STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225199	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Worcester Rehabilitation & Health Care Center	119 Providence Street Worcester, MA 01604

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44129 Based on observations (which included taking photographs), interviews and records reviewed, for four of four resident units, the facility failed to ensure it provided a safe, clean, comfortable and homelike environment for it's residents, when during the course of the survey observations conducted in common areas, resident rooms, and resident care areas, there was obvious signs of various stages of disrepair, aging and unclean conditions, on flooring, walls, ceilings and windows, all of which were in areas accessed and utilized by residents in their daily lives, and were either unsafe, in need of immediate repair and/or created potentially hazardous conditions, none of which supported that a homelike environment was being provided for facility residents. Findings include: The Facility was unable to provide the surveyors with any policies related to the maintenance of a clean, homelike environment or pest control. During an environmental tour of Unit 5 on 10/01/24 at 7:50 A.M., Surveyor #1 observed the following: Wall between main elevators on Unit 5 had black streaks, gouges and chipped/peeling paint, and the vinyl baseboard was stained with black streaks. room [ROOM NUMBER] - Bathroom light did not turn on with wall switch and there was exposed spackle under bathroom sink. Bed A -wall adjacent to the bathroom was heavily damaged with gouges and chipped paint. -Vinyl baseboard around perimeter of room was pulling away from the wall exposing black, grimy wall underneath, and instead of being secured with adhesive, it was secured by nails which created multiple gaps between the nails where wall underneath was exposed. -Built up brownish-rust colored grime on floor behind the room's main entry door. -Vertical crack leaving a gap in wall along entry wall. -Window drape liners were shredded and shedding white fibers when moved. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Exposed round head and flat head screws were in the wall. -Section of baseboard heater was missing in the bathroom exposing a sharp top edge. room [ROOM NUMBER] - Large patch and numerous smaller patches of rust and chipped paint along top of floor heating/air conditioning unit and wall mounted heating/air conditioning unit. -Area of grime/rust all along the floor underneath and on the floor heating/air conditioning unit. -Exposed metal hanging brackets on wall above heating/air conditioning unit. room [ROOM NUMBER] - Bed B -dresser was missing drawer handle on bottom right-hand draw. -Exposed metal hanging brackets on the wall. Bed A - had an exposed flat head screw in wall above the dresser. room [ROOM NUMBER] - Bathroom with exposed spackle on the wall above the baseboard heater. -Plywood that covered the bathtub with puddle of liquid on it. -Entry wall to room was badly damaged with gouges, stains, black streaks and damaged spackle. -Exposed flat head screws protruded from the wall above the television. room [ROOM NUMBER] - Closet with damaged/missing slats. room [ROOM NUMBER] - Entry door to the room with chipped paint exposing pink color underneath. -Bathroom baseboard heater was rusty and coming apart. Bed A - wall between bathroom and bed badly damaged, gouged with black streaks, chipping, and exposed spackle. -Window blinds were broken. -Heating/air conditioning unit front cover panel was disconnected from unit. -Wall behind the television had an unpainted outline of the former television wall mount and damaged wall/wallpaper. room [ROOM NUMBER]- Bed A - wall between bathroom and the bed was heavily damaged and gouged with black streaks and exposed spackle. Bed B - wall contained an exposed, protruding flat head screw that protruded from the wall, which was heavily damaged with gouges and exposed spackle. -The top portion of the vinyl baseboard was pulling away from wall creating a gap. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	room [ROOM NUMBER] - Front of heater/air conditioning panel was disconnected/unsecured. -Exposed round head screw protruded from the wall. room [ROOM NUMBER] - Walls in the room were gouged/damaged with exposed spackle, front of heater/air conditioning panel was disconnected/unsecured. room [ROOM NUMBER] - Broken window blinds, with missing slats. -Non-Sampled (NS) Resident #11 said the broken blinds with missing slats created a glare for him/her, so he/she made his/her own valances which were hanging sideways from the corner from the left-hand window. -The wall surrounding the emergency call light housing was damaged with drywall anchors exposed and chipped paint. room [ROOM NUMBER] - There were two pink basins with standing water under the sink, as well as a puddle of water on the floor next to the basins in the bathroom and the toilet that did not flush effectively. Non-sampled Resident #10 said the bathroom sink leaked, filling one basin per day, and he/she said he/she kept the second basin as a back-up. NS Resident #10 said the sink had been leaking for weeks and he/she had told facility staff, but nobody had come to repair the leak. In addition, NS Resident #10 demonstrated to Surveyor #1 that the toilet does not flush effectively, by placing a piece of toilet paper in the bowl. After he/she flushed the toilet three times, the toilet paper remained in the bowl. -The wall that separated the bathroom from Bed A and door jamb was heavily chipped, contained exposed spackle, and had black scrape marks extending the length of the wall. -There was broken linoleum tile exposing brown flooring underneath approximately eight inches long by two inches wide and adjacent linoleum tile was cracked. -There were missing slats and a missing knob on the closet, as well as a rusty heater in the bathroom. room [ROOM NUMBER] - Emergency call light housing was hanging out of the wall, attached only by electrical wire inside the wall, there was exposed spackle on walls and adhesive Command strips were stuck in various places on the wall. room [ROOM NUMBER]- Bed A- wall between bathroom and the bed was heavily damaged with chips, black scrape marks, cracks, and the corner edge of the wall contained a gap extending up the wall from the baseboard approximately two feet in height. -There were exposed roundhead screws that protruded from the wall. