STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225443	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blaire House of Worcester	116 Houghton Street Worcester, MA 01604

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish an infection prevention and control program (IPCP) to identify and prevent the potential spread of communicable diseases for 14 Residents (#55, #21, #51, #3, #23, #38, #60, #41, #12, #5, #31, #6, #39, #57), out of a total sample of 17 Residents. Specifically, the facility failed to:1. For Resident #55, identify Covid-19 infection when the Resident was exhibiting symptoms of a respiratory infection.2. For Resident #21, to appropriately disinfect a shared hallway bathroom after use when the Resident who used the shared bathroom tested positive for Covid-19.3. ensure staff performed proper hand hygiene and donned PPE (Personal Protective Equipment) upon entering and exiting Resident rooms when posted signage indicated it was required.4. For Residents (#51, #3, #23, #38, #60, #41, #12, #5, #31, #6, #39, #57), follow infection control practices by determining the type and duration of the isolation, depending upon the infectious agent or organism involved, and maintaining precautions for Residents with Covid-19, when the Residents were unable to maintain a mask outside of their rooms.5. utilize updated infection control signage outside of resident rooms, to provide appropriate guidance for staff on specific PPE required upon entering the resident rooms.6. For Resident #5, adhere to Enhanced Barrier Precautions (EBP) when providing direct care for the Resident, who had multiple open wound areas. Findings include: Review of the facility's policy titled Coronavirus Covid-19 Policy, revised 1/2024, indicated the following: -The facility will comply with the requirements of the most recent DPH LTC Testing guidance, which may be updated from time to time in response to further recommendations by DPH, CMS, or the Centers for Disease Control and Prevention (CDC). -The facility must conduct testing of all residents and staff if symptomatic. -Residents who have signs and symptoms of Covid-19 must be tested. Once test results are obtained, the facility must take the appropriate actions based on the results. -Compliance with the testing program is required. -Once a positive resident and /or staff member has been identified, then outbreak testing and contact tracing begins according to established regulatory Guidelines. -When prioritizing individuals to be tested, facilities should prioritize individuals with signs and symptoms of Covid-19 first, then perform testing triggered by an outbreak. -Residents and staff who have symptoms of an illness with Covid-19 should be tested using the FDA/EUA Antigen test: (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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Blaire House of Worcester	116 Houghton Street Worcester, MA 01604

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	>Fever (100.0) Fahrenheit or higher, chills, or shaking chills >Cough >Difficulty breathing or shortness of breath >New loss of smell or taste >Sore throat > Headache >Muscle Aches or body aches >Nausea, vomiting, diarrhea, >Fatigue >Nasal congestion or runny nose -Separation of Covid-19 Residents: -These residents should not share a bathroom with others who are not Covid-19 positive. -Residents with Covid-19 may be released from isolation after five days of symptom onset , if without a fever for at least 24 hours, any symptoms have improved, and they have a negative viral test collected on day 5 or later , or, if asymptomatic after five days from specimen collection date of the positive Covid-19 test and have a negative viral test collected on day 5 or later. -These residents must be able to tolerate and wear a mask around others day 6 through 10. >Personal Protective Equipment (PPE) and Hand Hygiene: -Post precaution signs immediately outside of resident rooms indicating appropriate infection control and prevention precautions. See DPH Precautions Signs. -DPH recommends that a fit-tested N95 filtering facepiece respirator or alternative, eye protection, isolation gown and gloves be used for patients with suspected or confirmed Covid-19 or confirmed exposure. -Covid-Positive Residents: >Full PPE upon room entry to include N95 respirator or alternative Faceshield/goggles, gown and gloves, gown and gloves must be changed between residents. >Isolation sign -Isolation and Quarantine Chart for Residents>Isolate for 10 days with release on day 11 or release after day 5 with a negative test or later. If released before day 11, residents must be ablet to wear a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	mask around others through day 10 and must have substantial improvement in symptoms (if any). 1. Resident #55 was admitted to the facility in April 2024 with diagnoses including Alzheimer's Disease and unspecified Dementia. Review of Resident #55's Physician orders indicated but was not limited to the following: -May conduct Covid-19 test as indicated in accordance with CDC and MA DPH guidance, initiated 4/4/24. -Review of Resident #55's Nursing Progress Notes dated 8/14/25 at 14:52, indicated: >presented with a fever of 104 F (Fahrenheit) >facial paleness >wheezes heard upon lung assessment >occasional cough >Pox (pulse oximetry): 80% Review of Resident #55's Nursing Progress Note dated 8/14/25 at 20:16, indicated: >presented as hypoxic with Pox: 76% on 2.5 (L) liters via NC (nasal cannula). >Non-rebreather mask applied at 15 L. >sent out to the emergency room due to a change in condition with hypoxia. Review of Resident #55's Nursing Progress Note dated 8/22/25 at 16:34, indicated: -Resident returned from the hospital. -Discharge diagnoses included Acute Hypoxemic Respiratory Failure, Covid Positive, Pneumonia. During an interview on 8/27/25 at 11:44 A.M., the Director of Nursing (DON) said that Resident #55 presented with symptoms of Covid-19 on 8/14/25 and should have been tested in the facility prior to being sent out to the hospital but was not tested. The DON said the hospital called the facility on 8/15/25 to alert them that Resident #55 tested positive for Covid-19 by test on 8/14/25. The DON said that it would have been important for the facility to conduct a Covid-19 test for Resident #55 when he/she presented with symptoms, so that the facility could have initiated outbreak testing in a timely manner and could potentially have prevented the spread of Covid-19 to other residents. The DON said they initiated outbreak testing in the facility on 8/16/25 but it should have been initiated on 8/14/25. 