| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225439 | A. Building<br>B. Wing | 12/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Odd Fellows Home of Massachusetts | 104 Randolph Road<br>Worcester, MA 01606 |

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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 0582<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>51571<br><br>Based on interview and record review, the facility failed to ensure that Skilled Nursing Facility Advanced Beneficiary Notices of Non-coverage (SNF ABN- notice issued to a resident when a facility determines the beneficiary no longer qualifies for Medicare Part A skilled services and the resident has not used all his/her Medicare benefit days) were issued for three Residents (#17, #35 and #38), out of three applicable residents, so that the Residents could decide if they wished to continue receiving skilled services that may not be paid for by Medicare, and were aware of the financial responsibility they may have to assume.<br><br>Specifically, the facility failed to issue a SNF ABN:<br><br>1. For Resident #17, when the Resident no longer qualified for Medicare Part A skilled services and chose to remain in the facility.<br><br>2. For Resident #35, when the Resident no longer qualified for Medicare Part A skilled services and chose to remain a Resident in the facility.<br><br>3. For Resident #38, when the Resident no longer qualified for Medicare Part A skilled services and chose to remain in the facility.<br><br>Findings include:<br><br>Review of the Centers for Medicare and Medicaid Services (CMS) website for SNF ABN last modified 9/10/24, https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-snf-abn indicated:<br><br>-Skilled Nursing Facilities (SNFs) must issue a notice to Original Medicare (fee for service - FFS) beneficiaries in order to transfer potential financial liability before the SNF provides:<br><br>>an item or service that is usually paid for by Medicare, but may not be paid for in this particular instance because it is not medically reasonable and necessary, or<br><br>>custodial care (non-medical assistance with daily tasks and basic living needs for those who are not sick or disabled).<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 |
|---|---|---|

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| F 0582<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | 1. Resident #17 was admitted to the facility in February 2024, with diagnoses including Hypertension, Depression, and Hyperlipidemia.<br><br>Review of Resident #17's medical record indicated that the Resident's Medicare Part A benefit ended on 5/31/24. The facility was unable to provide any SNF ABN notice corresponding with the Resident ending his/her Medicare benefit on 5/31/24, for review.<br><br>2. Resident #35 was admitted to the facility in October 2023, with a diagnosis of Diabetes Mellitus.<br><br>Review of Resident #35's medical record indicated that the Resident's Medicare Part A benefit ended on 7/5/24. The facility was unable to provide any SNF ABN notice corresponding with the Resident ending his/her Medicare benefit on 7/5/24, for review.<br><br>3. Resident #38 was admitted to the facility in January 2020, with diagnoses including Anemia, Coronary Artery Disease, and Heart Failure.<br><br>Review of Resident #38's medical record indicated that the Resident's Medicare Part A benefit ended on 7/5/24. The facility was unable to provide any SNF ABN notice corresponding with the Resident ending his/her Medicare benefit on 7/5/24, for review.<br><br>During an interview on 12/5/24 at 3:14 P.M., the Social Worker (SW) said that the previous Physical Therapy (PT) Director assisted with Medicare Part A beneficiary notices, and the SW began doing them when the PT Director left. The surveyor and the SW reviewed Resident's #17, #35, and #38, SNF ABN forms and the SW said that SNF ABN forms were not issued for the three Residents. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48206<br><br>Based on observation, and interview, the facility failed to provide a clean and homelike environment for one Resident (#35) out of a total sample of 18 residents.<br><br>Specifically, the facility failed to provide Resident #35 with a wheelchair that was maintained in a clean manner and address promptly any cleaning needs as required.<br><br>Findings include:<br><br>Resident #35 was admitted to the facility in October 2023 with diagnoses including Dementia.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident was mildly cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of 15 total possible points.<br><br>On 12/4/24 at 8:30 A.M., Resident #35 was observed seated in a wheelchair next to the bed in his/her room eating his/her breakfast meal. The surveyor observed the wheelchair was dusty with crumbs and debris on the frame of the chair and cushion. During an interview at the time, Resident #35 said that he/she uses the wheelchair at times because he/she was worried about falling. Resident #35 said that the wheelchair had not been cleaned since he/she had been using it. The Resident further said that his/her family member visited regularly and were involved in his/her care.<br><br>During an interview on 12/4/24 at 12:04 P.M., Family Member #1 said he/she had asked staff several times to have Resident #35's wheelchair cleaned but the wheelchair had not be cleaned as requested.<br><br>During an observation and interview on 12/5/24 at 8:59 A.M., Resident #35 said his/her wheelchair was still filthy and had been that way since he/she was admitted to the facility. The surveyor observed that the wheelchair remained dusty with debris.<br><br>During an interview and observation on 12/5/24 at 12:38 P.M., the Housekeeping Manager (HM) said that there is a schedule to clean the wheelchairs wing by wing. The HM further said she did not have a log to track the cleaning process but she would let the Unit Managers (UM) know to make the wheelchairs available so they can be cleaned. The HM said that she did not have evidence of when the wheelchair used by Resident #35 had last been cleaned. The surveyor and HM observed that the wheelchair in Resident #35's room remained dusty with debris. The HM said that the wheelchair was unacceptable and would be cleaned right away.<br><br>During an interview on 12/6/24 at 1:13 P.M., the Administrator said the facility did not have a policy relative to wheelchair cleaning, but that a policy and procedure would be developed. |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>42761<br><br>Based on record review and interview, the facility failed to accurately complete a Level I PASRR for one Resident (#83) out of a total sample of 18 residents, which resulted in the Resident not receiving a Level II PASRR Evaluation to determine whether the Resident met criteria for serious mental illness (SMI) and whether specialized services were required to treat the Resident's SMI.<br><br>Specifically, the facility failed to:<br><br>-Identify Resident #83's diagnosis of Schizophrenia on the Resident's Level I PASRR when the Resident had a diagnosis of Schizophrenia.<br><br>-Indicate legal involvement within two years prior to admission to the facility when the Resident had a legal guardian appointed through the court system within two years prior to admission to the facility.<br><br>Findings include:<br><br>Resident #83 was admitted to the facility in August 2023 with a diagnosis of Schizophrenia.<br><br>Review of Resident #83's Hospital Patient Health Summary, dated 1/20/23, indicated the following:<br><br>-The Resident had been admitted to the hospital for steadily worsening Dementia and developing hallucinations and violent behavior.<br><br>-The reason for the hospital visit was Schizophrenia.<br><br>Review of Resident #83's Decree and Order of Appointment of Guardian for an Incapacitated Person, dated 5/5/23, indicated the powers and duties of the Guardian included the following:<br><br>-Authorization to admit the Incapacitated Person to a nursing facility. The Court found that such admission was in the Incapacitated Person's best interest.<br><br>Further review of the Resident's Decree and Order of Appointment of Guardian for an Incapacitated Person indicated:<br><br>-The Court authorized treatment of the Incapacitated Person with antipsychotic medication<br><br>Review of Resident #83's Level I PASRR, dated 8/3/23, indicated the following:<br><br>-The Resident had a court appointed Legal Guardian.<br><br>-The Resident did not have a documented diagnosis of a mental illness or disorder (MI/D) . that may lead to chronic disability.<br><br>(continued on next page) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Question Number Six was completed with an answer of No indicating that the Resident did not require legal intervention that was, or may have been, due to MI/D within the previous two years.<br><br>-If the answer to Question Number Six was Yes, check Positive SMI screen. Otherwise, check Negative SMI screen.<br><br>Further review of the Resident's Level I PASRR indicated:<br><br>-Negative SMI screen was checked.<br><br>-A Level II PASRR Evaluation was not indicated due to no diagnosis or suspicion of SMI.<br><br>Review of Resident #83's Physician order dated 8/4/23, with no stop date, indicated the following:<br><br>-Olanzapine (antipsychotic medication) tablet, one 2.5 milligram (mg) tablet once a day for Psychosis .<br><br>During an interview on 12/5/24 at 9:33 A.M., the Social Worker (SW) said that Resident #83 had a court appointed Guardian. The SW said that the Resident having a court appointed Guardian within two years of admission to the facility would indicate legal involvement, and that legal involvement within two years prior to the Resident being admitted to the facility would result in a positive SMI screen and referral to the PASRR Office for a Level II PASRR evaluation to be completed for the Resident.<br><br>During a follow-up interview on 12/5/24 at 12:27 A.M., the SW said Resident #83's Level I PASRR was not completed accurately. The SW said that the Resident had a diagnosis of Schizophrenia prior to being admitted to the facility, was being treated with antipsychotic medication, and had a legal Guardian appointed through the court less than two years prior to admission to the facility. The SW said that the Level I PASRR should have been completed to indicate the Resident had a diagnosis of Schizophrenia and legal involvement through the court. The SW further said that the Level I PASRR should have been completed to indicate the Resident had a positive SMI screen and that the Resident should have been referred to the PASRR Office for a Level II PASRR evaluation to determine whether the Resident met criteria for SMI and to determine whether the Resident required specialized services for SMI. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>42761<br><br>Based on observation, record review, and interview, the facility failed to provide services that met professional standards of quality for two Residents (#83 and #37) out of a total sample of 18 residents.<br><br>Specifically, the facility failed to:<br><br>1. assess Resident #83's swallowing ability in a timely manner, as ordered by the Nurse Practitioner (NP) when the Resident had experienced a decline in swallowing function and weight loss, and required a diet texture downgrade, resulting in a delayed treatment for the Resident.<br><br>2. ensure Resident #37 had the correct Physician ordered size indwelling urinary catheter (a soft flexible tube that drains urine from the bladder) in place, placing the Resident at risk for complications related to the urinary catheter.<br><br>Findings include:<br><br>1. Resident #83 was admitted to the facility in August 2023 with diagnoses including Dementia and Muscle Weakness.<br><br>Review of Resident #83's Nutrition Care Plan, initiated 8/14/23 and last revised 10/11/24, indicated:<br><br>-The Resident presented at potential nutrition risk related to medical conditions requiring long term care placement.<br><br>-The Resident was independent with set up at meals.<br><br>-Registered Dietician (RD)/Speech Language Pathologist (SLP) screen and treat PRN (as necessary).<br><br>Review of Resident #83's Nursing Progress Note, dated 10/15/24, indicated:<br><br>-The Resident was in the supervised dining area for his/her meal.<br><br>-Nursing staff observed that the Resident had some difficulty with the meal.<br><br>-A rehabilitation screen was submitted for Speech [sic].<br><br>Review of Resident #83's Minimum Data Set (MDS) Assessment, dated 10/21/24, indicated:<br><br>-The Resident was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of three out of 15 total possible points.<br><br>-The Resident required supervision or touching assistance for eating.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The Resident had no signs or symptoms of a possible swallowing disorder.<br><br>-The Resident had experienced no significant weight loss in the prior six months.<br><br>Review of Resident #83's Dietary Progress Note, dated 10/24/24, indicated the following:<br><br>-The Resident was seen by the Registered Dietician (RD) for a significant change in status assessment related to changes in activities of daily living (ADLs).<br><br>-The Resident's diet was a Regular Texture House Diet.<br><br>-The Resident received a four- ounce House Supplement twice daily.<br><br>-The Resident received diuretic (used to remove excess fluid from the body) medication daily.<br><br>-The Resident fed him/herself independently after set- up.<br><br>-The Resident's weight was stable over 30 days and the Resident had experienced an 8.3% weight gain over the previous six months.<br><br>-No changes were recommended.<br><br>Review of Resident #83's Nurse Practitioner (NP) Progress Note, dated 10/25/24, indicated:<br><br>-The Resident was seen for intermittent cough with meals.<br><br>-The Resident was on a regular texture diet with thin liquids.<br><br>-Nursing staff reported that the Resident was coughing with meals, and that the Resident was attempting to clear his/her throat after eating.<br><br>Further review of the NP Progress Note indicated the following assessment and plan:<br><br>-Cough: New order for chest x-ray, downgraded diet to ground soft diet with a referral to be evaluated by Speech Therapy.<br><br>Review of Resident #83's NP orders, dated 10/25/24, indicated the following:<br><br>-Chest x-ray<br><br>-Downgrade diet to ground soft diet.<br><br>-Refer Resident to Speech Therapy for cough with eating.<br><br>Review of Resident #83's clinical record indicated:<br><br>-A chest x-ray had been completed as ordered.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The Resident's diet had been downgraded to a ground soft diet, as ordered.<br><br>-There was no evidence the Resident had been referred to Speech Therapy for cough while eating, as ordered by the NP.<br><br>Review of Resident #83's interdisciplinary Facility Weight - Initial Focus Note, dated 11/14/24, indicated:<br><br>-The Resident was on a minced/moist texture diet.<br><br>-The Resident received house supplements twice daily.<br><br>-The Resident received diuretic medication.<br><br>-Use of diuretic medication may have contributed to the Resident's weight loss.<br><br>-A recommendation was made for consultation/evaluation by the SLP.<br><br>Review of Resident #83's NP Progress Note, dated 11/16/24, indicated:<br><br>- . referral to be evaluated by Speech Therapy .<br><br>Review of Resident #83's interdisciplinary Facility Weight - Initial Focus Note, dated 11/21/24, indicated:<br><br>-The Resident was on a minced/moist texture diet.<br><br>-The Resident received house supplements twice daily.<br><br>-The plan included adding fortified food and drink, continuing use of the house supplement twice daily, and discontinuing use of the diuretic medication.<br><br>Further review of the plan indicated whether a consult with Hospice was appropriate for the Resident.<br><br>Review of Resident #83's clinical record indicated that a referral for consultation by the SLP was not completed until 11/21/24.<br><br>Review of Resident #83's Rehab Request/Screen Form, dated 11/21/24, indicated the following:<br><br>-The Resident had weight changes (166.4 pounds (lbs) 30 days prior; current weight 141.4 lbs)<br><br>-The Resident's diet had been downgraded on 10/25/24.<br><br>Review of Resident #83's SLP Evaluation and Plan of Treatment, dated 11/27/24, indicated:<br><br>-The Resident was referred for evaluation of swallowing due to recent weight loss of 23 pounds since the Resident's diet was downgraded on 10/25/24.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The Resident's diet was downgraded due to concerns with coughing.<br><br>-The Resident had not previously received Speech Therapy services.<br><br>-The Resident weighed 151.5 lbs on 10/31/24 and 139.6 lbs on 11/26/24 (significant weight loss).<br><br>-The Resident's mandibular (lower jaw bone) range of motion, strength, and coordination were impaired.<br><br>-The Resident's lingual (various components of tongue movement) function was impaired.<br><br>-The Resident presented with moderate oropharyngeal (middle part of the throat and back of the mouth) dysphagia (difficulty swallowing).<br><br>-Strategies for safe swallowing were recommended.<br><br>-Treatment of swallowing dysfunction and/or oral function for feeding was recommended at a frequency of eight times over four weeks.<br><br>-The long term goal was for the Resident to have safe and adequate intake on the least restrictive diet without signs/symptoms of aspiration (when something that is meant to be swallowed enters one's airway or lungs) and use of strategies.<br><br>On 12/4/24 at 9:42 A.M., the surveyor observed Resident #83 sitting upright in bed. When the surveyor spoke to the Resident, the Resident responded verbally, and the surveyor observed scrambled eggs in the Resident's mouth, in between the Resident's front teeth and lips and over the top of the Resident's tongue.<br><br>During an interview on 12/5/24 at 9:49 A.M., SLP #1 said she evaluated Resident #83's swallowing function on 11/27/24, when the facility's Director of Rehabilitation (DOR) had informed her that a referral for Speech Therapy had been made by nursing staff due to the Resident having experienced weight loss. SLP #1 said that she did not know when the referral was submitted because she had just started working at the facility the week prior to completing the Resident's evaluation.<br><br>During an interview on 12/5/24 at 10:27 A.M., the DOR said that there were two SLPs with time available to work at the facility. The DOR said that the SLPs did not work full time, and that the SLPs were available on an as necessary (Per Diem) basis. The DOR said that SLP #1 recently began working at the facility and that the other SLP was available to work during the time that the NP ordered a Speech Therapy evaluation on 10/25/24. The DOR said that he was not made aware of the NP's order for a speech therapy evaluation for Resident #83 because a referral had not been submitted to him from facility staff. The DOR further said that if he had known the Resident required an evaluation to be completed by an SLP, he would have scheduled the evaluation with the SLP that was available, and the evaluation would have been completed timely. The DOR said that the evaluation with an SLP should have been completed when the evaluation was ordered by the NP on 10/25/24 and that the Resident should not have had to wait until 11/27/24 to be evaluated by the SLP. The DOR said he was not sure why a referral had not been submitted for a speech therapy evaluation when the NP ordered the evaluation to be completed.<br><br>(continued on next page) |

