STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225577	A. Building B. Wing	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Notre Dame Long Term Care Center	559 Plantation Street 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 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. 47901 Based on observation, and interview, the facility failed to ensure that a Licensed Nurse (Nurse #2) had the specific competencies and skill sets necessary to provide wound care for one Resident (#84). Specifically, the facility failed to ensure that Nurse #2 had the knowledge, competency and skills relative to infection control practices when providing wound care for Resident #84. Findings include: Review of the facility policy titled, Competency, undated, indicated: -Facility would ensure all nursing staff maintain high standards of patient care and safety. -Each nurse is responsible for maintaining their competency through training, evaluation, and professional development. -Nurses are required to periodically demonstrate continued proficiency in their roles through assessments, evaluations or skills check. -Common areas assessed include clinical skills, patient care, medication administration, infection control practices, communication skills and ethical decision-making. -Nurses undergo regular performance evaluations where their competencies are assessed by supervisors or managers. -All competency assessments, training activities, and evaluations are documented to ensure transparency and accountability. Review of the facility policy titled Enhanced Barrier Precautions, dated 2001, revised August 2022, included but was not limited to: -Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms (MDROs) to residents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. -EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. Review of the facility policy titled Handwashing/Hand Hygiene, dated 2001, indicated: -All personnel are trained and regularly in-serviced to the importance of hand hygiene in preventing the transmission of healthcare-associated infections . -Hand hygiene is indicated immediately after glove removal. Resident #84 was admitted to the facility in March 2024 with diagnoses including Unstageable Pressure Ulcer to coccyx and Methicillin Resistant Staphylococcus Aureus (MRSA) Infection. Review of Resident #84's February 2024 Physician orders indicated: -Unstageable pressure ulcer on coccyx (a small triangular-shaped bone located at the bottom of the spine), clean with normal saline, pat dry, apply Santyl (used to remove damaged tissue from chronic skin ulcers), pack with Calcium Alginate (wound exudate absorbing agent) then cover with a silicone border foam dressing daily, initiated on 1/24/25. On 2/11/25 at 10:05 A.M., the surveyor observed the following during a wound care observation for Resident #84: -An Enhanced Barrier Precaution (EBP) sign at the Resident's door indicating the Resident was on precautions. -Nurse #2 washed her hands with soap and water in the Resident's bathroom, then donned (put on) a gown and gloves. -Nurse #2 repositioned the Resident to his/her side, and removed the old wound dressing. -Nurse #2 doffed (removed) her gloves, did not wash or sanitize her hands, and donned new gloves. -Nurse #2 cleansed the Resident's wound bed with wound cleanser, pat dried the wound, doffed her gloves, did not wash or sanitize her hands, and donned new gloves. -Nurse #2 reached into her pocket and took out scissors, did not disinfect the scissors, then cut a piece of Calcium Alginate and placed the piece of Calcium Alginate on the overbed table. -Nurse #2 doffed her gloves, did not wash or sanitize her hands, and donned new gloves. -Nurse #2 applied Santyl to the Resident's wound bed, then applied the Calcium Alginate. -Nurse #2 doffed her gloves, did not wash or sanitize her hands, reached into her pocket and took out a pen, then donned new gloves. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nurse #2 opened the silicone foam protective dressing, dated the foam dressing, put the pen back in her pocket and applied the foam dressing to the Resident's wound. -Nurse #2 doffed the old gloves, did not wash or sanitize her hands, donned new gloves, then repositioned the Resident. -Nurse #2 removed a trash bag from the Resident's bedside table and dropped the trash bag in the Resident's bathroom trash can, doffed her gloves, did not wash or sanitize her hands, donned new gloves and assisted the Certified Nurses Aide (CNA) with transferring the Resident out of bed. During an interview on 2/11/25 at 10:48 A.M., Nurse #2 said she thought washing her hands with soap and water in the beginning was sufficient when completing Resident 84's wound care. During an interview on 2/11/25 at 10:58 A.M., the Infection Preventionist (IP)/Staff Development Coordinator (SDC) said she had not performed nursing competency relative to infection control during wound care with the Nurses and she should have. During a follow-up interview on 2/11/25 at 11:35 A.M., Nurse #2 said she should have cleaned or sanitized her hands between removing gloves, but she had not. Please Refer to F880