2. Resident #21 was admitted to the facility in August 2025 with diagnoses including non-traumatic Brain Dysfunction. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the provided list of Covid-Positive Residents indicated Resident #21 tested positive for Covid-19 on 8/24/25 and was on Precautions. On 8/28/25 at 9:20 A.M. - 9:41 A.M., the surveyor observed Resident #21 exit his/her room which had a Droplet/Contact Precaution sign, without wearing a mask and entered a hallway bathroom. Resident #21 was observed yelling for assistance from the bathroom and a staff member donned PPE and assisted the Resident from the hallway bathroom back to his/her room. The surveyor observed that the hallway bathroom was not sanitized after being used by Resident #21, before another resident who was self-propelling a wheelchair in the hallway opened the hallway bathroom door, went into the bathroom touching the doorknob and door surface, and then proceeded to propel the wheelchair down the hallway by pulling on the hallway handrails and using other resident doorknobs for movement assistance, while contaminating all the areas being touched. During an interview on 8/28/25 at 10:33 A.M., the Housekeeping Director (HD) said that if a Covid-Positive resident uses a bathroom, a CNA is supposed to alert housekeeping right away so that the bathroom can be sanitized. The HD said that he and his staff did not receive notification from the nursing staff that Resident #21 had used the hallway bathroom and therefore the bathroom was not sanitized in a timely manner to prevent possible cross contamination. During an interview on 8/29/25 at 11:20 A.M., the DON said that the nursing staff is responsible to alert housekeeping right away if a Covid-19 positive resident uses a bathroom because the bathrooms are all shared. The DON said that the nursing staff did not alert housekeeping after Resident #21 used the hallway bathroom but should have. 3. Resident #6 was admitted to the facility in November 2024 with diagnoses including unspecified Dementia and Anxiety. Review of Resident #6's Nursing Progress notes indicated Resident #6 tested positive for Covid-19 on 8/22/25. Resident #51 was admitted to the facility in June 2021 with diagnoses including unspecified Dementia with mood disturbance. Review of Resident #51's Nursing Progress Notes indicated Resident #51 tested positive for Covid-19 on 8/20/25. Resident #39 was admitted to the facility in May 2024 with diagnoses including Dementia with other behavioral disturbances. Review of Resident #39's Nursing Progress Notes indicated Resident #39 tested positive for Covid-19 on 8/22/25. On 8/27/25 at 8:28 A.M., the surveyor observed Housekeeping Staff #1 enter Resident #6's room and changed the trash bag. Housekeeping Staff #1 was not observed to don PPE or perform hand hygiene upon entering or exiting the Resident's room. Housekeeping Staff #1 was then observed entering Resident #51's room and changed the trash bag, without donning PPE or performing hand hygiene prior to entering or exiting Resident #51's room. On 8/27/25 at 9:37 A.M., the surveyor observed Housekeeping Staff #1 standing at the trash container (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Resident #41 tested positive for Covid-19 on 8/22/25 and was removed from Isolation Precautions on 8/27/25. -Resident #12 tested positive for Covid-19 on 8/22/25 and was removed from Isolation Precautions on 8/27/25. -Resident #5 tested positive for Covid-19 on 8/22/25 and was removed from Isolation Precautions on 8/27/25. -Resident #31 tested positive for Covid-19 on 8/22/25 and was removed from Isolation Precautions on 8/27/25. -Resident #6 tested positive for Covid-19 on 8/22/25 and was removed from Isolation Precautions on 8/27/25. -Resident #39 tested positive for Covid-19 on 8/22/25 and was removed from Isolation Precautions on 8/28/25. -Resident #57 tested positive for Covid-19 on 8/22/25 and was removed from Isolation Precautions on 8/27/25. During an interview on 8/28/2025 at 8:05 A.M., Nurse #4 said that Resident #39 and Resident #5 had tested negative for Covid-19 and were no longer on Droplet Precautions. During an interview on 8/28/25 at 8:15 A.M., the ADON said that Resident #5 was positive on 8/22/25 and tested negative on 8/27/25 (day 5) of Covid-19 illness. The ADON said she was unsure if the Resident should remain on Droplet Precautions and was not sure if Droplet/Contact Precaution signage should remain on his/her door. During an interview 8/28/25 at 8:34 A.M., the Facility Scheduler said that she is responsible for resident and staff Covid-19 testing. The Facility Scheduler said that if resident tests negative on day 5, we remove the signs for Precautions. On 8/28/25 at 9:05 A.M., the surveyor observed Resident #5 sitting in the hallway next to other residents and at the side of the nurse's medication cart. The surveyor observed that no Isolation Precautions signage was on the Resident's door. On 8/28/25 at 9:12 A.M., the surveyor observed Resident #39 ambulating in the