| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225467 | A. Building<br>B. Wing | 04/17/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Regalcare at Worcester | 25 Oriol Drive<br>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.

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|---|---|
| F 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to organize and participate in resident/family groups in the facility.<br><br>Based on interview and record review, the facility failed to provide privacy for residents during Resident Council meetings.<br><br>Specifically, the facility failed to provide a private meeting space for Resident Council meetings where facility staff was not using the meeting space area as a conduit to other building areas during times when Resident Council meetings were in progress.<br><br>Findings include:<br><br>Review of the facility's Residents Rights located in the admission Packet, undated indicated:<br><br>-You have the right to organize and participate in Resident groups in the facility.<br><br>-You have the right to privacy in accommodations, in receiving personal and medical care and treatment, in written and telephone communications, in visits, and meetings with family and Resident groups.<br><br>During the Resident Group meeting held on 4/16/25 at 11:00 A.M., the surveyor interviewed 15 residents who were in attendance:<br><br>-10 of the 15 Residents in attendance said that the space provided by the facility was not private and that staff frequently cut through the space during their meetings to get to other units in the building.<br><br>-The Resident Council President said that this was the first time in a long time that the group had had privacy during their meeting.<br><br>The surveyor observed that the Resident Council group meeting space that was reserved by the facility staff was divided by a hallway running down the middle, with two sets of double doors that were closed on either end.<br><br>During an interview on 4/16/25 at 1:54 P.M., the Activities Director (AD) said that she was responsible for helping the Residents organize the Resident Council meetings. The AD said that in 2024, the Resident Council meetings had been interrupted by staff walking through the hallway approximately four times. The AD also said that staff should not have been present at the Resident Council meetings because the Residents wanted their privacy, and privacy had not been respected. |

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 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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** Based on observations, and interviews, the facility failed to maintain a homelike environment on two units (Unit 2 and Unit 4) out of four resident units.<br><br>Specifically, the facility failed to:<br><br>-On Unit 2, maintain eight out of 22 resident rooms and the activity room in a safe, clean, comfortable and homelike environment.<br><br>-On Unit 4, ensure that 19 out of 19 resident rooms were maintained in a safe, clean, comfortable and homelike environment.<br><br>Findings include:<br><br>Review of the facility policy titled, Resident Rights: Accommodation of Needs and Preferences and Homelike Environment, not dated, indicated:<br><br>-that the facility will provide a safe, clean, comfortable and homelike environment.<br><br>On 4/15/25 from 2:49 P.M. to 3:08 P.M., on Unit 2, the following was observed in Resident Rooms and the Activity Room by Surveyor #1:<br><br>room [ROOM NUMBER]- Gouges in the wall behind the headboard of one resident's bed.<br><br>room [ROOM NUMBER]- The room nightlight was nonfunctional.<br><br>room [ROOM NUMBER]- The bathroom door and both closet doors had large gouges, scrapes, and holes.<br><br>room [ROOM NUMBER]- The closet door had a deep hole and the wall had gouges and scrapes.<br><br>room [ROOM NUMBER]- The bathroom sink was clogged, the wall underneath the window had gouges, scrapes, and holes, and the heating vent was dented with the ends exposed and uncovered.<br><br>room [ROOM NUMBER]- The wall had scrapes with missing paint behind the headboard of one resident's bed.<br><br>room [ROOM NUMBER]- The wall had scrapes with missing paint behind the headboard of one bed.<br><br>room [ROOM NUMBER]- The night light was missing a cover with the lightbulb and wiring exposed.<br><br>Activity/Unit Dining Room- The wall had gouges and scrapes.<br><br>On 4/15/25 from 3:10 P.M to 3:36 P.M., on Unit 4, the following was observed in Resident rooms by Surveyor #2:<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | room [ROOM NUMBER]- Gouges in the wall, the wallpaper was torn, and one window had silver utility tape on the edges.