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|---|---|
| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 12/5/24 at 2:36 P.M., the Director of Nursing (DON) said that she recently began working at the facility and had initiated weekly interdisciplinary team (IDT) Risk Meetings where the IDT discussed residents at risk for changes in condition, including weight loss. The DON said the first time Resident #83 was discussed at the Risk Meeting was on 11/14/24. The DON said that the referral for the SLP to evaluate Resident #83 was not completed and submitted to the DOR until 11/21/24. The DON also said that the NP was unavailable for interview and that the RD would be available to speak with the surveyor.<br><br>During an interview on 12/5/24 at 3:46 P.M., the RD said she participated in weekly interdisciplinary team (IDT) Risk Meetings to identify residents at risk for changes in condition. The RD said that she participated in the Risk Meeting on 11/21/24 and that during this same meeting, the IDT identified that Resident #83 had not been evaluated by the SLP, as ordered by the NP on 10/25/24. The RD said that a referral for the SLP to see the Resident was not completed and submitted to the Therapy Department until 11/21/24.<br><br>Please refer to F689 and F842.<br><br>50138<br><br>2. Resident #37 was admitted to the facility in October 2018 with diagnoses including Unspecified Neuromuscular Dysfunction of Bladder (condition caused by damage to the brain, spinal cord or nerves that control bladder function).<br><br>Review of Resident #37's November 2024 Physician's orders indicated:<br><br>-Foley (a type of indwelling urinary catheter) 16 Fr (Fr-French, a form of measurement for indwelling urinary catheters [16 French - 5.3 millimeters (mm) circumference])/ 10 (10 milliliter (ml) balloon [a saline inflated balloon used to anchor the indwelling urinary catheter in the bladder]) to bedside drainage at all times.<br><br>-Foley catheter care every shift.<br><br>-Change Foley catheter 16 Fr/10 ml monthly on the 1st of the month.<br><br>-Irrigate (flush) Foley catheter with 50 ml of normal saline for blockage/drainage every shift day, evening, and night.<br><br>During an interview on 12/4/24 at 3:56 P.M., Nurse #3 said she had irrigated Resident #37's Foley catheter during the day shift (7:00 A.M. to 3:00 P.M.) on 12/4/24 but had not noticed if the correct catheter size was in place. Nurse #3 said she had not changed the Foley catheter during her shift.<br><br>(continued on next page) |

