STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225219	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vantage at Worcester LLC	59 Acton 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)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews for one of six sampled residents (Resident #3), the Facility failed to ensure they protected his/her right to privacy, when a staff member took a screenshot of his/her facility face sheet image which included his/her personal and health information, without his/her knowledge or consent, and sent a copy of the screenshot to another person (who was subsequently identified as not being a facility employee).Findings include:Review of the facility's policy titled Release of Information, revised date of November 2009, included the following:-Our facility maintains the confidentiality of each resident's personal and protected health information.-All information contained in the resident's medical record is confidential and may only be released by the written consent of the resident or his/her legal representative, consistent with state laws and regulations.Review of the Report submitted by the facility via the Health Care Facility Reporting System (HCFRS), dated 04/29/26, indicated that on 04/28/26 the facility received a report from the [NAME] County Sheriff's Department informing them that a Certified Nurse Aide (later identified as CNA #1), reportedly sent a photograph to an inmate at the [NAME] County Jail. The report indicated that the photograph contained Resident #3's protected health information including his/her name, date of birth , and additional health related details. Resident #3 was admitted to the facility in January 2026, diagnoses included Type 2 Diabetes Mellitus and Chronic Obstructive Pulmonary Disease (COPD).Review of Resident #3's Minimum Data Set (MDS) assessment, dated 04/30/26, indicated he/she was alert and oriented and had a Brief Interview for Mental Status (BIMS) score of 15 (0-7 suggests severe cognitive impairment, 8-12 suggests moderate cognitive impairment, and 13-15 suggests no cognitive impairment).Review of the Facility's Investigation indicated that the facility received a copy of the photograph from the [NAME] County Sheriff's Department which included Resident #3's name, date of birth , room number, allergies, blood pressure, and respiratory rhythm. The Facility's name was also visible on the right-hand corner of the computer screen in the photograph.Further review of the Investigation indicated CNA #1 was blocked from accepting or working any further shifts at the facility and his/her staffing agency was notified of the allegation. The Investigation indicated that the Administrator and Social Worker notified Resident #3 of the alleged breach and he/she declined further action.The Surveyor was unable to interview CNA #1, as she did not respond to the Department of Public Health's telephone or letter requests for an interview.During an interview on 05/21/26 at 10:01 A.M., the Director of Nurses (DON) said that she expected facility staff to keep all residents' personal information private and confidential. The DON said CNA #1 should not have shared Resident #3's information with anyone.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on records reviewed and interviews, for three of six sampled residents (Residents #1, #4, and #5), whose physician's orders included wound care and dressing changes, the facility failed to ensure professional standards of practice were maintained, when after completing dressing changes nursing staff did not document specific wound characteristics, as well as effectiveness of treatment, in accordance with nursing best practice and facility policy.Findings include:Review of the National Pressure Injury Advisory Panel (NPIAP) website, included the following:-The NPIAP emphasizes that all pressure injury care, including dressing changes, must be documented in a way that supports evidenced-based practice, quality improvement, and regulatory compliance.-Core documentation elements for dressing changes (aligned with NPIAP and related clinical guidelines) include:*Date, time, and location (body area) of the dressing change*Type of dressing used*Condition of the wound- size, depth, base (granulation-healing tissue, slough-tissue consisting of dead cells and bacteria, necrosis- dead tissue), drainage type/amount, odor, and color.*Surrounding skin condition*Patient response- pain level, comfort, adverse reactions.*Signs of infection or complications- redness, warmth, purulent drainage, odor.*Provider signature and date/time- to confirm the documentation is current and accurate.Review of the facility's policy titled Non-Sterile Dressing Change, dated August 2016, indicated the following:-Designated staff members will use non-sterile dressing techniques for all dressing changes unless otherwise indicated by physician or manufacturer guidelines.-Procedure includes:*Assess wound characteristics and determine appropriate interventions.*Document the dressing change in the medical record.1. Resident #1 was admitted to the facility in March 2026 diagnoses included Type 2 Diabetes Mellitus and acute and chronic respiratory failure. Review of Resident #1's Physician's Orders for the month of March 2026 indicated he/she had orders for the following:-Left heel unstageable (wound bed is covered with slough/dead tissue) pressure wound- cleanse with Normal Saline (NS), apply Betadine to entire wound and cover with dry gauze dressing daily and as needed for soilage (ordered 03/03/26 and discontinued 03/05/26).