

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225648	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/23/2024
NAME OF PROVIDER OR SUPPLIER Holy Trinity Eastern Orthodox N & R Center		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Barber Avenue Worcester, MA 01606	
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)		
<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>45429</p> <p>Based on record and policy review, and interview, the facility failed to ensure that a Level II [comprehensive evaluation that identifies the specialized services required] Preadmission Screening and Resident Review (PASRR- evaluation done if it was determined by the Level I [initial pre-screening] screen that a resident had an intellectual or developmental disability and/or serious mental illness [SMI] and if a resident was in need of additional support services at the facility) screen was submitted for one Resident (#73) out of a total sample of 18 residents.</p> <p>Specifically, for Resident #73, the facility staff failed to request a Level II PASRR evaluation when the Resident demonstrated an increase in behavioral, psychiatric, and mood-related symptoms resulting in a change to the Resident's plan of care.</p> <p>Findings Include:</p> <p>Resident #73 was admitted to the facility in August 2023, with diagnoses including Anxiety (feeling of unease, such as worry or fear, that can be mild or severe/ intense, excessive, and persistent worry and fear about everyday situations) and Depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).</p> <p>Review of Resident #73's Level I PASRR screen from a previous nursing facility admitted d 4/7/22, indicated that he/she had a history of a mood disorder, severe anxiety, and did not meet criteria for SMI, therefore a Level II PASRR evaluation was not needed.</p> <p>Review of the facility policy for Pre-Admission Screening and for Mental Disorder (MD) and/or Intellectual Disability (ID) Patients, last reviewed 2/16/24, indicated the following:</p> <p>-Social Services will coordinate and/or inform the appropriate agency to conduct the evaluation and obtain results if there is a significant change in status that results in new evidence of possible mental disorder, intellectual disability or a related condition.</p> <p>-Social Services will be responsible for coordinating updates as needed per state requirements.</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 225648
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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Social Services will be responsible for notifying the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a patient who has a MD or ID for patient review.</p> <p>Review of the Behavioral Health Note dated 10/5/23, indicated the Resident was experiencing increased behaviors (yelling), delusions (false beliefs) and hallucinations (false perceptions of objects or events involving the senses: sight, sound, smell, touch and taste).</p> <p>Further review of the Behavioral Health Note indicated that Resident #73 had been given an increase in the antipsychotic (drugs used to treat psychosis- a collection of symptoms that affect your ability to tell what is real and what is not) medication Zyprexa for management of these symptoms.</p> <p>Review of Resident #73's Social Services Progress Notes indicated that the Resident had experienced repeated episodes of calling out and yelling behaviors during the following dates:</p> <p>-10/6/23 - 10/8/23</p> <p>-10/15/23</p> <p>-11/2/23</p> <p>-11/9/23</p> <p>-11/12/23</p> <p>-11/14/23 -11/16/23</p> <p>-11/26/23 -11/27/23</p> <p>Review of Resident #73's medical record indicated that the Resident had been diagnosed with Visual Hallucinations on 10/26/23 and Delusional Disorder on 10/30/23.</p> <p>Further review of the Resident's medical record failed to indicate that the Level I PASRR was updated and re-submitted for an additional Resident Review (a review that assesses the need for a more in-depth assessment: Level II evaluation) when new mental health diagnoses were identified on 10/26/23 and 10/30/23.</p> <p>Review of Resident #73's Psychosocial/Behavior care plan, last revised 8/29/24 indicated:</p> <p>-The Resident has a history of audio and visual hallucinations that can be very upsetting to him/her.</p> <p>-The Resident has a disruptive behavior of constant/repetitive calling out for others.</p> <p>-The Resident can become weepy at times.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/23/24 at 9:35 A.M., Social Worker (SW) #1 said that she was responsible for reviewing the PASRR evaluations. SW #1 also said that she had not been aware until May 2024 that the facility was required to re-submit a Level I when a Resident had a change in condition such as a new mental health diagnosis. SW #1 further said that Resident #73's Level I PASRR had not been re-submitted to the Department of Mental Health PASRR office but that it should have been.