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| | 225439 | A. Building<br>B. Wing | 12/10/2024 |

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| Odd Fellows Home of Massachusetts | 104 Randolph Road<br>Worcester, MA 01606 |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview and observation on 12/4/24 at 4:00 P.M., Nurse #2 said that she had not changed the Foley catheter for Resident #37. The surveyor and Nurse #2 observed that Resident #37 had an 18 French/ 30 ml balloon Foley catheter in place. Nurse #2 said that Resident #37 had a Physician order for a 16 French/ 10 ml balloon. Nurse #2 said that Resident #37 did not have the correct size Foley catheter in place. Nurse #2 said that Physician's orders should be followed so that the Resident had the correct Foley catheter in place. Nurse #2 further said that all Nurses in the facility had access to the central supply room (room in the facility where supplies are stored before use) and could obtain any size Foley catheter ordered by the Physician.<br><br>During an interview and observation on 12/4/24 at 4:30 P.M., the facility Staff Educator said all residents with Foley catheters should have Physician orders followed for the correct size. The Staff Educator said size was important because if the catheter and balloon size were too small, the Foley catheter could leak urine and/or fall out of the bladder. The Staff Educator said if the Foley catheter and balloon size were too big, the Foley catheter could cause pain and discomfort to the resident. The surveyor and the Staff Educator observed the stock in the central supply room, and the Staff Educator located 16 French/ 10 ml balloon Foley catheters readily available for use. The Staff Educator said Nurses had access to the central supply office and should have had the correct catheter size in place for Resident #37.<br><br>During an interview on 12/5/24 at 8:50 A.M., the Director of Nursing (DON) said that Nurses should insert Foley catheters as ordered by the Physician. The DON said the 18 French/ 30 ml balloon was too big for Resident #37 and could cause trauma. The DON said that the facility did not have a policy and procedure relative to the insertion of indwelling Foley catheters but inserting the correct size as ordered by the Physician was a professional standard of practice. |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>47646<br><br>Based on observation, record review, and interview, the facility failed to ensure that one Resident (#46) out of a total sample of 18 residents with contractures received services and treatment to increase range of motion and/or prevent further decrease in range of motion.<br><br>Specifically, the facility failed to timely assess, monitor and/or treat Resident #46's right third and fourth finger mild contractures.<br><br>Findings include:<br><br>Review of the facility's policy titled Resident Mobility and Range of Motion (ROM) Policy (undated) indicated but was not limited to the following:<br><br>>Residents with limited ROM will receive treatment and services to increase and/or prevent a further decrease in ROM.<br><br>>As part of the residents' comprehensive assessment, the nurse will identify the residents':<br><br>-Current ROM of his or her joints<br><br>>As part of the comprehensive assessment, the nurse will also identify conditions that place the residents at risk for complications related to ROM and mobility, including:<br><br>-Contractures .<br><br>>The care plan will be developed by the interdisciplinary team based on the comprehensive assessment and will be revised as needed.<br><br>>The care plan will include specific interventions, exercises, and therapies to maintain, prevent avoidable decline in, and/or improve mobility and ROM.<br><br>Resident #46 was admitted to the facility in January 2020, with diagnoses including Dementia and generalized muscle weakness.<br><br>On 12/4/24 at 10:31 A.M., the surveyor observed Resident #46 lying in bed and his/her right hand was contracted with the third and fourth digits (fingers) in flexion (bending at the joint). There was no positioning device/splint seen in the Resident's area or room. During an interview at the time, Resident #46 said he/she had no pain and has never had a positioning device. Resident #46 said staff do not provide any ROM exercises and he/she does not know if the contractures have gotten worse. The Resident was unable to open his/her hand when the surveyor asked if he/she was able to do so.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 12/9/24 at 2:23 P.M., the surveyor and Unit Manager (UM) #1 observed Resident #46's right upper extremity with the Resident's third and fourth digits in a flexed state. UM #1 asked the Resident if he/she could flex or extend those two fingers and he/she said no. UM #1 said she was unaware of any issues. UM #1 also said she was unsure if Resident #46 was seen by therapy at any point during his/her admission to the facility.<br><br>Review of the most recent Minimum Data Set (MDS) assessment, dated 10/31/24, indicated that Resident #46 had no impairment in functional limitation in range of motion (ROM) to upper extremities (shoulder, elbow, wrist, hand).<br><br>Review of the medical record indicated a Visit Note from Physician Assistant (PA) #1 dated 9/5/24.<br><br>Further review of the PA Visit Note indicated the following in the Additional Notes section:<br><br>-Musculoskeletal: Right third and fourth finger mild contractures.<br><br>Further review of the medical record failed to indicate any follow-up to the PA Visit Note or reference to the contractures or limited ROM to the right third and fourth fingers for Resident #46.<br><br>During an interview on 12/10/24 at 10:06 A.M., the Director of Rehabilitation (DOR) #1 said he has not treated Resident #46. The DOR reviewed the Rehab notes and evaluations and said there was nothing about service for the Resident. The DOR said he received a Rehab request for screen this morning for the third and fourth digit trigger finger (a condition that makes the fingers or thumb difficult to move, and can freeze the fingers in a flexed position) for the Resident and he would screen Resident #46 today.<br><br>Review of the medical record indicated a Physician Interim/Telephone order dated 12/10/24, for the following new order:<br><br>-add dx (diagnosis) trigger finger.<br><br>-PT (Physical Therapy) screen.<br><br>During a telephone interview on 12/10/24 at 10:33 P.M., PA #1 said she noticed the mild contractures to Resident #46's third and fourth fingers during her evaluation on 9/5/24. PA #1 said the Resident had no functional limitations, pain or skin integrity issues and she had never noticed the contractures before. PA #1 said she discussed with nursing and had no new orders. PA #1 said the treatment (for contractures) is surgical and Resident #46 refuses most interventions. PA #1 said she did not feel rehab would be needed at that time, but expected nursing to monitor for pain, skin integrity issues, decrease in function/ROM and to notify her if anything has changed.<br><br>Review of the medical record failed to indicate any assessment and/or intervention to monitor the Resident's right third and fourth finger or hand for a decrease in function or ROM.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 12/10/24 at 10:48 A.M., DOR #1 said he screened Resident #46's right hand and the Resident agreed to the evaluation and treatment. DOR #1 said the Resident's active ROM (the range of motion of a joint that occurs when a person uses their muscles to move without assistance) was impaired. DOR #1 said the Resident would benefit from therapy treatment for the contractures and evaluation for a splint to prevent the contractures from worsening and possibly help improve ROM and use. DOR #1 further said the contractures are noticeable when you see him/her and if it had not been evaluated today, it could have gotten worse.<br><br>Review of the Physical Therapy (PT) Evaluation and Plan of Treatment dated 12/10/24, indicated:<br><br>-diagnosis of trigger finger.<br><br>-Plan of treatment including therapeutic exercises, manual therapy techniques, PT evaluation: moderate complexity and therapeutic activities.<br><br>>Frequency: Three times/week<br><br>>Duration: Eight Weeks<br><br>>Intensity: Daily<br><br>-Short Term Goal: Patient will tolerate hand splint or roll for 2 hours without signs or symptoms of skin issues to reduce the risk of contracture development.<br><br>During an interview on 12/10/24 at 11:15 A.M., UM #1 said that after PA #1 found Resident #46's contractures, nursing should have started monitoring the Resident's fingers to ensure there were no complications and that it did not get worse. UM #1 said she would expect Nurses to evaluate the area, complete a pain assessment, assess skin integrity and mobility. UM #1 said Resident #46's contractures were profound but she had not noticed it until it was pointed out to her by the surveyor. UM #1 said she has provided care for Resident #46 multiple times, asking him/her to roll and grab the side rail and she just never saw the contractures.<br><br>During an interview on 12/10/24, at 11:34 A.M., the Director of Nursing (DON) said that she would have expected a rehab screen to be performed in September when the PA identified that Resident #46 had contractures. The DON said she would have expected nursing to monitor, assess, establish baseline, and try to prevent the contractures from worsening. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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** 42761<br><br>Based on observation, record review, and interview, the facility failed to provide and environment as free of accident hazards as possible for three Residents (#83, #35, and #53) out of a total sample of 18 residents.<br><br>Specifically, facility failed to:<br><br>1. implement safe swallow strategies for Resident #83 when the Resident had a history of swallowing difficulty, oropharyngeal (middle part of the throat and back of the mouth) dysphagia (difficulty swallowing), Dementia, and had an overall decline in function requiring dependence on staff for eating, which increased the Resident's risk for choking and/or aspiration (when food or liquids enters one's airway or lungs).<br><br>2. complete fall risk assessments for Resident #35 when the Resident was readmitted to the facility following hospitalization s, including one hospitalization resulting from a fall with fracture that required surgical intervention, putting the Resident at risk for further falls, injury and abnormal bleeding resulting from anticoagulation (medication used to prevent blood clots) medication use.<br><br>3. For Resident #53, complete a fall risk assessment when the Resident was readmitted to the facility following a hospitalization for a fall with fracture and surgery, putting the Resident at risk for further falls and injury and increased risk for abnormal bleeding from anticoagulant use.<br><br>Findings include:<br><br>1. Resident #83 was admitted to the facility in August 2023 with diagnoses of Dementia and Muscle Weakness.<br><br>Review of Resident #83's Nutrition Care Plan, initiated 8/14/23 and last revised 10/11/24, indicated the following:<br><br>-The Resident presented as potential nutrition risk related to medical conditions requiring long term care placement.