hallway, then stood at the nurse's medication cart. Resident #39 was observed not wearing a mask. 5. During an interview on 8/28/25 at 1:41P.M., the DON said that there was confusion amongst the staff and Residents had been removed from Droplet/Contact Precautions too early. The DON said that Residents #51, #3, #23, #38, #60, #41, #12, #5, #31, #6, #39, and #57 were removed from Droplet/ Contact Precautions when they tested negative prior to day 10 of their Covid-19 infection, but should not have been removed from Precautions because the Residents were unable to maintain a mask outside of their room and still had the potential of spreading Covid-19 to others. During an interview on 8/29/25 at 11:20 A.M., the DON said that the facility has been utilizing the yellow Droplet/ Contact Precaution signage for when a resident is Covid-19 positive, but those signs (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	were outdated and instructed staff to only use a gown for high contact care. The DON said that the facility should have been utilizing the updated signs from DPH that indicated staff should use gowns, gloves, N95 and eye protection, to enter the room of any resident that is positive for Covid-19 but was not utilizing the updated signs. 6. Review of professional standards on Enhanced Barrier Precautions (EBPs), titled Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes, revised on June 28, 2024, retrieved from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html, indicated: -Enhanced Barrier Precautions expand the use of gown and gloves beyond anticipated blood and body fluid exposures. -EBPs focus on the use of gown and gloves during high-contact resident care activities that have been demonstrated to result in transfer of Multi-Dru Resistant Organisms (MDROs) to hands and clothing of healthcare personnel, even if blood and body fluid exposure is not anticipated. -EBPs are recommended for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). -Standard Precautions still apply while using Enhanced Barrier Precautions. For example, if splashes and sprays are anticipated during the high-contact care activity, face protection should be used in addition to the gown and gloves. Resident #5 was admitted to the facility in March 2025 with diagnoses including Stage 3 Pressure Ulcer and Impaired Mobility. Review of the Minimum Data Set (MDS) Assessment, dated 8/14/25, indicated Resident #5: -was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of zero out of a total possible score of 15. -had one unhealed pressure ulcer -was dependent on staff for activities of daily living (ADL'S - Bathing, grooming, dressing). Review of Resident #5's Physician orders dated 8/27/25, indicated: -Right heel pressure wound stage 3, cleanse with wound cleanser (a sterile solution used to clean and irrigate wounds), pat dry, apply Santyl (medication used to clean and remove dead tissue from chronic skin ulcers), followed by Calcium Alginate (used to manage moderate to heavily draining wounds), followed by ABD pad (absorbent dressing used to manage large, heavily draining wounds), followed by rolled gauze two times a day, start date 7/31/25. -Enhanced Barrier Precaution (EBP) every shift, start date 6/24/25. On 8/27/25 at 12:14 P.M., the surveyor observed the following while Nurse #5 and Certified Nurse Aide (CNA) #3 were providing wound care to Resident #5: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Signage posted outside of Resident #5's room indicating that the Resident was on Enhanced Barrier Precaution. -Nurse #5 and CNA #3 failed to don gowns prior to entering Resident #5's room. -Nurse #5 performed wound dressing changes and CNA #3 assisted in positioning for Resident #5, both without donning gowns to provide direct contact care. -Nurse #5 was observed to not perform hand hygiene after doffing soiled gloves and before donning new gloves between the wound dressing changes. During an interview on 8/27/25 at 12:34 P.M., CNA #3 said Resident #5 was not on Precautions and there was no need to wear a gown when providing direct contact care. During an interview on 8/27/25 at 12:28 P.M, Nurse #5 said there was no need to wash/sanitize her hands between removal of gloves since the dressing changes were being performed on the same Resident. Nurse #5 said the Enhanced Barrier Precaution did not apply to Resident #5 and the EBP signage at the door was to remind staff to sanitize their hands before they entered the Resident's room. Nurse #5 said there was no need to wear a gown as the Resident was not on any form of Precautions. During an interview on 8/27/25 at 1:58 P.M., the surveyor, Nurse #5, and the Unit Manager (UM), reviewed Resident #5's treatment orders, and Nurse #5 said she had never been educated on the use of EBP and was not aware of the need for EBP for Resident #5. During a follow-up interview on 8/27/28 at 4:00 P.M., the UM said Nurse #5 and CNA #3 should have worn gowns before they entered Resident #5's room. The UM said Nurse #5 should have changed gloves after the removal of the old dressings and sanitized her hands before donning new gloves, but she did not.