<br><br>Rooms 402, 403, 404, and 405 - had gouges in the wall behind one resident's bed.<br><br>room [ROOM NUMBER]- Gouges in the wall behind one resident's bed, torn wallpaper, and a lightbulb with an exposed lightbulb in the hallway outside of the room.<br><br>room [ROOM NUMBER]- The wall behind the door had a hole from the door handle.<br><br>room [ROOM NUMBER]- Gouges in the wall behind one resident's bed.<br><br>room [ROOM NUMBER]- Gouges in the wall behind one resident's bed and a hole in the plastic trim.<br><br>room [ROOM NUMBER]- Gouges in the wall and the wallpaper was ripped behind one resident's bed.<br><br>room [ROOM NUMBER]- The wall had a hole with an exposed wire, gouges in the wall behind one resident's bed, and the wallpaper was ripped.<br><br>room [ROOM NUMBER]- Gouges in the wall behind one resident's bed.<br><br>room [ROOM NUMBER]- The wall had holes behind both resident's beds.<br><br>room [ROOM NUMBER]- The wall behind the door had a hole from the door handle, and a missing electrical outlet cover.<br><br>room [ROOM NUMBER]- Gouges in the wall behind one resident's bed, the floor was missing a floor tile, and the wallpaper was ripped.<br><br>room [ROOM NUMBER]- Gouges in the wall behind one resident's bed, the wall had a hole behind the bathroom door from the door handle, and the wallpaper was ripped.<br><br>room [ROOM NUMBER]- The wall had holes behind both resident's beds.<br><br>room [ROOM NUMBER]- The wall had scrapes behind both resident's beds and the wallpaper was ripped.<br><br>room [ROOM NUMBER]- The wall had scrapes behind one resident's bed, the base board trim had a hole, and the wallpaper was ripped.<br><br>During an interview on 4/16/25 at 9:11 A.M., with surveyor #1 and Unit Manager (UM) #1, UM #1 said she was the manager for both Units 2 and 4. UM #1 said when there are maintenance issues identified, she will document a maintenance request in the log book on the unit. UM #1 said any staff are able to put requests in the log book and that the Maintenance Director is responsive and rounds on the units. UM #1 showed surveyor #1 where the Maintenance log book is kept at the nurses stations. Surveyor #1 and UM #1 reviewed the log book and failed to find any maintenance requests for repairs to walls, doors, lights, or electrical outlets documented for Rooms 201, 203, 206, 207, 211, 216, 217, 218, or the Activity/Dining Room.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 4/16/25 at 9:40 A.M., with surveyor #1, the Administrator and the Director of Clinical Operations, the Administrator said that the Maintenance Director was newly promoted into the position and works with the Regional Maintenance Director for support in the role. The Director of Clinical Operations said the facility is hiring for a second maintenance department staff member and other staff to complete painting projects.<br><br>On 4/16/25 at 10:58 A.M., surveyor #1, the Maintenance Director and the Director of Clinical Operations toured Unit 2 and reviewed Rooms 201, 203, 206, 207, 211, 216, 217, 218, and the Activity/Dining Room. The Maintenance Director said he was aware of the need for repair to the wall in room [ROOM NUMBER] but that materials needed to be ordered for the repair. The Maintenance Director said that nursing staff put maintenance requests in the log books on each unit and he will do rounds in the morning, midday, and at the end of each day to check the books. The Maintenance Director said if there were immediate or emergent needs, nursing staff can contact him directly and he is easily available. Surveyor #1, the Maintenance Director, and the Director of Clinical Operations reviewed the last 90 days of maintenance logs for Units 2 and 4 and failed to find any documented requests relative to the damaged areas observed in the resident rooms.<br><br>On 4/16/25 at 11:00 A.M., surveyor #1 conducted a Resident Council Group with 14 residents in attendance, who resided on four out of four units. During an interview at the time, 12 of the 14 residents in attendance said there were issues with the facility environment and problems such as holes in the walls, broken heating vents, and bathrooms needing repairs. The residents expressed frustration that these issues continued, and nothing happens.<br><br>During an interview on 4/17/25 at 1:05 P.M., with surveyor #1, the Administrator said that the current facility renovation and remodeling project was partially complete and included future plans to remodel Unit 2 and Unit 4. The Administrator further said there was no quality improvement (QI) project relative to repairs or improving the environment on Unit 2 and Unit 4 prior to the survey team entrance. |