<br><br>-The Resident was independent with set up at meals.<br><br>-Registered Dietician (RD)/Speech Language Pathologist (SLP) screen and treat PRN (as necessary).<br><br>Review of Resident #83's Minimum Data Set (MDS) Assessment, dated 10/21/24, indicated:<br><br>-The Resident was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of three out of 15 total possible points.<br><br>-The Resident required supervision or touching assistance for eating.<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 - Some | -The Resident had no signs or symptoms of a possible swallowing disorder.<br><br>-The Resident had experienced no significant weight loss in the prior six months.<br><br>Review of Resident #83's Nurse Practitioner (NP) Progress Note, dated 10/25/24, indicated:<br><br>-The Resident was seen for intermittent cough with meals.<br><br>-The Resident was on a regular texture diet with thin liquids.<br><br>-Nursing staff reported that the Resident was coughing with meals and that the Resident was attempting to clear his/her throat after eating.<br><br>Further review of the NP Progress Note indicated the following assessment and plan:<br><br>-Cough - . downgraded diet to ground soft diet .<br><br>Review of Resident #83's NP Order, dated 10/25/24, indicated:<br><br>-Downgrade diet to ground soft diet.<br><br>Review of Resident #83's interdisciplinary Facility Weight - Initial Focus Note, dated 11/14/24, indicated:<br><br>-The Resident was on a minced/moist texture diet.<br><br>-A recommendation was made for consultation/evaluation by the SLP.<br><br>Review of Resident #83's Rehab (Rehabilitation) Request/Screen Form, dated 11/21/24, indicated:<br><br>-The Resident's diet had been downgraded on 10/25/24.<br><br>-Intervention recommended was for the SLP to assess the Resident.<br><br>Review of Resident #83's SLP Evaluation and Plan of Treatment, dated 11/27/24, indicated the following:<br><br>-The Resident's diet was downgraded on 10/25/24 due to concerns with coughing.<br><br>-The Resident had not previously received speech therapy services.<br><br>-The Resident's mandibular (lower jaw bone) range of motion, strength, and coordination were impaired.<br><br>-The Resident's lingual (various components of tongue movement) function was impaired.<br><br>-The Resident presented with moderate oropharyngeal (middle part of the throat and back of the mouth) dysphagia (difficulty swallowing).<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 - Some | -The Resident presented with decreased ability for breaking down and clearing bolus' (rounded mass of a substance, especially of chewed food at the moment of swallowing) from his/her mouth and decreased attention to task during meals.<br><br>-The Resident presented with moderate lingual residue and residuals in the anterior portion of his/her oral cavity that accumulated over time.<br><br>-Food residuals were eventually cleared by liquid wash.<br><br>-The Resident presented with limited attention to bolus in the oral cavity.<br><br>-Treatment of swallowing dysfunction and/or oral function for feeding was recommended at a frequency of eight times over four weeks.<br><br>-The long term goal was for the Resident to have safe and adequate intake on the least restrictive diet without signs/symptoms of aspiration (when something that is meant to be swallowed enters one's airway or lungs) and use of strategies.<br><br>Further review of Resident #83's SLP Evaluation and Plan of Treatment indicated the following relative to swallowing strategies recommended:<br><br>-Upright positioning during all meals and 30 minutes following meals.<br><br>-Alternate solids and liquids t assist with oral and pharyngeal clearing of bolus.<br><br>-Rate modification.<br><br>-Bolus size reductions.<br><br>-General safe swallow techniques.<br><br>Review of Resident #83's SLP Discharge Summary, dated 12/3/24, indicated the following:<br><br>-The Resident had experienced an overall decline in function.<br><br>-The Resident had become dependent on staff for meal intake and use of safe swallow strategies.<br><br>-The Resident's meal intake had reduced due to the Resident becoming increasingly confused and having decreased attention to task during meals.<br><br>-Skilled interventions provided during speech therapy sessions included education provided to facility staff.<br><br>-Speech therapy services were being discontinued for the Resident as the Resident was being admitted to Hospice services on 12/3/24.<br><br>-Discharge Strategies recommended for the Resident included:<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 - Some | > upright positioning for all meals and greater than 30 minutes following intake<br><br>>bolus size reductions<br><br>>rate modifications<br><br>>alternating solids and liquids with a two to one ratio to assist with oral and pharyngeal clearing of bolus<br><br>>general safe swallow precautions<br><br>On 12/4/24 at 9:42 A.M., the surveyor observed the following:<br><br>-the surveyor entered Resident #83's room and observed the privacy curtain was pulled between the beds in the room and the Resident was sitting upright in bed.<br><br>-The surveyor observed that there were no staff in the Resident's room at this time.<br><br>-The surveyor spoke to the Resident and the Resident responded verbally and softly so that the surveyor had to ask the Resident to repeat what he/she said.<br><br>-The Resident then smiled and began to speak, and the surveyor observed scrambled eggs in the Resident's mouth, in between the Resident's front teeth and lips and over the top of the Resident's tongue.<br><br>-The surveyor asked the Resident about having scrambled eggs in his/her mouth, and the Resident said, No.<br><br>-The surveyor asked the Resident again about the eggs in his/her mouth and the Resident swallowed the eggs.<br><br>-The surveyor observed that there was no meal tray in the Resident's room.<br><br>During an interview on 12/5/24 at 9:00 A.M., CNA #2 said that she worked at the facility three days per week and that frequently assisted Resident #83 with eating. CNA #2 said that she had noticed a few days prior that the Resident was having difficulty swallowing and was unable to swallow any lumpy food. CNA #2 said she had assisted Resident #83 with eating over the previous three days and the Resident required his/her food to be ground up so that it was really smooth. CNA #2 said that she thought the SLP was supposed to see the Resident for swallowing and she was not sure if the SLP had seen the Resident yet. CNA #2 also said that she had not received any education or instructions from the Nurse or the SLP relative to swallowing strategies for the Resident. When the surveyor inquired about the scrambled eggs observed in Resident #83's mouth on 12/4/24 at 9:42 A.M., CNA #2 said, I'm glad you were here to see that.<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 - Some | During an interview on 12/5/24 at 9:07 A.M., Nurse #1 said that Resident #83 had trouble when drinking and would cough when drinking. Nurse #1 said that the SLPs had been treating the Resident, and the treatment was being discontinued due to the Resident being admitted to Hospice services. Nurse #1 said that Hospice personnel had been in the facility on 12/3/24 to admit the Resident to Hospice services, and she had not seen Hospice personnel with the Resident since 12/3/24. Nurse #1 said that Hospice personnel would be responsible to further assess Resident #83's swallowing function.<br><br>During an interview on 12/5/24 at 9:20 A.M., Unit Manager (UM) #1 said Resident #83 had been evaluated by the SLP and that speech therapy services were discontinued on 12/3/24 when the Resident was admitted to Hospice services. When the surveyor discussed the observation of Resident #83 from 12/4/24 at 9:42 A.M. , UM #1 said she was not aware the Resident had been pocketing food in his/her mouth and that she would need to notify Hospice personnel so that the Resident could be assessed. The surveyor and UM #1 reviewed the results of the Resident's SLP Evaluation and Plan of Treatment from 11/27/24, which indicated the Resident had decreased awareness of food in his/her mouth and that the Resident held food in his/her mouth during the evaluation. UM #1 said she did not know the Resident had been holding food in his/her mouth and she could not recall any recommendations made by the SLP for Resident #83 relative to safe swallowing strategies. UM #1 further said Resident #83 was very confused and would not be aware of food left in his/her mouth. UM #1 further said if Resident #83 held food in his/her mouth, he/she would need to be cued by staff to swallow the food. UM #1 said that staff who assisted residents to eat knew to check residents' mouths for residual food before leaving them alone, and that staff who assisted Resident #83 on 12/4/24 should have made sure the Resident was not left with food in his/her mouth.<br><br>During an interview on 12/5/24 at 9:49 A.M., SLP #1 said she evaluated Resident #83's swallowing function on 11/27/24, when the facility's Director of Rehabilitation (DOR) had informed her that a referral for speech therapy had been made by nursing staff due to the Resident having experienced weight loss. SLP #1 said when she evaluated the Resident, the Resident was very confused. SLP #1 said that the Resident was unable to pay attention to his/her meal, unable to feed him/herself, and was unaware of the presence of food in his/her mouth. SLP #1 said Resident #83 held food in his/her mouth and could eventually clear the food with alternating solids and liquids and with cues provided by SLP #1. SLP #1 said that after she completed Resident #83's evaluation, she spoke with one CNA and instructed the CNA to alternate solids and liquids for Resident #83. SLP #1 said she could not recall who the CNA was and that she did not discuss safe swallow strategies for the Resident with any other staff at that time. SLP #1 said she saw the Resident again on 12/3/24 and the Resident required full assistance from staff to eat at that time. SLP #1 said that she was informed on 12/3/24 that Resident #83 was being admitted to Hospice services and that she was to discontinue speech therapy services. SLP #1 said that she would normally complete a written staff education sheet with recommendations for safe swallowing strategies to be implemented for residents when they were discharged from speech therapy services, but that she did not complete a written staff education sheet for Resident #83 because she had to discontinue services due to Hospice admission. SLP #1 further said that she was not made aware Resident #83 was being admitted to Hospice until after she treated the Resident that same day, so education to staff for safe swallow strategies had not been completed prior to discontinuing speech therapy services. SLP #1 said that she could not speak to how CNAs were educated regarding swallowing safety for residents, but she thought they would know not to leave a Resident with confusion and swallowing impairments, who required assistance and cues to eat, alone with food in their mouth.<br><br>(continued on next page) |