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to complete a performance review of every Certified Nurse Aide (CNA) at least once every 12 months, for five Certified Nurse Aides (#4, #5, #6, #7, and #8), out of five total records reviewed. Specifically, the facility failed to ensure that annual performance reviews to identify any areas of weakness were completed every 12 months, with regular in-service education provided based on the outcome of those performance reviews. Findings include: Review of the Employee Policy Manual, revised 6/2025 indicated: -Employees will be evaluated after 90 days of employment and after 12 months of employment. -Employees continuing their at-will employment will be evaluated at the end of each 12-month period. The employee's evaluation, known as a performance appraisal is made on a standard form that is signed by you and your supervisor and is reviewed by the administrator. -These evaluations are an opportunity for you and your supervisor to discuss your performance to date and, at the same time, to set goals for the future. -Your evaluation becomes part of your permanent personnel record. -Performance appraisals, attendance and length of employment are some of the elements considered for granting of pay increase. Review of the facility provided CNA Active Employee Listing, undated, indicated the following: -CNA #4 was hired 12/18/23. -CNA #5 was hired 6/24/13. -CNA #6 was hired 5/16/17. -CNA #7 was hired 11/30/06. -CNA #8 was hired on 2/1/24. Review of the Employee Records for CNA's #4, #5, #6, #7, and #8, failed to indicate that an annual performance review was completed as required. During an interview on 8/29/25 at 10:04 A.M., the Administrator said CNA's #4, #5, #6, #7, and #8, did not have a performance review in the past 12 months. The Administrator said that each CNA should have a performance review completed by the nursing department at least every 12 months and the facility should have provided education based on the outcome of those performance reviews.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide specialized rehabilitative services consistent with the comprehensive plan of care for one Resident (#9) out of a total sample of 17 residents. Specifically, for Resident #9, the facility failed to ensure that lateral supports were implemented on the Resident's wheelchair as recommended by the Occupational Therapist (OT) and ordered by the Physician to ensure appropriate positioning, placing the Resident at potential risk for poor positioning, accidents related to falls, skin conditions, and pain. Findings include:Resident #9 was admitted to the facility in October 2021 with diagnoses including Dementia with behavioral disturbance, weakness, abnormal gait and mobility, low back pain, and Scoliosis. On 8/26/25 at 9:15 A.M., the surveyor observed the following:-Resident #9 was dressed and seated in a wheelchair in the hallway and leaning heavily on his/her right side of the wheelchair with his/her arm and upper body hanging over the right side of the wheelchair.-Numerous facility staff were observed in the hallway and walking by Resident #9 without providing assistance with the Resident's positioning in the wheelchair. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #9:-was rarely/never understood or understands, speech was unclear.-Staff interview indicated the Resident was severely cognitively impaired.-was dependent on staff for activities of daily living (ADLs).-required substantial to maximum assistance of staff with transfers and repositioning. Review of Resident #9's Certified Nurse Aide (CNA) Care Card, undated, indicated:-Lateral supports while in the scoot chair (type of wheelchair) . Review of Resident #9's August 2025 Physician's orders indicated:-Lateral supports while in the scoot chair (type of wheelchair), every shift, initiated on 4/10/25. Review of Resident #9's August 2025 Treatment Administration Record (TAR) indicated the lateral supports were signed off by the nursing staff as administered from 8/1/25 through 8/29/25 on the 7:00 A.M. to 3:00 P.M. (Day) shift. Review of Resident #9's Impaired Mobility Care Plan, initiated 11/21/21, included the following intervention added 4/10/25:-Lateral supports while in scoot chair. The surveyor observed Resident #9 seated in his/her scoot chair and heavily leaning to the right over the right armrest on the following dates and times:-8/26/25 at 2:56 P.M.-8/27/25 at 8:59 A.M. (a folded blanket was observed on inside of the Resident's right side of the wheelchair against the arm rest)-8/28/25 at 3:40 P.M. During an interview on 8/29/25 at 10:25 A.M., CNA #9 said the following relative to Resident #9:-required total care assistance from staff.-can self-propel in his/her scoot chair.-leans to the right while seated in his/her scoot chair so the staff place a pillow or folded blanket on the Resident's right side.-removes the blankets/pillows positioned on the right side of his/her scoot chair so the facility staff have to replace them. On 8/29/25 at 12:50 P.M., the surveyor and the Director of Nursing (DON) observed the following:-Resident #9 was seated in a scoot chair in the hallway.-Resident #9 was leaning heavily on the right side of the wheelchair with his/her head against the chair rail on the wall.-there were no lateral supports in place on the scoot chair, nor pillow or folded blanket on the Resident's right side. During an interview on 8/29/25 at 12:55 P.M., the OT said he was able to locate the back portion of the lateral supports in Resident #9's room and that he was unsure where the side cushions for the lateral supports were at this time. The OT said the lateral support attach to the wheelchair and has a back cushion and two side cushions, one on each side, which supported the Resident so that he/she was in a more upright position. The OT said Resident #9 did not have lateral supports in place. During a follow-up interview on 8/29/25 at 12:57 P.M., CNA #9 said the following:-Resident #9 did not have lateral supports that she was aware of.-Resident #9 had a scoot chair so staff were trying other things to assist with his/her positioning while in the scoot chair.-It would be the decision of the Physician and Rehabilitation Staff to decide if Resident #9 needed lateral supports while in the wheelchair. During interviews on 8/29/25 at 1:03 P.M. and 1:25 P.M., with Nurse #4 while observing Resident #9, Nurse #4 said Resident #9 leans to the right side (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blaire House of Worcester	116 Houghton Street Worcester, MA 01604

