STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225385	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Christopher House of Worcester	10 Mary Scano Drive Worcester, MA 01605

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 50563 Based on interview, record and policy review, the facility failed to ensure that one Resident (#130) of four applicable residents reviewed, out of a total sample of 29 residents, received care and services for his/her pressure ulcer (a wound, usually over a bony prominence, that is caused by unrelieved pressure to the area) in accordance with professional standards. Specifically, the facility failed to ensure a wound care recommendation from the hospital, that was approved by the facility Nurse Practitioner (NP) was implemented placing the Resident at risk for worsening of his/her pressure ulcer. Findings include: Resident #130 was admitted to the facility in April 2024 with diagnoses of Stage 4 Pressure Ulcer (a wound, usually over a bony prominence, that is caused by unrelieved pressure to the area and extends to muscle, tendon and or bone tissue), and Quadriplegia (paralysis, or inability to move below the neck including the arms and legs). Review of the Hospital After Visit Summary dated 5/29/24, for re-admission to the facility included a wound care recommendation to: -wash Resident #130's wound thoroughly with warm soap and water -pat dry -apply Santyl (an ointment used to help remove dead tissue from a wound) to the wound base -followed by saline moistened kerlix (type of bandage wrap) -and cover wound with square Mepilex (type of self-adhering foam dressing). Review of the Nurse's Progress Note (late entry) dated 5/29/24 at 10:14 A.M., indicated until a repeat debridement (procedure where dead tissue is removed from a wound either by surgical means or chemical means) was completed, the Resident should undergo twice a day Santyl wet-to-dry dressings (a dressing where bandage is moistened and then applied to wound and allowed to dry, causing dead tissue to adhere to the bandage and then be removed from the wound bed). (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further Review of the Nurse's Progress Note dated 5/29/24 at 10:27 P.M., indicated that all of the hospital orders were reviewed with NP #1 and no new orders were obtained. Review of the Physician's orders dated 5/29/24 and discontinued 6/13/24, included: -an order for a treatment to the Resident's right ischium (an area over the back of the right hip) open area: >wash with soap and water then pat dry >apply Santyl to the wound bed >apply Triad (a zinc-based cream that provides a moisture barrier) to peri-wound (skin/area surrounding the wound) >followed by biatain (a type of self-adhering foam dressing) twice a day Review of the Wound Observation Records for the right ischium indicated deterioration of the wound as evidenced by the following: >5/29/24 at 11:01 A.M.- the wound healing status was documented as stable with light exudate (drainage from wound) that had no odor. Stage of the wound (how significant or bad the wound is with 1 being the least significant, 4 being the most significant and unstageable being unable to see the base of the wound) documented as Stage 2 >6/3/24 at 4:09 P.M.- the wound healing status was documented as stable with heavy exudate that had no odor. Stage of the wound documented as unstageable. >6/10/24 at 10:02 A.M.- the wound healing status was documented as declining with heavy exudate and odor documented as foul. Stage of the wound documented as unstageable. Review of the clinical record for Resident #130 indicated no evidence that the hospital discharge recommendation for wound care on 5/29/24 at 10:14 A.M., which included twice daily Santyl wet-to-dry dressing was implemented upon the Resident's re-admission to the facility. During an observation of the wound on 6/12/24 at 12:05 P.M. with UM #1, the wound was noted with a strong odor. The surveyor observed that the wound bed (the bottom of the wound) had a significant area (approximately 75% of the wound) with yellowish brown colored necrotic (dead) tissue. The surveyor observed that the remainder of the wound had healthy appearing red tissue and undermining (the tissue under the edge of the wound becomes eroded causing an open pocket underneath the skin extending out from the wound). The surveyor further observed UM #1 providing dressing care that included the following: -UM #1 cleansed the wound with soap and water -patted the wound dry (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-applied Santyl to the wound bed -applied Triad cream to the periwound -then covered the entire area with a biatain dressing The surveyor did not observe UM #1 applying the Santyl wet-to-dry dressings during the dressing care provided at the time of the observation. During an interview on 6/13/24 at 12:06 P.M., NP #1 said he would have given the order to implement whatever the hospital recommended for wound care on admission as he would not have seen the wound on the day of admission. During an interview on 6/13/24 at 4:34 P.M., the surveyor and the Admission Nurse reviewed the hospital recommendations and current Physician order for wound care. The Admission Nurse said that the hospital recommendations included using saline soaked kerlix as part of the dressing, but that this was not part of the Resident's current wound care orders. The surveyor and the Admission Nurse reviewed her personal notes that were written the day of the Resident's re-admission. The Admission Nurses's personal notes included the hospital recommendation for wound care and the use of saline soaked kerlix and indicated that the Admission