

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225199	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2024
NAME OF PROVIDER OR SUPPLIER Worcester Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 119 Providence Street Worcester, MA 01604	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42741</p> <p>Based on observations and interviews, the facility failed to provide a safe, clean, comfortable, and homelike environment for the facility residents on four Units (Unit Two, Unit Three, Unit Four, and Unit Five) out of four units observed.</p> <p>Specifically, the facility staff failed to repair, replace and clean:</p> <ol style="list-style-type: none"> 1. On Unit Two: holes in the walls, soiled curtains, stained ceiling tiles, and a leaky bathroom sink. 2. On Unit Three: missing mirror, stained and damaged ceilings, damaged walls, loose toilets and soiled curtains. 3. On Unit Four: broken closet door, urine odor, and a damaged wall. 4. On Unit Five: leaking bath tub faucet. <p>Finding include:</p> <ol style="list-style-type: none"> 1. During an initial observation on Unit Two on 3/13/23 between 8:10 A.M. and 12:24 P.M., the surveyor observed the following: <p>>room [ROOM NUMBER]- damage to the wall at the head of the bed (an approximately six inches by six-inch [6 x 6] tear in the wall covering). The wall covering was wrinkled and lifted away from the wall and a small piece of tape was attached to the wall. Above the 6 x 6 inch tear in the wall were 6 large lumps of plaster attached to the wall.</p> <p>>room [ROOM NUMBER]- a window curtain with a large dark stain starting from the bottom of the curtain and extending up approximately six inches and across the width of the curtain, and a stained ceiling tile in the corner near the window.</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
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/15/24 at 9:00 A.M., the surveyor and the Maintenance Director inspected the wall in room [ROOM NUMBER], and the Maintenance Director said the wall should not look that way and that it looked like someone had attempted to repair the wall but the repair was not done correctly. The surveyor and the Maintenance Director also inspected the curtain and the ceiling in room [ROOM NUMBER]. The Maintenance Director said the curtain should have been removed, cleaned and re-hung and the ceiling tile should have been replaced.</p> <p>During the Resident Council meeting held on 3/14/24 from 10:00 A.M. through 10:57 A.M., a Resident residing in room [ROOM NUMBER] on Unit Two stated the bathroom sink in his/her room continuously leaked when in use and there was a basin that catches the leaking water which needed to be emptied multiple times a day.</p> <p>On 3/14/24 at 12:10 P.M., the surveyor observed room [ROOM NUMBER] on Unit Two, and saw the bathroom sink to have a plastic basin underneath with greyish water collecting in it. The surveyor turned on the sink and observed that as water drained from the sink into the pipe below the sink, a stream of water also leaked out from the pipe into the plastic basin.</p> <p>2. During an initial observation on Unit Three on 3/13/24 from 8:22 A.M. through 10:44 A.M., the surveyor observed the following:</p> <p>>room [ROOM NUMBER]- missing mirror in the bathroom, and the ceiling surrounding the bathroom exhaust fan with patched plaster and brown stains.</p> <p>>room [ROOM NUMBER]- ceiling surrounding the bathroom exhaust fan with bubbling paint, exposed plaster that was stained black and a large, triangular chunk of ceiling plaster was missing. The wall behind the toilet was damaged, and repaired with plaster that was unpainted.</p> <p>>room [ROOM NUMBER]- both closet ceilings with water stains. The window curtains had large red stains extending from the top to bottom of the curtains.</p> <p>-For 316-2, the closet had no rubber molding along the bottom walls and a black, crumbly substance was observed around the edges of the interior closet. The wall behind 316-2's bed had peeling wallpaper and damaged plaster, and the rubber molding along the bottom of wall was pulled away from the wall revealing crumbling plaster.</p> <p>>room [ROOM NUMBER]- the ceiling surrounding the bathroom exhaust fan was patched with plaster and stained black/brown. The wall behind the bathroom sink was stained with rust/brown streaks and the wall behind the sink/toilet area was patched with plaster and unpainted.</p> <p>>room [ROOM NUMBER]- the ceiling surrounding the bathroom exhaust fan was damaged and patched with plaster, and stained black/brown.</p> <p>During a follow-up observation of the environment on Unit Three on 3/14/24 from 4:30 P.M. through 5:00 P.M. , the surveyor observed the following:</p> <p>>room [ROOM NUMBER]- the window drapes had missing hooks resulting in large areas of the drapes sagging from the curtain rod.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>>room [ROOM NUMBER]- the bathroom wallpaper was stained rust/brown behind the sink and toilet, the bathroom had exposed, unpainted plaster, and the toilet not secured to the floor causing the toilet to move from side to side.</p> <p>>room [ROOM NUMBER]- the bathroom had a broken, stained baseboard heater cover, missing tiles under the toilet, the toilet was not secured to the floor causing the toilet to move from side to side. The surveyor observed water stained ceiling tiles near the windows.</p> <p>>room [ROOM NUMBER]- the wall between 308-1 and the bathroom was damaged, window drapes were missing hooks resulting in large areas of the drapes sagging from the curtain rod.</p> <p>>room [ROOM NUMBER]- window drapes were missing hooks resulting in large areas of the drapes sagging from the curtain rod.</p> <p>>room [ROOM NUMBER]- there was no mirror in the bathroom, the ceiling surrounding the bathroom exhaust fan had patched plaster and brown stains.</p> <p>>room [ROOM NUMBER] through room [ROOM NUMBER] remained unchanged from the 3/13/24 observation.</p> <p>3. During an initial observation on Unit Four on 3/13/23 between 11:54 A.M. through 12:32 P.M., the surveyor observed the following:</p> <p>>room [ROOM NUMBER]- window drapes were missing hooks resulting in large areas of the drapes sagging from the curtain rod, there was peeling wallpaper in the room, and the bathroom wall had exposed plaster repair, that was unpainted.</p> <p>>room [ROOM NUMBER]- a strong odor of urine in the bathroom. The closet door had several broken/missing louvers/slats. The wall outside the bathroom was buckled inward with visible plaster crumbling underneath the rubber base molding.</p> <p>During an interview on 3/14/24 at 1:25 P.M., the Maintenance Director said the closet and the crumbling wall in room [ROOM NUMBER] required repair and the room had a strong, deep urine smell.</p> <p>During a follow-up observation of the environment on Unit Four on 3/14/24 from 5:00 P.M. through 5:30 P.M., the surveyor observed the following:</p> <p>>room [ROOM NUMBER]- window drapes missing hooks resulting in large areas of the drapes sagging from the curtain rod.</p> <p>>room [ROOM NUMBER]- a strong odor of urine in the bathroom, and the closet door had several broken/missing louvers/slats. The wall outside the bathroom was buckled inward with visible plaster crumbling underneath the rubber base molding.</p> <p>4. During the Resident Council meeting held on 3/14/24 from 10:00 A.M. through 10:57 A.M., a Resident residing in room [ROOM NUMBER] on Unit Five stated the bathroom tub in his/her room had a leak which creates a puddle on the floor. The Resident further said he/she had difficulty walking in the bathroom because he/she felt he/she may slip if the water puddle was not taken care of multiple times a day.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 3/15/24 at 2:25 P.M., the surveyor and the Maintenance Director observed room [ROOM NUMBER] to have a leaking faucet in the bathtub. A hand towel was placed under the leaking faucet to collect the water and was noted to be wet.