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| F 0641<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, and interviews, the facility failed to accurately code a Minimum Data Set (MDS) Assessment for one Resident (#102), out of a total sample of 25 residents.<br><br>Specifically, the facility failed to:<br><br>1. For Resident #102, accurately code that the Resident used corrective lenses during the MDS observation period putting the Resident at risk for not receiving required vision care and services.<br><br>Findings include:<br><br>Review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual version 1.19.1 dated October 2024, indicated the following:<br><br>>Hearing, Speech and Vision: Document whether the resident is comatose, the resident's ability to hear, understand, and communicate with others and the resident's ability to see objects nearby in their environment.<br><br>>Corrective Lenses:<br><br>-Decreased ability to see can limit the enjoyment of everyday activities and can contribute to social isolation and mood and behavior disorders.<br><br>-Many residents who do not have corrective lenses could benefit from them, and others have corrective lenses that are not sufficient.<br><br>1. Resident #102 was admitted to the facility in November 2023 with diagnoses including Chronic Systolic (Congestive) Heart Failure, Chronic Kidney Disease, Type 2 Diabetes Mellitus, and other Vascular Syndromes of Brain in Cerebrovascular Disease.<br><br>Review of Resident #102's Optometry Evaluation, dated 10/8/24, indicated:<br><br>-Resident was alert, oriented to person and place.<br><br>-Resident has Cataract<br><br>-Glasses Dispensed +2.25 Near [sic]<br><br>Review of the MDS assessment dated [DATE], indicated Resident #102:<br><br>-was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of nine out of a possible 15 points.<br><br>-had adequate vision and saw fine detail, such as regular print in newspapers/books.<br><br>-did not use corrective lenses (contacts, glasses, or magnifying glass).<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | During an interview on 4/15/25 at 9:28 A.M., Resident #102 said he/she wears eyeglasses. The surveyor observed two pairs of eyeglasses laying on the Resident's nightstand next to his/her bed.<br><br>During an interview on 4/17/25 at 12:03 P.M., the Corporate MDS Nurse said that she was unaware that Resident #102 wears eyeglasses. The Corporate MDS Nurse said she would investigate, and get back to the surveyor.<br><br>During a follow-up interview on 4/17/25 at 12:19 P.M., the Corporate MDS Nurse said that Resident #102 wears eyeglasses, and was not coded for corrective lenses in error on the MDS assessment dated [DATE]. The Corporate MDS Nurse said the MDS should be coded as corrective lenses used.<br><br>Surveyor: [NAME], [NAME] |

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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>Based on observations, and interviews, the facility failed to maintain a safe and sanitary smoking environment for residents, staff, and visitors.<br><br>Specifically, the facility failed to:<br><br>-Ensure that proper signage was visible to designate resident smoking areas.<br><br>-Ensure residents were smoking in the designated smoking areas and not on the facility sidewalks and driveways.<br><br>-Ensure residents were safely disposing of cigarette materials/refuse in the designated receptacles to prevent the risk of starting a fire when cigarettes were thrown near shrubs, mulch and on the ground with other trash.<br><br>Findings include:<br><br>Review of the facility policy titled, Smoking, effective April 2017 Revised March 2022, indicated:<br><br>-This facility shall establish and maintain safe resident smoking practices.<br><br>-Smoking is only permitted in designated resident smoking areas, which are located outside of the building.<br><br>-Metal containers with self-closing cover devices are available in smoking areas.<br><br>-Ashtrays are emptied only into designated receptacles.<br><br>On 4/16/25 between 10:02 A.M. - 10:27 A.M., surveyor #1 observed the following:<br><br>-Ten residents smoking on the sidewalk along the left side of the building.<br><br>-Several chairs, a fire extinguisher and three covered cigarette receptacles were located in the sidewalk area.<br><br>-Three residents were observed to be smoking in the circular driveway in front of the facility main entrance.