STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225467	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Worcester	25 Oriol Drive Worcester, MA 01605

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 37086 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who upon admission had specific physician's orders for treatment of his/her pressure injury, the facility failed to ensure that the treatment orders transcribed and provided by nursing were appropriate and adequate to treat his/her wound. Findings include: Review of the Facility's policy titled Pressure Ulcer/Injuries Overview, with a revision date of 03/2022, indicated the following: -Pressure Ulcer/Injury refers to localize damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. -Debridement is the removal of devitalized/necrotic tissue and foreign matter from a wound to improve or facilitate the healing process. Debridement methods may include a range of treatments such as the use of enzymatic dressings to surgical debridement in order to remove tissue or matter from a wound to promote healing. Resident #1 was admitted to the facility in April 2025, diagnoses included End Stage Renal Disease with dependence on dialysis (a life-saving treatment that filters waste products and excess fluid when the kidneys stop working), Stage IV (full thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage or bone in the wound, slough and/or eschar/dead tissue may be visible) sacrum pressure injury, and diabetes mellitus. Review of Resident #1's Hospital Discharge Summary, dated 04/03/25, indicated he/she had a Stage IV sacral pressure injury and to continue wound care which consisted of Collagenase Topical (medication used to treat severe burns or pressure injuries in adults, helps to remove dead skin tissue and aid in wound healing) 250 units per gram ointment that was to be applied daily. Review of Resident #1's Admission Nursing Evaluation, dated 04/03/25 and signed by Nurse #5, indicated Resident #1 had a pressure injury on the coccyx [sacral area]. Review of Resident #1's Nursing Progress Note, dated 04/04/25 and written by Nurse #1, indicated he/she had a sacral wound which measured 4.4 centimeters (cm) x 8.5 cm, wash area with normal saline, pat dry, and apply dry protective dressing (DPD) until seen by the Physician. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 05/06/25 at 12:50 P.M., Nurse #5 said he was the nurse on duty for the 3:00 P.M. through 11:00 P.M. shift on 04/03/25 and completed the Admission Nursing Evaluation for Resident #1. Nurse #5 said it was protocol to follow the wound treatment orders that were listed on the Hospital Discharge Summary. Nurse #5 said he was the only nurse on that night so he may not have entered Resident #1's wound treatment orders but that the next shift nurse could pick-up any orders that may have been missed. Review of Resident #1's Initial Admission History and Physical, dated 04/05/25 and signed by Physician #1, indicated Resident #1 had multiple wounds including a Stage IV sacral wound and the plan included wound care and pressure relief. During a telephone interviews on 05/06/25 at 12:15 P.M. and 05/07/25 at 11:40 A.M., Nurse #1 said she was Resident #1's nurse for the day shift (7:00 A.M. through 3:00 P.M.) on 04/04/25. Nurse #1 said she did not reference Resident #1's Hospital Discharge Summary when she notified Resident #1's provider to obtain wound care treatment orders. Nurse #1 said she did not remember what Resident #1's wound looked like but said the facility's protocol was to put a treatment order in place until the resident could be evaluated by the Facility's Wound Nurse Practitioner (NP). Review of Resident #1's Treatment Administration Record (TAR) for the month of April 2025, indicated Resident #1 received wound care to his/her sacrum which consisted of the following: normal saline wash and a DPD, which was applied daily from 04/05/25 through 04/07/25. During a telephone interview on 05/07/25 at 9:00 A.M., Physician #1 said he was in the facility on 04/05/25 to complete Resident #1's Initial History and Physical. Physician #1 said he did not visualize Resident #1's wound but knew that he/she had a quite advanced pressure injury. Physician #1 said he expected nursing staff to refer to the Hospital Discharge Summary when requesting wound care treatment orders and thought Resident #1 was receiving Collagenase to his/her [sacral] wound because that was what he/she received in the Hospital. Physician #1 said it was their fault that the correct treatment was not initiated. During a telephone interview on 05/08/25 at 10:32 A.M., the Director of Nurses (DON) said the facility's protocol was to follow the wound care treatment orders listed on the Hospital Discharge Summary until the resident could be seen by the facility's Wound Nurse Practitioner (NP). The DON said the Wound NP comes to the facility weekly but Resident #1 was transferred to the hospital before the Wound NP was able to assess his/her wound. The DON said Normal Saline with a DPD would not be the standard of care for the treatment of a Stage IV pressure injury and the wound treatment orders on Resident #1's Hospital Discharge Summary should have been implemented.