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 44222 Based on observation, record review, and interview, the facility failed to provide Adaptive Eating Equipment for one Resident (#75) out of a total sample of 23 residents. Specifically, the facility failed to provide built-up handled adaptive utensils for meals as required to preserve Resident #75's current level of function during meals. Findings include: Review of the facility policy titled Adaptive Equipment, undated, indicated: -Adaptive equipment for meal service in a nursing home is designed to help residents with varying physical abilities eat independently, safely, and comfortably. -Built-up Handle Utensils: These have thicker handles to make gripping easier for people with limited hand strength or dexterity . Resident #75 was admitted to the facility in April 2021 with diagnoses including Unspecified Dementia and Muscle Weakness (Generalized). Review of the Resident's Activities of Daily Life (ADL) care plan, revised 6/3/24, included an intervention for eating of .Black Silverware .during meals. Review of the Nutritional Risk Assessment, dated 12/4/24, indicated that the Resident required an intervention of black handled utensils. Review of the Resident's Nutrition Care Plan, revised 12/4/24, included an intervention of adaptive equipment with meals. Review of the most recent Minimum Data Set (MDS) Assessment, dated 12/6/24, indicated that the Resident was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 3 out of 15 possible points. Review of the Resident's Occupational Therapy (OT) Discharge Summary, dated 12/27/24, indicated: - .instructed patient and primary caregivers in use of adaptive utensils in order to preserve current level of function . (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/7/25 at 9:05 A.M., the surveyor observed Resident #75 lying in bed, with a breakfast meal tray set-up in front of him/her. The diet slip on the tray indicated that adaptive equipment including Black Silverware was required. The surveyor observed the silverware on the breakfast meal tray was silver in color and of standard size, and the food served on the plate included scrambled eggs. The surveyor further observed the Resident attempt to feed himself/herself the eggs using the spoon provided, but when the Resident picked up the spoon with scrambled eggs on it, the spoon tipped and the scrambled eggs spilled onto the Resident's chest. Review of Resident #75's Certified Nurses Aide (CNA) Kardex, dated 2/10/25, indicated that the CNA should ensure the Resident was provided with Black silverware for meals. On 2/10/25 at 8:45 A.M., the surveyor and Nurse #1 observed the Resident feeding himself/herself in bed. The Resident's breakfast meal included scrambled eggs, home fries, a muffin, and orange juice in a clear plastic cup. The silverware observed on the meal tray was silver in color and of standard size. The Resident was observed attempting to use the silver handled spoon to feed himself/herself some scrambled eggs. The Resident was unable to keep the eggs on the spoon, he/she grabbed both ends of the spoon to steady it, but was unable to get the spoon to his/her mouth. The Resident then grabbed the eggs with his/her hand and put the eggs in his/her mouth. The surveyor and Nurse #1 reviewed the diet slip located on the breakfast tray, dated 2/10/25, which indicated Adaptive Equipment: Black Silverware. During an interview at the time, Nurse #1 said that Resident #75 required the black handled utensils to be able to feed himself/herself, because the black handled utensils were built-up and easier to grab. During an interview on 2/10/25 at 9:00 A.M., CNA #1 said Resident #75 required the black handled utensils because those utensils were built up and easier for him/her to grasp. CNA #1 said that if the Resident did not get those utensils at meals it was a mistake because the diet slip said to provide them. CNA #1 said that the adaptive equipment required was highlighted in yellow on the diet slip and the staff serving the breakfast trays were supposed to check any special needs before serving the meal tray. During an interview on 2/12/25 at 1:00 P.M., the Staff Development Coordinator (SDC) said that the staff were trained in meal tray delivery, and the adaptive equipment listed on the diet slip should be provided. The SDC said that both the CNA and the Licensed Nurse should check each meal tray before delivery to the residents, to ensure that the correct diet and adaptive devices have been provided.