<br><br>-A No Smoking sign was observed on the right side of the lawn next to the facility main entrance.<br><br>-The ground surrounding the front entrance was observed with copious amounts of cigarette butts thrown on the ground.<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 cigarette butts and other smoking associated trash were observed along the sidewalk of the circular driveway, in the landscaped area in front of the covered porch around the shrubbery and mulch, and on the grass and sidewalk surrounding the chairs on the left side of the building where the ten residents were observed smoking.<br><br>-Four residents in the designated smoking area were observed throwing their cigarettes on the ground when they were done smoking.<br><br>-Three residents in the circular driveway were also observed throwing their cigarettes on the ground.<br><br>-The Staff Aide supervising the resident smokers was not observed directing the residents to use the covered cigarette receptacles to dispose of their cigarettes.<br><br>-No staff intervention was observed when the residents did not dispose of their cigarettes in the covered cigarette receptacles.<br><br>During an interview at the time, the Administrator said the smoking area is regularly cleaned, but the residents are always out smoking, and it was difficult to keep up and keep the area clean. The Administrator said the residents should be using the cigarette receptacles to dispose of their cigarettes and the staff supervising smoking should be directing the residents to dispose of the cigarettes in the appropriate covered receptacles.<br><br>On 4/16/25 between 10:29 A.M. - 10:37 A.M., surveyor #2 observed the following:<br><br>-The covered porch area next to the main entrance of the facility had three chairs, a bench, a table and a fire extinguisher.<br><br>-Multiple cigarette butts were observed on the lawn next to the facility main entrance and on the circular driveway.<br><br>-One resident sitting in the designated smoking area which had 3 smoking receptacles and several chairs.<br><br>-Cigarette butts were observed on the ground in the designated smoking area.<br><br>-Residents were observed throwing cigarettes on the ground instead of disposing in the smoking receptacles.<br><br>During an interview on 4/17/25 at 12:20 P.M., the Administrator said when there is inclement weather the residents smoke on the covered patio next to the facility main entrance. The Administrator said he considers both areas, the covered porch by the main entrance and the sidewalk area at the end of the driveway on the left side of the building, as designated smoking areas, and that was where the residents should be smoking. The Administrator said the No Smoking sign only pertains to the right side of the area by the main entrance. The Administrator said there was no signage to designate smoking areas because all the residents know where the smoking areas were located, and smoking designated area signs were not needed. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary care and services relative to enteral feeding (providing nutrition directly into the stomach/intestines through a feeding tube), for one Resident (#114) out of a total sample of 25 residents.<br><br>Specifically, for Resident #114, the facility failed to record the total amount of administered enteral feeding as ordered by the Physician, and perform weekly weight monitoring with the Resident experiencing a significant weight loss over a one-month period.<br><br>Findings include:<br><br>Review of the facility policy titled Weight Management last revised 4/2022, indicated:<br><br>-Weights will be done weekly for the first four weeks and then monthly unless otherwise recommended by the Dietician or RN.<br><br>-Weekly weights should be done on residents who are (identified) as high nutritional risk.<br><br>-Weight change is defined as any unplanned weight gain or loss as follows:<br><br>>+/- 5% weight change in one month<br><br>>+/- 7.5% weight change in 3 months<br><br>>+/- 10% weight change in 6 months<br><br>Review of the facility policy titled Enteral Nutrition, last revised 4/2022, indicated:<br><br>-The Registered Dietician completed the Nutrition Care Process to include:<br><br>-calculations of estimated energy, protein and fluid requirements<br><br>-recommendations as needed for alternative formulas, rates, or amounts of the formula or water to meet the resident's needs<br><br>-monitoring of weight .tolerance to feeding and oral food/fluid intakes (if applicable)<br><br>Resident #114 was admitted to the facility in March 2025, with diagnoses including Traumatic Brain Injury (TBI), Acute Respiratory Failure, Dysphagia, Gastrostomy Status (G-tube - a flexible tube inserted through the abdomen and stomach to deliver nutrition, fluids and medication directly to the stomach).