</p> <p>On 3/15/24 from 1:35 P.M. through 2:25 P.M., the surveyor and the Maintenance Director toured Units Two, Three, Four, and Five. The Maintenance Director said he was aware of the sink faucet leak in room [ROOM NUMBER], however in order to fix the leak, he needed to order parts and the company would not provide the parts until the facility paid their prior bill. The Maintenance Director said room [ROOM NUMBER] should have a bathroom mirror, that the facility did not have extra drapery hooks, which needed to be purchased, and that the rooms with the sagging drapes needed to be repaired. The Maintenance Director also said that the stained drapes needed to be taken down and laundered, the damaged ceilings required repair and the rooms that had exposed plaster required painting. The Maintenance Director further said he was not aware the bathtub faucet in room [ROOM NUMBER] leaked prior to the observation with the surveyor, and it required repair. The Maintenance Director said all of the concerns the surveyor brought to his attention did not reflect a homelike environment for the residents in the facility.</p> <p>On 3/19/24 at 7:48 A.M., the surveyor observed the strong odor of urine in the bathroom of room [ROOM NUMBER] was still unresolved.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42741</p> <p>Based on interview and record review, the facility failed to ensure that Minimum Data Set (MDS) Assessments were coded accurately for one Resident (#135) out of three closed record residents and for four Residents (#3, #23, #32, and #67) out of a total sample of 26 residents.</p> <p>Specifically, the facility staff failed to ensure that an MDS Assessment:</p> <ol style="list-style-type: none"> 1. For Resident #135, was accurately coded relative to the Resident receiving Hospice (End of Life) services. 2. For Resident #3, was accurately coded relative to the Resident having a Significant Mental Illness (SMI) per a Preadmission Screening and Resident Review (PASRR) Level II (an evaluation that confirms whether an individual has a SMI or Intellectual/Developmental Disability). 3. For Resident #23, was accurately coded relative to pressure ulcers (injury to the skin resulting from prolonged pressure) when the Resident had non-pressure related ulcers. 4. For Resident #32, was accurately coded relative to the use of a physical restraint. 5. For Resident #67, was accurately coded relative to the Resident's ability to communicate. <p>Findings include:</p> <ol style="list-style-type: none"> 1. Resident #135 was admitted to the facility in January 2016 with diagnoses including metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood), Cauda Equina Syndrome (injury to the collection of nerve roots at the bottom of the spinal cord that effect lower extremities and bladder), and adult failure to thrive (FTT - a global decline in older adults as a worsening of physical frailty that is frequently compounded by cognitive impairment). <p>Review of the Nursing Progress Note dated 8/31/22, indicated the Resident signed onto Hospice Services.</p> <p>Review of the Nursing Progress Note dated 1/1/24, indicated the Resident remained on Hospice Services until the time of his/her discharge.</p> <p>Review of the MDS assessment dated [DATE], indicated the Resident was not receiving Hospice Services.</p> <p>During an interview on 3/18/24 at 1:40 P.M., MDS Nurse #1 said the Resident was on Hospice Services at the time the 11/23/23 MDS Assessment was completed, and that the MDS Assessment was inaccurately coded.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Resident #3 was admitted to the facility in December 2017 with diagnoses including major depressive disorder(symptoms lasting greater than two weeks of a persistently low or depressed mood and a loss of interest in activities that a person used to enjoy), anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with daily activities), and personality disorder (a lifelong mental health condition that involves patterns of thoughts and behaviors that are different from what is considered normal which cause serious problems in relationships, work, and social activities).</p> <p>Review of the Resident's PASSR Level II, dated 2/5/20, indicated he/she had a SMI.</p> <p>Review of the MDS assessment dated [DATE], indicated that per the Resident's PASSR Level II he/she did not have a SMI.</p> <p>During an interview on 3/14/24, at 2:08 P.M., MDS Nurse #2 said she had reviewed the Resident's PASSR Level II, and it indicated the Resident had a SMI. MDS Nurse #2 further said the Resident's MDS assessment dated [DATE], was inaccurately coded.</p> <p>3. Resident #23 was admitted to the facility in November 2023 with diagnoses including Type 2 Diabetes Mellitus (Type II DM - long-term condition where the pancreas is unable to produce enough insulin to regulate blood glucose [sugar] levels resulting in higher than normal blood sugar levels), chronic osteomyelitis (chronic bone infection), and had multiple non-pressure related wounds due to Type II DM.</p> <p>Review of the Initial Weekly Skin Audit, with an effective date of 11/30/23, indicated the Resident had wounds including a diabetic ulcer to the left heel, a diabetic ulcer to the right heel, and diabetic ulcer to left great toe.</p> <p>Review of the MDS assessment dated [DATE], indicated that the Resident had unhealed pressure ulcers.</p> <p>During an interview on 3/14/24 at 2:08 P.M., MDS Nurse #2 said Resident #23 did not have any unhealed pressure ulcers, he/she had diabetic ulcers during the review period (time frame used to complete a MDS Assessment) for the MDS Assessment, and the MDS assessment dated [DATE] was coded inaccurately.</p> <p>44129</p> <p>4. Resident #32 was admitted to the facility in January 2023 with diagnoses including Anxiety (feeling of unease, such as worry or fear, that can be mild or severe/ intense, excessive, and persistent worry and fear about everyday situations) and Depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).</p> <p>Review of the MDS assessment dated [DATE], indicated the Resident utilized side rails on his/her bed and the side rails were considered a restraint.</p> <p>Review of the Side Rail Evaluation dated 1/21/23, indicated side rails were the Resident's preference and were being utilized for positioning and/or support and to aid in bed mobility.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/14/24 at 3:08 P.M., the MDS Nurse said the MDS Assessment was not coded correctly and required modification.</p> <p>45429</p> <p>5. Resident #67 was admitted to the facility in September 2023 with diagnoses including Parkinson's Disease (a degenerative disorder of the central nervous system characterized by tremor and impaired muscular coordination) and dysphasia (difficulty swallowing).</p> <p>Review of Resident #67's care plan for communication, last revised 12/21/23, indicated that the Resident had difficulty making themselves understood.</p> <p>Review of Resident #67's most recent MDS dated [DATE], indicated that the Resident had been coded in Section B0600 as a 0 indicating he/she had clear speech.</p> <p>Review of the Centers for Medicare and Medicaid Services Resident Assessment Instrument (RAI) Manual dated October 2023, instructed that clear speech is coded when the resident usually utters distinct intelligible words.</p> <p>On 3/1/24 at 8:54 A.M., the surveyor observed the Resident while in his/her bedroom. Resident #67 was having difficulty communicating intelligibly and became tearful while attempting to communicate. Unit Manager (UM) #1 approached the Resident at the time and was not able to communicate with him/her and went to retrieve a communication board for assistance with understanding why he/she had become upset.</p> <p>During an interview on 3/13/24 at 8:56 A.M., Nurse #9 said Resident #67 has difficulty communicating but he/she does understand yes or no questions.</p> <p>During an interview on 3/18/24 at 2:51 P.M., the MDS Nurse said that she had met with Resident #67, that their speech had not been clear and that the MDS has been coded inaccurately.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44337</p> <p>Based on observation, interview and record review, the facility failed to implement the plan of care for one Resident (#132) out of a total sample of 26 residents.</p> <p>Specifically, the facility staff failed to monitor fluid intake and output for Resident #132 as ordered.