Nurse reviewed the hospital recommendations for wound care with NP #1 when she wrote the admission Nursing Progress Note. The Admission Nurse further said she took the orders for Resident #130's wound care on admission from NP #1, but that the Nursing Supervisor helped her that evening and put in the orders for her. The Admission Nurse said that as the Nurse who took the orders it was her responsibility to ensure the orders were implemented correctly. The Admission Nurse said that the facility uses 24-hour chart checks, and the night shift Nurse will check the orders for each resident on their unit for the previous day after midnight to ensure they were entered correctly. The Admission Nurse said that the Nursing Supervisor and Unit Manager also review new admissions as well, to ensure orders are entered correctly. During an interview on 6/13/24 at 5:01 P.M., the surveyor and the Nursing Supervisor reviewed the hospital recommendations and current Physician's order for wound care for Resident #130. The Nursing Supervisor said she failed to enter the wet-to-dry portion of the Santyl dressing order upon the Resident's re-admission to the facility, and that this could have impacted the healing of the wound. During an interview on 6/14/23 at 1:38 P.M., the Director of Nursing (DON) said if a Nurse took an order to follow the hospital recommendation it was that Nurse's responsibility to ensure the order was entered correctly into the Resident's clinical record. The DON further said that if an order was obtained not to follow the hospital recommendation, it should have been documented in a progress note in the Resident's clinical record. The DON said that the night Nurse and Unit Manager (UM) would review orders for admissions and if there was a variance identified during the review, the person completing the review should have contacted the Provider (Physician, NP or Physician's Assistant) to verify which order should have been implemented and document the outcome of the conversation with the Provider in the Resident's clinical record as well as update the order if indicated.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50563 Based on observation, interview, record and policy review, the facility failed to adhere to infection control standards in order to prevent the potential transmission of communicable diseases and infections within the facility for two Residents (#130 and #241), out of a total sample of 29 residents. Specially, the facility failed to: 1) For Resident #130, ensure that staff performed hand hygiene after the removal of gloves during a dressing change procedure placing the Resident at risk for infection in his/her wound. 2) For Resident #241, ensure that staff: a) wore the required Personal Protective Equipment (PPE-items used to prevent the spread of infection such as gowns, gloves, face masks) and/or wore the required PPE correctly while caring for the Resident, placing others at risk for exposure to a communicable disease (a disease or infection that is easily spread from one individual to another). b) changed a urinary catheter drainage bag (a bag used to collect urine) after it had been disconnected from the Foley Catheter (a thin, flexible tube placed through the urethra [the small tube that carries urine from the bladder to outside the body] and into the bladder) after the Resident was found self-ambulating, and positioned his/her urinary catheter drainage bag off the floor, to prevent the risk of infection. Findings include: Review of the facility policy titled Hand Hygiene dated 1/28/19, indicated but was not limited to the following: -Handwashing (cleaning the hands with soap and water) is required in the case of a resident with Clostridium Difficile (C-diff: an infection of the bowels that is considered a communicable disease and causes diarrhea) -Decontaminate hands if moving from a contaminated body site to a clean body site. Review of the facility policy titled Contact Precautions dated 1/28/19, indicated but was not limited to the following: -Contact Precautions, in addition to standard precautions are set in place for residents known or suspected to have serious illnesses easily transmitted by direct resident contact or by contact with items in the resident's environment. -Hand hygiene should be completed prior to donning (putting on) gloves -Gloves should be worn when entering the room and while providing care for a resident (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A gown should be worn when entering the room if it is anticipated that clothing will have substantial contact with the resident, environmental surfaces Review of the facility policy titled Wound Care dated 2/9/24 indicated but was not limited to the following: -Perform hand hygiene, before and after wound care, even if gloves are worn, after removal of PPE including if gloves are changed during the procedure. -Gloves should be changed, and hand hygiene performed when moving from dirty to clean tasks. 1) Resident #130 was admitted to the facility in April 2024 with diagnoses of Stage 4 Pressure Ulcer (a wound, usually over a bony prominence, that is caused by unrelieved pressure to the are and extends to muscle, tendon and or bone tissue), and Quadriplegia (paralysis, or inability to move, below the neck including arms and legs). On 6/12/24 at 12:05 P.M., the surveyor observed the following during a wound care procedure for Resident #130: -Unit Manager (UM) #1 cleansed the wound with soap and water, removed her gloves and applied a new pair of gloves without performing hand hygiene, then proceeded to rinse the wound with water. -During the same wound care observation, UM #1 began to apply the dressing covering the wound, removed her gloves and put on a new pair of gloves without performing hand hygiene, and then returned and finished securing the dressing. During an interview on 6/14/24 at 11:45 A.M., the facility Staff Development Coordinator (SDC) said when gloves are changed, hand hygiene should be performed to prevent contamination of the gloves and potential spread of infection. 