<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #114 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of five out of a total possible score of 15.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/15/25 at 9:57 A.M., the surveyor observed Resident #114 lying in bed and enteral formula being administered via a feeding controller pump set at 75 milliliters/hour (ml/hr).<br><br>Review of the active Physician orders dated 4/17/25, indicated:<br><br>-NPO (nothing per os-nothing by mouth) diet, initiated 3/13/25<br><br>-Enteral feed order, Jevity 1.2 cal @75 ml/hr x 20 hours until 1500 ml total infused, down at 1300 hours (1:00 P.M.) and up at 1700 hours (5:00 P.M.), Document total amount of enteral feed infused every day shift, initiated 3/13/25<br><br>Review of Resident #114's Comprehensive Nutritional Evaluation dated 3/13/25, indicated:<br><br>-recommendation to initiate weekly weight monitoring x 4 weeks.<br><br>-goal to maintain weight within 5% of current body weight and experience no significant weight changes.<br><br>Review of Resident #114's weight record indicated the following weights:<br><br>-3/13/25: 148.9 pounds<br><br>-4/7/25: 132.4 pounds<br><br>-Further review of Resident #114's weight record failed to indicate that weekly weights were obtained for four weeks.<br><br>Review of Resident #114's Nutrition/Dietary Progress Note dated 4/7/25, indicated the Resident experienced a significant weight loss of 11.1% over a one-month period.<br><br>Review of Resident #114's March 2025 and April 2025 Medication Administration Record (MAR) failed to indicate documentation recording the total amount of enteral formula that was administered to the Resident during the day shift as ordered.<br><br>During an interview on 4/17/25 at 9:15 A.M., the Dietician said that it is important to know exactly how much enteral formula Resident #114 received because the amount of enteral formula was specifically calculated based on the Resident's height, weight and nutritional requirements. The Dietician said that all newly admitted residents were placed on weekly weights for four weeks and then if the weights were stable, the resident was moved to monthly weight monitoring. The Dietician said that all weights were documented on the weight record in the electronic medical record. The surveyor and the Dietician reviewed Resident #114's weight record and the Dietician said that there was no evidence that weekly weight monitoring had been performed for the Resident, but should have been. The Dietician further said that the amount of enteral formula that had been administered to Resident #114 had not been documented as ordered but should have been documented. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure that medications were secure and inaccessible to unauthorized persons, for one Resident (#91), out of a total sample of 25 residents.<br><br>Specifically, for Resident #91, the facility failed to ensure that medications prepared for the Resident was handled in a safe and secure manner, when Nurse #3 left medications reconstituted in a cup of coffee, with Certified Nurses Aide (CNA) #4, and instructions that CNA #4 ensure the Resident consumed the coffee/ medications, and Nurse #3 did not remain with the Resident to ensure safe medication administration.<br><br>Findings include:<br><br>Review of the facility's policy titled Oral Medication Administration, effective April 2017 and last revised April 2022, indicated the following:<br><br>-The purpose of this procedure is to provide guidelines for safe administration of oral medications.<br><br>-Verify that there is a Physician's medication order for this procedure.<br><br>-If the resident cannot hold his or her own medications, place the cup near the lips and gently introduce each medicine one at a time, followed by a sip of water. Do not rush the resident.<br><br>-Remain with the resident until all medications have been taken.<br><br>Resident #91 was admitted to the facility in March 2022, with diagnoses including Dementia, Major Depressive Disorder, Anxiety Disorder, Gastro-Esophageal Reflux Disease without Esophagitis, and Unspecified Blepharitis Unspecified Eye.<br><br>Review of Resident #91's recent MDS assessment dated [DATE], indicated the Resident was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of four out of a possible 15 points.<br><br>Review of Resident #91's April 2025 Physician's orders indicated the following:<br><br>-Amlodipine Besylate Tablet 10 milligrams (mg), Give 1 tablet by mouth one time a day for hypertension (HTN), initiated 3/2/22.<br><br>-Multivitamin Tablet (Multiple Vitamin), Give 1 tablet by mouth one time a day for supplement, initiated 3/2/22.<br><br>-Pepcid Oral Tablet 20 mg (Famotidine), Give 1 tablet by mouth two times a day related to Gastroesophageal reflux disease without esophagitis, initiated 2/27/23.<br><br>(continued on next page) |