</p> <p>Findings include:</p> <p>Review of the facility policy titled Intake and Output Monitoring, April 2015, indicated the following:</p> <ul style="list-style-type: none"> -Intake and output is documented each shift beginning with the 11:00 P.M. to 7:00 A.M. shift (night shift). -Intake and output is totaled daily by the 3:00 P.M. to 11:00 P.M. (evening shift) shift nurse and the 24 hour totals are transcribed to the Medication Administration Record (MAR). <p>Resident #132 was admitted to the facility in February 2024, with a diagnosis of Cirrhosis (liver damage that can cause swelling and abdominal bleeding).</p> <p>Review of the Minimum Data Set assessment (MDS) dated [DATE], indicated that Resident #132 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of a total score of 15.</p> <p>On 3/13/24 at 11:23 A.M., the surveyor observed Resident #132 sitting on the edge of the bed and swelling to both legs were noted.</p> <p>Review of the active Physician's orders dated 3/14/24, indicated the following:</p> <ul style="list-style-type: none"> -Fluid Restriction: 1500 milliliters (ml) Daily .document intake every shift on Intake and Output (I&O) sheet, initiated 3/1/24. <p>Review of the clinical record flowsheets did not indicate any evidence that fluid I&O had been documented every shift as ordered.</p> <p>Review of the March 2024 MAR for Resident #132 did not indicate any documented evidence of the required 24 hour totals of fluid I&O for the Resident.</p> <p>During an interview on 3/14/24 at 10:51 A.M., the Director of Nurses (DON) said that when a resident is on I&O monitoring, all fluid intake for the day is documented on the Intake and Output Record and then the 24-hour fluid total is documented on the MAR. The DON said that she could not provide any evidence that fluid intake and output had been monitored and documented for Resident #132 as ordered.</p>		

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<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>45435</p> <p>Based on interview, policy and record review, the facility failed to maintain professional standards of practice related to psychiatric services for one Resident (#28) out of a total sample of 26 residents.</p> <p>Specifically, the facility staff failed to ensure that recommendations made by the Psychiatric Nurse Practitioner (NP) for medication changes were reviewed by Resident #28's Attending Physician resulting in delayed management of anxiety and pain symptoms.</p> <p>Findings include:</p> <p>Review of the facility policy titled Consultant Services, dated April 2015, indicated the following:</p> <p>-A note should be recorded on the consultation form by any health care consultant who sees the resident/patient at the request of the MD or the family. The consultant should document findings and recommendations on this form.</p> <p>-The charge nurse will then notify the attending physician of findings and he/she can then order the specific treatments as outlined by the consultant.</p> <p>Resident #28 was admitted to the facility in June 2023 with diagnoses including generalized anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with daily activities), major depressive disorder (symptoms of a persistently low or depressed mood and a loss of interest in activities that a person used to enjoy lasting greater than two weeks), insomnia (sleep disorder with trouble falling and/or staying asleep), and alcohol abuse.</p> <p>Review of the Behavioral Health Group Medication Management note dated 2/16/24, indicated the following:</p> <p>-Requested to be seen for increased anxiety and neuropathic pain (nerve pain).</p> <p>-Plan/Recommendation - start Gabapentin (an anti-seizure medication that can be used to treat nerve pain) 100 milligrams (mg) PO (by mouth) BID (twice a day) for anxiety with neuropathic pain.</p> <p>Further review of the medical record indicated no evidence that the Behavioral Health Group (BHG) recommendation had been reviewed by the Attending Physician.</p> <p>(continued on next page)</p>		

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<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 3/14/24 at 10:02 A.M., the surveyor and Nurse #5 reviewed the Behavioral Health Group Medication Management note dated 2/16/24. Nurse #5 said she was not aware of the BHG note or the recommendation. Nurse #5 said that she does not always know when a resident is seen by Psychiatric services. Nurse #5 said that when the NP from the BHG writes a recommendation the supervisor should print the report, bring it to the Nurse to get approval from the Attending Physician, and then the Nurse will enter the order. Nurse #5 said she did not know if the Attending Physician had reviewed the recommendation.</p> <p>During an interview on 3/14/24 at 1:03 P.M., the Staff Development Coordinator (SDC) said when the Behavioral Health Group sees a resident their notes are automatically entered into the electronic health record (EHR). The SDC said the Nurse, or the Nursing Supervisor needs to go into the EHR under the miscellaneous tab, check to see if there are any new recommendations, print them, and get them approved by the Attending Physician. The SDC said the BHG does not leave a list of which residents were seen and the Nurses do not always know which residents have new recommendations. The SDC said the recommendation from 2/16/24 was not followed up on until today (3/14/24) after the survey team investigation.</p>		

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<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42741</p> <p>Based on observation, interview, and record review, the facility failed to provide assistance to ensure activities of daily living (ADLs) were maintained for two Residents (#109 and #14) who required assistance for self-care out of a total sample of 26 residents.</p> <p>Specifically, the facility staff failed to ensure:</p> <ol style="list-style-type: none"> 1. For Resident #109, that staff assisted the Resident with maintaining the cleanliness and length of his/her fingernails. 2. For Resident #14, that staff assisted with grooming and ensured the Resident was free from facial hair per personal and Resident Representative preference and Physician's orders. <p>Findings include:</p> <ol style="list-style-type: none"> 1. Resident #109 was admitted to the facility in June 2023 with diagnoses including Vascular Dementia (problems with memory, reasoning, planning, judgement and other thought processes caused by brain damage from impaired blood flow to the brain), vision loss in his/her right eye, major depressive disorder (symptoms lasting greater than two weeks of a persistently low or depressed mood and a loss of interest in activities that a person used to enjoy), and a history of a Cerebral Infarction (stroke: damage to tissues in the brain caused by blood clots, disrupted blood supply and restricted oxygen supply to the specific area). <p>Review of the most recent comprehensive Minimum Data Set (MDS) Assessment indicated the Resident was able to make him/herself understood and needed substantial/maximal assistance for self care.</p> <p>Review of the Resident's ADLs care plan, initiated 6/27/23, indicated the following:</p> <p>-Needs intervention with the following areas:</p> <p>*Grooming: Assist of one person.</p> <p>During an interview and observation on 3/13/24 at 8:53 A.M., Resident #109 showed the surveyor his/her nails which were long and had orange/brown material underneath the fingernails. Resident #109 said he/she needed his/her fingernails cleaned and trimmed. Resident #109 further said that no one ever trims his/her nails.</p> <p>During an interview and observation on 3/14/24 at 11:53 A.M., the Resident again showed the surveyor his/her nails which remained long and had orange/brown material underneath the fingernails. Resident #109 said he/she needed to have his/her nails cut and cleaned, as his/her nails were so long, that he/she may scratch him/herself.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Worcester Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 119 Providence Street Worcester, MA 01604	
