| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225305 | A. Building<br>B. Wing | 12/18/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Mary Health Care Center | 39 Queen Street<br>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 0637<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assess the resident when there is a significant change in condition<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51466<br><br>Based on interview, and record review, the facility failed to identify and complete in the required time frame, a Minimum Data Set (MDS) for a Significant Change in Status Assessments (SCSA) for two Residents (#9 and #34) out of a total sample of 21 residents.<br><br>Specifically, the facility failed to:<br><br>1. For Resident #9, complete a SCSA within 14 days after the Resident had a decline in bowel functioning, bladder functioning, and a new pressure injury.<br><br>2. For Resident #34, complete a SCSA within 14 days after the Resident was admitted to a Hospice program.<br><br>Findings include:<br><br>Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.19.1 dated October 2024 indicates:<br><br>-A significant change is a major decline or improvement in a resident's status that:<br><br>>Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered self-limiting.<br><br>>Impacts more than one area of the resident's health status.<br><br>>Requires interdisciplinary review and/or revision of the care plan.<br><br>-The SCSA is appropriate when:<br><br>>There is determination that a significant change (either improvement or decline) in a resident's condition from their baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent quarterly assessments.<br><br>(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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225305 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/18/2024 |
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| F 0637<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | >A SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The Assessment Reference Date (ARD) must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). A SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place.<br><br>Review of the facility policy titled Admission Criteria, dated 2/2024, indicated:<br><br>-Definition of a Significant Change - A major decline or improvement in an individual's status that:<br><br>a. In the case of a decline, will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered self-limiting.<br><br>b. Impacts more than one area of the resident's health status.<br><br>c. Requires interdisciplinary review or revision of the care plan .<br><br>1. Resident #9 was admitted to the facility in October 2020.<br><br>Review of Resident #9's MDS assessment dated [DATE], indicated:<br><br>-Resident #9 was frequently incontinent of bladder function<br><br>-Resident #9 was frequently incontinent of bowel function<br><br>-Resident #9 had no pressure injury<br><br>Review of Resident #9's most recent MDS assessment dated [DATE], indicated the following:<br><br>-Resident #9 was always incontinent of bladder function<br><br>-Resident #9 was always incontinent of bowel function<br><br>-Resident #9 had a Stage 3 pressure injury<br><br>During an interview on 12/18/24 at 9:18 A.M., MDS Nurse #1 said that Resident #9 should have had a Significant Change MDS Assessment completed during the most recent assessment period with an Assessment Reference Date (ARD) of 1/2/24, when facility staff identified a decline in bowel function, a decline in bladder function, and a change in skin condition with the development of a Stage 3 pressure injury.<br><br>50320<br><br>2. Resident #34 was admitted to the facility in August 2021.<br><br>(continued on next page) |