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|---|---|---|---|
| | 225467 | A. Building<br>B. Wing | 04/17/2025 |

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

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Trazodone HCL Oral Tablet 50 mg (Trazodone HCL), Give 25 mg by mouth two times a day related to Major Depressive, Recurrent, Unspecified, give ½ tab in A.M. & 2:00 P.M., initiated 2/19/24.<br><br>-Valproic Acid Solution 250 mg/5 milliliters (ml), Give 375 mg by mouth two times a day for Mood Disorders related to Unspecified Dementia, Unspecified Severity, with Other Behavioral Disturbance [7.5 ml per dose equals 375 mg], initiated 3/19/25.<br><br>-May crush allowable Meds, initiated 3/2/22.<br><br>Review of Resident #91's 4/16/25, Medication Administration Record (MAR) indicated Nurse #3's initials that Amlodipine Besylate, Multivitamin, Pepcid, Trazodone, and Valproic Acid medications were administered to the Resident as ordered by the Physician.<br><br>Review of Resident #91's Nursing Evaluation: Medication Reconciliation/Self-Admin [administration] of Meds, dated 3/31/25 indicated:<br><br>-Resident wishes not to administer his/her own medications.<br><br>-No documentation that Resident #91 was able to self-administer his/her scheduled medications prescribed by the Physician.<br><br>On 4/16/25 at 8:21 A.M., the surveyor observed Nurse #3 enter the dining room on Unit 4. The surveyor observed Nurse #3 holding a small plastic medication cup containing a pink liquid, a clear pill crush bag containing a powered substance, and a spoon. The surveyor observed Nurse #3 approach Resident #91 who was seated in a wheelchair at the dining table. The surveyor also observed CNA #4 seated in a stationary chair at the table next to Resident #91. Nurse #3 was observed mixing the pink liquid substance and the powered substance into Resident #91's cup of coffee. The surveyor observed Nurse #3 instruct CNA #4 to ensure that Resident #91 drank the coffee because the cup of coffee contained Resident #91's medications. Nurse #3 was observed exiting the dining room and leaving the cup of coffee containing the medications unattended with CNA #4.<br><br>During an interview on 4/16/25 at 8:23 A.M., CNA #4 said that Nurse #3 told the CNA that she mixed medications in Resident #91's cup of coffee and for CNA #4 to ensure that Resident #91 drank the coffee.<br><br>During an interview on 4/16/25 at 8:24 A.M., Nurse #3 said that she reconstituted medication into Resident #91's cup of coffee and instructed CNA #4 to ensure that Resident #91 drank the coffee because the cup contained Resident's #91's morning scheduled medications. Nurse #3 said that she thought instructing CNA #4 to ensure that the Resident drank the coffee was okay.<br><br>On 4/16/25 at 8:26 A.M., the surveyor observed Nurse #3 standing next to the medication cart at the nurses station and out of direct line of sight from Resident #91 who was seated in the dining room. The surveyor observed Resident #91 pick up the cup of coffee, bring it to his/her lips to drink. Nurse #3 was not observed to re-enter the dining room.<br><br>During a follow-up interview on 4/16/25 at 8:32 A.M., CNA #4 said that Nurse #3 did not return to the dining room to remove the cup of coffee containing Resident #91's medication. CNA #4 said that the Resident consumed the coffee without Nurse #3 present.<br><br>(continued on next page) |