2a) Resident #241 was admitted to the facility in June 2024, with diagnoses including urinary tract infection (UTI: bacterial infection of the urinary tract), Enterocolitis (inflammation in both intestines at once, often caused by severe infections) due to Clostridium Difficile (C-Diff: a bacterium that causes an infection of the colon [the longest part of the large intestine]. Symptoms can range from diarrhea to life-threatening damage to the colon). Review of Resident #241's medical record indicated a Physician's order to maintain Contact Precautions for C-diff with a start date of 6/7/24. On 6/14/23 at 8:35 A.M., the surveyor observed Certified Nurses Aide (CNA) #1 in Resident #241's room. CNA #1 was observed not wearing a gown or gloves and was assisting the Resident to organize his/her bedside table. The surveyor observed CNA #1 pick up the Resident's breakfast tray, exit the room, place the tray on the tray caddy and then proceed to the nurses station where she began to work without washing her hands. During an interview following the observation, the surveyor and CNA #1 reviewed the Contact Precautions sign that was hanging outside Resident #241's doorway. CNA #1 said the sign indicated she should have worn a gown and gloves to go into the Resident's room and provide care of any kind. CNA #1 also said she should have washed her hands when she left the room before having contact with the nurses' station. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/14/24 at 9:21 A.M., Rehabilitation Services Staff (Rehab Staff) #1 was observed in Resident #241's room completing rehabilitation exercises with the Resident. Rehab Staff #1 had on gloves and a gown however the gown ties at the waist were observed to be untied, with the gown falling away from Rehab Staff #1's clothing and person while she was assisting the Resident with his/her exercises. The surveyor and the facility Staff Development Coordinator (SDC) observed Rehab Staff #1 while still working with the Resident in his/her room. The SDC said Rehab Staff #1's gown should have been tied at the waist. The SDC further said there was a concern with the untied gown that Rehab #1 could become contaminated while caring for Resident #241 and the infection could spread to others. 45429 2b) Review of the Centers for Disease Control and Prevention (CDC) Guideline for Prevention of CAUTI (catheter associated urinary tract infection), dated 2009, section III, titled Proper Techniques for Urinary Catheter Maintenance indicated the following: -If breaks in aseptic (free from contamination caused by harmful bacteria, viruses, or other microorganisms) technique, disconnection, or leakage occur, replace the catheter and collecting system using aseptic technique and sterile equipment. Review of the Lippincott Nursing Procedure - 9th Edition (2023) Indwelling Catheter Care indicated the following: -Inspect the urinary catheter system for disconnections and leakage, because a sterile, continuously closed system is required to reduce the risk of catheter associated urinary tract infection. -Replace the catheter and drainage system using sterile no-touch technique (the practice of avoiding contamination by not touching key elements of the system) when a break in sterile technique, disconnection, or leakage occurs. Review of the facility policy for Urinary Catheters, last revised 11/1/23, indicated that nursing will insert and remove catheters using aseptic techniques and sterile equipment. Review of Resident #241's Physician's orders for June 2024 indicated the following: -Urinary bedside drainage bag and leg bag: change with each use, discard used bag and re-connect catheter using a new bag per protocol, initiated 6/7/24. -Urinary bedside drainage bag to be changed to a leg bag during the day as Resident allows, to use a new bag with each bag change with each use, discard used bag and re-connect catheter using new bag per protocol, initiated 6/7/24. Review of Resident #241's Nursing Progress Notes indicated that on 6/10/24 at 6:41 A.M., the Resident was found by Nurse #2 and had walked away from the catheter drainage bag causing it to disconnect. Further review of the Nursing Progress Notes indicated that Nurse #2 had reconnected the bag but the notes did not indicate that a new catheter bag had been placed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor observed Resident #241 lying in bed with the catheter drainage bag on the floor during the following dates and times: -6/11/24 at 9:17 A.M. -6/12/24 at 8:06 A.M. During an interview on 6/12/23 at 1:58 P.M., Nurse #3 said that a new drainage bag should have been placed after the drainage bag became disconnected from the urinary catheter. Nurse #3 also said that the catheter drainage bags should have been hanging from the Resident's bed frame and off the floor for infection control purposes. During an interview on 6/13/24 at 8:14 A.M., Nurse #2 said when the Resident's urinary catheter tubing disconnected on 6/10/24, she had used an alcohol wipe to sterilize the tube prior to re-connecting it to the drainage bag. Nurse #2 said that she should have changed the urinary drainage bag after it had become dislodged but did not do so as required.