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>42741</p> <p>Based on observation, interview, and record review, the facility failed to develop a care plan for the use of a positioning aid for one Resident (#6) out of a total sample of 18 residents.</p> <p>Specifically, for Resident #6, the facility failed to ensure a care plan was developed for the use of bilateral (both sides) wedge cushions (a triangular shaped cushion used to aid in positioning for health issues or comfort) while the Resident was in bed.</p> <p>Findings include:</p> <p>Review of the facility policy titled Body Positioning, released 1/17/17, indicated the following:</p> <ul style="list-style-type: none"> -Positioning techniques should be used with residents with stroke and other neurological impairments for the following reasons: >Orthopedic enhancement of postural alignment >Increase stability -Documentation >In the care plan, document positioning needs and interventions and approaches to meet resident's needs. <p>Resident #6 was admitted to the facility in March 2020, with diagnoses including a history of Cerebral Infarction (stroke: damage to tissues in the brain caused by blood clots, disrupted blood supply and restricted oxygen supply to the specific area) with spastic hemiplegia [paralysis of one side of the body] affecting the right side (a possible side effect from a stroke that causes muscles to be in a constant state of contraction).</p> <p>Review of the most recent Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 7/31/24, indicated Resident #6:</p> <ul style="list-style-type: none"> -was dependent for bed mobility, -never spoke, -was rarely and/or never understood, -and rarely and/or never able to understand. <p>During an observation on 9/18/24 at 9:54 A.M., the surveyor observed Resident #6 lying in bed and he/she had large wedge cushions bilaterally placed on either side of his/her upper body.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 9/19/24 at 8:53 A.M., the surveyor observed Resident #6 to be lying in bed. The surveyor further observed that large wedge cushions were bilaterally placed on either side of his/her upper body.</p> <p>Review of Resident #6's September 2024 Physician's orders did not indicate any order in place for the use of the bilateral wedge cushions.</p> <p>Review of Resident #6's Care Plan did not indicate that a care plan had been developed for the use of the bilateral wedge cushions while Resident #6 was in bed.</p> <p>Further review of the Resident's medical record indicated no additional documentation on when the bilateral wedge cushions were recommended for use for the Resident or who recommended that the Resident needed the bilateral wedge cushions.</p> <p>During an interview on 9/19/24 at 9:06 A.M., Nurse #1 said there should be a care plan developed when a Resident utilized wedge cushions in bed, so staff knew to place them on either side of the Resident when he/she was in bed.</p> <p>During an interview on 9/19/24 at 9:27 A.M., Certified Nurses Aide (CNA) #1 said Resident #6 utilized the bilateral wedge cushions when he/she was in bed because he/she had a stroke and needed the wedge cushions for positioning.</p> <p>During an interview on 9/19/24 at 9:43 A.M., Unit Manager (UM) #1 said Resident #6 used the bilateral wedge cushions when he/she was in bed. UM #1 said the use of wedge cushions while in bed to help with positioning had been recommended by the Therapy Department and there should have been a care plan in place for the use of the wedge cushions. UM #1 further said a care plan for the use of wedge cushions for Resident #6 had not been developed.</p> <p>During an interview on 9/19/24 at 11:12 A.M., the Director of Rehabilitation (DOR) was unable to find any documentation that Resident #6 had been evaluated by the Therapy Department for the use of bilateral wedge cushions while in bed. The DOR said when a Resident needed a positioning aid the Therapy Department would evaluate the use of a positioning aid, document in therapy notes that the positioning aid was needed and why, acquire a Physician's Order for the use of the positioning aid, update or create a Care Plan for the positioning aid, and provide education to staff, and this was not done for Resident #6. The DOR further said she could find no documentation on when the bilateral wedge cushions were recommended or who recommended the bilateral wedge cushions for Resident #6's use while he/she was in bed.</p>