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| Regalcare at Worcester | 25 Oriol Drive<br>Worcester, MA 01605 |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/16/25 at 9:49 A.M., the Assistant Director of Nursing (ADON) said that residents have a Physician order to crush medications and to mix with the fluid of choice. The ADON said that Nurse #3 should have stayed with the Resident when she reconstituted the medications with the cup of coffee. The ADON said that Nurse #3 should have ensured that the Resident consumed the medication dose ordered by the Physician prior to exiting the dining room. The ADON said that the expectation for nursing staff during medication administration was to remain with residents to ensure that medications are administered as ordered. The ADON said the medications should not have been left with CNA's to be administered to Residents as CNA's were not identified as Licensed Nurses. |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or obtain dental services for each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and observation, the facility failed to provide routine dental services for one Resident (#29) out of a total sample of 25 residents.<br><br>Specifically, for Resident #29, the facility failed to schedule a follow-up appointment for dental care in a timely manner which resulted in a delay in dental care and increased risk for oral pain and infection.<br><br>Findings include:<br><br>Review of the facility policy titled Dental Services, last revised January 2025, indicated:<br><br>-Routine and 24-hour emergency dental services are provided to our residents through:<br><br>>a contract agreement with a licensed dentist that comes to the facility monthly<br><br>>referral to the resident's personal dentist<br><br>>referral to community dentists<br><br>>referral to other health care organizations that provide dental services<br><br>-Selected dentists must be available to provide follow-up care. Failure of a dentist to provide follow-up services will result in the facility's right to use its consultant dentist to provide the resident's dental needs<br><br>-Social Services Representative will assist residents with appointments<br><br>Resident #29 was admitted to the facility in March 2015 with diagnoses including Dementia and muscle weakness.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #29:<br><br>-was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of a possible total score of 15.<br><br>-reported frequent moderate pain [sic] within the last five days.<br><br>Review of Resident #29's Medical Record indicated:<br><br>-an activated Healthcare Proxy (HCP), effective 2/20/23.<br><br>-the HCP signed a consent for Dental services, effective 2/20/23.<br><br>Review of Resident #29's Dental Group Consultant Sheet dated 6/21/23, unsigned indicated:<br><br>(continued on next page) |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Patient needs extractions will reschedule with proxy (HCP) permission.<br><br>Review of Resident #29's Dental Group Consultant Sheet dated 8/31/23, signed by the Dental Hygienist indicated:<br><br>-Patient was having trouble with pain during treatment.<br><br>-Patient will need a deep clean.<br><br>-Patient will need to see the Doctor for treatment plan for decay.<br><br>During an interview on 4/15/25 at 8:49 A.M., Resident #29 said that his/her back tooth was sore and that he/she had seen the Dentist in the past, but had not seen the Dentist for a while.<br><br>During an interview on 4/16/25 at 1:46 P.M., Unit Manager (UM) #1 said that Resident #29's dental care recommendations should have been followed up on and they were not. UM #1 also said that a dental appointment had been canceled, and had never been rescheduled but should have been. |

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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** Based on observation, interview, and record review, the facility failed to adhere to infection control standards of practice for one Resident (#48) out of a total sample of 25 residents, increasing the risk of contamination and the spread of infections within the facility.<br><br>Specifically, for Resident #48, the facility staff failed to 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), while providing high contact care to the Resident during ADLs (Activities of Daily Living: such as bathing, dressing, grooming, personal hygiene) when providing high contact care to the Resident.<br><br>Findings include:<br><br>Review of the facility policy titled Enhanced Barrier Precautions (EBP), last revised September 2022, indicated the following:<br><br>-Enhanced barrier precautions are infection prevention intervention designed to reduce the transmission of multidrug-resistant organisms (MDROs) in the facility.<br><br>>The precautions involve gown and glove use during high contact care activities for residents known to be colonized or infected with an MDRO, as well as those with an increased risk of contracting an MDRO.<br><br>-Use of Enhanced Barrier Precautions includes, but not limited to residents, with indwelling medical devices or wounds (regardless of MDRO colonization or infection status) .<br><br>-Examples of indwelling medical devices include central lines, urinary catheters, feeding tubes, and tracheostomies/ventilators.