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/14/24 at 12:19 A.M., with Certified Nurses Aide (CNA) #1 and CNA #2, CNA #2 said a resident's nails should be trimmed and cleaned once or twice a week. CNA #2 further said resident's nails should be checked daily with care and she was unsure when Resident #109 last had his/her nails cleaned and trimmed. CNA #1 said sometimes the activities staff will provide nail care.</p> <p>During an interview on 3/14/24 at 12:24 P.M., the Activities Director (AD) said the activities department does offer a manicure activity, however this activity does not include trimming nails as a staff member needs to be certified to trim nails and only the Activities Director was certified, and she does not always run the manicure activity. The AD further said the CNAs on the unit should be making sure the resident nails are trimmed and cleaned regularly but the CNAs do not always keep on top of ensuring nail trimming and cleaning was being done regularly.</p> <p>During an interview on 3/18/24 at 11:28 A.M., the Director of Nurses (DON) said CNAs on the units should be providing nail care. The DON further said CNAs should be looking for long nails, and when there is dirt underneath a resident's nails, and taking care of the nails as part of the resident's daily ADL care.</p> <p>44129</p> <p>2. Resident #14 was admitted to the facility in February 2017 with diagnoses including Alzheimer's Disease (a progressive disease beginning with mild memory loss and leading to the loss of the ability to carry on a conversation and respond to the environment) and muscle weakness.</p> <p>Review of the Resident's ADL Care Plan revised 3/19/19, indicated the Resident had an ADL deficit related to Alzheimer's disease and he/she required assistance of staff members for grooming.</p> <p>Review of MDS assessment dated [DATE], indicated the Resident had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) Score of 3 out of a total 15.</p> <p>Further review of the MDS assessment dated [DATE] indicated:</p> <p>-the Resident had bilateral upper and lower extremity impairment and was dependent on staff for all of his/her Activities of Daily Living (ADLs) including eating, oral hygiene, toileting, showering/bathing, dressing, and personal hygiene which included combing hair, shaving, applying facial products, washing/drying face and hands.</p> <p>Review of the March 2024 Physician's orders indicated the following:</p> <p>-Shave patient's facial hair, initiated 4/23/21.</p> <p>The surveyor observed the Resident seated in a wheelchair in the main hallway across from the nursing station with long facial hair above his/her lip and on his/her chin on the following days and times:</p> <p>-3/13/24 at 9:08 A.M.</p> <p>-3/14/24 at 8:00 A.M.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-3/14/24 at 9:15 A.M.</p> <p>On 3/14/24 at 8:35 A.M., the surveyor observed the Resident in the unit dining room with long facial hair above his/her lip and on his/her chin.</p> <p>On 3/14/24 at 9:34 A.M., the surveyor observed the Resident seated in a wheelchair with a staff member getting ready to bring the Resident downstairs for a Resident Council meeting. The surveyor observed that the Resident remained with long facial hair above his/her lip and on his/her chin.</p> <p>During an interview on 3/14/24 at 2:18 P.M., the Resident's Representative said he/she would prefer the Resident's facial hair to be removed and believed the Resident would feel better without any facial hair.</p> <p>During an observation and interview on 3/14/24 at 3:05 P.M., the surveyor and CNA #4 observed the Resident who was seated in a wheelchair in the main hallway across from the nursing station, and remained with long facial hair above his/her lip and on his/her chin. CNA #4 said the Resident's facial hair was very long and needed to be removed. CNA #4 said the CNAs document the care they provide in the Electronic Medical Record (EMR) and that shaving fell under the Personal Hygiene category. CNA #4 further said that if a resident refused care, the CNAs were expected to document the refusals.</p> <p>During an interview on 3/14/24 at 3:18 P.M., Unit Manager (UM) #1 said the Personal Hygiene category of the CNA documentation included: combing hair, brushing teeth, shaving, applying makeup, and washing/drying face and hands. UM #1 further said if a resident refused one of these tasks there was no way to indicate that separately [itemize one specific task] and if a CNA documented the resident refused, it would encompass all of those tasks in the category. UM #1 said if a resident refused any of the tasks separately, it was the expectation the CNA would alert the Nurse on duty and the Nurse would document the refusal in a Nursing Progress Note.</p> <p>Review of the CNA Documentation Report for February 2024 and March 2024 indicated no evidence that the Resident refused Personal Hygiene.</p> <p>Review of the Nursing Progress Notes for February 2024 and March 2024 indicated no evidence that the Resident refused Personal Hygiene, and specifically facial hair removal.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44129</p> <p>Based on observation, interview, and record review, the facility failed to provide care and services to prevent a decrease in range of motion (ROM) for one Resident (#15) out of a total sample of 26 residents.</p> <p>Specifically, the facility staff failed to ensure that a resting hand splint (a device to properly position and protect hand joints) to prevent hand contracture (a condition of shortening and hardening of muscle, tendons or other tissue often leading to deformity and rigidity of joints).</p> <p>Findings include:</p> <p>Resident #15 was admitted to the facility in May 2021 with a diagnosis of Cerebral Infarction (stroke-damage to tissues in the brain caused by blood clots, disrupted blood supply and restricted oxygen supply to the specific area) affecting the right dominant side and right hemiparesis (muscle weakness or partial paralysis on one side of the body).</p> <p>Review of the Facility's policy titled, Splints/Orthotics/Prosthetics dated April 2015, included but was not limited to:</p> <ul style="list-style-type: none"> -Residents will receive splint/orthotic/prosthetic devices as deemed appropriate by the physician and rehabilitation services. -Nursing staff will apply/remove the designated splint/orthotic/prosthetic device during scheduled wearing times. -Nursing staff should notify the rehabilitation department of any worn, ill-fitting and/or misplaced splint/orthotic/prosthetic device. -If the resident refuses to wear the device, notify the rehabilitation department, physician, and responsible party. <p>Review of the Occupational Therapy (OT) Inservice Training sheet dated 12/13/23, indicated:</p> <ul style="list-style-type: none"> -Contracture Management/Splint Wear -Resident to wear resting hand splint for right hand -Caregiver to place resting hand splint on right hand daily -Don (apply) hand splint on right hand in the morning, remove in the evening -Please check for signs of skin redness or irritation. <p>Review of the OT Discharge Summary dated 12/20/23, indicated:</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Short Term Goal - Resident will tolerate resting hand splint to right hand for contracture management. Goal met on 11/30/23.</p> <p>-Patient and caregiver training .self-care, skin checks and splinting schedule in order to facilitate improved functional abilities, increase safety and decrease need for assistance.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident had impairment to both the upper and lower part of one side of his/her body and was dependent on staff for mobility and dressing.</p> <p>Further Review of the MDS assessment dated [DATE], indicated the Resident had mild cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of eight out of a total 15.</p> <p>Review of the March 2024 Physician's orders, initiated 11/18/23, indicated the following:</p> <p>-Don resting hand splint with morning care and doff (remove) with evening care.</p> <p>-Resident to wear as tolerated.</p> <p>-Monitor skin before applying [hand splint] and after removal.</p> <p>Review of the March 2024 Treatment Administration Record (TAR) indicated Nursing staff were signing off (as being completed) daily on donning and doffing of the resting hand splint.</p> <p>During an observation and interview on 3/13/24 at 8:23 A.M., the surveyor observed the Resident lying in bed. Resident #15 said he/she was unable to use his/her right hand. The surveyor observed the Resident's right hand to be without a hand splint and laying flaccid at the Resident's right side.</p> <p>During an observation on 3/14/24 at 12:45 P.M., the surveyor observed the Resident lying in bed without a hand splint on his/her right hand.