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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. 44222 Based on observation, interview, and record review, the facility failed to adhere to infection control standards of practice for two Residents (#103 and #84) out of a total sample of 23 residents, increasing the risk of contamination and the spread of infection to the Residents and other residents within the facility. Specifically, the facility failed to: 1. For Resident #103, ensure that staff appropriately followed 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. 2. For Resident #84, ensure that staff adhered to infection control standards and hand hygiene practices while performing wound care. Findings include: Review of the facility policy titled Enhanced Barrier Precautions, dated 2001, revised August 2022, included but was not limited to: -Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. -EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. -gloves and gown are applied prior to performing the high contact resident care activity -examples of high contact care activities requiring the use of gown and gloves for EBPs include: device care or use (central line, urinary catheter (a device inserted into the bladder to drain urine), feeding tube, tracheostomy/ventilator, etc.) -EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. 1. Resident #103 was admitted to the facility in September 2024 with diagnoses including Age Related Cognitive Decline, other specified Disorders of the Kidney and Ureter, and Type 2 Diabetes Mellitus with other Circulatory Complications. Review of Resident #103's Care Plan for Enhanced Barrier Precautions, initiated 12/9/24, included: -Enhanced Barrier Precautions related to implanted medical device. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-High risk for MDRO transmission Resident with an implanted medical device - Foley catheter (urinary catheter). Review of Resident #103's Care Plan for Hospice, initiated 1/13/25, included: -All aspects of care to be coordinated with the Hospice Care Team. Review of Resident #103's Minimum Data Set (MDS) Assessment, dated 1/17/25, indicated that the Resident: -was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 4 out of a possible 15 points. -had an indwelling urinary catheter. -required substantial/maximal assistance with personal hygiene. -was now under the care of Hospice services. Review of Resident #103's Physician's orders for February 2025 included: -16 Fr (Fr-French a metric size of a catheter) 10 ml (milliliters) Foley (urinary) catheter to continuous drainage every shift, start date 12/6/24 -Enhanced Barrier Precautions r/t (related to) Foley catheter every shift, start 12/9/24 -Admit to Hospice services via Hospice, as of 1/12/25 On 2/7/25 at 11:11 A.M., the surveyor observed an Enhanced Barrier Precaution sign posted outside Resident #103's doorway, which indicated: -Providers and staff must also wear gloves and a gown for the following High-Contact Resident Care Activities Device care or use: central line, urinary catheter, feeding tube, tracheostomy. On 2/10/25 at 9:00 A.M., the surveyor observed an EBP sign in the Resident's doorway, PPE supplies, and a waste receptacle at the doorway. Upon entering the room the surveyor observed Hospice Staff #1 standing beside the Resident's bed and was not wearing a gown. The surveyor observed Hospice Staff #1 adjust the Resident's urinary catheter drainage bag and tubing. Hospice Staff #1 was observed to adjust the Resident's blankets. Hospice Staff #1 told the surveyor that she was about to provide morning care for Resident #103. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/10/25 at 9:05 A.M., Hospice Staff #1 said that she had not noticed the Enhanced Barrier Precaution sign posted outside the Resident's doorway, and was not sure the sign was there when she first entered the Resident's room. Hospice Staff #1 said that the Resident had been on Hospice services for about two months and she cared for the Resident about two times each week. Hospice Staff #1 said that she last cared for the Resident last week. Hospice Staff #1 said that she had never worn a gown to care for the Resident. Hospice Staff #1 said that she was not exactly sure what Enhanced Barrier Precautions stood for but after reading the sign