<br><br>-Examples of high contact care activities include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care.<br><br>Resident #48 was admitted to the facility in March 2022 with diagnoses including Neuromuscular Dysfunction of Bladder and Cerebral Palsy.<br><br>Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #48:<br><br>-was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a total possible 15.<br><br>-has an indwelling catheter (Foley) in place.<br><br>Review of Resident #48's April 2025 Physician's orders indicated:<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 | -Enhanced Barrier Precautions related to (r/t) Foley, every shift, initiated 1/4/25.<br><br>Review of Resident #48's Plan of Care for Enhanced Barrier Precautions, initiated 1/18/23 and revised 2/7/25, indicated the Resident was on EBP for suprapubic catheter care.<br><br>On 4/15/25 from 9:24 A.M. to 9:33 A.M., the surveyor observed the following:<br><br>-Signage outside of Resident #48's room, attached to the room name plate, indicating Enhanced Barrier Precautions (EBP).<br><br>The EBP sign indicated:<br><br>>Perform hand hygiene before and after patient contact, contact with environment, and after removal of PPE (Personal Protective Equipment).<br><br>>Wear gown and gloves prior to these activities:<br><br>*During High Contact Care Activities:<br><br>*Dressing<br><br>*Bathing/Showering<br><br>*Transferring<br><br>*Providing hygiene<br><br>*Changing linens<br><br>*Changing briefs or assisting with toileting<br><br>*Device Care or use of a device (i.e central lines, urinary catheters, feeding tubes, tracheostomies, ventilators).<br><br>-Clear storage bin with PPE including gloves and clean disposable blue gowns outside of the room.<br><br>-Black trash bin outside of the room.<br><br>>9:24 A.M.:<br><br>-Nurse #1 was observed standing at the medication cart across the hall from Resident #48's room.<br><br>-Staff Development Coordinator (SDC) was observed standing in the hall near Resident #48's room and assisting staff collecting breakfast trays.<br><br>-Certified Nurses Aide (CNA) #1 and CNA #2 were observed to don gloves, did not don gowns, and entered Resident #48's room with a mechanical lift and closed the door for privacy.<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 | >9:29 A.M.:<br><br>-CNA #1 was observed to open the door to reposition the mechanical lift in the room and Resident #48 was observed lifted in the mechanical lift.<br><br>-CNA #1 and CNA #2 were observed wearing gloves, but were not observed wearing gowns.<br><br>>9:33 A.M.:<br><br>-CNA #1 was observed exiting the Resident's room with the mechanical lift, removed her gloves, and disposed of the gloves in the black trash bin.<br><br>During an interview on 4/15/25 at 9:33 A.M., CNA #1 said that she was not sure what the signage outside of Resident #48's room indicated, or to which resident in the room the signage applied.<br><br>During an interview on 4/15/25 at 9:37 A.M., with Nurse #1 and the SDC, Nurse #1 said that Resident #48 was on EBP due to use of an indwelling catheter. The surveyor and the SDC reviewed the signage outside of Resident #48's room, and the SDC said the sign indicated that staff should wear a gown and gloves when providing care to the Resident. The SDC said that CNA #1 and CNA #2 should have worn gowns and gloves when providing care to Resident #48.<br><br>During an interview on 4/15/25 at 10:20 A.M., Resident #48 was observed in bed and dressed for the day. The Resident said that he/she had a urinary catheter in place and that sometimes the urinary catheter did leak urine.<br><br>During an interview on 4/17/25 at 9:52. A.M., the Infection Control Nurse/Assistant Director of Nursing (ADON) said that residents who have wounds, ostomies, catheters, or tracheostomies would be on EBP and the facility has signage outside of the resident rooms that require EBP. The ADON said that if any staff are unsure of the signage or which PPE to wear, they can ask the Unit Nurse. The ADON further said that CNA #1 was a recent hire in the past 90 days, had completed her orientation process, and that she should have been wearing a gown and gloves when providing care to Resident #48. The surveyor requested evidence of staff education to CNA #1 relative to infection control.<br><br>Review of the Education Record for CNA #1 indicated the following:<br><br>-Education on Hand Hygiene and PPE donning observation was completed on 1/29/25.<br><br>-Education regarding Enhanced Barrier Precautions was completed on 2/5/25. |