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The floor transition between the bathroom tile and linoleum in the room entrance was heavily soiled with a thick black substance. -The bathroom door jamb was damaged. room [ROOM NUMBER] -Bed A wall was soiled with brownish, red splatters and drip marks. -Blank wall plate (a protective plate used to cover electrical hazards) had the bottom right corner missing exposing electrical box underneath. -The wall over the heating unit had chipped and peeling paint. During an environmental tour of Unit 4 on 10/01/24 at 2:57 P.M., Surveyor #1 observed the following: room [ROOM NUMBER] - Dresser missing top right-hand drawer. The drawer was located in the bathroom on the plywood covered bathtub with a metal drawer track resting inside the drawer. -Heater/air conditioning unit was loose/pulling away from wall. room [ROOM NUMBER] - Broken closet door louvers/slats. room [ROOM NUMBER] - Bed B wall was damaged and the wall alongside left window had peeling paint, spackle and torn wallpaper on top edge. -There were no screens in the windows and drape liners were shredded and torn. room [ROOM NUMBER] - Bathroom ceiling had brown water stains surrounding ceiling vent. -Persistent water damage was present as evidenced by layers of spackle surrounding vent and brown water stains bleeding through repaired areas. -Lower portion of wall next to the bed was gouged with chipped paint and there was an oval shaped hole in linoleum next to bed. -Wall behind the bed was severely damaged with alternating areas of chipped, peeling paint, there was a thick gray-blue substance on the wall and there was exposed spackle. -Nightstand had drawers that did not align, leaving a large gap above the top drawer. Bed B's footboard was removed from the bed and leaning against dresser. -There were various insects in the room (round black bugs and long, orange-colored bugs). -Windows lacked screens, drapes on the right hand window only secured on the right side causing them to droop. -Adhesive Command strips were adhered to the wall. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Exposed round head screws protruded from the wall, and vinyl baseboard was peeling off the wall next to the room entrance. room [ROOM NUMBER] - Bathroom heater/baseboard had peeling paint, jagged edges with rust exposed and missing end cap. -Bathroom walls with chipped and peeling paint. -Wall at the entry to the room had gouges, black streaks and chipped paint. -Windows were without screens. -Vinyl baseboard was missing along lower edges of the wall exposing broken plaster/drywall and a hole in the wall. room [ROOM NUMBER] - Bed B television was mounted behind the bed. NS Resident #12 said the television has never worked since he/she has been there, and he/she did not know why it was mounted where he/she could not view it. -The floor in front of heating/air conditioner unit was stained yellow, top of heating/air conditioner unit was covered in rust along the air ducts and windows had no screens. -There were no knobs on the closet doors. -The light over the bed did not have a pull chain to turn on the light. -There were screw holes in the walls. -The corners of floors in room contained a built up debris. Bed A -there was stained black linoleum behind the nightstand, and there was an alive, orange-colored insect crawling on the floor. -The toilet in the bathroom was missing a bolt, the toilet itself was loose and therefore not secured to the floor properly. The mirror in the bathroom was hanging crooked with the right-hand side much lower than the left side. -The bathroom wall was damaged and had peeling paint and the bathroom floor tiles were stained black. -The baseboard heater contained exposed rust, peeling paint and was missing an end-cap. room [ROOM NUMBER] - Windows were without screens. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-There was a raised area of cracked linoleum 12 inches from the back wall of the room approximately 30 inches across and one inch wide with a crumbly brown substance exposed within the crack. -A padded fall mat (used to protect residents in the event of a fall) next to the bed, the vinyl edges were peeling away from the foam. -There was a broken metal handle on the top drawer of the nightstand containing a rough edge. -There was an electrical outlet without a cover and an exposed round head screw extending from the wall. room [ROOM NUMBER] - Bed A -call bell cord was laden with black grime. 37086 During an environmental tour on Unit 2 on 10/01/24 , Surveyor #2 observed the following: -room [ROOM NUMBER]- Bathroom ceiling was peeling around the vent, which was surrounded with unfinished spackle. -room [ROOM NUMBER]- Light fixture upon entry to the resident room with a yellow stain and dead insects inside of the fixture. -room [ROOM NUMBER]- Bathroom ceiling with large area of unfinished spackle, and a large brownish stain with gouged area adjacent to the ceiling vent. -room [ROOM NUMBER]- Window blinds with brown stains. -The heating unit was pulling away from the wall, leaving a jagged edge along the wall and a space between the wall and the heating unit. -The base of the heating unit had a jagged edge along the floor and was not firmly attached to the wall. -The back of the toilet had a pool of brown liquid surrounding the base of the pipe which connected the toilet to the wall. During an environmental tour on Unit 2 on 10/02/24, Surveyor #2 observed the following: -room [ROOM NUMBER]- The bathroom door kick-plate had black gouges and the bottom corner was peeling away from the door, leaving a jagged edge between the door and the plate. -The exposed corner of the wooden bathroom door was blackened. -The resident's closet doors had large scratches with chipped paint going across the bottom of both doors. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-room [ROOM NUMBER]- Bed A ceiling tile had a large brownish, gray stain. The ceiling tile next to it was not flush to the drop grid suspension, leaving a space between the ceiling and the drop grid suspension. During an environmental tour on Unit 3 on 10/01/24, Surveyor #2 observed the following: -room [ROOM NUMBER]- Bed A floor had large dark areas of grime and was very sticky when standing or walking on it. -There was no threshold (transition) between the bathroom floor and flooring in the room. -The wall and bathroom door frame were separated from each other, creating a space between the wall and the frame. -The bathroom ceiling had a large, gouged area on the ceiling adjacent to the ceiling vent. -room [ROOM NUMBER]- Light fixture upon entry to the resident room had a large brown stain with dead insects inside of the fixture. -room [ROOM NUMBER]- Bathroom ceiling had a large hole, hanging piece of plaster, and unfinished spackle around the ceiling vent. Several pieces of the bathroom ceiling material had fallen onto the bathroom floor. -The baseboard heater in the bathroom had rust on the top and a broken cover. -room [ROOM NUMBER]- Bathroom ceiling had scattered brownish stains. Unfinished spackle surrounded the ceiling vent. -Residents' clothes were hung along the shower curtain pole under the ceiling which was in disrepair. -room [ROOM NUMBER]- Bathroom ceiling had brownish stains and unfinished, peeling spackle surrounding the ceiling vent. During an environmental tour on Unit 3 on 10/02/24, Surveyor #2 observed the following: -room [ROOM NUMBER]- Ceiling tile adjacent to the window had a large brown stain. -Bed A -ceiling tile had several circular stains, the center was dark brown, and the periphery was gray stained. -The ceiling tile across from Bed A had a brown circular stain in the bottom left corner. -The wall along the entry to the room had a large gouge that went across half the wall, adjacent to the vent on the lower portion of the wall. -The bathroom door had multiple large, deep gouges along the kick-plate, and the door jamb had gouges and missing pieces of plaster on both sides. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The ceiling on the inside of the resident's closet had a hole, approximately two inches wide, that went around the base of the sprinkler head. -There was a dead, brownish colored insect on the closet floor. -The handrail in the hallway next to the elevator was broken off, leaving a jagged edge on either side. -The walls next to the elevator were gouged and dirty. During a group interview on 10/02/24 at 1:25 P.M., with the Administrator, Director of Housekeeping and the Plant Manager, they said the following. The Administrator said he did not do environmental rounds with the Plant Manager or the Director of Housekeeping, but said if he noticed any issues of concern or things that required repairs, he would reach out to either the Plant Manager or the Director of Housekeeping. The Administrator said he did not keep written logs of any requests he had made related to the Facility's environmental needs. Surveyor #1 and Surveyor #2 reviewed their findings from their environmental tours, including sharing showing them the photos that were taken of each concern area. After reviewing all the photos, Surveyor #1 and Surveyor #2 asked the Administrator, Plant Manager and the Director of Housekeeping if they provided a safe, clean, homelike environment for the Residents. The Administrator said, we could do better and the Plant Manager shook his head and said no.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 37086 Based on records reviewed and interviews, the Facility failed to ensure that resident grievances related to services provided by the Dietary Department, including reports of cold food, were addressed and resolved by the Facility in a timely manner, when review of the last two months of Resident Council Meeting minutes, and interviews with residents, indicated there were still ongoing and unresolved resident concerns. Findings include: Review of the Facility's Policy for Resident Council, with a revision date of October 2015, indicated the following: Policy: -The Recreation Department will provide support and assistance in the formation of a Resident Council. The residents will have an opportunity to express their concerns or grievances, contribute ideas and make recommendations regarding the operation of the home. Procedure: -Notify Department Heads in writing of concerns that come up during the meeting. -Retain a copy of the resolution that addresses each concern. Report submitted by the Facility via the Health Care Facility Reported System (HCFRS), dated 08/15/24, indicated the Facility's dishwasher was no longer functioning, a new dishwasher had been delivered and was waiting installation. The Report included the Facility's plan to wash, rinse, and sanitize the dishes in the interim. On 10/01/24 the surveyor obtained written permission from the Resident Council President to review the Resident Council Meeting Minutes from the previous three months. Review of the Facility's Resident Council Meeting Minutes, dated 08/22/24, indicated five residents attended the meeting and under the Realm of Food Services the Minutes indicated that residents stated the food was cold. Further review of the Minutes indicated the concerns were forwarded to the Food Service Director (FSD). Review of the Resident Council Concern Follow-Up Form, dated 08/22/24, indicated the residents stated the food was cold, the FSD responded that the new dishwasher would be installed in the next few weeks, dietary would serve food as hot as possible and meal trays would be passed quickly. The Form included a resolution date of 08/22/24 and was signed by the FSD and Administrator. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Facility's Resident Council Meeting Minutes, dated 09/19/24, indicated seven residents attended the meeting and under the Realm of Food Services the Minutes indicated that the residents stated the food was cold. Further review of the Minutes indicated the concerns were forwarded to the FSD. Review of the Resident Council Concern Follow-up Form, dated 09/19/24, indicated the residents complained the food was cold at dinner, the FSD responded that the dishwasher was currently being installed and the dietary staff were serving the residents meals on Styrofoam and once the dishwasher was installed, they would go back to serving the meals on regular plates. The Form included a resolution date of 09/19/24 and was signed by the FSD and Administrator. On 10/01/24 at 7:53 A.M., Surveyor #2 observed the breakfast meal on Unit 3. The meals were served on and covered with, Styrofoam plates. During interviews on 10/01/24 at 7:53 A.M., 8:59 A.M. and 10/02/24 at 10:15 A.M. and 10:28 A.M. with Non-sampled Resident's #2, #3, #7, #8, #9 and Resident #2 regarding the food served at the facility, they said hot food items were usually cold and that meals had been served on Styrofoam for the last few months. During an interview on 10/02/24 at 4:41 P.M., the Food Service Director (FSD) said he had received complaints of cold food through the Resident Council and said the cold food concern would be resolved once the new dishwasher was installed. The FSD said he did not do any test meal trays or change any protocols in an effort to resolve the residents' concern of cold food. During a telephone interview on 10/04/24 at 12:00 P.M., the Administrator said he had received the Resident Council Follow-Up forms in August and September 2024 and was aware residents had stated the food was often cold. The Administrator said he had not anticipated that the new dishwasher would take so long to install and that the installation had been delayed because it required a custom fit. The Administrator said they had tried to use regular plates and wash them after each meal but it was a daunting, unsustainable task, so they went back to serving all resident meals on Styrofoam plates.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44129 Based on records reviewed and interviews for one of three sampled residents (Resident #1), who was at risk for developing Diabetes-related foot complications, with physician's orders for diabetic foot care, the Facility failed to ensure Resident #1 received proper care and treatment to maintain good foot health. Findings include: Review of the Facility policy titled, Diabetic Foot Care, dated June 2015 indicated but was not limited to: - Diabetic foot care is provided by qualified nursing staff. Foot condition is noted and changes reported as warranted. - Nurse to contact physician for podiatry consult regarding trimming of nails. - Podiatry will be scheduled to trim toenails. - Report any irregularities to charge nurse. - Document all appropriate information in medical record including foot assessment. - Assessment will be completed on admission and with routine skin assessment. - Any pertinent findings should be reported to physician and/or appropriate practitioner. Resident #1 was admitted to the facility in April 2019 with diagnoses including Type 2 Diabetes and Dementia. During a telephone interview on 09/27/24 at 1:40 P.M., Witness #1 said Witness #2 contacted him and sent a video Witness #2 recorded at the facility of Resident #1's feet and said Resident #1's toenails looked like vulture's claws. Witness #1 said Resident #1's toenails were long, discolored, and curled over the tops of his/her toes. Witness #1 also said family had been in to visit Resident #1 previously, but he/she always had socks and shoes on so they would not have noticed if his/her toenails were overgrown. Witness #1 said Resident #1 required help from staff for everything except for eating and was unable to put his/her own socks on because he/she was unable to dress him/herself. Witness #1 said Resident #1 was always very particular about his/her appearance, never had any problems with his/her feet and would be very upset if he/she realized what his/her feet looked like. During a telephone interview on 09/27/24 at 3:30 P.M., Witness #2 said during a visit on 05/14/24, Resident #1 wanted to rest in bed, so he tried to make Resident #1 comfortable by removing his/her socks, and it was then he noticed the toenails on both of his/her feet were so long, they had grown far beyond the tips of his/her toes, were curling downward and sideways towards his/her pinky toe. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Witness #2 said he told a Nurse (exact name unknown), and said the Nurse acted like she had no idea Resident #1's nails were that long, and did not offer any resolution at that time. Witness #2 said that as far as he knew, the Facility staff did not do anything about this until Witness #1 contacted the facility five to six weeks ago. Witness #2 said he was never made aware that the Resident had repeatedly refused any type of foot care and had he known, he would have tried to intervene in some way. Review of Resident #1's Quarterly Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #1 required maximum assistance from staff members with all his/her activities of daily living (ADLs) except for eating and ambulation and that the Resident was severely cognitively impaired. Review of Resident #1's ADL Care Plan, reviewed with the most recent Quarterly MDS Assessment, indicated that Resident had an ADL Deficit related to Dementia with behavioral disturbance, required assistance with bathing, grooming, and toileting and could be combative with care. Review of Resident #1's Care Plan related to non-compliance, reviewed with the most recent Quarterly MDS Assessment, indicated the Resident became very combative due to Dementia with behavioral disturbance. Resident #1's The Care Plan also indicated to inform the Resident about risks of non-compliance and to discuss with Resident his/her objections, reasons, fears, and ideas. Review of Resident #1's Behavior Care Plan, reviewed with the most recent Quarterly MDS Assessment indicated the Resident was verbally abusive and physically abusive/combative with care. The Care Plan also indicated redirecting the Resident with food and activities when agitated, explaining to the Resident why his/her behavior is unacceptable, to identify stressors that may be contributing to his/her inappropriate behavior. Review of Resident #1's Diabetes Care Plan, reviewed with the most recent Quarterly MDS Assessment, indicated the Resident required diabetic foot care and Podiatry consult, as ordered. Review of an e-mail, dated 10/01/24 at 6:05 P.M., (provided by Social Worker #1), addressed to Social Worker #1 from the contracted agency that provided Podiatry care to the Facility indicated their electronic medical record system only went back to October 2021 and any documentation related to Resident #1 refusing foot care was no longer available. The e-mail further said Resident #1 was placed on the Do Not Treat for Podiatry list on 10/02/21 due to repeated refusals. Review of the contracted Podiatrist Visit Summary, dated 09/03/24 indicated Resident #1 was on the schedule to be treated, however was not treated with the reason documented as being No Time. During an observation and interview on 10/01/24 at 11:30 A.M., Certified Nurse Aide (CNA) 1, along with Surveyor #1, approached Resident #1 while he/she was lying in bed under the covers. CNA #1 asked Resident #1 if he/she would allow us to look at his/her feet. Resident #1 did not respond verbally; however, he/she maintained eye contact with CNA #1. CNA #1 then removed the Resident's covers and explained what she was going to do. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 started to move away slightly; however, CNA #1 then offered him/her a package of cookies. CNA #1 said Resident #1 can be resistant to care; however, he/she usually responds well and allowed care if offered a snack. Resident #1 happily took the cookies and began eating them while allowing CNA #1 to remove his/her socks and position and handle his/her feet to allow Surveyor #1 to observe the condition of them. Resident #1 tolerated CNA #1's handling and positioning of his/her feet to allow the surveyor to assess their condition very well, the whole time enjoying his/her cookies. Resident #1 allowed CNA #1 to then re-apply his/her socks and covers with no resistance or combativeness. CNA #1 said Resident 1 had Diabetes and diabetic foot care should be provided daily to the him/her. During an interview on 10/01/24 at 2:30 P.M., Unit Manager #1 said Resident #1 required assistance from staff for all personal care, had Diabetes and required diabetic foot care to be performed by the Nurse every evening (3:00 P.M. - 11:00 P.M.) shift. Unit Manager #1 said after the nurse performed diabetic foot care, they were supposed sign it off on the Treatment Administration Record (TAR). Unit Manager #1 said Resident #1 could be resistant to care but staff attempted to redirect his/her behavior and said snacks helped to calm Resident #1 down. Unit Manager #1 said that the contracted Podiatrist attempted several times to provide foot care to Resident #1 in the past, however after Resident #1 refused multiple times, he/she was removed from their list. Unit Manager #1 said she had recently learned from the Facility's Medical Records Coordinator when she reached out to and requested Resident #1 be placed on the Podiatry list, that he/she had refused care. Unit Manager #1 further said these refusals occurred prior to her working at the facility which was almost two years ago. Surveyor #1 asked Unit Manager #1 if she knew how long Resident #1 had gone without having his/her nails cut and Unit Manager #1 said she did not know. Unit Manager #1 said that because nurses were not allowed to cut toenails at the facility, they referred residents' foot care to the contracted Podiatrist. Unit Manager #1 said staff should have been notifying Resident #1's representative, the Nurse Practitioner and/or Physician if Resident #1 refused treatment as well as document the refusals in a Progress Note, and then said she did not know if any of them had ever been notified that Resident #1 had refused foot care. During an interview on 10/02/24 at 11:40 A.M., Nurse #1 said she knew Resident #1 and was not aware he/she had excessively long toenails. Surveyor #1 asked Nurse #1 who was responsible for performing diabetic foot care and how often it should be completed. Nurse #1 said both the CNAs and Nurses provided diabetic foot care weekly on residents' shower days. Nurse #1 said that diabetic foot care included looking at the resident's feet, making sure the feet were clean and dry and if they found something like thick calluses or wounds, they notified the Nurse Practitioner. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse #1 said that Nurses were not allowed to cut residents' toenails and if they noticed they were long, they put the resident on the list for the Podiatrist to visit. Surveyor #1 reviewed the e-mail from the contracted Podiatrist provided by the Facility's Social Worker that indicated Resident #1 was placed on the contracted Podiatrist Do Not Treat list effective 10/02/21 due to Resident #1 refusing care and asked Nurse #1 what happened when a resident repeatedly refuses care. Nurse #1 said the Resident's Representative, the Physician and/or the Nurse Practitioner were to be notified, and the Nurse was supposed to write a Progress Note to document the refusals. Nurse #1 said if Resident #1 refused to have his/her toenails cut, nursing staff should have attempted different interventions for him/her to accept care and that Resident #1 should not have gone months without foot care, especially since he/she had Diabetes. Nurse #1 further said to the best of her knowledge, she had never contacted Resident #1's representative or Nurse Practitioner to notify them of Resident #1 refusing foot care. During an interview on 10/02/24 at 12:16 P.M., CNA #2 said she regularly cared for Resident #1 and that Resident #1 required assistance from staff for bathing/showering, dressing, and incontinent care. CNA #2 said that she cleaned, dried and moisturized Resident #1's feet well and did this either in the shower room or in the Resident's room. CNA #2 said she recalled Resident #1's toenails to be very long and curled over the tops of his/her toes, but CNAs were not allowed to cut toenails, so she informed the Nurse, but did not recall which one. CNA #2 said Resident #1 tried to refuse care because he/she did not understand what was being done to him/her, but if she simply explained to Resident #1 what she was doing, he/she allowed her to provide care. CNA #2 said that Resident #1's behaviors of refusing care did not include physical violence such as kicking or hitting and that he/she would just stiffen up and try to physically pull away from the staff member. During a telephone interview on 10/03/24 at 4:33 P.M., CNA #3 said she knew Resident #1 and that Resident #1 required assistance of staff for all his/her personal care. CNA #3 said that Resident #1 could be resistant to care occasionally and that sometimes two CNAs had to provide care to Resident #1. CNA #3 said when Resident #1 refused care, he/she would try to get up and move out of the caregivers' reach and sometimes put his/her hands up to attempt to push caregivers away but would never yell, hit or kick the caregivers. CNA #3 said that when Resident #1 started to behave in this way, she would just try to talk to the him/her. CNA #3 said she would tell Resident #1 she needed to do something, and explain to him/her why, and Resident #1 would then accept the care. CNA #3 said that CNAs were not allowed to cut residents' toenails, but if she noticed they were long, she always let the Nurse know so they could get the resident on the Podiatry list. Review of Resident #1's Podiatrist Progress Note dated 09/16/24 indicated the following: - Reason for visit: Initial exam; Atherosclerosis (build-up of fats, cholesterol and other substances in and on the artery walls which can obstruct blood flow) of the extremities with increased risk of infection, Onychomycosis (a nail fungus that causes thickened, brittle, crumbly or ragged nails), - Progress Note: Initial exam and evaluation performed, reviewed chart and medical history, debrided nails (a procedure that removes diseased or infected tissue from nail bed and surrounding area) to patient's tolerance. - Non-professional treatment is hazardous to the patient. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Nail thickness is four millimeters, reduced to two millimeters after procedure. - Trimmed calluses x 4 to patient's tolerance without incident During a telephone interview on 10/03/24 at 10:20 A.M., the Podiatrist said he saw Resident #1 on 09/16/24 because he was told by facility staff that somebody filed a complaint regarding the condition of Resident #1's feet. The Podiatrist said Resident #1's toenails had already been trimmed before his visit, however the Resident had significant callous formation on both feet. The Podiatrist said he knew Resident #1's nails were not cut by a Podiatrist because if they had, that person would have also addressed the thick calluses present on the his/her feet. Surveyor #1 asked the Podiatrist what he meant in his progress note that indicated, Non-Professional treatment is hazardous for the patient. The Podiatrist said Resident #1 had Diabetes and because of this, he/she would be at a very high risk for diabetic-related complications such as increased risk of infection, slow healing and chronic wounds that could result in amputation of the toes or feet. The Podiatrist said that often a well-meaning person may accidentally nick or cut a toe while trimming a resident's toenails or filing calluses which could introduce bacteria into the area, which could then cause an infection, and it was important that Diabetics receive meticulous foot care and maintenance. The Podiatrist said that when he provided care to Resident #1, the Nurse was present and he/she very accepting of care and not combative or resistant. During an interview on 10/02/24 at 1:00 P.M., the Administrator said the issue of Resident #1's toenails was brought to his attention in August 2024 via a telephone call from Resident #1's family member. The Administrator said that he assessed the Resident's toenails and found them to be very long, thick and scaly and he cut them immediately. The Administrator said Resident #1's toenails were so long and thick they required the use of large nail clippers to cut them effectively. Prior to the Administrator cutting the Resident's toenails, the Administrator said Unit Manager #1 told him that Resident #1 was combative with care, however he said he found that Resident #1 was not combative at all when he cut his/her nails. Surveyor #1 asked the Administrator how long it had been since Resident #1's toenails had been cut and the Administrator said he could not speculate on the amount of time that had passed. The Administrator said there was no documentation in Resident #1's medical record to support that Resident #1 had refused foot care multiple times, that the contracted Podiatrist ceased visiting the Resident due to multiple refusals and or that Resident #1's Representative had been notified of the Resident's refusals. The Administrator said he, himself failed to document the foot care he provided to the Resident in his/her medical record. During an interview on 10/02/24 at 3:15 P.M., the Director of Nurses (DON) said that Nurses were allowed to cut residents' toenails, however if a resident had Diabetes, they should be referred to the contracted Podiatrist for care. The DON said that Nurses were responsible for performing diabetic foot care and were to document this on the Treatment Administration Record (TAR). The DON said if Resident #1 repeatedly refused care, staff should have re-approached him/her and attempted to come up with interventions that would allow staff to complete the necessary care. The DON said that if Resident #1 repeatedly refused care, the Nurse should have notified the Resident's Representative, the Nurse Practitioner and/or Physician and documented the refusal in a Progress Note. Surveyor #1 asked the DON if a resident should go for months without foot care and the DON said they should not. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 10/02/24 at 4:36 P.M., the DON said she reviewed Resident #1's medical record, which included his/her Care Plans and Progress Notes and was unable to find any documentation to support that Resident #1 repeatedly refused foot care, or that his/her Representative, Nurse Practitioner and/or Physician were notified of Resident #1's refusals of foot care. The DON said there were not personalized interventions on Resident #1's care plan related to ADL care, Diabetic foot care or Behaviors. .