it seemed she should have been wearing a gown when she cared for the Resident. Hospice Staff #1 said that she had been trained on putting on Personal Protective Equipment (PPE) but she just made a mistake because she did not see the sign. During an interview on 2/10/25 at 9:10 A.M., Nurse #1 said that the Resident was on EBP because he/she had an indwelling urinary catheter. Nurse #1 said that the Resident had been on EBP since before entering onto Hospice Services just over one month ago. Nurse #1 said that anyone providing direct care to the Resident should wear a gown and gloves. Nurse #1 said that Hospice Staff #1 should not have provided care for the Resident's urinary catheter without wearing a gown. During an interview on 2/12/25 at 1:00 P.M., the Staff Development Coordinator (SDC) said that the expectation was that the Hospice Staff were trained in precautions and use of PPE. The SDC said that Hospice Staff #1 should have donned (put on) a gown before she provided direct care to the Resident. 47901 Review of the facility policy titled Handwashing/Hand Hygiene, dated 2001, indicated: -All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. -Personnel are educated regarding ways to prevent contact dermatitis and other skin irritations and provided with supplies that support healthy hand skin. -Hand hygiene is indicated immediately after glove removal. Resident #84 was admitted to the facility in March 2024 with diagnoses including Unstageable Pressure Ulcer to coccyx and Methicillin Resistant Staphylococcus Aureus (MRSA) Infection. Review of Resident #84's Minimum Data Set (MDS) Assessment, dated 12/6/24, indicated that the Resident: -was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) Score of 8 out of a possible 15 points. -was dependent on staff for his/her Activities of Daily Living (ADL - washing, grooming and dressing) care. Review of Resident #84's February 2024 Physician orders indicated: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Unstageable pressure ulcer on coccyx (a small triangular-shaped bone located at the bottom of the spine), clean with normal saline, pat dry, apply Santyl, pack with Calcium Alginate then cover with a silicone border foam dressing daily, initiated 1/24/25. On 2/11/25 at 10:05 A.M., the surveyor observed the following during a wound care procedure for Resident #84: -An Enhanced Barrier Precaution (EBP) sign at the Resident's door indicating the Resident was on precautions. -Nurse #2 washed her hands with soap and water in the Resident's bathroom, then donned a gown and gloves. -Nurse #2 repositioned the Resident to his/her side, and removed the old wound dressing. -Nurse #2 doffed (removed) her gloves, did not wash or sanitize her hands, and donned new gloves. -Nurse #2 cleansed the Resident's wound bed with wound cleanser, pat dried the wound, doffed her gloves, did not wash or sanitize her hands, and donned new gloves. -Nurse #2 reached into her pocket and took out scissors, did not disinfect the scissors, then cut a piece of Calcium Alginate and placed the piece of Calcium Alginate on the table. -Nurse #2 doffed her gloves, did not wash or sanitize her hands, and donned new gloves. -Nurse #2 applied Santyl to the Resident's wound bed, then applied the Calcium Alginate. -Nurse #2 doffed her gloves, did not wash or sanitize her hands, reached into her pocket and took out a pen, then donned new gloves. -Nurse #2 opened the silicone foam protective dressing, dated the foam dressing, put the pen back in her pocket and applied the foam dressing to the Resident's wound. -Nurse #2 doffed the old gloves, did not wash or sanitize her hands, donned new gloves, then repositioned the Resident. -Nurse #2 removed a trash bag from the Resident's bedside table and dropped the trash bag in the Resident's bathroom trash can, doffed her gloves, did not wash or sanitize her hands, donned new gloves and assisted the Certified Nurses Aide (CNA) with transferring the Resident out of bed via hoyer lift. During an interview on 2/11/25 at 10:48 A.M., Nurse #2 said she thought washing her hands with soap and water before initiating the dressing change was enough to complete the wound care. During a follow-up interview on 2/11/25 at 11:35 A.M., Nurse #2 said she should have cleaned or sanitized her hands between removing gloves, but she did not.