</p> <p>During an observation and interview 3/14/24 at 3:15 P.M., the surveyor observed the Resident lying in bed without a splint on his/her right hand. Resident #15 said he/she could not remember the last time he/she wore the hand splint. The Resident requested the surveyor look around his/her room to find the hand splint, but the surveyor was unable to locate the hand splint.</p> <p>During an observation and interview on 3/14/24 at 5:15 P.M., the surveyor Unit Manager (UM) #2 observed that the Resident was not wearing his/her resting hand splint on his/her right hand. UM #2 looked around the Resident's room and was unable to locate the right-hand splint. UM #2 said staff should not be documenting that the Resident was wearing his/her right-hand splint if he/she was not wearing the hand splint.</p> <p>During an interview on 3/14/24 at 5:36 P.M., the Resident said if he/she had the right-hand splint available, he/she would wear it.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/15/24 at 9:43 A.M., CNA #6 said she was aware the Resident did have a right-hand splint at one time but did not remember the last time she had seen it. CNA #6 said that all CNAs caring for the Resident should know the Resident required the use of a right-hand splint because it appeared on the Resident's CNA care card in the computer that a splint should be applied with morning care.</p> <p>During an observation and interview on 3/15/24 at 9:52 A.M., the surveyor observed the Resident lying in bed without a hand splint on his/her right hand. The Resident said that staff were unable to locate the hand splint.</p> <p>During an observation and interview on 3/15/24 at 11:40 A.M., Nurse #3 said she did not remember the last time the Resident wore his/her right hand splint. The surveyor and Nurse #3 observed the Resident was not wearing his/her hand splint and Nurse #3 was unable to locate the right-hand splint in the Resident's room.</p> <p>During an interview on 3/15/24 at 12:00 P.M., CNA #5 said she could not remember when she last saw Resident #15's right hand splint.</p> <p>During an interview on 3/15/24 at 12:43 P.M., the Director of Rehabilitation (DOR) said the the facility staff alerted her that the Resident's right hand splint was missing on 3/14/24, after the surveyor brought it to their attention. The DOR said she was not aware the right-hand splint was missing, and that the Resident had not been wearing the splint, and it was recommended the Resident wear the splint on his/her right hand to prevent contractures. The DOR said the expectation would be for the nursing staff to notify the Rehabilitation Department with any concerns regarding a hand splint or any other positioning devices so the Rehabilitation Department can either replace the device or re-assess the Resident for another appropriate intervention. The Rehabilitation Director said when a Resident is discharged from Rehab services, the Rehabilitation Department provide education to the clinical staff relative to the follow-up care that will need to be provided to the Resident post Rehab-discharge.</p> <p>During an interview on 3/15/24 at 2:30 P.M., the Director of Nurses (DON) said that the Rehabilitation Department had to supply a new right resting hand splint for the Resident as his/her hand splint was nowhere to be found.</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44337</p> <p>Based on observation, interview, policy and record review, the facility failed to provide care and services in accordance with professional standards of practice for two Residents (#18 and #77) out of a total sample of 26 residents, who required vascular access devices (devices that provide access to the veins for the delivery of medications or fluids).</p> <p>Specifically, the facility staff failed to:</p> <ol style="list-style-type: none"> 1) For Resident #18, obtain Physician orders for the care and maintenance of a midline catheter (a flexible tube inserted through a peripheral vein above the elbow that ends just below the axilla [armpit]). 2) For Resident #77, ensure that the external length of a Peripherally Inserted Central Catheter (PICC: a thin, flexible tube inserted into a vein in the upper arm then guided (threaded) into a large vein above the right side of the heart called the superior vena cava) had been measured as ordered to monitor and prevent potential complication of catheter migration. <p>Findings Include:</p> <p>Review of the facility policy titled Midline/Extended Dwell Catheter Dressing Change effective January 2022, indicated:</p> <p>-The IV (intravenous: in the vein) therapy order for care and maintenance is required.</p> <p>1) Resident #18 was admitted to the facility in January 2024, with a diagnosis of Cellulitis (potentially serious bacterial infection of the skin) of the right lower extremity.</p> <p>Review of the Minimum Data Set (MDS) assessment indicated Resident #18 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a total score of 15.</p> <p>On 3/14/24 at 9:41 A.M., the surveyor observed a midline catheter located in the Resident's left upper arm with a transparent dressing dated 3/13/24. The Resident said that he was supposed to receive IV medication through the midline catheter for three more days.</p> <p>Review of the active Physician orders dated 3/18/24, indicated the following:</p> <p>-May unclog or replace midline. Initiated 2/28/24.</p> <p>Further review of the active Physician's orders did not indicate any other orders relative to the care and maintenance of the midline catheter.</p> <p>Review of the March 2024 Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not indicate any documentation evidence that care and maintenance was provided relative to the Resident's midline catheter.</p> <p>(continued on next page)</p>

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/18/24 at 3:00 P.M., Nurse #2 said that the Resident still had a midline catheter in his/her left arm but the IV medication had been discontinued. Nurse #2 said that usually there are Physician orders for the care of the midline catheter. Nurse #2 said dressing changes to midline catheters are done on Wednesdays and are documented on the MAR. Nurse #2 also said that the midline catheter is supposed to be flushed with 10 milliliters (ml) of Normal Saline a couple of times a day and documented on the MAR. During a record review at the time with Nurse #2 and the Staff Development Coordinator (SDC), both said there were no Physician orders in place for the care and maintenance of the midline catheter. Nurse #2 and the SDC also said there was no documentation evidence on the MAR relative to the care of Resident #18's midline catheter. The SDC said there should have been Physician's orders put into place for flushing of the catheter, and dressing changes to the catheter.</p> <p>2) Resident #77 was admitted to the facility in February 2024, with diagnoses including abscess of the left elbow and Osteomyelitis (inflammation of bone or bone marrow due to infection).</p> <p>Review of the MDS assessment dated [DATE], indicated Resident #77 was cognitively intact as evidenced by a BIMS score of 15 out of a total score of 15.</p> <p>On 3/14/24 at 9:13 A.M., the surveyor observed a double lumen (two entry ports) PICC located on Resident #77's right upper arm, with a dressing dated 3/13/24.</p> <p>Review of the current active Physician's orders dated 3/18/24, indicated the following:</p> <ul style="list-style-type: none"> -Change catheter site dressing on admission, weekly, and as needed in the morning every Wednesday. Initiated 2/16/24. -Change needleless connector on admission, weekly with dressing change, and as needed. Initiated 2/16/24. -Measure external catheter length on admission, weekly with dressing change, in the morning every Wednesday. Initiated 2/16/24. -Sodium Chloride Flush: use 10 milliliters (ml) every eight hours for IV line maintenance. Initiated 2/16/24. <p>Review of the March 2024 MAR for Resident #77 did not indicate any documentation that the external length of the PICC was being measured as ordered.</p> <p>Review of the March 2024 Nursing Progress Notes did not indicate any documentation of the measurements for the external length of the PICC.