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| F 0637<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #34's clinical record indicated the Resident had a Physician's order to admit to Hospice services effective 9/10/24.<br><br>Review of the Resident's MDS Assessments indicated no SCSA was completed within 14 days of Resident #34 signing onto Hospice services.<br><br>Further review of the Resident's clinical record the MDS Nurse Progress Notes dated 11/19/24, indicated:<br><br>-The Resident had experienced a significant change related to signing on to Hospice services on 9/9/24.<br><br>-A SCSA was not completed within the required time frame per guidelines.<br><br>-A SCSA was initiated on 11/19/24 to capture the Resident's current status and ensure accurate planning.<br><br>During an interview on 12/17/24 at 11:59 A.M., the MDS Nurse said the SCSA was late and was not done within the 14 days as required because she was unaware of the start of Hospice services. The MDS Nurse said the significant change MDS should have been completed within 14 days of the Resident's sign on to Hospice, but it was not completed. |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>44222<br><br>Based on record review, and interview, the facility failed to coordinate an assessment with the Preadmission Screening and Resident Review (PASRR - a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care) program for two Residents (#13 and #84) out of a total sample of 21 residents.<br><br>Specifically, the facility failed to complete a new Level I PASRR Assessment for:<br><br>1. For Resident #13, when there was a significant change in status on two dates with behavioral changes identified, new diagnoses of Major Depressive Disorder on 11/30/23 and Delusional Disorders on 7/30/24, were added to the Resident's clinical record, and adjustments to the Resident's psychotropic medication and plan of care were made.<br><br>2. For Resident #84, when there was a significant change in status on 2/8/22 with behavioral changes identified, a new diagnosis of Psychotic Disorder with delusions due to known physiological condition was added to the Resident's clinical record, and adjustments to the Resident's antipsychotic medication and plan of care were made.<br><br>Findings include:<br><br>Review of the facility policy titled Admission Criteria, reviewed 2/2024, included:<br><br>-The facility will notify the State mental health authority or State intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental health illness or intellectual disability for resident review.<br><br>-Definition of Significant Change- A major decline or improvement in an individual's status that Requires interdisciplinary review or revision of the care plan May result in a positive Level I Screening for SMI (SMI-Serious Mental Illness) or may result in a change in previous PASRR determinations.<br><br>1. Resident #13 was admitted to the facility in July 2023 with diagnoses including Dementia and Diabetes.<br><br>Review of the PASRR assessment completed for the Resident on the day of admission to the facility, indicated that the Resident did not have any documented SMI.<br><br>Review of the Resident's clinical record included a list of diagnoses which indicated:<br><br>-Major Depressive Disorder was added on 11/30/23<br><br>-Delusional Disorders was added on 7/30/24<br><br>Review of the Resident's Behavioral Health Consultant Progress Notes indicated:<br><br>(continued on next page) |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | >11/30/23:<br><br>-may benefit from antidepressant for management of Depression<br><br>-Primary Diagnosis: Major Depressive Disorder<br><br>-Recommend to start Zoloft (antidepressant medication) 25 milligrams (mg) by mouth daily for Depression.<br><br>>12/28/23:<br><br>-chief complaint Depression<br><br>-managed with .Zoloft 25 mg, seen today following medication changes<br><br>-plan to continue current medication regime, recommend to document mood .<br><br>>8/29/24:<br><br>-Diagnosis of Delusional Disorders<br><br>-Target symptoms: agitation, behavioral disturbance<br><br>-managed with Zyprexa (antipsychotic medication - a class of drugs used to treat symptoms of psychosis, including hallucinations, delusions, and Dementia) 2.5 mg QAM (each morning) + 5 mg HS (at hour of sleep).<br><br>During an interview on 12/17/24 at 11:25 A.M., the Social Worker (SW) said that the Resident should have had a new Level I PASRR screening done when a new SMI was identified and added to the Resident's diagnosis profile. The SW said that a new PASRR Level I screen should have been submitted to the PASRR Portal on 11/30/23 when a diagnosis of Major Depressive Disorder was added to the Resident's diagnosis list, and on 7/30/24 when a diagnosis of Delusional Disorder was added to the Resident's diagnosis list, but the PASRR screen had not been submitted.<br><br>2. Resident #84 was admitted to the facility in December 2021 with diagnoses including Unspecified Dementia with behavioral disturbance and Failure to Thrive.<br><br>Review of the PASRR assessment completed for the Resident on the day of admission to the facility, indicated that the Resident did not have any documented SMI.<br><br>Review of a Physician's order dated 2/8/22, indicated to add a diagnosis of Psychotic Disorder with Delusions due to known physiological condition.<br><br>Review of the Resident's clinical record included a list of diagnoses which indicated:<br><br>-Psychotic Disorder with delusions due to known physiological condition was added on 2/9/22<br><br>Review of the Resident's clinical record included:<br><br>(continued on next page) |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Nursing Progress Note dated 2/9/22, Olanzapine (antipsychotic medication) 5 milligrams (mg) by mouth every morning and at bedtime<br><br>-Physician Progress Note dated 2/19/22 .much better adjusted now .patient is on Zyprexa (OLANZapine).<br><br>During an interview on 12/17/24 at 11:44 A.M., the Social Worker (SW) said that the Resident should have had a new Level I PASRR screening done when a new SMI was identified and added to the Resident's diagnosis profile. The SW said the Resident should have had a new PASRR Level I screening submitted when the new diagnosis of Psychotic Disorder with delusions due to known physiological condition was added to the Resident's diagnoses profile on 2/9/22, but the screen had not been done. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45429<br><br>Based on observation, record review, and interview, the facility failed to ensure the environment was free from accidents and hazards for one Resident (#24) out of a total sample of 21 residents.<br><br>Specifically, the facility failed to ensure hazardous items (razor blades) were not stored on the Resident's bedside table and easily accessible to Resident #24, who had a history of suicidal ideation (thoughts or ideas centered around death or self-harm) and other cognitively impaired residents on the unit.<br><br>Findings include:<br><br>Review of the facility policy for Behavioral Health Services, last reviewed February 2024 , indicated:<br><br>-the facility will provide, and residents will receive behavioral health services as needed to attain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care.<br><br>-staff must promote dignity, autonomy, privacy, socialization and safety as appropriate for each resident and are trained in ways to support residents in distress.<br><br>Review of Resident #24's medical record indicated the Resident had a Guardian (a court appointed person who makes important personal and healthcare decisions for an adult who lacks the capacity to make their own decisions) in place since 9/28/20.<br><br>Resident #24 was admitted to the facility in January 2023 with diagnoses including Anxiety, Major Depressive Disorder and Cognitive Communication deficit.<br><br>Review of Resident #24's clinical record revealed a Nurses Progress Note written by the Director of Nursing (DON) dated 2/12/24 that indicated:<br><br>-the Resident has broken a fork with a plan to harm him/herself.<br><br>-the Resident's room had been searched and all utensils, razors and clippers had been removed from the room.<br><br>-the intervention was to provide plastic utensils for all meals and that the Nurses were to provide the Resident with razors or nail clippers.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #24 had moderate cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 10 out of 15.<br><br>Review of the Resident #24's care plans last reviewed 11/12/24, indicated:<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -the Resident has a court appointed Guardian.<br><br>-the Resident is dependent on staff for physical needs due to cognitive deficits.<br><br>-the Resident has an ADL self-care performance and mobility deficit.<br><br>-the Resident requires skin inspection every week and during care. Observe for redness, open areas, scratches, cuts, bruises and report changes to the Nurse.<br><br>-on 2/12/24, the Resident verbalized making weapon out of a fork, related to Depression and suicidal ideation.<br><br>-the Resident has a history of making accusations towards staff, sexually harassing the opposite gender and making inappropriate comments towards others.<br><br>-an intervention to monitor the Resident for change in behavior/mood/cognition, hallucinations/delusions, social isolation, suicidal thoughts, withdrawal.<br><br>-an intervention to monitor/document/report as needed any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing meds or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness.<br><br>Review of the Nurse-to-Nurse Report sheet provided to the surveyor on 12/12/24 indicated that Resident #24 had a history of suicidal ideation and should have plastic silverware at all meals.<br><br>On 12/12/24 at 11:26 A.M., the surveyor observed three disposable razor blades laying on top of Resident #24's bedside dresser. During an interview at the time, Unit Manager (UM) #1 said that the razors should not have been at the Resident's bedside as he/she has made a shiv (a handcrafted weapon resembling a knife) in the past. UM #1 was observed removing the three disposable razor blades from the Resident's room.<br><br>During an interview on 12/16/24 at 2:07 P.M., the DON said that the disposable razors should not have been on Resident #24's bedside table.<br><br>Please Refer to F742 |