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| | 225439 | A. Building<br>B. Wing | 12/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Odd Fellows Home of Massachusetts | 104 Randolph Road<br>Worcester, MA 01606 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 12/5/24 at 10:15 A.M., the Staff Development Coordinator (SDC), who was also the Infection Preventionist (IP) said that Certified Nurse Aides' training included assisting residents to eat and feeding residents. The SDC said that she provided education to CNAs during orientation, regarding feeding residents and that a portion of the training was to remind staff to check residents' mouths, to ensure no food was left, for the residents' safety.<br><br>Immediately following the interview with the SDC/IP, the SDC/IP provided CNA #2's Orientation Checklist to the surveyor which indicated the following:<br><br>-The Orientation Checklist had been completed for CNA #2 on 4/4/24.<br><br>-The CNA had been provided education and deemed competent relative to assisting residents with feeding.<br><br>During an interview on 12/5/24 at 10:27 A.M., the Director of Rehabilitation (DOR) said that Resident #83 was evaluated by the SLP on 11/27/24, following a nursing staff referral for difficulty swallowing and weight loss. The DOR said that the SLP had to discontinue services for Resident #83 on 12/3/24, because the Resident was being admitted to Hospice services. The DOR said that he did not think the SLP would have been required to educate staff on safe swallowing strategies for Resident #83 upon discontinuing speech therapy services because the Resident transitioned to Hospice services. The DOR said it would now be the Hospice personnel's responsibility to assess the Resident and make recommendations relative to safe swallowing. When the surveyor asked who was responsible to ensure interventions were put in place for the Resident to ensure the Resident's safety with swallowing until Hospice personnel assessed the Resident's swallowing abilities, the DOR said, That is a good question. The DOR further said that education had not been completed with nursing staff relative to recommendations for safe swallowing strategies for Resident #83.<br><br>Please refer to F842.<br><br>48206<br><br>2. Review of the facility policy titled Falls Accident/Accident Policy and Procedure, dated 2/24/24, indicated:<br><br>-The Fall Risk Assessment Tool .will be completed on all residents immediately upon admission, quarterly, annually, and whenever there is a significant change in resident status. The Tool will be completed by the Unit Nurse or designee.<br><br>-New admissions: Any new admissions who have had a fall previously, and/or who are a known risk for falls will have an appropriate intervention initiated on admission.<br><br>-Nursing will document in the nursing notes for 72 hours after admission if the intervention implemented on admission is effective and if any new intervention has been implemented.<br><br>Resident #35 was admitted to the facility in October 2023 with diagnoses including difficulty in walking, Atrial Fibrillation (irregular and rapid heart rhythm), and Dementia.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #35:<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 - Some | -was mildly cognitively impaired as evidenced by Brief Interview for Mental Status (BIMS) score of 12 out of a possible total of 15.<br><br>-was able to ambulate short distances independently.<br><br>-needed supervision to ambulate greater than 50 feet.<br><br>-was prescribed an anticoagulant medication.<br><br>Review of the current Physician's orders for Resident #35 included:<br><br>-Eliquis (anticoagulant medication) 5 mg (milligrams), twice a day at 8:00 A.M. and 8:00 P.M. for diagnosis of atrial fibrillation, initiated 3/15/24<br><br>Review of the Nursing Progress notes indicated the following:<br><br>-4/29/24: Resident #35 complained of chest pain and orders were obtained from the Nurse Practitioner (NP) to send to the emergency room (ER) for further evaluation.<br><br>-5/2/24: Resident #35 returned to the facility from hospitalization where he/she was admitted for increased confusion and UTI (urinary tract infection).<br><br>-5/7/24: Resident #35 sustained a fall around 2:40 P.M. at the nurses station .tripped on his/her roller walker and fell on his/her right side .stated he/she hit his/her head. The Resident complained of hip pain, sustained three skin tears .vomited undigested food twice .orders were obtained from the NP to send to ER for further evaluation.<br><br>-5/13/24: Resident #35 returned from hospital where he/she had been a admitted for closed displaced comminuted (sic) fracture of shaft of right femur (broken thigh bone) and he/she underwent fixation surgery.<br><br>Review of Resident #35's Care Plan for Risk of Falls, initiated 10/12/23, indicated:<br><br>-Resident is at risk for fall related injury due to history of fall with fracture (right leg), history of dizzy spells leading to falls (per Resident), generalized weakness, limited range of motion to right arm and leg, and altered mobility.<br><br>-Intervention of Fall Risk Assessment quarterly and PRN (as needed), initiated 10/12/23<br><br>Review of Resident #35's care plan for risk for Abnormal Bleeding, initiated 10/12/23, indicated:<br><br>-Resident is at risk for abnormal bleeding due to use of [anticoagulant] for Atrial Fibrillation<br><br>-Goal that Resident will not have excessive bleeding related to anticoagulant therapy<br><br>-Intervention to handle Resident carefully when turning, positioning, or transferring to avoid injury, initiated 10/12/23.<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 - Some | Further review of Resident #35's medical record did not indicate evidence of a fall risk assessment relative to 5/2/24 and 5/13/24 when the Resident returned from hospitalization .<br><br>During an interview on 12/6/24 at 8:20 A.M., UM #1 said that a falls assessment would evaluate neurological status, vital signs, medication review, ambulation status, changes in skin, and include any care plan interventions implemented to prevent falls. The surveyor and UM #1 reviewed Resident #35's medical record and UM #1 said that Resident #35 should have been assessed for falls risk on re-admission after each hospitalization s but had not been.<br><br>During an interview on 12/6/24 at 9:50 A.M., Nurse #4 said that when a resident is readmitted to the facility, Nursing will conduct evaluations for pain, elopement, falls, and a Norton Scale and those evaluations are documented in the resident records under observations. Nurse #4 further said that she closely monitors residents on anticoagulant medications due to the higher risk of internal bleeding should a fall or injury occur. Nurse #4 said if a fall occurs, she would contact the Doctor or NP immediately and obtain an order for emergency room evaluation if indicated by the medical practitioner.<br><br>No additional evidence of post-hospitalization fall risk assessments for Resident #35 were provided to the survey team at the time of survey exit.<br><br>3. Resident #53 was admitted to the facility in April 2024 with diagnoses including Dementia with other behavioral disturbance, Vestibular Neuritis (inner ear disorder that causes symptoms such as sudden, severe vertigo [a sudden internal or external spinning sensation, often triggered by moving your head too quickly], dizziness, balance problems, nausea and vomiting), and Atrial Fibrillation.<br><br>Review of the MDS assessment dated [DATE], indicated Resident #53 was moderately cognitively impaired as evidenced by a BIMS score of 9 out of a total possible 15.<br><br>Review of the current Physician's orders for Resident #53 included:<br><br>-Eliquis 2.5 mg (milligrams), twice a day at 8:00 A.M. and 8:00 P.M. for diagnosis of atrial fibrillation, initiated 11/21/24.<br><br>-LSO (Lumbar Sacral Orthosis, specialty device) Brace to lumbar spine every shift while out of bed, remove during care and inspect skin integrity every shift, once a day, initiated 12/2/24.<br><br>Review of the Nursing Progress notes indicated:<br><br>-11/30/24: Resident was out on loa (leave of absence) since 11/28 and was due to return tonight. [Spouse] called the facility at 6:00 P.M., and stated that the Resident fell at home this morning and has been in the ER since then .writer called the hospital for an update .testing revealed an L3 burst compression fracture (severe break in the spine when the vertebrae are crushed in all directions) .Patient is to be evaluated by physical therapy and they will acquire an LSO brace.<br><br>-12/1/24, Resident returned from hospital where he/she was admitted following a fall while away with family. Hospital discharge notes indicated L3 Fracture with recommendation of LSO brace and ambulation with therapy.<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 - Some | Review of Resident #53's Care Plan for Risk for Falls, initiated 4/19/24, indicated:<br><br>-Resident was at risk for fall related injury due to altered mobility, use of psychotropic medications, Meniere's disease (inner ear problem that can cause dizzy spells, also called vertigo, and hearing loss), and Dementia with behavioral disturbances.<br><br>-Intervention for fall risk assessment quarterly and PRN (as needed), initiated 4/19/24<br><br>During an interview on 12/5/24 at 9:07 A.M., Nurse #5 said that Resident #53 had a recent fall which occurred outside of the facility, and he/she is now wearing an LSO brace to promote healing of the fracture. Nurse #5 said that the Resident is to wear the brace while out of bed and the Resident is receiving physical therapy treatments as well. Nurse #5 further said Resident #53 is at risk of bruising or bleeding due to his/her use of anticoagulant medication. Nurse #5 said that if a fall were to occur, she would immediately complete a falls assessment, monitor the Resident's vitals closely, complete an incident report and skin check, and contact the Doctor or NP immediately as the Resident may need transfer to hospital for emergency evaluation due to risk of internal bleeding with the anticoagulant use.<br><br>Further review of Resident #53's medical record did not indicate evidence of a falls risk assessment relative to 12/1/24 when the Resident returned to the facility from hospitalization .<br><br>During an interview on 12/5/24 at 12:04 P.M., UM #1 said that Resident #53 was not re-assessed for fall risk when he/she was readmitted to the facility, and should have been. |