</p> <p>During an interview on 3/18/24 at 1:40 P.M., the Director of Nurses (DON) said she could not provide the surveyor with any evidence that staff had measured the external length of the Resident's PICC line as ordered. The DON said the measurements should have been documented on the MAR but they were not documented as required.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>42741</p> <p>Based on observation, interview, and record review, the facility failed to provide necessary respiratory care and services in accordance with professional standards of practice for one Resident (#75) out of a total sample of 26 residents.</p> <p>Specifically, the facility staff failed to ensure that Resident #75 was administered the appropriate liter per minute (LPM- the amount of supplemental Oxygen someone received through an oxygen delivery device) of Oxygen as ordered by the Physician.</p> <p>Findings include:</p> <p>Review of the facility policy titled Oxygen Administration Nasal Cannula, revised November 2020, indicate the following:</p> <ul style="list-style-type: none"> -Set oxygen liter flow to the prescribed liters flow per minute {sic} <p>Review of the AARC (American Association for Respiratory Care) Clinical Practice Guideline, updated 2014: https://www.aarc.org/wp-content/uploads/2014/08/08.07.1063.pdf indicates:</p> <ul style="list-style-type: none"> -All Oxygen must be prescribed and dispensed in accordance with federal, state, and local laws and regulations. -Oxygen is a medical gas and should only be dispensed in accordance with all federal, state, and local laws and regulations. -Undesirable results or events may result from noncompliance with Physicians' orders or inadequate instruction for Oxygen therapy. -There is a potential in some spontaneously breathing hypoxemic patients with hypercapnia [high carbon dioxide levels in the blood) and chronic obstructive pulmonary disease that oxygen administration may lead to an increase in PaCO2 (carbon dioxide). -Equipment maintenance and supervision: All oxygen delivery equipment should be checked at least once daily Facets to be assessed include proper function of the equipment, prescribed flowrates, remaining liquid or compressed gas content, and backup supply. <p>Resident #75 was admitted to the facility in October 2022, with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe).</p> <p>Review of the most recent Minimum Data Set (MDS) Assessment indicated Resident #75 utilized Oxygen and was usually able to make him/herself understood.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the March 2024 Physician Order Summary Report indicated the following order:</p> <p>-Oxygen at 2 LPM via nasal cannula continuously .related to COPD .</p> <p>Further review of the Physician Order Summary Report indicated no orders to titrate (increase or decrease) the Resident's Oxygen liter flow from 2 LPM.</p> <p>During an observation and interview on 3/13/24 at 8:43 A.M., the surveyor observed the Resident to be seated in bed with Oxygen flowing via nasal cannula (tubing placed in the nostrils/nose that delivers supplemental Oxygen). The surveyor observed that the liter flow on the oxygen concentrator (medical device that uses air in the atmosphere, filters it, and delivers air that is 90 - 95% Oxygen concentrated) was set to 3.5 LPM. Resident #75 said he/she had been on Oxygen for a while and his/her LPM should be set at 2 LPM.</p> <p>During an observation on 3/14/24 at 12:14 P.M., the surveyor observed the Resident to be seated in bed with Oxygen flowing via nasal cannula and the liter flow on the oxygen concentrator set to 3 LPM.</p> <p>During an observation and interview on 3/18/24 at 11:47 A.M., the surveyor and Nurse #5 observed Resident #75 who was seated in bed with Oxygen flowing via nasal cannula and the liter flow set at 3 LPM. Nurse #5 said the Resident's Physician's order was for 2 LPM and his/her Oxygen should not be set higher than 2 LPM.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225199	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2024
NAME OF PROVIDER OR SUPPLIER Worcester Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 119 Providence Street Worcester, MA 01604	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42741</p> <p>Based on interview and record review, the facility failed to ensure that one Resident (#3) out of a total sample of 26 residents, who had a history of Post Traumatic Stress Disorder (PTSD - a disorder that develops when someone has experienced a traumatic event) had a care plan developed that included the Resident's identified PTSD triggers (certain stimuli that bring back strong memories from a traumatic event these can include but are not limited to sounds, smells, physical actions, and thoughts, that can cause an adverse reaction).</p> <p>Specifically, the facility staff failed to identify physical abuse as a trigger for Resident #3, causing retraumatization when a male staff member put his hand on the Resident's shoulder.</p> <p>Findings include:</p> <p>Resident #3 was admitted to the facility in December 2017, with a diagnosis of PTSD.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident had a diagnosis of PTSD and he/she scored a 15 out of 15 on the Brief Interview of Mental Status (BIMS-cognitive functioning test) indicating that he/she was cognitively intact.</p> <p>During an interview on 3/13/24 at 10:06 A.M., Resident #3 said he/she had a history of physical abuse and that he/she was very uncomfortable when a male staff member put his hand on his/her shoulder in an attempt to comfort/ reassure the Resident. Resident #3 further said he/she knew the male staff meant no harm but the staff's gesture was triggering for him/her due to the past history of physical abuse trauma.</p> <p>Review of the Social Service Trauma-Informed Care Screening Tool, dated 4/15/21, indicated the following:</p> <p>-What are the triggers that cause the experience to bother you?</p> <p>-Pain, Anxiety, and Other Behaviors</p> <p>Review of the Resident's care plan titled, Resident has a history of trauma with potential for retraumatization ., initiated 10/15/21, indicated no specific PTSD triggers had been included in the Resident's care plan to make staff aware of what his/her PTSD triggers were.</p> <p>During an interview on 3/18/24 at 10:34 A.M., Social Worker (SW) #2 said when a resident had a diagnosis of PTSD, an assessment is completed at the time of admission, and then a care plan is created from the assessment. SW #2 further said the care plan should include what Resident's #3 PTSD triggers were.</p> <p>During a follow-up interview on 3/19/24 at 10:13 A.M., SW #2 said Resident #3's care plan did not include the Resident's PTSD triggers and the triggers should be incorporated into the care plan so staff would know what the triggers are.</p>		

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<p>F 0710</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44337</p> <p>Based on observation, interview, policy and record review, the facility failed to provide appropriate medical care and supervision for one Resident (#77) out of a total sample of 26 residents.</p> <p>Specifically, the facility staff failed to obtain a Physician order for the continued treatment of a left elbow surgical wound for Resident #77, after removal of a wound therapy device.</p> <p>Findings include:</p> <p>Review of the facility policy titled Skin and Wounds last revised in March 2023 indicated the following:</p> <ul style="list-style-type: none"> -Wound treatments are done per Medical Doctor (MD) order -Residents with non-pressure wounds (arterial, venous, and diabetic ulcers, post -op surgical incisions and skin tears) are assessed, documented and provided appropriate treatment to promote healing. <p>Resident #77 was admitted to the facility in February 2024, with diagnoses including abscess (an enclosed collection of pus in tissues, organs, or confined spaces in the body) and open wound of the left elbow and Osteomyelitis (inflammation of bone or bone marrow due to infection).</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #77 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a total score of 15.</p> <p>On 3/14/24 at 9:13 A.M., the surveyor observed Resident #77 sitting in a wheelchair in the hallway with a large white gauze wrap on his/her left elbow. The Resident said that he/she had an open wound on the elbow from a surgical procedure and infection of the wound. Resident #77 also said that the elbow was draining a lot, and the staff were going to change the dressing to the elbow.</p> <p>Review of the facility Non-Pressure Wound Evaluation form dated 3/4/24, indicated Resident #77 had a surgical wound to the antecubital (the bend of the elbow) area of the left arm.</p> <p>Review of the current active Physician's orders for Resident #77 indicated no orders for wound care treatment to the left elbow.</p> <p>Review of the March 2024 Medication Administration Record (MAR) and Treatment Administration Record (TAR) indicated no evidence of Physician orders for wound care treatment to the Resident's left elbow.</p> <p>(continued on next page)</p>