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when in his/her scoot chair. Nurse #4 said the staff try to use a pillow or blanket to position the Resident while in the scoot chair. Nurse #4 said she was not aware of any other devices for positioning for Resident #9, and he/she did not currently have lateral supports in place. Nurse #4 said relative to the TAR which indicated the lateral supports were in place, she could maybe recall that the Resident used to have lateral supports but no longer had them and could not remember the reason as to why. Nurse #4 said if the Resident's lateral supports were not in place, the Nurses should be entering a code on the TAR and documenting in the medical record that the lateral supports were not in place. During a follow-up interview on 8/29/25 at 2:02 P.M., the OT said the lateral supports were implemented for Resident #9 to assist with his/her right sided leaning while in the wheelchair. The OT said Resident #9's leaning to the right put him/her at risk for injuries including skin tears, pain including low back pain associated with poor positioning and at risk for skin integrity issues because the Resident was often leaning heavily to the right. During an interview on 8/29/25 at 3:04 P.M., the surveyor and the Unit Manager (UM) reviewed Resident #9's medical record, and the UM said there was no indication that the Resident's lateral supports were refused, discontinued or not available. The UM also said the August 2025 TAR was signed off by the Nursing staff that the lateral supports were in place. The UM further said the Nurses should not be signing off that the lateral supports were in place if they were not. Please Refer to F842

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to provide care and services consistent with professional standards of practice for wound care for one Resident (#5), of two applicable residents with pressure ulcers, out of a total sample of 17 residents.Specifically, for Resident #5, the facility staff failed to:-adhere to the Physician's orders when completing dressing changes for the Resident's Stage 3 Pressure Ulcer, right hip pressure wound, and left elbow skin tear.-implement infection control practices during the Resident's dressing changes to prevent the potential for infection and/or deterioration of the wounds. Findings include: Review of the facility policy titled Wound Care, revised September 2013, indicated:-Purpose is to provide guidelines for the care of the wounds to promote healing.-Verify Physician's order.-Wash your hands thoroughly.-Put on exam glove. Loosen tape and remove dressing.-Pull glove over dressing and discard into appropriate receptable. Wash and dry your hands thoroughly.-Use no-touch technique. Use sterile tongue blades and applicators to remove ointments and creams from the containers. -Wear sterile gloves when physically touching the wound or holding a moist surface over the wound.-Wipe reusable supplies with alcohol as indicated.-Take only the disposable supplies that are necessary for the treatment into the room. Disposable supplies cannot be returned to the cart.-Wash hands and dry your hands thoroughly. Review of professional standards on Enhanced Barrier Precautions (EBP), titled Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes, revised 6/28/24, retrieved from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html, indicated:-Enhanced Barrier Precautions expand the use of gown and gloves beyond anticipated blood and body fluid exposures.-They focus on the use of gown and gloves during high-contact resident care activities that have been demonstrated to result in transfer of Multi-Drug Resistant Organisms (MDROs) to hands and clothing of healthcare personnel, even if blood and body fluid exposure is not anticipated.-Enhanced Barrier Precautions are recommended for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).-Standard Precautions still apply while using Enhanced Barrier Precautions. For example, if splashes and sprays are anticipated during the high-contact care activity, face protection should be used in addition to the gown and gloves. Resident #5 was admitted to the facility in March 2025 with diagnoses including Stage 3 Pressure Ulcer and Impaired Mobility. Review of the Minimum Data Set (MDS) Assessment, dated 8/14/25, indicated Resident #5:-was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of zero out of a total possible score of 15.-had one unhealed pressure ulcer.-was dependent on staff for activities of daily living (ADL'S - Bathing, grooming, dressing). Review of Resident #5's Physician orders dated 8/27/25, indicated:-Right heel pressure wound Stage 3, cleanse with wound cleanser (a sterile solution used to clean and irrigate wounds), pat dry, apply Santyl (medication used to clean and remove dead tissue from chronic skin ulcers), followed by Calcium Alginate (used to manage moderate to heavily draining wounds), followed by ABD pad (absorbent dressing used to manage large, heavily draining wounds), followed by rolled gauze, two times a day, start date 7/31/25.-Enhanced Barrier Precaution (EBP) every shift, start date 6/24/25.-Right hip open area, cleanse with wound cleanser, pat dry followed by Calcium Alginate then cover with bordered foam, daily and prn (as needed), start date 7/30/25.-Left elbow skin tear, wash with normal saline (a sterile solution containing 0.9% sodium chloride in water) and cover with dry clean dressing, monitor for signs and symptoms of infection, start date 8/22/25. On 8/27/25 at 12:14 P.M., the surveyor observed the following during wound care performed by Nurse #5 and Certified Nurse Aide (CNA) #3:-Signage posted outside of Resident #5's room indicating that the Resident was on Enhanced Barrier Precaution (EBP).-Nurse #5 and CNA #3 did not don a gown before entering the Resident's room.