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| F 0790<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide routine and 24-hour emergency dental care for each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47646<br><br>Based on observation, record review, and interview, the facility failed to provide routine dental services for one Resident (#46), out of a total sample of 18 residents.<br><br>Specifically, the facility failed to schedule dental appointments when consent was given, to ensure that Resident #46 received routine dental services as requested, resulting in complications related to dental deterioration for the Resident.<br><br>Findings include:<br><br>Review of the facility policy titled Dental Services dated 11/28/17, indicated but was not limited to the following:<br><br>- residents are assisted in obtaining regular and emergency dental care through the dentist or dental services indicated at the time of the admission<br><br>Resident #46 was admitted to the facility in January 2020, with diagnoses including Dementia and Dysphagia.<br><br>On 12/4/24 at 10:29 A.M., the surveyor observed Resident #46 lying in bed. The Resident was observed to have several missing and broken teeth in his/her mouth.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #46:<br><br>-was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15.<br><br>-required substantial /maximal assistance with oral hygiene.<br><br>Review of the medical record indicated a Physician order dated 3/25/21, that indicated:<br><br>-Dentist Consult as needed.<br><br>Review of Resident #46's Dental Care Plan indicated but not limited to:<br><br>-Problem Start Date: 8/11/21, revised 11/5/24<br><br>-Resident #46 is assessed with cavity or broken teeth.<br><br>-Approach Start Date: 8/11/21 - refer to dental as indicated.<br><br>(continued on next page) |

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| F 0790<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the medical record indicated a completed Dental Consent Form (a check off form indicating a resident's interest in receiving dental services) for Resident #46. The Dental Consent Form directed the Resident check the statement for which he/she wished to apply. The statement - I would like Dentist to provide dental care was checked off. The form was signed by Resident #46 and was dated 1/20/20. Resident #46 was the responsible party at that time.<br><br>Further review of the medical record failed to indicate that Resident #46 received any dental services from the Dentist as requested.<br><br>During an interview on 12/6/24 at 2:20 P.M., Unit Manager (UM) #1 said that she looked through the medical record and cannot find anything about Resident #46 being seen by dental services. UM #1 said that Resident #46 refuses care a lot. UM #1 said she will reach out to the dental provider to see whether the Resident has ever been seen for routine dental services.<br><br>During an interview on 12/9/24 at 1:10 P.M., UM #1 said she talked with the dental provider's office and Resident #46 had never been seen by that Dentist since signing the consent and was not on the list to be seen. UM #1 said that Resident #46 was seen after the surveyor asked about dental services last week. UM #1 said the Resident allowed the Dentist to take some x-rays and consented to cleaning during the next visit. UM #1 said there were no other visits attempted prior to this visit.<br><br>On 12/9/24 at 2:57 P.M., UM #1 provided the surveyor with the recent dental visit information. The form indicated but was not limited to the following:<br><br>-the Resident was given a Comprehensive Oral Evaluation and x-ray by the Dentist.<br><br>-the text note indicated the Resident was sitting up in bed and consented to be seen.<br><br>-Findings: very poor dentition with fractured teeth/multiple roots/poor oral hygiene/limited occlusal stop (the point where opposing teeth touch). Obvious decay/ moderate to severe gingivitis/Patient (Pt) refuses any extractions then dentures.<br><br>-the Resident Ok'd (agreed to) a cleaning which I will put him/her on the list.<br><br>Review of the dental x-rays dated 12/7/24, indicated:<br><br>-13 teeth were fractured to the root (Tooth #1, 3, 4, 8, 9, 10, 11, 12, 14, 15, 22, 23, 26)<br><br>-8 teeth were decayed (Tooth #6, 7, 18, 21, 24, 25, 27, 28)<br><br>During an interview on 12/9/24 at 3:27 P.M., UM #1 said that once a consent is signed by a Resident, he/she should be added to the list to see the Dentist. UM #1 said she is surprised that this consent was signed so long ago and Resident #46 was never seen by the Dentist. UM #1 said Resident #46 should have been seen right after the consent was signed.<br><br>During an interview on 12/9/24 at 3:52 P.M., the Director of Nursing (DON) said her expectation is that when a Resident requests dental services and signs a consent, he/she should receive services as soon as possible. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51571<br><br>Based on observation, record review and interview, the facility failed to maintain complete and accurate medical records for three Residents (#46, #69, and #83), out of a total sample of 18 residents.<br><br>Specifically, the facility failed to:<br><br>1. accurately document measurements of urinary output as ordered when Resident #46 was identified as having a urinary catheter drainage system that provided numerical output measurements.<br><br>2. accurately document 24-hour fluid intake and urinary output (I & O) for Resident #69 when the Physician ordered 24-hour I & O monitoring to be completed and documented by staff.<br><br>3. maintain a complete clinical record for Resident #83 to include the Resident's Speech Therapy Evaluations, Speech Therapy Treatment Notes, and Speech Therapy Discharge Summary when the Resident had been evaluated, treated, and discharged from speech therapy services and recommendations for safe swallowing strategies were included in the Resident's Speech Therapy Discharge Summary.<br><br>Findings include:<br><br>Review of the Facility Policy titled Intake, Measuring and Recording Policy, undated, indicated the following:<br><br>-The purpose of procedure is to accurately determine the amount of liquid a resident consumes in a 24-hour period.<br><br>-Record all fluid intake on the intake and output record in cubic centimeters (cc or milliliters [mls]).<br><br>-Post an intake and output record form in the resident's room.<br><br>Review of the Facility Policy titled, Nutrition/Hydration Status Maintenance revised 10/6/23, indicated the following:<br><br>-Based on a resident's comprehensive assessment, the facility will ensure that a resident is offered sufficient fluid intake to maintain proper hydration and health<br><br>1. Resident #46 was admitted to the facility in January 2020, with diagnoses including Benign Prostatic Hyperplasia without Lower Urinary Tract Symptoms, and Chronic Kidney Disease (CKD), Stage 3.<br><br>Review of the Resident's Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #46:<br><br>-was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of a total score of 15.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -had an indwelling foley catheter (a thin, flexible tube that is inserted into the bladder to drain urine into a collection bag).<br><br>Review of the Comprehensive Person-Centered Care Plan dated 11/25/24, indicated:<br><br>-Indwelling Catheter, active 11/25/24<br><br>-Assess the drainage system every shift and PRN (as needed). Record the amount, type, color, odor. Observe for leakage, active 12/4/24<br><br>-Document urinary output every shift. Record the amount, type, color, odor. Observe for leakage, active 11/25/24<br><br>Review of Resident #46's December 2024 Physician orders indicated:<br><br>-24-hour total intake and output to be calculated daily on the 11:00 P.M. to 7:00 A.M. (11-7) shift. Please indicate totals here, initiated 11/25/24.<br><br>-Encourage fluids every shift, initiated 11/26/24.<br><br>Review of Resident #46's November 2024 and December 2024 Nursing Documentation of Urine Output indicated no exact measurements of urine output were documented on the following dates:<br><br>-urine output was documented as 'medium' on: 11/19/24, 12/2/24, 12/4/24 and 12/5/24<br><br>-urine output was documented as 'large' on: 11/30/24 and 12/1/24<br><br>-urine output was documented as 'none' on: 11/27/24 and 11/28/24<br><br>During an interview on 12/6/24 at 10:30 A.M., Nurse #1 said that residents who are on antibiotics and have Foley catheters are placed on intake and output (I&O) monitoring. Nurse #1 also said that the 11:00 P.M. to 7:00 A.M. (11-7) shift tallies the totals for the 24-hour period by adding the total fluid amounts from the 7:00 A. M. to 3:00 P.M. (7-3) and the 3:00 P.M. to 11:00 P.M. (3-11) shifts from the prior day and then add their 11-7 shift which includes supplements, meal fluids, medications fluids.<br><br>During an interview on 12/6/24 at 10:45 A.M., the Director of Nursing (DON) said that the process for monitoring intake and output totals was as Nurse #1 described, and that this process was something that she had wanted to change since she has been at the facility. The DON said she did not believe that residents who were stable with an indwelling catheter needed to be on intake and output monitoring. The DON further said that staff would monitor output but not necessarily the intake if the resident were eating and drinking well and the Foley catheter were chronic (long term use). The DON said that the intake and output totals should indicate an accurate amount of intake and output for monitoring purposes. The DON said that Resident #46's Physician's order for intake and output monitoring was confusing and she had never seen an intake and output order like that. The DON said she knows that the intake and output process needed to be revised.<br><br>42761<br><br>(continued on next page) |

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| | 225439 | A. Building<br>B. Wing | 12/10/2024 |