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| F 0732<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>45429<br><br>Based on record review, and interview, the facility failed to post the required nurse staffing information daily.<br><br>Specifically, the facility failed to:<br><br>-post the total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: >Registered Nurses (RN), >Licensed Practical Nurses (LPN) or Licensed Vocational Nurses (LVN), >and Certified Nurses Aides (CNA).<br><br>-maintain a copy of the staffing records for 18 months as required.<br><br>Findings include:<br><br>During the facility survey, the surveyor observed that the nurse staffing information was posted in the front lobby on the following days:<br><br>-12/12/24<br><br>-12/16/24<br><br>-12/17/24<br><br>The surveyor observed that the nurse staffing postings did not include the total number of hours and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: RNs, LPNs, LVNs, and CNAs.<br><br>On 12/17/24, the surveyor requested copies of the nurse staffing information for the month of December 2024 which was provided by the facility Administrator.<br><br>Review of all the nurse staff postings provided by the facility for the month of December 2024 did not include the total number of hours and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: RNs, LPNs, LVNs, and CNAs.<br><br>During an interview on 12/17/24 at 1:53 P.M., the Administrator said he was unaware that the actual and total number of hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift needed to be on the nursing staff posting. The Administrator also said the facility has not been maintaining the posted daily staffing for 18 months as required and they should have been. |

