STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225500	A. Building B. Wing	12/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Side House Ltc Facility	35 Fruit Street Worcester, MA 01609

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47901 Based on observation, interview, and record review, the facility failed to ensure the right of residents to be free from physical restraints for one Resident (#2) out of a total sample of 14 residents. Specifically, for Resident #2, the facility failed to: -appropriately assess and re-assess the use and the need for a wheelchair seat belt used as a restraint when the Resident was seated in the wheelchair. -obtain informed consent and review the risk/benefits with the Resident's Representative for the use of the wheelchair seat belt, which was used to prevent Resident #2 from sliding off the wheelchair, increasing the potential risk of accidental falls and injury. Findings include: Review of the facility policy titled Device/Restraints Policy and Procedure, revised April 2017, indicated it was the policy of the facility to ensure each resident attains/maintains the highest practicable well-being in an environment that improves functional status and ability. The policy also included the following: -every resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience . -when the use of restraints is indicated, the facility will use the least restrictive alternative for the least amount of time and document ongoing evaluation of the need for the restraints. -physical restraints are any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. -physical restraints may include, but are not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, lap cushions and lap trays that the resident cannot remove easily. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-also included as restraints are facility practices that meet the definition of a restraint, such as: >using the side rails that keep a resident from voluntarily getting out of bed. >tucking in or using velcro to hold a sheet, fabric, or clothing tightly so that a resident's movement is restricted. >placing a chair or bed so close to a wall that the wall prevents the resident from rising out of the chair or voluntarily getting out of the bed. >using a device in conjunction with a chair, such as trays, tables, bars or belts, that the resident cannot remove easily, that prevent the resident from rising. -removes easily means that the manual method, device, material, or equipment can be removed intentionally by the same manner as it was applied by the staff (e.g., side rails are put down, not climbed over) considering the resident's physical condition and ability to accomplish the objective . -convenience is defined as any action taken by the facility to control a resident's behavior or manage a resident's behavior with a lesser amount of effort by a facility and not in the resident's best interest. -freedom of movement means any change in place or position for the body or any part of the body that the person is physically able to control. -before initiating any device that has a potential to act as a restraint, the licensed nursing staff shall determine the necessity of initiating a device/restraint by completing the Device/Physical Restraint Assessment Form. -The Device/Physical Assessment will include the medical justification, risk factor and potential complication. The form is forwarded to the licensed nursing staff to review with the resident and next of kin or responsible party. -The restraint policy is reviewed, and authorization is obtained. -In the event the resident is confused and unable to sign the authorization, a verbal authorization will be obtained from the next of kin or legal guardian until written authorization is obtained. -The team will assure the process is complete and the restraint will be added onto the resident's care plan and ADL guide/Kardex. -The Device/Physical Restraint Assessment form is then filed in the resident's chart. -There must be written, signed, and dated physician's orders for devices/physical restraints, and all orders must be reviewed and signed with each required physician's visit. -The need for the continued device/restraint or restraint reduction trials will be conducted quarterly with the MDS review, while restraints are being used. (continued on next page)

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2 was admitted to the facility in March 2019, with diagnoses including Non-Alzheimer's Dementia, Traumatic Brain Injury (TBI), Major Depressive Disorder, and Anxiety. Review of Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #2 was severely cognitively impaired as evidenced by a Brief Interview of Mental Status (BIMS) score of 3 out of 15. On 12/26/24 at 9:29 A.M., the surveyor observed Resident #2 seated in a wheelchair with a seat belt on while in the dining area after the breakfast meal. During an interview at the time, the Resident said he/she kept the seat belt on for safety. On 12/26/24 at 9:32 A.M., the surveyor and the Unit Manager (UM) observed Resident #2 seated in a wheelchair with the seat belt on while in the dining room. During an interview at the time, the UM said Resident #2 preferred the seat belt on him/her while seated for fear of falling or sliding out of the chair. Review of Resident #2's December 2024 clinical record did not indicate any assessments for the use of the seat belt while the Resident is in the wheelchair. During an interview on 12/26/24 at 12:44 A.M., the Director of Nursing (DON) said there was no assessment indicating the need/use of the wheelchair seat belt. During an interview on 12/26/24 at 2:07 A.M., the Rehabilitation Director and the DON said Resident #2 was admitted to the facility in 2019 with his/her own wheelchair with the seat belt. The Rehabilitation Director and the DON said Resident #2 had not been assessed for the seat belt, neither had there been a Physician's order or consent from the Resident's Guardian for the use of the seat belt in the wheelchair. During a follow-up interview on 12/27/24 at 1:05 P.M., the DON said Resident #2 should have been assessed for the use of the seat belt, but the assessment had not been done. The DON said if the seat belt were to be used, the Resident's Guardian would need to be educated on the seat belt use, consent would have to be obtained, a Physician's order for the use of the seat belt would need to be in place, and the seat belt use as a restraint would need to be reviewed periodically.