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| Odd Fellows Home of Massachusetts | 104 Randolph Road<br>Worcester, MA 01606 |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Resident #69 was admitted to the facility in October 2021, with diagnoses including Obstructive (blockage) and Reflux (backward flow) Uropathy (in the urinary tract) and Retention of Urine.<br><br>Review of Resident #69's clinical record indicated the Resident had an indwelling urinary catheter.<br><br>Review of Resident #69's Indwelling Catheter Care Plan, initiated 4/10/24 and last reviewed/revised on 10/3/24, indicated:<br><br>-The Resident required an indwelling urinary catheter related to Obstructive Uropathy.<br><br>-Assess the drainage system every shift and PRN (as necessary).<br><br>-Record the amount .<br><br>Review of Resident #69's Minimum Data Set (MDS) assessment dated [DATE], indicated:<br><br>-The Resident was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of five out of 15 total possible points.<br><br>-The Resident was dependent on staff for toileting.<br><br>-The Resident had an indwelling urinary catheter.<br><br>Review of Resident #69's November 2024 Physician Orders indicated the following order, dated 11/2/23 with no stop date:<br><br>-24-hour total intake and output to be calculated daily on 11:00 P.M. to 7:00 A.M. (11-7) shift.<br><br>-Please indicate totals .<br><br>Review of Resident #69's November 2024 Treatment Administration record (TAR) indicated:<br><br>-The Resident's 24-hour intake total on 11/1/24 was recorded as 640 milliliters (ml) +.<br><br>-There was no 24-hour total intake and output recorded on 11/3/24.<br><br>-The Resident's 24-hour output total was recorded as 850 +, medium on 11/13/24.<br><br>-The Resident's 24-hour intake total was recorded as 620 + and 24 hour output total was recorded as 800 + on 11/25/24.<br><br>-There was no 24-hour total intake and output recorded on 11/27/24.<br><br>On 12/4/24 at 9:54 A.M., the surveyor observed Resident #69 lying in bed with a catheter tube extending out from under the sheets, leading to a covered bedside drainage bag visible on the right side of the Resident's bed.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview at the time, Resident #69 said he/she did not have an indwelling urinary catheter.<br><br>During an interview on 12/6/24 at 10:30 A.M., Nurse #1 said that all Residents with indwelling urinary catheters were placed on I & O monitoring. Nurse #1 said that Nurses who worked on the 11-7 shift were responsible to tally the 24-hour intake and output totals for Residents on I & O monitoring and to record the totals on the TAR. Nurse #1 said that the totals recorded for intake and output were supposed to be exact measurements.<br><br>During an interview on 12/6/24 at 10:45 A.M., the Director of Nursing (DON) said that Nurses who worked on the 11-7 shift were responsible to tally and record the 24-hour intake and output totals for Residents with indwelling urinary catheters. The DON said that the totals recorded were to accurately reflect the total amount of fluid taken in and put out during the 24 hour period. The surveyor and the DON reviewed Resident #69's November 2024 TAR and the DON said that she did not know what the use of the + sign following recorded mls meant. The DON further said that she did not know how the measurements for I & O using the + sign should be interpreted relative to how much liquid the Resident took in and how much urine was put out. The DON said that none of the 24-hour totals for I & O should have been left blank. The DON said I & O monitoring was not recorded accurately in Resident #69's clinical record.<br><br>3. Resident #83 was admitted to the facility in August 2023 with diagnoses including Dementia and muscle weakness.<br><br>Review of Resident #83's Rehabilitation Request/Screen Form, dated 11/21/24, indicated:<br><br>-The Resident had experienced weight loss.<br><br>-The Resident's diet had been downgraded on 10/25/24.<br><br>-Intervention recommended was for the Speech Language Pathologist (SLP) to assess the Resident.<br><br>Review of Resident #83's clinical record on 12/4/24, did not include any evidence the Resident had been assessed by the SLP.<br><br>On 12/4/24 at 9:42 A.M., the surveyor observed Resident #83 room sitting upright in bed and that there were no staff or meal tray present in the Resident's room at this time. The surveyor spoke to the Resident who responded verbally and softly so the surveyor had to ask the Resident to repeat what he/she said. Resident #83 smiled and began to speak, and the surveyor observed scrambled eggs in his/her mouth, in between the Resident's front teeth and lips and over the top of the Resident's tongue. When the surveyor asked the Resident about having scrambled eggs in his/her mouth, the Resident said, No. When the surveyor asked the Resident again about the eggs in his/her mouth, the Resident swallowed the eggs.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 12/5/24 at 9:00 A.M., CNA #2 said that she assisted Resident #83 frequently with eating. CNA #2 said she had noticed that the Resident was having difficulty swallowing. CNA #2 said that she thought the SLP was supposed to see the Resident for swallowing and that she was not sure if the SLP had seen the Resident yet. When the surveyor asked how CNA #2 would know whether any recommendations had been made by the SLP relative to swallowing for Resident #83, CNA #2 said that the SLP would normally provide verbal education and a written education sign-in sheet for staff. CNA #2 said she had not yet received any education relative to safe swallowing strategies for Resident #83.<br><br>During an interview on 12/5/24 at 9:07 A.M., Nurse #1 said that Resident #83 had difficulty swallowing and would cough when drinking. Nurse #1 said that the SLPs had evaluated and treated the Resident and that the treatment was being discontinued due to the Resident being admitted to Hospice services. Nurse #1 said she was not sure if the Resident's speech therapy services had been discontinued yet. Nurse #1 also said that alternating solids and liquids when assisting Resident #83 to eat was important for safety with swallowing and that she was not aware of any other recommendations made for safe swallow strategies for the Resident.<br><br>During an interview on 12/5/24 at 9:20 A.M., Unit Manager (UM) #1 said Resident #83 had been evaluated by the SLP and that speech therapy services were discontinued on 12/3/24 when the Resident was admitted to Hospice services. The surveyor asked about any recommendations relative to safe swallow strategies that were made by the SLP upon discontinuing speech therapy services and UM #1 said that she did not recall any recommendations made by the SLP relative to safe swallow strategies for Resident #83. UM #1 reviewed Resident #83's electronic health record (EHR) and paper record on the Unit and said that there was no documentation in the Resident's record relative to speech therapy services. UM #1 further said that she did not know how to access the SLP's documentation for Resident #83.<br><br>During an interview on 12/5/24 at 9:49 A.M., SLP #1 said she completed an evaluation for Resident #83 on 11/27/24. SLP #1 said that the evaluation was completed in an electronic format and she did not know if the evaluation automatically became part of the Resident's electronic health record (EHR) or if the evaluation needed to be scanned into the Resident's EHR. SLP #1 said she printed a copy of the evaluation on 11/27/24 and left the copy for the Director of Rehabilitation (DOR), but she was not sure if the DOR filed the printed copy of the evaluation in the Resident's paper record located on the Unit. SLP #1 said she treated Resident #83 for two visits and discharged the Resident from speech therapy services on 12/3/24.<br><br>Review of Resident #83's clinical record on 12/5/24 did not include the evaluation completed by SLP #1, nor did the clinical record include any speech therapy treatments notes and speech therapy discharge summary.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 12/5/24 at 10:27 A.M., the DOR provided copies of the speech therapy evaluation, progress notes, and discharge summary completed for Resident #83 from 11/27/24 through 12/3/24. The DOR said evaluations, progress notes, and discharge summaries completed by Rehabilitation Therapists were completed electronically in a separate system from the Residents' EHRs that facility staff had access to. The DOR said that once each of the evaluations, progress notes and discharge summaries were completed, the electronic submissions were supposed to automatically transfer into the Residents' EHRs. The DOR said that he did not know Resident #83's speech therapy evaluation, progress notes, and discharge summary did not transfer into the Resident's EHR and that since the surveyor inquired about the notes, he identified other residents whose notes also did not transfer into their EHRs. The DOR said that SLP #1 did leave a printed copy of Resident #83's speech therapy evaluation on 11/27/24 and that the DOR had not yet placed the copy into the Resident's clinical record because the evaluation had not been signed by the Physician yet. The DOR also said he did not place copies of therapy evaluations into residents' clinical records until the evaluations were signed by the Physician. The DOR further said that facility staff did not have access to the electronic system used by the Therapists.<br><br>Following the interview with the DOR that occurred on 12/5/24 at 10:27 A.M., the surveyor reviewed the Speech Therapy Evaluation, Speech Therapy Progress Notes, and Speech Therapy Discharge Summary provided by the DOR which indicated:<br><br>-The Resident was evaluated by SLP #1 on 11/27/24.<br><br>-The Resident has difficulty swallowing.<br><br>-The Resident received two speech therapy sessions following the evaluation.<br><br>-The Resident was discharged from speech therapy services on 12/3/24 with recommendations for safe swallowing strategies.<br><br>-Safe swallowing strategies recommended for the Resident included upright positioning during all intake and greater than 30 minutes following intake, bolus size reductions, rate modifications, alternate solids with liquids at a two to one ratio to assist with oral and pharyngeal clearing of bolus, .<br><br>During a follow-up interview on 12/5/24 at 4:30 P.M., the DOR said that Resident #83's Speech Therapy Evaluation, Speech Therapy Progress Notes, and Speech Therapy Discharge Summary should have been available in Resident #83's record, but they were not. |