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| F 0742<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45429<br><br>Based on record review, and interview, the facility failed to provide mental health services for one Resident (#24) out of a total sample of 21 residents, with a documented history of mental health concerns.<br><br>Specifically, the facility failed to assess Resident #24's mental health status in timely manner after he/she expressed a plan to self-harm.<br><br>Findings include:<br><br>Review of the facility policy for Suicide Threats, last reviewed 2/2024, indicated:<br><br>-Resident suicide threats shall be taken seriously and addressed appropriately.<br><br>-all nursing personnel and other staff involved in caring for the resident shall be informed of the suicide threat and instructed to report changes in the resident's behavior immediately.<br><br>-as indicated, a psychiatric consultation or transfer for emergency psychiatric evaluation may be initiated.<br><br>-if the resident remains in the facility, staff will monitor the resident's mood and behavior and updated care plans accordingly, until a physician has determined the risk does not appear to be present.<br><br>-staff shall document details of the situation objectively in the Resident's record.<br><br>Review of the facility policy for Behavioral Health Services, last reviewed 2/2024, indicated:<br><br>-the facility will provide, and residents will receive behavioral health services as needed to attain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care.<br><br>-staff must promote dignity, autonomy, privacy, socialization and safety as appropriate for each resident and are trained in ways to support residents in distress.<br><br>Resident #24 was admitted to the facility in January 2023 with diagnoses including Anxiety, Major Depressive Disorder and Cognitive Communication deficit.<br><br>Review of Resident #24's medical record indicated he/she had a Guardian in place since 9/28/20.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #24 had moderate cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 10 out of 15.<br><br>(continued on next page) |

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| F 0742<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #24's care plans last reviewed 11/12/24, indicated the Resident:<br><br>-has a court appointed Guardian.<br><br>-is dependent on staff for physical needs due to cognitive deficits.<br><br>-has an ADL self-care performance and mobility deficit.<br><br>-requires skin inspection every week and during care. Observe for redness, open areas, scratches, cuts, bruises and report changes to the Nurse.<br><br>-on 2/12/24, the Resident verbalized making a weapon out of a fork, related to Depression and suicidal ideation.<br><br>-the Resident has a history of making accusations towards staff, sexually harassing the opposite gender and making inappropriate comments towards others.<br><br>-an intervention to monitor the Resident for change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal.<br><br>-an intervention to monitor/document/report as needed any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness.<br><br>Review of Resident #24's clinical record with a Nurses Progress Note written by the Director of Nursing (DON) dated 2/12/24, that indicated:<br><br>-the Resident has broken a fork with a plan to harm him/herself.<br><br>-the Resident's room had been searched and all utensils, razors and clippers had been removed from the room.<br><br>-the intervention was to provide plastic utensils for all meals and that the nurses were to provide him/her with razors or nail clippers.<br><br>-the DON made a verbal contract with the Resident for safety (term used to describe an agreement between a patient and a clinician to reduce the risk of self-harm or suicide).<br><br>-the DON notified the Physician and the Physician would meet with the Resident.<br><br>-that Psychiatric services would meet with the Resident.<br><br>Further review of Resident #24's clinical record indicated that the Resident was not seen/assessed by the Physician or Psychiatric services until 2/15/24, three days after the Resident indicated suicidal expression.<br><br>(continued on next page) |

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| F 0742<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 12/16/24 at 2:07 P.M., the DON said that the Resident had been assessed for safety. The DON also said that she had been concerned that Resident #24 would harm another person as well as him/herself. The facility was unable to provide documentation that the Resident had been assessed for risk of self-harm by a Clinician prior to 2/15/24, and any evidence that the Resident had been continuously monitored for safety.<br><br>During an interview on 12/17/24 at 11:32 A.M., Social Worker (SW) #1 said that when a Resident expresses wanting to self-harm that the expectation is to provide one-on-one supervision with the Resident until they can be seen by the Consulting Psychiatric team to be assessed for risk and safety. SW #1 also that that if the Resident cannot be seen onsite in the building, then the Resident should be sent out for a psychological evaluation at the hospital.<br><br>During an interview on 12/18/24 at 11:38 A.M., Physician #1 said that she had not been present in the facility when Resident #24 had expressed suicidal ideation and that the DON had notified her of the Resident's state. Physician #1 also said that Resident #24 had a long history of mental health concerns, paranoid delusions, a history of suicidal ideation, and had been sent out to the hospital by Physician #1 in the past for suicidal statements. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225305 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/18/2024 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 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.