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 37086 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who required hemodialysis (a life-saving treatment that filters waste products and excess fluid when the kidneys stop working) three times a week for end stage renal disease (ESRD), the facility failed to ensure Resident #1 received the care and services consistent with his/her care plan, when Resident #1 missed a dialysis session because of a transportation issue and miscommunication with the dialysis center, he/she went four days without receiving dialysis and when he/she was transported to the dialysis center for treatment, he/she required Hospital transfer due to a change in status. Findings include: Review of the Facility's Policy, titled Care of Resident with End Stage Renal Disease, dated as revised 4/2022, indicated the following: -Residents with ESRD will be cared for according to currently recognized standards of care. -If a resident has been identified in need of hemodialysis, the resident will receive dialysis treatment from a Dialysis Facility. -Transportation to and from an off-site [dialysis treatment] location will be arranged by the nursing staff. Resident #1 was admitted to the facility in April 2025, diagnoses included ESRD with dependence on dialysis, Stage IV (full thickness tissue skin and tissue loss with exposed muscle, tendon, ligaments, cartilage or bone in the ulcer; slough and/or eschar/dead tissue may be visible) sacrum pressure injury, and Diabetes Mellitus. Review of Resident #1's Hospital Discharge Summary, dated 04/03/25, indicated he/she was to continue with hemodialysis every Monday, Wednesday, and Friday. Review of Resident #1's Admission Nursing Evaluation, dated 04/03/25, indicated Resident #1 received his/her most recent dialysis treatment on (Wednesday) 04/02/25. Review of Resident #1's Nursing Progress Note, dated (Friday) 04/04/25, indicated Nurse #1 received a call from Resident #1's Dialysis Center because he/she did not attend the dialysis treatment scheduled for that morning. The Note indicated that Resident #1 was re-scheduled to receive dialysis on (Saturday) 04/05/25. During a telephone interview on 05/07/25 at 10:08 A.M., the Dialysis Center's Clinical Manager said she notified the Facility on (Friday) 04/04/25 that there were no openings to accommodate Resident #1 until his/her next scheduled dialysis treatment on (Monday) 04/07/25. The Clinical Manager said she was confused when Resident #1 arrived at the Dialysis Center on (Saturday) 04/05/25 because there was no scheduled dialysis treatment for him/her that day. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Clinical Manager said when Resident #1 arrived at the Dialysis Center on (Monday) 04/07/25, he/she was unstable, confused, and lethargic, therefore, he/she was transferred to the Hospital ED for evaluation. Review of Resident #1's Nursing Progress Note, dated 04/05/25, indicated Resident #1 was transported to the Dialysis Center but they did not have an opening to accommodate Resident #1 and he/she was transported back to the facility [without having received dialysis treatment]. The Note indicated that a Nurse Practitioner was notified and advised that Resident #1 remain at the facility until his/her scheduled dialysis treatment on Monday (04/07/25). During a telephone interview on 05/06/25 at 9:13 A.M., the Facility's Admission Liaison said the Facility was aware of Resident #1's pending admission several days prior to him/her being admitted to the facility and that nursing was responsible for booking transportation to his/her dialysis treatments. During an interview on 05/06/25 at 3:15 P.M., the Assistant Director of Nurses said it was her understanding that Resident #1's family member booked his/her transportation for the scheduled dialysis treatments. During a telephone interview on 05/07/25 at 10:00 A.M., the Customer Service Representative at the Transportation Company said the first transportation booking for Resident #1 in April 2025 was for a pick up at the facility on (Saturday) 04/05/25. Review of Resident #1's Medication Administration Record (MAR) for the month of April 2025 indicated his/her physician's order to attend dialysis three days a week on Monday, Wednesday, Friday with a transport pick up time of 6:30 A.M., was not obtained by the nursing staff until 04/09/25 (several days after Resident #1's admission to the facility and two days after he/she was transferred to the Hospital ED). During a telephone interview on 05/08/25 at 10:32 A.M., the Director of Nurses (DON) said that it was her understanding that Resident #1's family had set up transportation for him/her to attend their dialysis treatments, but usually the Unit Managers booked transportation for the residents who required dialysis services. The DON said that Resident #1's physician's orders for dialysis should have been put in place at the time of his/her admission to the facility. The DON said that the whole admission process [for Resident #1] was a mess from the start.