STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225305	A. Building B. Wing	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Mary Health Care Center	39 Queen Street Worcester, MA 01610

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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

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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on records reviewed and interviews for one of three sampled residents, (Resident #1), who had an invoked Health Care Proxy, the facility failed to ensure his/her representative was notified when he/she developed an alteration of his/her skin integrity to his/her buttocks and a fluid filled blister on his/her left foot, requiring physician ordered treatments.Findings include:Review of the Facility's policy, titled Notification of Changes, dated 08/2024, indicated the following:-The purpose of the policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his/her authority, the resident's representative when there is a change requiring notification.-Circumstances requiring notification include: A new treatment.Resident #1 was admitted to the facility in February 2023, diagnoses included Type II Diabetes Mellitus and vascular dementia.Review of Resident #1's medical record indicated his/her Health Care Agent (HCA) was invoked permanently due to severe dementia on 08/12/2020 (prior to admission to the facility).Review of Resident #1's Physician's Order Review Report indicated his/her Health Care Agent was invoked upon admission to the facility.During a telephone interview on 10/28/25 at 9:38 A.M., Family Member #1 (HCA) said that she had not been notified of any changes in Resident #1's skin condition until Resident #1 was transferred from the facility to the Hospital Emergency Department on 09/12/25. Family Member #1 said she called the facility weekly and was not notified of the impaired skin condition to Resident #1's buttocks or feet.Review of Resident #1's Physician's Orders for the month of September 2025 indicated he/she had an order dated 09/02/25, to apply Calazinc (cream used to protect the skin from moisture) to his/her buttocks every shift.During a telephone interview on 10/30/25 at 8:02 A.M., Nurse #2 said she completed Resident #1's Skin Check Form on 09/01/25 and Resident #1's buttocks were very excoriated. Nurse #2 said if she had notified Resident #1's HCA of his/her change in skin condition, she would have documented it on the Skin Check Form.Review of Resident #1's Skin Check Form, dated 09/01/25, indicated Resident #1 had a new area of Moisture Associated Skin Damage (MASD) on his/her buttocks. The box on the form that nursing completed to indicate if the family/HCA had been notified was left blank.Review of Resident #1's Nursing Progress Note, dated 09/10/25, indicated Resident #1 had a newly acquired fluid filled blister on his/her left medial (inside aspect of) foot.Review of Resident #1's Treatment Administration Record (TAR) for the month of September 2025 indicated he/she had a new Physician's order, dated 09/11/25, to cleanse the left foot blister with normal saline, apply skin prep (forms a protective film on the skin) to the area and edges, and leave the area open to air twice per day.During an interview on 10/29/25 at 1:22 P.M., Nurse #4 said she discovered Resident #1's left foot blister on 09/10/25 and attempted to call Resident #1's HCA but the call would not go through, and she did not reattempt. During a telephone interview on 10/30/25 at 8:02 A.M., Nurse #2 said Resident #1 was on her assignment on the 7:00 A.M. through 3:00 P.M. (day) shift on 09/11/25. Nurse #2 said she assumed Resident #1's HCA had been notified of his/her newly acquired foot blister at the time it was discovered.Review of Resident #1's medical record indicated there was no documentation to support that Resident #1's HCA had been notified of Resident #1's changes in skin condition on 09/01/25 or 09/10/25.During a telephone interview on 10/30/25 at 10:02 A.M., the Director of Nurses (DON) said it was his expectation that Resident #1's Health Care Agent should have been notified of his/her change in skin condition on both 09/01/25 and 09/10/25. The DON said it was part of facility protocol to notify the family/HCA at the same time the provider is notified of a change in resident condition.