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>51466<br><br>Based on observation, and interview, the facility failed to ensure that pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) were available to meet the needs of each resident in the facility for two medication storage rooms (Fourth and Fifth Floor Units).<br><br>Specifically, the facility failed to ensure that Insulin (medication used to treat Diabetes) emergency medication kits (E-Kits) were re-ordered and replaced timely by the Pharmacy after being opened.<br><br>Findings Include:<br><br>Review of the facility Pharmacy policy titled Emergency Kit Policy & Procedure dated 01/01/2024, indicated the following:<br><br>-A portable emergency kit or kits shall be made available for immediate administration of a medication not otherwise obtainable in the time required. The emergency kits are not a source of supplemental supply but are for emergency use.<br><br>-The nurse will complete a full record of the drug withdrawal from the emergency kit on the emergency kit usage log. The pharmacy copy of this log is placed inside the emergency kit and is returned to the pharmacy with the kit after use.<br><br>-The pharmacy shall be notified (by fax back sheet, or E-Kit pickup call) of the use of the emergency kit prior to the next scheduled delivery.<br><br>-The pharmacy must exchange open emergency kits during the next business day after the kit is opened. Kits are not exchanged on holidays or outside of regular Monday thru Friday business days.<br><br>-The pharmacy will send a new emergency kit and pick up the used one within the next routine day of business.<br><br>On 12/17/24 at 8:38 A.M., the surveyor and Nurse #2 observed the Fifth Floor Medication Storage Room. Nurse #2 identified the Emergency Insulin kit was opened and had medication receipts dated 7/22/24 and 12/15/24, indicating the Insulin E-Kit was opened on 7/22/24 and medications had been removed on 7/22/24 and 12/15/24. During an interview at the time, Nurse #2 said that the Insulin E-kit had been opened on 7/22/24. Nurse #2 inventoried the open kit and said that a Humalog Quick Pen (rapid acting insulin) had been removed on 7/22/24 and Lantus Insulin (long-acting insulin) had been removed on 12/15/24. Nurse #2 said whenever an E-Kit is opened, the Nurse fills out a medication receipt for what was removed and sends it to the Pharmacy for re-ordering on the same day. Nurse #2 further said that a new E-kit usually gets delivered within a day of re-ordering. Nurse #2 was unable to provide evidence that the Insulin E-kit had been re-ordered from the Pharmacy after being opened on 7/22/24 and said that is should have been ordered but was not.<br><br>(continued on next page) |

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

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|---|---|
| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 12/17/24 at 9:24 A.M., the surveyor and Nurse #3 observed the Fourth Floor Medication Storage Room. Nurse #3 identified the Insulin E-kit was opened and had a medication receipt dated 12/10/24, indicating that the E-kit was opened, and medication was removed on 12/10/24. During an interview at the time, Nurse #3 said that the Insulin E-kit was open and then inventoried the contents of the kit and said that Glargine Insulin (long-acting, synthetic version of insulin) was removed on 12/10/24. Nurse #3 was unable to provide evidence that the E-kit had been re-ordered from the Pharmacy, and that it should have been re-ordered when it was opened on 12/10/24. Nurse #3 said whenever an E-kit is opened, it should be re-ordered the same day and usually is delivered by the Pharmacy the next day. Nurse #3 also said that if the E-kit is not delivered the next day, it is the Nurses' responsibility to call the Pharmacy and further request the E-kit get delivered to have the medications on hand in case of an emergency. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 225305 | A. Building<br>B. Wing | 12/18/2024 |

