accommodate resident's choices during the breakfast meals and ensure that the unpasteurized eggs being used were appropriately cooked until all parts of the egg were completely firm placing the residents who were served the over easy, unpasteurized eggs at risk for foodborne illness. Findings include:Review of the facility's policy titled Enhanced Dining, last revised 4/24, included but not limited to:-Fried eggs prepared to order must be cooked over hard (eggs cooked until both the whites and the yolk are completely solid and firm, with no runny liquid left) due to the fact that we do not use pasteurized whole eggs. -No eggs over easy or sunny side up (fried egg that is cooked on only one side, resulting in a fully set white and a bright, runny yolk that resembles the sun). Review of the facility invoices from the facility vendor dated 10/6/25, 10/13/25, 10/16/25, 10/20/26, 11/6/25, 11/10/25, 11/20/25, 12/1/25, 12/4/25, 12/11/25, 12/18/25 and 12/29/25, indicated that the whole eggs purchased to make the over easy eggs in the facility were unpasteurized. On 1/16/26 at 8:16 A.M., the surveyor observed a staff member in the third-floor dining room serve breakfast to one resident which included one egg cooked over easy. The resident was observed to cut the over easy egg with his/her fork and then eat the over easy egg with runny yolk. On 1/20/26 at 8:05 A.M. through 8:17 A.M., the surveyor observed the breakfast meal in the third-floor dining room. The surveyor observed that two residents were eating over easy eggs with running yoks. During an interview on 1/20/26 at 8:25 A.M., Dietary Staff #1 who was the facility cook said that the Food Service Director (FSD) orders pasteurized eggs and she could make over easy eggs for the residents. Dietary Staff #1 said she had prepared over easy eggs with runny yolks and served to residents on 1/16/26 and 1/20/26, and the eggs were not pasteurized. During an interview on 1/20/26 at 8:34 A.M., Dietary Staff #1 said that the facility does not purchase pasteurized whole eggs. Dietary Staff #1 said that the whole eggs she used for the over easy eggs for breakfast were not pasteurized. During an interview on 1/20/26 at 9:05 A.M., the FSD said that he was responsible for ordering food for the facility including eggs. The FSD said that the whole eggs purchased were not pasteurized. The FSD said that the whole eggs used by Dietary Staff #1 for the over easy eggs at breakfast were not pasteurized. The FSD said that the eggs should not have runny yolks and should have been cooked through to prevent foodborne illness for the residents.