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Based on records reviewed and interviews, for one of three sampled residents (Resident #1), the Facility failed to ensure he/she was provided with quality of care that met professional standards of practice, when he/she did not receive routine laboratory testing to ensure his/her Type 2 Diabetes Mellitus was controlled, when on 09/12/25 he/she experienced a significant change in condition, was found to be hyperglycemic (elevated blood sugar level) with critically high blood sugar reading, he/she required transfer to the Hospital Emergency Department (ED) for evaluation and was admitted for treatment. Findings include:Review of the Facility's policy, titled Diabetes, undated, indicated the following:-For residents who meet the criteria for diabetes testing, the Physician will order pertinent screening; for example [Hg] A1c (Hemoglobin A1c is a test that measures the average glucose level over the previous two to three months).Review of the American Diabetes Association website indicated the following:- A1C testing should be performed routinely in all people with diabetes at initial assessment and as part of continuing care. Measurement approximately every 3 months determines whether glycemic goals have been reached and maintained. Adults with type 1 or type 2 diabetes who have achieved and are maintaining glucose levels within their target range may only need A1C testing or other glucose assessments twice a year. Resident #1 was admitted to the Facility in February 2023, diagnoses included Type 2 Diabetes Mellitus and vascular dementia.Review of Resident #1's medical record indicated his/her Health Care Agent (HCA) was invoked permanently due to severe dementia on 08/12/2020 (prior to admission to the facility).Review of Resident #1's Physician's Order Review Report indicated his/her Health Care Agent's invocation was continued upon admission to the facility.During a telephone interview on 10/28/25 at 9:38 A.M., Family Member #1 (HCA) said that on 09/12/25 she was notified that Resident #1 was unresponsive, his/her blood sugar level was 611 milligrams/deciliter (mg/dl) (critically high, normal range is 70 mg/dl to 120 mg/dl) and he/she was being transferred to the Hospital ED for an evaluation. Family Member #1 said she wondered if the facility staff knew which residents had Diabetes Mellitus.Review of the Hospital ED Report, dated 09/12/25, indicated Resident #1 was admitted to the hospital with diagnoses of hyperosmolar hyperglycemic state (HHS- a serious complication of diabetes that happens when blood sugar levels are very high for a long period of time. Symptoms of HHS can include extreme thirst, frequent urination and confusion. HHS is an emergency that requires immediate medical care.) and hypernatremia (elevated sodium levels).Review of Resident #1's Diabetes Mellitus (DM) Care Plan, reviewed and renewed with the last Minimum Data Set (MDS) Assessment, indicated the goal was for Resident #1 to be free from any sign or symptom of hyper/hypoglycemia (high/low blood sugar) and have no complications related to DM.Further review of the Care Plan indicated for nursing to document and report any signs or symptoms of hyperglycemia: increased thirst, frequent urination, weight loss, poor wound healing, stupor, coma.Review of Resident #1's Nursing Progress Note, dated 09/12/25 at 5:38 P.M., indicated Resident #1 was observed leaning forward in his/her wheelchair and continued to lean forward despite repositioning, had been sleeping on and off throughout the day, and refused breakfast and lunch. The Nurse Practitioner was notified and ordered a urinalysis with culture and sensitivity, complete blood count and basal metabolic panel (laboratory tests). Review of Resident #1's Nursing Progress Note, dated 09/12/25 at 10:01 P.M., indicated Resident #1's laboratory results were reported, his/her glucose level was 611 mg/dl [critically high] and his/her sodium level was 160 mmol/l (millimoles/liter) [critically high- normal range is 133-145 mmol/l].Further review of the Note indicated Resident #1 was being transferred to the Hospital Emergency Department for an evaluation.During an interview on 10/29/25 at 12:47 P.M., Nurse #1 said she was on duty 09/12/25 for the day (7:00 A.M. through 3:00 P.M.) shift and the evening (3:00 P.M. through 11:00 P.M.) shift, that Resident #1 was on her assignment and was well known to her. Nurse #1 said that beginning in the morning on 09/12/25, Resident #1 was lethargic and did not look like him/herself. Nurse #1 said Resident #1's lethargy continued throughout the day and the other nurse on duty (Nurse #2) called the Nurse Practitioner for new orders.Nurse #1 said that she did not know Resident #1 had Diabetes Mellitus and said if she had known, she would have checked his/her finger stick blood sugar (blood sample taken from the fingertip for immediate blood glucose result) as part of her assessment.Although Nurse #1 said she was unaware that Resident #1 had DM, Nurse #1 was signing off on Resident #1's Treatment Administration Record (TAR) that she had provided Diabetic Foot Care (DFC) to him/her multiple evening shifts in August and September 2025. Review of Resident #1's TAR for the months of August and September 2025 indicated Nurse #1 signed off as providing DFC to him/her on 08/12/25, 08/16/25, 08/19/25, 08/22/25, 08/30/25