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<p>F 0710</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and record review on 3/18/24 at 9:55 A.M., Nurse #1 said that he had taken care of Resident #77 and was familiar with his/her care. Nurse #1 said that when the Resident returned from a surgical follow-up appointment the previous week, the Resident no longer had the VAC (Vacuum Assisted Closure - negative pressure wound therapy that involves a suction pump, tubing and a foam dressing to aid in wound healing) device, which was previously in place for the wound treatment. Nurse #1 said that currently the staff were putting an ABD pad (thick absorbent gauze pad) and a Kerlex wrap (a long gauze dressing used to secure another dressing in place) to the Resident's wound. Nurse #1 said that he really did not know what treatment was supposed to be provided to the surgical wound on the Resident's left elbow. Nurse #1 also said that there were no Physician orders pertaining to a wound treatment for the Resident's left elbow.</p> <p>During an interview on 3/18/24 at 11:50 A.M., the Director of Nurses (DON) said that there were no wound care treatment orders in place for the surgical wound on Resident #77's left elbow. The DON said that there should have been new wound care treatment orders put into place when the Resident returned from the surgical follow-up appointment and no longer had the VAC dressing device in place.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>45429</p> <p>Based on record review and interview, the facility failed to monitor the side effects and adverse reactions of psychotropic (drugs that affects how the brain works and causes changes in mood, awareness, thoughts, feelings or behavior and includes antipsychotic, antianxiety, antidepressant, and hypnotic medications) medications for three Residents (#67, #97 and #129) out of a total sample of 26 residents.</p> <p>Specifically, the facility staff failed to monitor for adverse consequences and improved behaviors:</p> <ol style="list-style-type: none"> 1. For Resident #67, who was ordered for, and was being administered Seroquel, Depakote, Remeron and Gabapentin (psychotropic) medications. 2. For Resident #97, who was ordered for, and was being administered Zyprexa, Trazodone, and Ativan (psychotropic) medications. 3. For Resident #129, who was ordered for, and was being administered Invega (psychotropic) medication. <p>Findings include:</p> <p>Review of the facility policy for Psychotropic Medication Management Guidelines, dated April 2015, indicated that it is the facility policy to optimize the functional abilities of residents while monitoring for adverse consequences and improved behaviors.</p> <p>1. Resident #67 was admitted to the facility in September 2023 with diagnoses including Parkinson's Disease (a degenerative disorder of the central nervous system characterized by tremor and impaired muscular coordination), Major Depressive Disorder (symptoms lasting greater than two weeks of a persistently low or depressed mood and a loss of interest in activities that a person used to enjoy), and Generalized Anxiety Disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with daily activities).</p> <p>Review of Resident #67's care plan for psychotropic drug use last revised 9/19/23, indicated:</p> <ul style="list-style-type: none"> -interventions to observe for any signs or symptoms of drug related adverse effects. -report to Physician any negative consequences associated with the use of the drug. <p>Review of Resident #67's Physician's orders for March 2024 indicated that the resident was prescribed:</p> <ul style="list-style-type: none"> -Seroquel (antipsychotic) 50 milligrams (mg) three times a day, start date 1/8/24 -Depakote (mood stabilizer) 250 mg two times a day, start date 9/1/23 <p>(continued on next page)</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Remeron (antidepressant) 15 mg one tab by mouth in the evening, start date 9/2/23</p> <p>-Gabapentin (anti-seizure used to treat mood) 300 mg three times a day, start date 9/1/23</p> <p>Review of the Resident #67's Medication Administration Record (MAR) for March 2024, indicated that he/she had been administered the Seroquel, Depakote, Remeron and Gabapentin daily as ordered.</p> <p>Further review of the March 2024 MAR did not indicate that Resident #67 was being monitored for the side effects or adverse reactions to the Seroquel, Depakote, Remeron and Gabapentin medications.</p> <p>Further review of the clinical record did not indicate that Resident #67 was being routinely monitored for side effects and/or adverse reactions of any of the psychotropic medication prescribed.</p> <p>2. Resident #97 was admitted to the facility in July 2021, with diagnoses including Major Depressive Disorder, Generalized Anxiety Disorder, and Wernicke's Encephalopathy (a brain and memory disorder caused by a lack of thiamine [Vitamin B1], which happens due to alcohol use disorder or malnutrition).</p> <p>Review of Resident #97's care plan for psychotropic drug use last revised 8/11/23, indicated:</p> <p>-interventions to observe for any signs or symptoms of drug related adverse effects.</p> <p>-report to Physician any negative consequences associated with the use of the drug.</p> <p>Review of Resident #97's Physician's orders for March 2024 indicated that the resident was prescribed:</p> <p>-Zyprexa (antipsychotic) 2.5 mg twice a day, start date 9/14/23</p> <p>-Trazodone (antidepressant) 50 mg by mouth at bedtime, start date 6/12/23</p> <p>-Ativan (antianxiety) 0.5 mg once a day, start date 6/13/23</p> <p>Review of the Resident #97's Medication Administration Record (MAR) for March 2024 indicated that he/she had been administered the Zyprexa, Trazodone, and Ativan daily as ordered.</p> <p>Further review of the MAR did not indicate that he/she was being monitored for the side effects or adverse reactions to these medications.</p> <p>Further review of the clinical record did not indicate that Resident #97 was being routinely monitored for side effects and/or adverse reactions of the Zyprexa, Trazodone, and Ativan medications.</p> <p>3. Resident #129 was admitted to the facility in January 2024, with diagnoses including Psychotic Disorder (a mental illness that causes abnormal thinking and perceptions. Psychotic illnesses alter a person's ability to think clearly, make good judgments, respond emotionally, communicate effectively, understand reality, and behave appropriately) and Post Traumatic Stress Disorder (PTSD: a mental health condition triggered by a terrifying event, causing flashbacks, nightmares and severe anxiety).</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #129's care plan for psychotropic drug use dated 1/22/24, indicated:</p> <ul style="list-style-type: none"> -interventions to observe for any signs or symptoms of drug related adverse effects. -report to Physician any negative consequences associated with the use of the drug. <p>Review of Resident #129's Physician's orders for March 2024 indicated that he/she was prescribed an antipsychotic medication Invega 6 mg by mouth at bedtime, start date 1/9/2024.</p> <p>Review of the Resident #129's Medication Administration Record (MAR) for March 2024 indicated that he/she had been administered the Invega daily.</p> <p>Further review of the March 2024 MAR did not indicate that he/she was being monitored for the side effects or adverse reactions to the Invega medication.</p> <p>Further review of the clinical record did not indicate that Resident #129 was being routinely monitored for side effects and/or adverse reactions of the antipsychotic medication prescribed.