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| F 0868<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Have the Quality Assessment and Assurance group have the required members and meet at least quarterly<br><br>44337<br><br>Based on record review and interview, the facility failed to ensure that the required members were included in the Quality Assessment and Performance Improvement (QAPI) committee quarterly meetings.<br><br>Specifically, the facility failed to provide evidence that the Medical Director attended two out of the four quarterly QAPI meetings as required.<br><br>Findings include:<br><br>Review of the facility document titled Facility QAPI Plan dated 1/16/2019, indicated the following:<br><br>-Medical Director must attend at least quarterly, preferred monthly.<br><br>-All attendees present sign in. If a member is unable to attend in person, due to an occasional schedule conflict, or vacation, indicate the reason they are not in attendance at the meeting.<br><br>Review of the facility QAPI meeting schedule indicated the QAPI Team met quarterly on 1/18/24, 4/18/24, 7/18/24 and 10/18/24.<br><br>During an interview on 12/10/24 at 3:15 P.M., the Administrator said the Medical Director is required to attend the quarterly QAPI meetings and that all attendees of the QAPI meeting were required to sign the attendance sheet. The surveyor and the Administrator reviewed the attendance sheets for the quarterly QAPI meetings held at the facility, and the Administrator said that the Medical Director had signed the attendance sheet for the QAPI meetings in April 2024 and October 2024, but did not sign the attendance sheets for the QAPI meetings that took place in January 2024 and July 2024. The Administrator further said that the Medical Director had not attended the quarterly QAPI meetings in January 2024 and July 2024, but should have attended the meetings as required. |

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51571<br><br>Based on observation, interview, and record review, the facility failed to adhere to infection control standards of practice for one Resident (#69) out of a total sample of 18 residents.<br><br>Specifically, for Resident #69, the facility failed to:<br><br>-appropriately follow Enhanced Barrier Precautions (EBP's: the use of protective gowns and gloves during high contact care activities that may provide opportunity for transmission of medication resistant organisms through staff hands and/or clothing), when providing high contact care for the Resident, increasing the risk of contamination and spreading infections to the Resident and other Residents within the facility.<br><br>Findings include:<br><br>Review of the facility policy titled Enhanced Barrier Precautions (EBP), indicated the following:<br><br>-The facility will implement EBP during high contact resident care activities for those residents who are colonized with an MDRO (multi-drug-resistant organisms) unless otherwise ordered by healthcare provider.<br><br>>Examples of high-contact resident care activities:<br><br>-Dressing<br><br>-Bathing/Showering<br><br>-Transferring<br><br>-Changing Linens<br><br>-Changing Briefs or Assisting with Toileting<br><br>-Device Care or Use: - central line, urinary catheter, feeding tube, tracheostomy/ventilator<br><br>-Wound care-any skin opening requiring a dressing<br><br>>The facility may choose to implement EBP to include any resident with an indwelling medical device or wound, regardless of MDRO colonization or infection.<br><br>>The Infection Preventionist (IP)/Designee will provide staff, residents and/or resident representatives with education regarding the purpose of enhanced barrier precautions.<br><br>>Staff will perform hand hygiene and don personal protective equipment (PPE) before entering resident's room.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | >Staff will remove PPE and perform hand hygiene before exiting resident's room.<br><br>Resident #69 was admitted to the facility in October 2021, with diagnoses including Obstructive and Reflux Uropathy, Urinary Tract Infection (UTI) and Urethral Fistula (an opening between the urethra and perineum that causes incontinence and recurrent urinary tract infections(UTIs).<br><br>Review of the Resident's Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #69:<br><br>-was severely cognitively impaired as evidenced by a score of 5 out of a total score of 15 on the Brief Interview for Mental Status (BIMS) exam.<br><br>-had an indwelling urinary catheter (also referred to as a Foley catheter).<br><br>Review of Resident #69's Comprehensive Person-Centered Care Plan dated 4/10/24, indicated:<br><br>-indwelling urinary catheter.<br><br>Review of Resident #69's Nursing Progress Note, dated 11/20/24, indicated:<br><br>-EBP for indwelling medical device.<br><br>On 12/5/24 at 9:10 A.M., the surveyor observed EBP signage posted outside of Resident #69's room which indicated for Everyone:<br><br>-to cleanse hands before entering and when leaving the room.<br><br>-wear gloves and a gown for high contact resident care activities including transferring and changing linens.<br><br>On 12/5/24 at 9:12 A.M., the surveyor observed two staff members transferring Resident #69 from the bed into a wheelchair with no protective gowns being worn by either staff. Certified Nurses Aide (CNA) #2 was observed to pick up Resident #69's Foley catheter and hang the Foley catheter containing urine in the bag on the Resident's wheelchair. CNA #2 then proceeded to handle the Resident's bed linen by making the bed with no protective gown on. The surveyor observed CNA #2 exit the Resident's room and re-entered a few minutes later and continued to assist the Resident without donning or doffing the appropriate PPE.<br><br>During an interview immediately following the observation on 12/5/24 at 9:19 A.M., CNA #2 said that she was getting the Resident up from bed to go to the dayroom. CNA #2 further said that the Resident was already dressed and that she did not need to utilize a gown. CNA #2 said she believed she had to sanitize her hands and utilize gloves when handling the Resident's Foley catheter. CNA #2 also said that the Resident was on the EBP because he/she had a Foley catheter but she did not need to use a gown when getting the Resident out of bed because the Resident was already dressed for the day.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 12/5/24 at 10:19 A.M., the Staff Development Coordinator/Infection Preventionist (SDC/IP) said that EBP signage and PPE were used for any Resident that had an indwelling medical device. The SDC/IP also said the use of EBP's were for any high contact care for a Resident who had an indwelling medical device and required care from staff such as transferring, and when handling Resident bed linens. The SDC/IP said that the expectation for staff following EBP signs depended on what staff were doing for the Resident. The SDC/IP also said that staff should know what to do, and the expectation was that staff utilize PPE supplies provided when caring for a Resident on EBP if transferring, handling a Foley catheter, and/or making the bed of a Resident's that has a Foley catheter.<br><br>During a follow-up interview on 12/5/24 at 1:50 P.M., the SDC/IP said that Residents were placed on EBP either upon admission or when something else comes up after the Resident had been admitted , such as a Foley catheter insertion and/or a Gastrostomy Tube (G-tube: a tube inserted through the abdomen that provides nutrition directly to the stomach). The SDC/IP said the Physician would enter an order in the Resident's records and a care plan would be developed for Residents who have been placed on EBP's so that staff were able to know what the expectations were. The SDC/IP further said that she was responsible for educating staff on EBP for Resident's and that she just did an education for staff and the expectation on PPE requirements. |

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| F 0909<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48206<br><br>Based on observation, record review and interview, the facility failed to complete an inspection of the bed rails, to identify areas of possible entrapment, for one Resident (#49) out of a total sample of 18 residents.<br><br>Specifically, the facility failed to assess the side rails and mattress in active use for entrapment when Resident #49 had limited mobility and utilized bilateral side rails, placing the Resident at risk for possible entrapment.<br><br>Findings include:<br><br>Review of the facility policy titled Side Rail Policy, undated, indicated:<br><br>-An assessment will be made to determine the resident's symptoms, risk of entrapment, and reason for using side rails .<br><br>-The resident will be checked periodically for safety relative to side rail use.<br><br>-When said rail usage is appropriate, the facility will assess the space between the mattress and the side rails to reduce the risk for entrapment .<br><br>Review of the facility policy titled Falls Accident/Accident Policy and Procedure, dated 2/24/24, indicated:<br><br>-All mattresses and side rails do require specific measurements to be obtained to rule out the risk of entrapment and does utilize a specific weighted apparatus.<br><br>-The side rail and mattress measurements are performed and maintained by Maintenance personnel.<br><br>-Measurements are to be obtained on an annual basis or with any new bedframe, new mattress application, weight changes in a resident, changes noted with resident physical abilities and/or whenever a resident is newly admitted .<br><br>Resident #49 was admitted to the facility in July 2020 with diagnoses including Vascular Dementia, Polyneuropathy, and muscle weakness.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #49:<br><br>-was cognitively intact as evidenced by Brief Interview for Mental Status (BIMS) score of 14 out of a total possible 15.<br><br>-had range of motion impairment to the lower extremities on both sides<br><br>-required maximum assistance by staff for upper body bathing and dressing<br><br>(continued on next page) |

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|---|---|---|---|
| | 225439 | A. Building<br>B. Wing | 12/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Odd Fellows Home of Massachusetts | 104 Randolph Road<br>Worcester, MA 01606 |

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 0909<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -was dependent on staff for lower body bathing and dressing<br><br>-was dependent with staff to roll left and right in bed<br><br>-was unable to go from lying to sitting<br><br>-did not ambulate.<br><br>On 12/4/24 at 9:17 A.M., the surveyor observed Resident #49 lying in bed, with the head of the bed elevated and bed in a low position with bilateral side rails in place. During an interview at the time, Resident #49 said that he/she was bed bound and was unable to ambulate or transfer out of bed.<br><br>On 12/6/24 at 12:04 P.M., the surveyor observed the Resident lying in bed sleeping, with the bed in low position and the head of the bed elevated with bilateral side rails in place.<br><br>Review of the Care Plan for Risk of Pressure Ulcer/Injury, initiated 7/27/20, indicated Resident #49:<br><br>-used 2 quarter side rails to enable him/her to participate in bed mobility.<br><br>During an interview on 12/6/24 at 1:47 P.M., the Maintenance Director (MD) said that he utilizes an entrapment assessment machine, and demonstrated to the surveyor how it is used to evaluate side rails and mattresses for entrapment risk. The surveyor requested evidence of any side rail assessments for Resident #49's current bed and mattress. The MD said that he did not have an assessment on file and was unable to provide evidence of past assessments for entrapment risk for Resident #49. |