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47901 Based on interview, and record review, the facility failed to accurately complete the Minimum Data Set (MDS) Assessment for one Resident (#19) out of a total sample of 14 residents. Specifically, for Resident #19, the facility staff failed to accurately code the use of an antipsychotic medication on one MDS Assessment. Findings include: Resident #19 was admitted to the facility in December 2024 with diagnoses including Paranoid Delusions. Review of Resident #19's December 2024 Physician orders indicated the following order dated 12/6/24: -Zyprexa (antipsychotic medication) 5 milligram (mg) oral. -Give 5 mg every night at 9 P.M. Review of Resident #19's MDS Assessment, dated 12/12/24, did not indicate that the Resident received the antipsychotic medication during the MDS Assessment observation period (12/6/24 - 12/12/24). Review of Resident #19's December 2024 Medication Administration Record (MAR) indicated the Zyprexa medication was administered to Resident #19 during the observation period for the Resident's MDS assessment dated [DATE]. During in interview on 12/27/24 at 9:14 A.M., the MDS Nurse said that Resident #19 received the Zyprexa medication during the observation period for the MDS assessment dated [DATE]. The MDS Nurse said that the antipsychotic medication should have been coded on the MDS Assessment as having been taken during the observation period. The MDS Nurse further said that the use of antipsychotic medication should have been coded on Resident #19's MDS assessment dated [DATE], but it was not.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45435 Based on observation, and interview, the facility failed to follow professional standards of practice for food safety in the main kitchen to prevent the potential spread of foodborne illnesses to residents who are at high risk. Specifically, the facility failed to ensure food temperatures were taken and documented prior to meal service in the facility's main kitchen to ensure the food temperatures were within acceptable parameters for food safety. Findings include: Review of the facility policy titled Food Temperature Testing, dated July 2013, indicated the following: -Temperature of food items in the steam table are to be taken at the beginning of service and at the end of service using the following method: a. Sanitize thermometers by cleaning with alcohol wipes. b. Insert the thermometer into food items in steam table. Take reading and document on Daily Temperature Checklist for Meal Service form after temperature plateaus. -Temperatures are to be taken from the steam table for all three meals on a daily basis. During a kitchen observation on 12/27/24, the surveyor observed the following: -11:20 A.M., the steam table contained the following items: >Whole baked fish >Pureed fish >Rice Pilaf >Mashed potato >Whole carrots >Ground carrots >Pureed carrots >Gravy (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-a pan of Barbecued pulled pork on the stove top. On 12/27/24 at 11:35 A.M., the surveyor observed the cook (Dietary Staff #2) begin to plate food from the steam table. The surveyor did not observe food temperatures being taken of the food on the steam table prior to the beginning of meal service. On 12/27/24 at 11:51 A.M., the surveyor and Dietary Staff #1 reviewed the Daily Temperature Checklist for Meal Service and found that no food temperatures had been documented on 12/27/24 for the breakfast or lunch meals. Dietary Staff #1 asked Dietary Staff #2 about the food temperatures missing from the Daily Temperature Checklist. Dietary Staff #2 said that she had a bad habit of not writing down the temperatures when she takes them but that she had taken the food temperatures for breakfast and lunch meals, and she remembered them. During an interview following the observation on 12/27/24 at 11:51 A.M., Dietary Staff #1 said that food temperatures should be taken, and the temperatures written on the Daily Temperature Checklist prior to tray line start. Dietary Staff #1 further said that all of the food temperatures from breakfast and lunch looked like too much information to remember. Review of the Daily Temperature Checklist for Meal Service forms dated 12/1/24 through 12/27/24 indicated the following meal temperatures were not taken: -12/1/24: no dinner meal temperatures -12/5/24: no breakfast, lunch or dinner temperatures -12/6/24: no breakfast, lunch or dinner temperatures -12/9/24: no dinner temperatures -12/15/24: no breakfast, lunch or dinner temperatures -12/16/24: no dinner temperatures -12/20/24: no dinner temperatures -12/27/24: no breakfast or lunch temperatures During an interview on 12/27/24 at 1:05 P.M., Dietary Staff #2 said that her routine was to check the food temperatures when the food was done. Dietary Staff #2 said that food temperatures were taken because bacteria could grow in food and result in foodborne illness. Dietary Staff #2 further said that the temperature of food in a steam table should be taken because sometimes steam tables are unreliable and the temperature of the food items could drop. During an interview on 12/27/24 at 1:31 P.M., the Food Service Director (FSD) said food temperatures should be taken three times, when the food was done cooking, when the food was placed on the steam table, and right before the meal service starts. The FSD said she had educated the Cooks about this, and that it was her responsibility to check to see that the Cooks check the food temperatures and record the results, but this had not been done.