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

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| F 0772<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Have an agreement with an approved laboratory to obtain services, if on-site laboratory services aren't provided.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50320<br><br>Based on record review, and interview, the facility failed to provide laboratory services for one Resident, (#33), out of a total sample of 21 residents.<br><br>Specifically, the facility failed to obtain blood tests every three months for Resident #33 as ordered by the Resident's Physician.<br><br>Findings include:<br><br>Review of the facility policy Lab and Diagnostic Test Results - Clinical Protocol, Reviewed February of 2024 indicated:<br><br>-The physician will identify, and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs.<br><br>-The staff will process test requisition and arrange for tests.<br><br>Resident #33 was admitted to the facility in November 2017 with diagnoses including Schizophrenia, Major Depressive Disorder and Benign Prostatic Hyperplasia.<br><br>Review of Resident #33's most recent Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of nine out of 15 points.<br><br>Review of Resident #33's clinical record indicated:<br><br>-An active Physician's order dated 12/6/21, to check fingerstick blood sugar (FSBS), white blood cell count (WBC), absolute neutrophil count (ANC), Basic Metabolic panel (BMP) this month and every three months.<br><br>-A WBC and BMP blood draw had been completed on 9/20/24.<br><br>-The clinical record showed no evidence the ANC and FSBS had been completed since 12/6/21, or that the WBC and BMP had been completed on any date other than the 9/20/24 blood draw.<br><br>During an interview on 12/17/24 at 8:38 A.M., the Unit Manager (UM) said an active order for labs such as the ones written for Resident #33 should have been completed or clarified with the Physician whether the labs were still needed.<br><br>During an interview on 12/17/24 at 9:53 A.M., the Director of Nursing (DON) said the order for blood tests for Resident #33 was still active as of 12/16/24. The DON was unable to provide evidence that the ANC, FSBS, WBC and BMP labs were drawn as ordered for Resident #33. |

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

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| F 0776<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50320<br><br>Based on record review, and interview, the facility failed to provide or obtain diagnostic services for one Resident (#4) out of a total sample of 21 residents.<br><br>Specifically, the facility failed to provide electrocardiogram (EKG- a test which records the electrical activity of the heart through repeated cardiac cycles) testing every six months for Resident #4 as ordered by the Resident's Physician for monitoring of antipsychotic medication use.<br><br>Findings include:<br><br>Review of the facility policy Lab and Diagnostic Test Results - Clinical Protocol, Reviewed February 2024 indicated:<br><br>-The physician will identify, and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs.<br><br>-The staff will process test requisition and arrange for tests.<br><br>Resident #4 was admitted to the facility in January 2022 with diagnoses including Unspecified Systolic Congestive Heart Failure, Major Depressive Disorder, and Borderline Personality Disorder.<br><br>Review of Resident #4's most recent Minimum Data Set (MDS) assessment dated [DATE] indicated the Resident:<br><br>-was significantly cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of 15 points.<br><br>-had heart failure<br><br>-was taking an antipsychotic medication.<br><br>Review of Resident #4's clinical record indicated:<br><br>-The Resident had an active order dated 7/10/22 for an EKG, repeat every six months: on psychotropic medications.<br><br>-No evidence found in the clinical record that any EKGs had been completed<br><br>During an interview on 12/17/24 at 8:40 A.M., the Unit Manager (UM) said the orders for Resident #4 to have an EKG every six months should have been being completed or clarified with the Physician whether they were still needed. The UM said the Resident had an EKG in 2023 but she was unable to confirm if any other EKGs had been performed since 2023. The UM said she spoke with the Resident's Physician and clarified the order for the EKGs and an EKG was going to be scheduled for the Resident.<br><br>(continued on next page) |

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

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| F 0776<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 12/17/24 at 9:53 A.M., the Director of Nursing (DON) said the order for the Resident to receive an EKG every six months was an active order as of 12/16/24. The DON was unable to provide evidence that any EKGs were completed in the last year. The DON said the orders for the EKG had been clarified with the Physician.<br><br>Review of the Active Physician's orders for Resident #4 dated 12/17/24, indicated the Resident should receive an EKG every three months: report results to the Physician. |

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

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>51466<br><br>Based on observation, interview, and record review, the facility failed to adhere to infection control standards to prevent the potential transmission of communicable diseases and infections for one Resident (#9) out of a total sample of 21 residents.<br><br>Specifically, the facility failed to ensure that staff performed proper hand hygiene between glove changes while providing wound care to Resident #9 to prevent contamination and the spread of infections.<br><br>Findings include:<br><br>Review of the facility policy titled Hand Hygiene Policy, dated 1/1/24 - 12/31/24 indicated:<br><br>-Hand Hygiene: cleaning your hands with either antiseptic hand rubs (i.e. alcohol-based hand sanitizer including foam or gel) or by handwashing (with soap and water).<br><br>-The Centers of Disease Control (CDC) and Prevention Hand Hygiene Guidelines in Healthcare Settings will be followed:<br><br>1. Alcohol-based hand sanitizers are the preferred method for hand hygiene, as it reduces the number of microorganisms on hands. Hand Sanitizers must be 60-95% alcohol.<br><br>>When to wash with alcohol-based sanitizer:<br><br>-before and after glove use<br><br>-before and after procedure or treatment administration<br><br>2. Using gloves does not replace the need for hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.<br><br>Resident #9 was admitted to the facility in October 2020, with diagnoses including Alzheimer's Disease, Atrial Fibrillation, and Congestive Heart Failure.<br><br>Review of Resident #9's Comprehensive Care Plan indicated:<br><br>-Resident has a MASD (Moisture Associated Skin Disorder)/Stage 4 (pressure injury that extends to muscle, tendon, or bone) Sacro-Coccyx from ulcer related to disease process, history of ulcers, immobility and diagnosis of protein-calorie malnutrition, effective 10/11/23<br><br>-Risk for infection related to sacro-coccyx wound with an intervention to maintain Enhanced Barrier Precautions (EBP: an infection control intervention designed to reduce transmission of multidrug resistance organisms that employs targeted gown and glove use during high contact resident care activities) every shift for close contact until wound is healed, effective 10/2/24<br><br>(continued on next page) |