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 37086 Based on records reviewed and interviews for one of three sampled residents (Resident #2), who was assessed to be at risk for nutritional decline secondary to wound healing needs, anemia, multiple food allergies, multiple food preferences, and who had planned weight loss goals, the Facility failed to ensure Resident #2's nutritional status including body weight, were accurately assessed and monitored appropriately by nursing and per facility policy, as a result Resident #2 experienced an undesired weight gain in three months. Findings include: Review of the Facility Policy titled Weights, dated 08/2015, indicated the following: -Newly admitted residents are weighed weekly for four weeks and monthly thereafter. -All weight loss/gain of five pounds on a resident weighing 100 lbs. or more requires a reweigh for verification. -Weights are documented in the resident's medical record. -If a significant weight loss/gain is identified (greater than 5% in 30 days or 10% in 6 months), the Interdisciplinary Team, Dietician, Physician and Family are notified. Resident #2 was admitted to the Facility in July 2024, diagnoses included status post left below the knee amputation and iron deficiency anemia. Review of Resident #2's Nutritional Assessment, dated 07/11/24, indicated Resident #2 weighed 150 lbs. Review of Resident #2's Nutrition Care Plan, dated 07/11/24, indicated Resident #2 was at risk for nutritional decline related to a recent below the knee amputation, anemia, multiple food allergies, multiple food preferences, dislike of protein sources and hyperlipidemia (abnormally high amounts of fat in the blood). The care plan goals included for Resident #2 to maintain a stable weight without significant changes and (achieve) a 5% weight loss of body weight (8 lbs.). The Care Plan included the following interventions: -Notify the Registered Dietician (RD), family and physician of significant weight changes -Obtain weights as ordered and record Review of Resident #2's Treatment Administration Record (TAR) for the months of July and August 2024 indicated he/she had a physician's order to obtain his/her weight on admission and for four consecutive weeks post admission then reassess every Monday for four weeks. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The TARs indicated that although Resident #2's weight was recorded on 07/08/24, no weights were entered on 07/15/24, 07/22/24, 07/29/24, or during the month of August 2024. Review of Resident #2's TAR for the month of September 2024, indicated there was no physician's order to obtain weights, despite the Facility's policy of obtaining monthly weights for all residents unless otherwise indicated. Review of the Dietician's Progress Note, dated 09/25/24, indicated Resident #2 reported to the Registered Dietician (RD) that he/she gained weight since admission. The Note indicated Resident #2 expressed a desire to lose weight and the RD reviewed basic meal and snack planning with a goal for gradual weight loss. During an interview on 10/02/24 at 9:33 A.M., the Registered Dietician (RD) said she was notified by Resident #2 that he/she requested to be seen, because Resident #2 felt he/she had gained weight. The RD said she requested staff to obtain Resident #2's weight that day (09/25/24) and that was when his/her significant weight gain of nearly 40 lbs. was identified. The RD said it was the Facility's policy to obtain a resident's weight on admission, then weekly thereafter for four weeks, then monthly unless otherwise indicated. The RD said she did not know why staff had not obtained Resident #2's weights as ordered. The RD said that once Resident #2's significant weight gain was identified, she provided him/her with education for healthy choices of meals and snacks. The RD said she checked the electronic medical record for identified weight triggers (gains or losses), but only the weights that were obtained and recorded would register. Review of Resident #2's weight record indicated the following: 07/05/24- 150 lbs. 07/08/24- 150 lbs. 09/25/24- 184.6 lbs. 10/01/24- 188 lbs. During an interview on 10/02/24 at 10:28 A.M., Resident #2 said he/she had gained almost 40 lbs. since his/her admission to the Facility, that he/she had never weighed that much in his/her whole life and he/she was unhappy with the weight gain. During an interview on 10/02/24 at 3:39 P.M., Unit Manager #2 said it was the Facility's policy to obtain a resident's weight on admission to the Facility, then weekly for four weeks, then monthly thereafter unless otherwise indicated. Unit Manager #2 said the resident weights were kept on a form on the resident unit, that the Certified Nurse Aides (CNAs) were responsible to obtain and record the resident's weight and then nursing was responsible to enter the weight into the resident's electronic medical record (EMR). Unit Manager #2 said that because Unit 3 was busy, either he, or the Assistant Director of Nurses (ADON) would enter the weights into each resident's EMR, not the charge nurse. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Unit Manager #2 reviewed Resident #2's Treatment Administration Records for the months of July, August, and September 2024 and said he did not know why Resident #2's weights were not obtained, as ordered. Unit Manager #2 said there should have been a physician's order to obtain Resident #2's weights monthly as of September 2024. Unit Manager #2 said part of the problem may have been how nursing entered the physician's orders into the EMR upon Resident #2's admission to the Facility. Unit Manager #2 said for any resident weights with a discrepancy of less than or greater than 5 lbs., the Registered Dietician and Physician were to be notified. During an interview on 10/02/24 at 4:24 P.M., the Director of Nurses (DON) said it was her expectation that resident's weights were obtained by staff as ordered by the physician. The DON said she did not know the weights for Resident #2 were not obtained as ordered and they needed to do better.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44129 Based on observations and interviews, for four out of four nursing units Nourishment Kitchens and in the facility's main kitchen, specifically the dish room, the Facility failed to ensured they maintained a sanitary environment related to food storage/preparation, which placed all residents at risk for food-borne illness. Findings include: Review of the Facility Policy titled, Cleaning Procedures, Revised 05/12 indicated: - All areas of the Dietary Department will be cleaned on a regular schedule. Review of the Facility Dietary Department Guidelines, undated, indicated but was not limited to: - All food preparation equipment, dishes and utensils must be maintained in a clean, sanitary and safe manner and used and repaired according to manufacturer's recommendations. - All food items should be labeled and dated . Review of the Facility Policy titled, Personal Food Policy, dated 04/28/19 indicated but was not limited to: - All personal food items brought into the facility must be in airtight packaging or covered storage containers to keep bacteria out. - The staff person receiving the personal food shall label the container with the date it was brought into the facility (or date of preparation, if known) and the name of the Resident receiving it. - No personal food may be brought to the facility kitchen. - Any perishable items that are found outside of the refrigerator or unlabeled shall be discarded unless it can be verified that the food has not been out for more than two hours. On 10/01/24 at 9:00 A.M., Surveyor #2 observed the following in the Nourishment kitchen on Unit 3: - Peeling wallpaper behind the microwave area. The edges of the peeled wallpaper were brown and thick. - The corner crease of the wallpaper between the counter and the cabinets had a brown stain from the bottom of the cabinet to the top of the counter. - The wallpaper was separated at the seams under the hand sanitizer pump station with heavily gray stained wallpaper adjacent to the sanitizer pump. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- There was a large flap of peeling wallpaper under the counter, near the trash bin. The backside of the peeled wallpaper had black specks and brown stains. The wall had large gray stains. - The kick-plate under the cabinets was separated from the cabinet, creating a one-half inch space. - The ceiling tiles in the corner of the room were not flush, creating a visible space between the ceiling tile and the wall. - A large brownish gray stain covered two ceiling tiles over the counter top. - A large grayish brown stain went from the ceiling down the corner of the wall. - The light fixture contained debris and dead insects. - The corner pieces of wallpaper from the top of the cabinet to the ceiling were peeling off. On 10/01/24 at 2:22 P.M., Surveyor #2 observed the following in the Nourishment kitchen on Unit 2: - Three ceiling tiles above the alcove next to the countertop had large brown stains. - The bottom half of the wall behind the door had large areas of cracked spackle. - The corner of the floor behind the door contained a thick, black pile of dirt. - A large area of wallpaper along the wall was peeling along the seam, with the seam edges stained black. On 10/02/24 at 10:15 A.M., Surveyor #1 observed the following in the Nourishment Kitchen on Unit 4: - Refrigerator - Bottom shelf contained a plastic beverage cup and plastic bowl of fruit in a plastic bag, unlabeled and undated. -There was a plastic container of assorted food and bowl of food loosely covered with torn aluminum foil inside a plastic bag, unlabeled and undated. - Top shelf had a plastic container with an orange lid containing unidentified food, unlabeled and undated. - Inside door had a white plastic squeeze bottle with a reddish/pink residue on the top and around the neck of the bottle, with an unidentified (unlabelled) reddish pink liquid inside the bottle. - Microwave - inside top of unit was worn away with patches of a black, crusty substance that when touched, fell on to the glass turntable below. - Counter top area, there was a bag of various items, including a bottle of prescription medication, Styrofoam cup with tea bags unlabeled and undated, and an empty plastic beverage cup with white lid containing pink stains and brown specks. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Cabinet contained an opened, unlabeled and undated bottle of chili sauce, and an opened unlabeled and undated container of peanut butter. - Wall above cabinet had peeling, torn wallpaper stained yellow adjacent to the ceiling, and wallpaper was also torn and peeling adjacent to the cabinet below with edge lifted creating a gap along the right side of the cabinet. - Ceiling tile adjacent to the wall, was lifted creating a one-half inch gap on the wall above the cabinet. - Under the sink there were large black stains, and gaps between the linoleum were laden with thick black substance, one tile was broken with diagonal open space stained black, one tile was broken with two circular areas missing stained brown, and the wall above the floor had dark gray and brown streaks. - Wall surrounding the trash bin was stained with a pink substance, with pink drip marks extending to the vinyl baseboard above the floor. - Floor surrounding the trash bin had black and rust colored crusty stains extending from the entry to the kitchen, around the edge of the trash bin and extending around the corner to the refrigerator area. On 10/02/24 at 10:55 A.M., Surveyor #1 observed the following in the Nourishment Kitchen on Unit 5: - Utensil drawer had sticky brown-black stains along the top lip of drawer, inside the front wall of drawer and on the drawer base and there was a plastic spoon lying on top of the sticky substance. - Microwave inside top of unit had peeling plastic, brownish gray and rust specks with three circular rusty areas that dropped particles onto the turntable when touched. The turntable contained sticky brown stains and had a translucent sticky substance with black specks. During an interview on 10/02/24 at 10:30 A.M., CNA #2 said all food stored in the Nourishment Kitchen needed to be labeled with a resident's name and dated when the food was brought into the facility. CNA #2 also said there should not be staff items such as medications and tea bags stored in the Nourishment kitchen. With Surveyor #1, CNA #2 viewed the inside top of the microwave, she said [NAME], the particles could drop into the resident's food and make them sick. During an interview on 10/02/24 at 11:15 A.M., CNA #4 said the inside top of the microwave was dirty and rusty, and particles from the top could fall into resident's food. CNA #4 also said that both the turntable and utensil drawer were dirty and needed to be cleaned. During an interview on 10/02/24 at 11:24 A.M., the Director of Housekeeping said the microwaves on Unit 4 and 5 needed to be replaced. The Director of Housekeeping said that the housekeeping staff were responsible for the overall cleanliness of the Nourishment Kitchens which included refrigerators, freezers, counters, floors, walls, drawers, and cabinets and that both Unit 4 and Unit 5 Nourishment kitchens needed a thorough cleaning. (continued on next page)

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Worcester Rehabilitation & Health Care Center	119 Providence Street Worcester, MA 01604

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a group interview on 10/02/24 at 1:20 P.M., with the Administrator, Director of Housekeeping and Plant Manager after viewing photos the surveyors provided of their findings, the Administrator said he would not expect the wall on the Unit 2 Nourishment kitchen to look like that, and the Director of Housekeeping said the Unit 2 ceiling tiles needed to be replaced. During an observation of the Main Kitchen dish room on 10/02/24 at 8:30 A.M., Surveyor #1 noted a foul odor emanating throughout the room, there was an industrial fan blowing, flying insects could be seen hovering over the floor drain and around the garbage disposal under the sink, there was an adherent, thick, black substance along the top right edge of the garbage disposal, two red buckets with standing water underneath the garbage disposal, and black crumbs and assorted debris around the floors perimeter of the entire room, including underneath the dishwasher. During an interview at 8:40 A.M., the Food Service Director (FSD) said the foul odor was likely due to the drains and pipes in the dish room remaining stagnant for a couple of months due to the dishwasher being out of service. During a follow up observation and interview with the FSD on 10/02/24 at 9:45 A.M., Surveyor #1 observed multiple flying insects within the dish room. When it was brought to the attention of the FSD that a Dietary Aide had been observed earlier today by Surveyor #1 and the Administrator, sanitizing a meal cart in the dish room, the FSD said the Dietary Aide should not have been cleaning the meal cart in the dish room given the current insect infestation because of the risk of the insects getting into the food. In addition, the FSD said he was aware the dish room was unsanitary and required thorough cleaning and that Maintenance needed to fix the leaks under the garbage disposal. During an observation and interview on 10/02/24 at 9:11 A.M., the Administrator said he was not sure of the exact date the dishwasher stopped working, but said that it should be ready for use today after the company came to provide the appropriate sanitizing chemicals. Immediately after the interview, the Administrator and Surveyor #1 together observed the dish room. A dietary aide was inside the dish room cleaning and sanitizing a meal cart readying it for the residents' lunch meal to be transported upstairs to the Nursing units. There were a couple small, black flying insects hovering around the floor drain and a large number (too numerous to count) flying around under the sink and around the garbage disposal. The Administrator said the insect problem was bad in the dish room as well as the odor, and before the dishwasher was put back into service the dish room required a thorough cleaning and should not have been this dirty.