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45429 Based on observation, interview, and record review, the facility failed to adhere to infection control standards of practice during a bolus feeding (a method of tube feeding administering a dose of the formula through a feeding tube using a catheter syringe [syringe without a needle]) procedure for one Resident (#51) out of a total sample of 14 residents. Specifically, for Resident #51, the facility 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), when providing high contact care for the Resident, increasing the risk of contamination and spreading infections to the Resident and other residents within the facility. -perform hand hygiene procedure as required between glove changes while providing care. -open/pierce a Jevity (therapeutic nutrition) container foil in a sanitary manner. Findings include: Review of the facility policy for Enteral (passing through the intestines) Tube Feeding via Syringe (Bolus), last revised November 2018 indicated: -use aseptic technique (refers to the manner of handling, preparing, and storing medications and injection equipment/supplies (e.g., syringes, needles) to prevent microbial contamination and infection) when preparing and administering enteral feedings -wash hands and dry thoroughly -wear clean gloves -remove gloves and discard into designated container -wash your hands Review of the facility policy titled Enhanced Barrier Precautions (EBP), last Revised August 2022, indicated the following: -EBP's are used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms (MDROs) to Residents. -gloves and gowns are applied prior to performing high contact resident care activity >examples of high contact resident care activities requiring the use of gown and gloves for EBP's include: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-dressing -bathing/showering -transferring -providing hygiene -changing linens -changing briefs or assisting with toileting -device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator -wound care >EBP's remain in place for the duration of the resident's stay or until . the discontinuation of the indwelling medical device that places them at increased risk. >Signs are posted on the door or wall outside the resident's room indicating the type of precautions and Personal Protective Equipment (PPE) required. Resident #51 was admitted to the facility in February 2024, with diagnoses including Adult Failure to Thrive and Dysphagia. Review of the Resident's Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #51: -was cognitively intact as evidenced by a score of 15 out of a total score of 15 on the Brief Interview for Mental Status (BIMS) exam. -had symptoms of a swallowing disorder, holding food in the mouth/cheeks or residual food in the mouth after meals. -had weight loss of 5% or more in a month or 10% or more in 6 months. Review of Resident #51's December 2024 Physician's orders indicated: -24 French (a universal gauge system to measure the size of catheters) gastrostomy [g-tube] placed 12/13/24 -every shift check g-tube (feeding tube) placement, dated 12/13/24 -Jevity 1.5 calorie, 120 milliliters (ml) via enteral tube every 4 hours, start date 12/20/24 -Resident to sit up during g-tube feeding. Have head of bed elevated to 45 degrees and sit up at least 1 hour after the feeding, start date 12/13/24 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #51's Comprehensive Person-Centered Care Plan dated 12/18/24, indicated: -that the Resident needs a feeding tube due to malnutrition and weight loss. -Enhanced Barrier Precautions every shift On 12/26/24 at 9:38 A.M., the surveyor observed EBP signage posted outside of Resident #51's room which indicated: >for Everyone: -to cleanse hands before entering and when leaving the room. >for Providers and Staff: -wear gloves and a gown for high contact resident care activities including device care or use: central line, urinary catheter, feeding tube, tracheostomy On 12/26/24 at 9:42 A.M., the surveyor observed the following while Nurse #1 performed a bolus feeding to Resident #51 in the Resident's room: -Nurse #1 removed (doffed) her gloves and did not perform hand hygiene after taking off the gloves. -Nurse #1 removed a set of keys from her pocket, using one key to pierce the foil barrier of the Jevity container to access the tube feed formula. -Nurse #1 provided a water flush, then bolus feeding and then another water flush to Resident #51without wearing the required gloves during the entire high contact treatment. During an interview immediately following the observation on 12/26/24 at 10:01 A.M., Nurse #1 said that she should have washed her hands after removing the gloves, that she should not have used a key to open the Jevity bottle and that she should have worn gloves while administering the feeding and water flushes to Resident #51, but she did not. During an interview on 12/26/24 at 10:54 A.M ., the Director of Nursing (DON) said that Nurse #1 should have worn gloves while administering the bolus feeding and water flushes to Resident #51. The DON also said that Nurse #1 should not have used a key to open the Jevity container and should have washed her hands after removing her gloves.