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

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #9's December 2024 Physician orders indicated:<br><br>-Maintain Enhanced Barrier Precautions (EBP) every shift: May discontinue precautions once wound is resolved.<br><br>-Treatment for Sacro-coccyx wound:<br><br>1) Cleanse with wound cleanser spray<br><br>2) Pat dry with gauze<br><br>3) Lightly pack wound with Iodoform packing strip (an antimicrobial packing)<br><br>4) skin prep (fast drying liquid skin protectant) peri-wound (surrounding area of the wound) and wound edges<br><br>6) Cover with white border gauze BID (twice a day) and as needed (PRN) for soilage<br><br>On 12/18/24 at 8:05 A.M., the surveyor observed Nurse #1 and CNA #2 provide the following wound care for Resident #9's sacro-coccyx wound:<br><br>-Nurse #1 and CNA #2 performed proper hand hygiene prior to entering room and put on (donned) gown and gloves.<br><br>-Nurse #1 and CNA #2 assisted the Resident into a right-side lying position.<br><br>-Nurse #1 removed (doffed) her gloves and donned new gloves without performing hand hygiene.<br><br>-Nurse #1 doffed Resident #9's brief, removed her gloves and put on new gloves without performing hand hygiene.<br><br>-Nurse #1 doffed the soiled dressing and disposed of it. She then doffed her gloves and donned new gloves without performing hand hygiene.<br><br>-Nurse #1 assessed the wound, by touching the wound and surrounding tissue. She then doffed her gloves and donned new gloves without performing hand hygiene.<br><br>-Nurse #1 told the surveyor that she needed to measure the wound, removed the sterile Q-Tip's from the nearby table, removed one Q-Tip from the package, put the other Q-Tip's back onto the nearby table, and used the sterile wrapping to measure the wound.<br><br>-Nurse #1 doffed her gloves and donned new gloves on without performing hand hygiene.<br><br>-Nurse #1 picked up her supplies off the nearby table and cleansed the wound according to the Physician orders.<br><br>-Nurse #1 went into the bathroom and performed hand hygiene with soap and water and donned new gloves.<br><br>(continued on next page) |

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| | 225305 | A. Building<br>B. Wing | 12/18/2024 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Nurse #1 dried the wound, doffed her gloves and donned new gloves without performing hand hygiene.<br><br>-Nurse #1 applied skin prep to the wound according to the Physician orders, then doffed her gloves and doffed new gloves without performing hand hygiene.<br><br>-Nurse #1 used her scissors from the nearby table to cut the Iodoform packing to size and applied the dressing to the wound according to Physician orders.<br><br>-Nurse #1 doffed her gloves and reapplied new gloves without performing hand hygiene.<br><br>-Nurse #1 applied the white border foam dressing according to Physician orders and doffed her gloves and used hand sanitizer.<br><br>During an interview on 12/18/24 at 8:25 A.M., Nurse #1 said that she should have either used hand sanitizer or soap and water in between taking off her gloves and applying new gloves. Nurse #1 said that she did not perform hand hygiene appropriately throughout the procedure which puts the Resident at risk for developing an infection.<br><br>During an interview on 12/18/24 at 9:48 A.M., the Director of Nursing (DON) said that Nurse #1 should have performed hand hygiene throughout the procedure whenever gloves were removed and prior to putting on clean gloves, according to the recommended Hand Hygiene guidelines and facility policy. |