-Left heel Deep Tissue Pressure Injury (DTPI: persistent deep red, maroon, or purple discoloration from pressure)- cleanse with NS, apply Betadine to entire wound and cover with ABD pad and wrap with kling daily and as needed for soilage (ordered 03/05/26).-Right heel unstageable pressure wound- cleanse with NS, apply Betadine (topical antiseptic) to entire wound and cover with dry gauze dressing daily and as needed for soilage (ordered 03/03/26 and discontinued 03/05/26).-Right heel DTPI- cleanse with NS, apply Betadine to entire wound and cover with ABD and wrap with kling daily and as needed for soilage (ordered 03/05/26).-Stage 4 (full-thickness skin loss where extensive tissue damage extends through the fascia, exposing underlying bone, muscle, tendons, or joints) sacral wound: Cleanse with NS, apply calcium alginate to wound bed, to peri wound apply TRIAD and cover areas with large border foam/super absorbent dressing daily and as needed for soilage (ordered 03/03/26 and discontinued 03/05/26).-Stage 4 sacral wound: Cleanse with NS, apply Santyl (used to remove dead tissue from chronic skin ulcers) followed by calcium alginate (used for moderate to heavy wound drainage) to wound bed, to peri wound apply TRIAD and cover areas with large border foam/super absorbent dressing daily and as needed for soilage (ordered 03/05/26).-Right lateral lower leg venous ulcer: Cleanse with NS, apply calcium alginate to wound bed, cover with ABD pad and wrap with kling daily and as needed for soilage (ordered 03/03/26 and discontinued 03/05/26).-Right lateral lower leg venous ulcer: Cleanse with NS, apply Bactroban and cover with xeroform, cover with ABD pad and wrap with kling daily and as needed for soilage (ordered 03/05/26).-Left top of foot DTPI- Apply skin prep daily (ordered 03/03/26).Review of Resident #1's Treatment Administration Record (TAR) for the month of March 2026 indicated that although nurses were signing off on the TAR that they were changing his/her wound dressings daily, there was no documentation to support that nursing documented the wound appearance, drainage type and amount, and/or odor, during the daily dressing changes.2. Resident #4 was admitted to the facility in March 2026, diagnoses included paraplegia and (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	polyneuropathy.Review of Resident #4's Physician's orders for the month of May 2026 indicated he/she had orders for the following:-Sacrum unstageable pressure wound: cleanse with NS, apply calcium alginate to wound bed and cover with border foam dressing daily and as needed for soilage (ordered 04/30/26 and discontinued 05/07/26).-Sacrum unstageable pressure wound: cleanse with Vashe or wound cleanser, apply gentamycin to wound bed and they Santyl to necrotic areas followed by border foam dressing daily and as needed for soilage (ordered 05/07/26).Review of Resident #4's TAR for the month of May 2026 indicated that although nurses were signing off on the TAR that they were changing his/her wound dressing daily, there was no documentation to support that nursing documented the wound appearance, drainage type or amount, and/or odor, during the daily dressing changes.3. Resident #5 was admitted to the facility in March 2010 diagnoses included quadriplegia and history of traumatic brain injury (TBI).Review of Resident #5's Physician's orders for the month of May 2026 indicated he/she had orders for the following:-Sacrum stage 4 pressure wound: Cleanse with NS, apply calcium alginate with border foam dressing daily and as needed for soilage (ordered 4/30/26 and discontinued 05/14/26).-Sacrum stage 4 pressure wound: Cleanse with Vashe solution, apply calcium alginate to wound bed and TRIAD to peri wound, cover with border foam dressing daily and as needed for soilage (ordered 05/14/26).-Right buttock DTPI: Cleanse with NS, apply calcium alginate and cover with foam dressing daily and as needed for soilage (ordered 05/07/26 and discontinued 05/14/26).-Right buttock DTPI: Cleanse with Vashe solution, apply collagen followed by calcium alginate and cover with foam border dressing daily and as needed for soilage (ordered 05/14/26).Review of Resident #5's TAR for the month of May 2026 indicated that although nurses were signing off on the TAR that they were changing his/her wound dressing daily, there was no documentation to support that nursing documented the wound appearance, drainage type or amount, and/or odor, during the daily dressing changes.During an interview on 05/21/26 at 11:51 A.M., the Director of Nurses (DON) said it was her expectation that the nurses document the location of the wound, drainage type and amount, if the resident had any pain during the dressing change, and if there are any signs or symptoms of infection, with each dressing change on the resident's Treatment Administration Record. The DON said she was unaware the option for nurses to document the specific wound characteristics was not available on each resident's TAR. The DON said it was important because it would help the nurses quickly identify a change or deterioration in a resident's wound status.