</p> <p>During an interview on 3/18/24 at 9:06 A.M., Unit Manager (UM) #1 said that the side effects and adverse consequences for Residents #67, #97, and #129, should be listed on the Physician's orders and documented in the MAR and the side effects and adverse consequences were not documented as required.</p> <p>During an interview on 3/18/24 at 10:23 A.M., the Director of Nurses (DON) said that Residents #67, #97, and #129, should have been monitored for the side effects of psychotropic medications in the MAR.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>45435</p> <p>Based on interview, record and policy review, the facility failed to offer the Pneumococcal Vaccination as recommended to one Resident (#28) out of five applicable residents, in a total sample of 26 residents.</p> <p>Specifically, for Resident #28, the facility failed to ensure that Resident #28 was offered the Pneumococcal Conjugate Vaccine (PCV- a vaccine that helps protect against diseases caused by pneumococcal bacteria) at the time of admission or shortly thereafter, putting the Resident at risk for developing facility acquired Pneumonia.</p> <p>Findings include:</p> <p>Review of the facility policy titled Immunization of Residents, dated January 2024 indicated the following:</p> <ul style="list-style-type: none"> -All eligible residents will be offered the Influenza and Pneumococcal vaccines unless medically contraindicated. -Adults age 19-64 with certain underlying medical conditions or other risk factors who have not previously received conjugate vaccine or whose previous vaccination status is unknown should receive one dose of PCV (either PCV20 or PCV15). -Adults who have received PPSV23 (Pneumococcal Polysaccharide Vaccine 23) only may receive a Pneumococcal Conjugate Vaccine (either PCV20 or PCV15) equal to or greater than one year after their last PPSV23 dose. -Underlying medical conditions or other risk factors include but not limited to alcoholism and HIV (human immunodeficiency syndrome). <p>Resident #28 was admitted to the facility in June 2023 with diagnoses including generalized anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with daily activities), major depressive disorder (symptoms lasting greater than two weeks of a persistently low or depressed mood and a loss of interest in activities that a person used to enjoy), insomnia (sleep disorder with trouble falling and/or staying asleep), alcohol abuse and HIV.</p> <p>Review of the Massachusetts Immunization Information System (MIIS) Vaccine Administration Record, provided by the facility indicated the Resident had no history of receiving the Pneumococcal Conjugate Vaccine.</p> <p>Review of Resident #28's medical record indicated no documentation that the Resident had a medical contraindication to or had been offered, received or declined a Pneumococcal Conjugate Vaccine.</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/14/24 at 1:49 P.M., the surveyor and the Infection Preventionist (IP) reviewed the immunization record and facility policy and the IP said Resident #28 should have been offered the PCV 15 or PCV 20 vaccine but had not been. The IP said when there is a new admission, she takes the information from MIIS and adds it to the facility electronic health record (EHR). The IP further said that every new admission should be offered a consent for Pneumococcal immunization, but she had not yet developed the system for tracking Pneumococcal vaccinations. The IP said Resident #28 had not been offered, received or declined a Pneumococcal Conjugate Vaccine.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45435</p> <p>Based on observation and interview, the facility failed to maintain a functioning call system that would allow residents to directly contact caregivers for one Resident (#119) out of a total sample of 26 residents, and in five resident rooms on Unit Two.</p> <p>Specifically,</p> <ol style="list-style-type: none"> 1. The facility failed to have functioning call bells in five resident rooms (room [ROOM NUMBER] - room [ROOM NUMBER]) on Unit Two when the communication system that relayed calls directly to staff or to a centralized work area was identified as not working. 2. The facility staff failed to provide Resident #119 with a call bell as an alternative means to call for assistance when the call system in the Resident's room was not working. <p>Findings include:</p> <p>Review of the policy titled Call Lights, Use of, dated April 2015 indicated the following:</p> <ul style="list-style-type: none"> -All residents/patients will have a call light or alternative communication device within his/her reach when unattended. -If call light is unable to be repaired immediately provide an alternative communication method. <ol style="list-style-type: none"> 1. During an interview on 3/12/24 at 9:54 A.M., the Ombudsman said the call light system on Unit Two have not worked since January 2024. The Ombudsman further said that she had spoken to the Administrator the prior week, and the issue was still not resolved. <p>On 3/13/24 at 11:00 A.M., during the initial screening process, the surveyor checked the call light system and determined that the call system to not be functioning in room [ROOM NUMBER] through room [ROOM NUMBER].</p> <ol style="list-style-type: none"> 2. Resident #119 was admitted to the facility in July 2023, and resided on Unit Two. <p>Review of the Minimum Data Set (MDS) Assessment, dated 1/24/24, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of a 15 indicating the Resident was cognitively intact.</p> <p>On 3/13/24 at 11:00 A.M., during the initial screening process, Resident #119 was observed walking with difficulty to his/her room. When the Resident walked past the surveyor, he/she said that his/her call bell was not working. The surveyor attempted to activate the call/light bell system in the Residents' room, but no audible sound or light was observed inside or outside the room or at the Nurse's station.</p> <p>(continued on next page)</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/14/24 at 8:10 A.M., the Resident was observed sitting on the edge of the bed, Resident #119 said her/his call bell was not working and that he/she was never given a hand bell like the other residents. Resident #119 said that his/her call bell had not worked for several weeks. The surveyor attempted to activate the call light/bell system which still did not work. The surveyor did not observe a hand bell at the Resident's bedside. The surveyor alerted Certified Nurses Aide (CNA) #7 that the Residents' call bell was not working and that he/she did not have a hand bell. CNA #7 said she would notify maintenance.</p> <p>On 3/15/24 at 8:33 A.M., the surveyor was at the Nurse's station on Unit Two and heard a hand bell ringing and a Resident calling out from Resident #119's room. The surveyor entered the room and observed that Resident #119's roommate was ringing the call bell and calling out. The roommate said he/she was ringing for Resident #119, because he/she did not have a hand bell. Resident #119 said he/she had asked his/her roommate to ring the call bell for him/her because he/she needed milk for his/her breakfast.</p> <p>During an interview on 3/15/24 at 9:30 A.M, the Maintenance Director said the call bell system has not been working correctly for a couple of months. He said that sometimes he re-sets the system, and it works for a while, and sometimes the call system does not work. The Maintenance Director said some of the call bells/lights on Unit Two have been repaired but that the calls bells/lights in room [ROOM NUMBER] through room [ROOM NUMBER] were not functioning at the time. He said that a vendor came in to check the call bell system and he was told that the system was very old. The Maintenance Director said the vendor gave the option to replace the call system like they had done on the fifth floor or said they could change all the batteries and all the light bulbs, and it might work. The Maintenance Director said he was in the process of changing the batteries and light bulbs but was waiting for them to arrive in the mail. The Maintenance Director further said that all of the Residents should have been provided with a hand bell and he did not know why Resident #119 did not have one.</p>