-Nurse #5 donned (put on) gloves, cut off the old dressing with scissors and removed the old dressing from the Resident's right heel. -Nurse #5 patted dry the wound bed of the right heel, with (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	moistened gauze.-Nurse #5 sprayed the entire wound bed of the right heel with skin prep spray (spray that creates a film-like barrier on the skin to prevent irritation and damage from adhesives, friction, and bodily fluids).-Nurse #5 cut the Aquacel pad with scissors, applied Santyl on the aquacel pad and placed the pad into the right heel wound bed.-Nurse #5 wrapped the Resident's right heel with a rolled gauze, then dated the wound dressing.-Nurse #5 doffed (removed) her gloves and donned new gloves.-Nurse #5 repositioned the Resident to his/her left side with the assistance of CNA #3.-Nurse #5 removed the old dressing from the Resident's right hip.-Nurse #5 wiped the Resident's right hip with a wet gauze, sprayed skin prep spray over the entire wound, then covered the wound with a foam dressing and dated the wound.-Nurse #5 doffed her gloves and donned new gloves.-Nurse #5 then repositioned the Resident to his/her right side with the assistance of CNA #3.-Nurse #5 wiped the Resident's left elbow with wet gauze, sprayed skin prep spray on the wound bed, applied foam dressing and dated the wound. During an interview on 8/27/25 at 12:34 P.M., CNA #3 said Resident #5 was not on precautions and there was no need to wear a gown when providing direct contact care. During an interview on 8/27/25 at 12:28 P.M, Nurse #5 said the following pertaining to Resident #5's wound care treatment:-there was no need to wear a gown as the Resident was not on any form of precautions.-there was no need to wash/sanitize hands between removal of gloves since the dressing changes were being performed on the same Resident.-the Enhanced Barrier Precaution (EBP) did not apply to Resident #5. The EBP signage at the door was to remind staff to sanitize their hands before they entered the Resident's room.-she sprayed the entire wound bed with skin prep spray to allow the dressing to stay on the wound. -there was no need to obtain Physician's order for the skin prep spray as this was her (Nurse #5's) practice to ensure the dressing adhered to the Resident's wound. During an interview on 8/27/25 at 1:58 P.M., the surveyor, Nurse #5 and the Unit Manager (UM) reviewed Resident #5's treatment orders, and Nurse #5 said she had never been educated on the use of EBP and was not aware of the need for EBP for Resident #5. Nurse #5 said it had always been her practice to spray skin prep spray on resident's wound beds to allow the dressings to adhere to the wounds. During a follow-up interview on 8/27/28 at 4:00 P.M., the UM said when Nurse #5 sprayed skin prep spray into Resident #5's wound bed, the skin prep spray would prevent the Santyl ointment from debriding the wound to allow for wound healing. The UM said Nurse #5 and CNA #3 should have worn gowns before they entered the Resident's room. The UM said Nurse #5 should have changed gloves after removal of the old dressings and sanitized her hands before wearing new gloves, but she did not. Please Refer to F726

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview, observation and record review, the facility failed to ensure that the appropriate competencies related to wound care services were completed for one Licensed Nurse (Nurse #5) and one Certified Nursing Assistant (CNA #3), out of 5 staff records reviewed.Specifically, the facility failed to provide documentation that Nurse #5 and CNA #3 had completed the appropriate nursing competencies for wound care and infection control practices. Findings include: Review of the facility policy titled, Clinical Competency Training for Licensed Nursing Staff, revised 7/2024, indicated:-The Director of Nursing (DON) will be responsible for coordinating a clinical competency program for all licensed nursing staff twice a year, according to the mandatory educational in-service schedule.-All licensed nurses will be required to attend clinical programs and competency programs yearly.>The following nursing modules and topics shall be covered, and tests will be given.-Infection control.-Nursing assessment, .-Clinical day for licensed nursing staff may also include any other topics that the facility has noted to be significant through the quality assurance process.-Based on training, further individualized in-servicing may be necessary and shall be carried out by nursing administration. Review of the facility policy titled, Clinical Day for Certified Nursing Assistants, revised 10/2024, indicated:-Director of Nursing will be responsible for coordinating a clinical competency program for all certified nursing assistants twice a year, according to the mandatory educational in-service schedule.>The following nursing modules and topics shall be covered, and tests will be given.-Infection control. Review of professional standards on Enhanced Barrier Precautions (EBP), titled Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes, revised on June 28, 2024, retrieved from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html, indicated:-Enhanced Barrier Precautions expand the use of gown and gloves beyond anticipated blood and body fluid exposures.-EBP focus on the use of gown and gloves during high-contact resident care activities that have been demonstrated to result in transfer of Multi-Dru Resistant Organisms (MDROs) to hands and clothing of healthcare personnel, even if blood and body fluid exposure is not anticipated.-EBPs are recommended for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).