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46138 Based on interview, record and policy review, the facility failed to ensure that the Pneumococcal (bacterial infection caused by streptococcus pneumoniae/ pneumococci, that can range from ear and sinus infections to Pneumonia and blood stream infections) Vaccination was administered to two Residents (#35, and #81) for five applicable residents, out of a total sample of 29 residents. Specifically, the facility staff failed to: 1. identify whether Resident #35 was up to date with Pneumococcal Vaccinations, administer the Pneumococcal Vaccine when the Resident was not up to date, and determine whether he/she was eligible to receive the Pneumococcal Vaccine when the Resident/Representative consented to receive the vaccination. 2. identify whether Resident #81 was up to date with Pneumococcal Vaccinations, administer the Pneumococcal Vaccine when the Resident was not up to date, and determine whether he/she was eligible to receive the Pneumococcal Vaccine when the Resident/Representative consented to receive the vaccination thereby increasing the risk for facility acquired Pneumococcal infections. Findings include: Review of the facility's policy, titled Vaccines for Residents, dated November 2023, indicated nursing will: -Assess the immunization status of the resident. -Obtain a consent for vaccines. If the resident has been previously immunized, the information is documented. -Provide education materials to the resident/representative. Review of CDC guidelines titled Pneumococcal Vaccination Timeline for Adults, dated 3/15/23, indicated the following for adults aged [AGE] years and older: -Make sure your patients are up to date with Pneumococcal Vaccination. -If no Pneumococcal doses have been received, administer either one dose of PCV20 (Pneumococcal Conjugate Vaccine/ Prevnar 20: vaccine used to protect against 20 types of pneumococcal bacteria that commonly cause serious infections) or one dose of PCV15 (Pneumococcal Conjugate Vaccine 15-valent: vaccine used to protect against 15 types of pneumococcal bacteria that commonly cause serious infections in adults) followed by one dose of PPSV23 (Pneumovax 23: vaccine used to help protect against serious infections caused by 23 types of pneumococcal bacteria) no earlier than one year following the administration of the prior PCV15 dose. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-If one dose only of PCV13 (Prevnar 13: vaccine used to protect against 13 types of pneumococcal bacteria that commonly cause serious infections) has been received at any age, one dose of PCV20 or PPSV23 should be administered no earlier than one year following the administration of the prior PCV13 dose. 1. Resident #35 was admitted to the facility in March 2023 with diagnoses including: Chronic Obstructive Pulmonary Disease (COPD- a chronic inflammatory lung disease that causes restricted airflow from the lungs and difficulty breathing) and Hypertensive Heart and Chronic Kidney Disease (CKD) without Heart Failure, Stage 3a (a group of medical problems that results when there is unmanaged high blood pressure for a prolonged time, with Stage 3a [CKD - mild to moderate loss of kidney function]). Review of Resident #35's medical record indicated the Resident was over [AGE] years of age. Review of Resident #35's Immunization Consent Form, dated and signed by the Resident on 3/2/23, indicated that Resident #35 consented to the administration of the Pneumococcal Vaccine. Review of Resident #35's Vaccination Administration Record, printed and provided by the facility on 6/14/24, indicated that the Resident received one dose of PCV13 on 7/1/2015. Further review of Resident #35's Immunization Report indicated no evidence the Resident had ever received any other dose of Pneumococcal Vaccination. 2. Resident #81 was admitted to the facility in October 2021 with diagnoses including: Diabetes Mellitus (DM - disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated blood glucose [sugar] levels in the blood). Review of Resident #81's medical record indicated the Resident was over [AGE] years of age. Review of Resident #81's Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident was cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 99 indicating the Resident interview not successful. Review of Resident #81's Immunization Consent Form, dated and signed by the Resident Representative (RR) on 10/13/21, indicated the Resident/RR wished to have Resident #81 receive the Pneumococcal Vaccine if it was indicated. Review of Resident #81's Vaccine Administration Report, printed and provided by the facility on 6/14/24, indicated that the Resident received one dose of PCV13 on 7/31/2019. During an interview on 6/14/24 11:30 A.M., the Infection Preventionist (IP) said she began working as the IP in June 2024 and the facility follows CDC requirements for immunizations. The IP further said she has not audited residents for the need for Pneumococcal Vaccines since starting in her position. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow-up interview on 6/14/24 12:30 P.M., the IP said she located additional vaccination information in the Massachusetts Immunization Information System (MIIS) for Residents #35 and #81. The surveyor and the IP reviewed the facility's Pneumococcal Vaccine Policy and Immunization Records for Residents #35 and #81. The IP said she had not had the opportunity to assess each Residents' Pneumococcal Vaccination status. The IP further said Resident's #35 and #81 were eligible to receive another dose of Pneumococcal Vaccination per CDC guidelines and this should have been offered based on the Resident and/or Representative consenting to receive the vaccination.