-Standard Precautions still apply while using Enhanced Barrier Precautions. For example, if splashes and sprays are anticipated during the high-contact care activity, face protection should be used in addition to the gown and gloves. On 8/27/25 at 12:14 P.M., the surveyor observed the following during wound care being provided to Nurse #5 and CNA #3 to Resident #5:-Signage outside of Resident #5's room indicating that the Resident was on Enhanced Barrier Precautions (EBP).-Nurse #5 and CNA #3 failed to don (put on) a gown before entering Resident #5's room.-Nurse #5 was not wearing a gown while providing wound care and CNA #3 did not wear a gown while assisting Nurse #5 with repositioning Resident #5 during the wound dressing changes.-Nurse #5 failed to remove her gloves after removing the old dressing from the Resident's right heel wound.-Nurse #5 failed to wash/sanitize her hands after doffing (removing) soiled gloves.-Nurse #5 sprayed skin prep spray on all of Resident #5's wound areas. -Nurse #5 failed to disinfect the scissors after using the scissors to cut the old dressing. During an interview on 8/27/25 at 12:34 P.M., CNA #3 said the Resident was not on precautions and there was no need to wear a gown when providing direct care. During an interview on 8/27/25 at 12:28 P.M, Nurse #5 said there was no need to wash/sanitize her hands between removal of gloves since the dressing changes were being performed on the same Resident. Nurse #5 said the Enhanced Barrier Precautions did not apply Resident #5 and the EBP signage at the door was to remind staff to sanitize their hands before they entered the Resident's room. Nurse #5 said there was no need to wear a gown, and the Resident was not on any form of precautions. During an interview on 8/27/25 at 1:58 P.M., the surveyor, Nurse #5 and the Unit Manager (UM) reviewed (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #5's treatment orders, and Nurse #5 said she had never been educated on the use of EBP and was not aware of the need for EBP for the Resident. Nurse #5 said it had always been her practice to spray skin prep spray on resident's wound beds to allow the dressings to adhere to the wounds even though there was no Physician's order for skin prep spray. During a follow-up interview on 8/27/28 at 4:00 P.M., the UM said there was no evidence that Nurse #5 had received nursing competency evaluation on infection control practices and wound care. The UM said there was no evidence that CNA #3 had received competency on assisting with wound care management and infection control practices. The UM further said wound care and infection control practice competencies should have been completed but they were not.Refer to F880

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, and interview, the facility failed to ensure that all drugs and biologicals were stored in accordance with accepted professional standards of practice on one out of one nurses station. Specifically, the facility to properly secure topical medications that were stored under the desk at the nurses station and was easily accessible to residents or staff. Findings include: Review of the policy title Storage and Expiration Dating of Medications and Biologicals, dated [DATE], indicated the following: -Facility should ensure all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked in a medication room that is inaccessible by residents and visitors. -Facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals in accordance with pharmacy return/destruction guidelines and other applicable law, and in accordance with policy. -Facility should inspect nurses station storage areas for proper storage compliance on a regularly scheduled basis. On [DATE] at 9:26 A.M., the surveyor and Nurse #5 found an unsecured bag of medications containing Skin prep swabs, Antifungal cream, Santyl Cream, Zinc Oxide, Bacitracin ointment, and [NAME] Cream under the desk at the nurses station. Nurse #5ˆsaid that the medications should not have been kept under the desk because the residents could access that area and could potentially consume the medications. Nurse #5 said the door to the nurses station was sometimes left unlocked. During an interview on [DATE] at 3:03 P.M., the Assistant Director of Nurses (ADON) said she was unsure how long the bag of medications had been stored under the desk at the nurses station. The ADON said the medications should not have been kept there because the desk at the nurses station was not considered a secure area.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that complete and accurate medical records were maintained for two Residents (#1 and #9), out of a total sample of 17 residents.Specifically, the facility failed to: 1. For Resident #1, ensure documentation relative to residuals (the amount of fluid that remains in the stomach between feedings when a person is fed through a gastrostomy tube [G-tube: tube inserted directly into the stomach to provide fluid and nutrition when it cannot be taken orally]) checks were accurately recorded in the medical record for the Resident with a history of Aspiration Pneumonia, putting the Resident at risk for complications relative to his/her G-tube.2. For Resident #9, ensure an accurate medical record when the nursing staff were documenting in the Treatment Administration Record (TAR) that lateral supports were in place on the Resident's wheelchair. Findings include: Review of the facility policy titled Charting and Documentation, revised July 2017, indicated the following: -Documentation in the medical record will be.complete, and accurate. 1.Resident #1 was admitted to the facility in April 2025 with diagnoses including Dysphagia, history of Aspiration Pneumonia, reduced mobility, muscle weakness, had a G-tube, and was NPO (nil per os - nothing by mouth). Review of Resident #1's August 2025 Physician's orders indicated: -Every shift check for residual if above 100 milliliters (ml), hold feeding for one hour and recheck. If below 100 ml then resume feeding, if greater than 100 ml notify Nurse Practitioner (NP)/Medical Doctor (MD), start date 7/14/25. Review of the August 2025 Treatment Administration Record (TAR) from 8/1/25 through 8/28/25 indicated the following residuals were obtained for Resident #1: -8/1/25: 350 ml -8/10/25: 120 ml -8/12/25: 240 ml Further review of the August 2025 TAR Failed to indicate that residual amounts were obtained for the following: -Shift Two (3 P.M. to 11 P.M.): 8/2/25, 8/3/25, 8/9/25, 8/16/25, 8/17/25, and 8/27/25 -Shift Three (11 P.M. to 7 A.M.): 8/17/25 Further review of Resident #1's medical record failed to indicate documentation on 8/1/25, 8/10/25, and 8/12/25 that Resident #1's feeding was held for an hour, residuals were rechecked, and feeding was restarted or that the NP or MD was notified if the residual remained over 100 ml. Resident #1's (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical record also failed to indicate documentation as to why residual amounts were not recorded on 8/2/25, 8/3/25, 8/9/25, 8/16/25, 8/17/25, and 8/27/25. During an interview on 8/28/25 at 10:13 A.M., the surveyor and Nurse #2 reviewed Resident #1's residual amount recorded on Shift Two on 8/1/25. Nurse #2 said she was the Nurse who recorded the 350 ml as the residual amount obtained but that was inaccurate documentation and Resident #1 never had residuals over 100 ml. Nurse #2 said she could not recall what the accurate residual amount on 8/1/25 was, but the accurate amount should have been recorded on the TAR and it was not. During a phone interview on 8/28/25 at 10:20 A.M., with Nurse #1, the surveyor reviewed documentation from Resident #1's August 2025 TAR indicating that Nurse #1 had recorded a residual of 120 ml on Shift Two on 8/10/25. Nurse #1 said she was the nurse working that day and that the 120 ml was inaccurate documentation. Nurse #1 said Resident #1 never had a residual amount over 10 ml and the amount recorded on the TAR was inaccurate. During an interview on 8/28/25 at 12:46 P.M., the Director of Nursing (DON) said Resident #1 had residual amounts checked every shift and the amount obtained was documented to ensure he/she was tolerating his/her feedings through his/her G-tube. The DON said Resident #1 had a history of Aspiration Pneumonia and it was important for staff to ensure accurate residual amounts were documented to make sure Resident #1 was not retaining too much fluid in his/her stomach and was tolerating his/her G-tube feeding. The DON said too much fluid left in the stomach could lead to Aspiration Pneumonia. The surveyor and the DON reviewed the August 2025 TAR and the DON said on 8/1/25, 8/10/25, and 8/12/25, if the Resident had residual amounts documented that were above 100 ml, there should have been documentation to show the Resident's feeding was held and residuals were rechecked after an hour. The DON said she was unable to find documentation to show this was done and the documentation on the TAR must be inaccurate. The DON further said on 8/2/25, 8/3/25, 8/9/25, 8/16/25, 8/17/25, and 8/27/25, residual amounts should have been recorded on the TAR or if they were not obtained documentation should have been completed in a nursing note as to why residuals were not obtained, and on those dates the medical record was incomplete. The DON said she was unaware there was inaccurate and incomplete documentation related to Resident #1's G-tube residuals and currently there was no way to monitor for residual amounts that fell outside a set parameter or for missing residual documentation. 2.Resident #9 was admitted to the facility in October 2021 with diagnoses including Dementia with behavioral disturbance, weakness, abnormal gait and mobility, low back pain, and Scoliosis. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #9: -was severely cognitively impaired as idicated by Staff Interview. -was dependent on staff for activities of daily living (ADLs). -required substantial to maximum assistance of staff with transfers and repositioning. Review of the August 2025 Physician's orders indicated: -Lateral supports while in the scoot chair (type of wheelchair), every shift, initiated 4/10/25. Review of the August 2025 Treatment Administration Record (TAR) indicated the lateral supports (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225443	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blaire House of Worcester	116 Houghton Street Worcester, MA 01604

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were signed off by the nursing staff as administered from 8/1/25 through 8/29/25 on the 7:00 A.M. to 3:00 P.M. (Day) shift. The surveyor observed Resident #9 seated in his/her scoot chair and heavily leaning to the right over the right arm rest with no lateral supports in place, on the following dates/times: -8/26/25 at 9:15 A.M. -8/26/25 at 2:56 P.M. -8/27/25 at 8:59 A.M. -8/28/25 at 3:40 P.M. -8/29/25 at 12:50 P.M. During an interview on 8/29/25 at 1:03 P.M. and 1:25 P.M., Nurse #4 said relative to the TAR which indicated the lateral supports were in place, that she could maybe recall the Resident used to have lateral supports but no longer had them and could not remember the reason as to why. Nurse #4 said if the Resident's lateral supports were not in place, the Nurses should be entering a code on the TAR and documenting in the medical record that the lateral supports were not in place. On 8/29/25 at 3:04 P.M., the surveyor and the Unit Manager (UM) reviewed Resident #9's medical record, and the UM said there was no indication that the Resident's lateral supports were refused, discontinued or not available.The UM said the August 2025 TAR was signed off by the Nursing staff that the lateral supports were in place and the Nurses should not be signing off that the lateral supports were in place if they were not.