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 37086 Based on records reviewed, interviews, and observations, the Facility failed to ensure they developed, implemented and maintained a Quality Assurance and Performance Improvement (QAPI) program that was comprehensive, ensured the residents' environment was maintained to promote a clean, safe, homelike environment, and was focused on indicators of quality of life for residents in the facility. Findings include: Review of the Facility's QAPI Policy, dated April 2015, indicated the following: -Policy-The Facility will have effective QAPI programs to improve the quality of life, and quality of care and services delivered. -When fully implemented, the QAPI program should address all systems of care and management practices, and should always include clinical care, quality of life, and resident choice. -The Facility uses a systematic approach to determine when in-depth analysis is needed to fully understand the problem, its causes, and implications of a change. -The Facility uses a thorough and highly organized/structured approach to determine whether and how identified problems may be caused or exacerbated by the way care and services are organized and delivered. Review of the June 2024 QAPI Meeting Minutes indicated the following information was submitted from the Department Heads: -Housekeeping and Laundry: Keeping track of mice sightings. Pest control comes monthly. -Plant: Working on the mouse problem, pest control comes regularly. Call lights have been serviced but [reports of non-working call lights] are on-going. Review of July 2024 QAPI Meeting Minutes indicated the following information was submitted from the Department Heads: -Housekeeping and Laundry: Keeping track of mice sightings. Pest control comes monthly. -Plant: Working on the mouse problem, pest control comes regularly. Review of the August 2024 QAPI Meeting Minutes indicated the following was submitted from the Department Heads: -Housekeeping and Laundry: Keeping track of mice sightings. Pest control came in July. -Nursing: Call lights on Unit 2 and Unit 4 are not working and we are waiting for [the company] to pay the bill to have them fixed. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of a QAPI plan specific to insects and rodents, dated 08/29/24, indicated the following: -The Problem: Residents collecting items that attract bugs and rodents. -The Goal: Remove food trash contraband from resident bedside tables. -Action Steps: Inspect and remove any food trash contraband from bedside tables. -Responsible Person: Director of Housekeeping -Estimated Completion Date: Ongoing. Review of the previous six months of Pest Control Services, provided by the Facility, indicated Pest Control Services were at the Facility on the following dates: -05/02/24, 05/16/24, 08/06/24, 08/23/24, 09/03/24, 09/17/24 and 10/01/24 (date of survey). Pest Control Service visits were not conducted at the Facility during the months of June 2024 and July 2024, despite QAPI meeting minutes which indicated the Pest Control Service visits were done monthly. Review of the Facility's Audit, titled Safe/Clean/Comfortable/Homelike Environment/Call Light Audit, dated 10/01/24, included the following: -Unit 2 -18 out of 18 resident rooms had no working call lights. -Unit 3-12 out 19 resident rooms had no working call lights. -Unit 4-20 out of 20 resident rooms had no working call lights. -Unit 5-3 out of 19 resident rooms had no working call lights. Despite the Facility having identified the non-functional call bell system months prior, the issues had not yet been resolved at the time of this survey. During a telephone interview on 10/04/24 at 12:00 P.M., the Administrator said more work needed to be done to combat the pest infestations. The Administrator said the QAPI for pest control should have been more detailed to determine its effectiveness. The Administrator said the call lights had been an on-going issue and should have already been fixed.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44129 Based on observations and interviews for four out of four resident units, the Facility failed to ensure they provided a functional Resident Call/Communication System which relayed to the cell directly to staff or a centralized staff work area, that allowed residents residing on the units, to call for staff assistance. Findings include: Review of the Facility policy titled, Call Light Use of, dated April 2015 indicated but was not limited to: - All [name of company] Health Care Systems residents/patients will have a call light or alternative communication device within his/her reach when unattended. - Report any defective call lights in the maintenance log. - If the call light is unable to be repaired immediately provide an alternative communication method. Review of the safe/clean/comfortable/home-like environment/call light audit provided to the Surveyors completed by the Plant Manager on 10/1/24 (on the date of the survey) indicated the following: - All call lights on Unit 2 were not working. - 24 call lights on Unit 3 were not working. - 38 call lights on Unit 4 were not working. - 3 call lights on Unit 5 were not working. During a tour of Unit 5 on 10/01/24 at 7:50 A.M., Surveyor #1 observed the following: - room [ROOM NUMBER]-A - Call light device missing the button that activated the system, there was no hand bell in the room - room [ROOM NUMBER]-B- Call light not functioning, there was no hand bell in the room. - room [ROOM NUMBER]- Emergency call light in the bathroom did not have a pull chain to activate the system. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 10/01/24 at 9:24 A.M., with Certified Nurse Aide (CNA) #1 and Maintenance Worker #1 (on Unit #4), Surveyor #1 attempted to activate the call system by pressing the call button for room [ROOM NUMBER]-A. Surveyor #1 observed that a light appeared on the panel behind the bed where the call light was plugged in, however the light above the door on the outside of the room did not illuminate. Surveyor #1 then attempted to activate the call system by pressing the call button for room [ROOM NUMBER]-B. Surveyor #1 observed there was no light on the wall panel behind the bed or out in the hallway above the door to the room. Surveyor #1 then went to the Nurse's station to look for a panel or system that would alert staff to where a call light had been activated, however the system was shut down. CNA #1 said staff would know if a resident activated the call system because there would be a beeping sound, the light outside the room would illuminate and it would appear on the computer at the Nurse's station. CNA #1 then proceeded to the Nurse's station to show Surveyor #1 the computer that would identify which room initiated the call system, however the computer was not functioning and CNA #1 requested Maintenance Worker #1's assistance. Maintenance Worker #1 found that the cable was disconnected from the monitor under the desk, reconnected it and was able to show Surveyor #1 the display. At that time, Maintenance Worker #1 then went into room [ROOM NUMBER]-B and attempted to activate the call system. Surveyor #1 and Maintenance Worker #1 both observed that the panel behind the bed did not light up, nor did the light outside above the resident's door. Maintenance Worker #1 said he did not think that any call lights on Unit 4 worked properly and did not work for some time. Surveyor #1 and Maintenance Worker #1 then went to room [ROOM NUMBER]-A and attempted to activate the call system and observed the panel behind the bed lit up, however the light outside above the resident's door did not, but the light above room [ROOM NUMBER] (which they had not activated) did illuminate. Maintenance Worker #1 said that was a problem. During an interview on 10/01/24 at 9:45 A.M., Nurse #2 said if the resident in room [ROOM NUMBER]-A rang for help, care could be delayed because staff would respond to room [ROOM NUMBER] because that would be the light staff would see to respond to, which was the wrong room. Nurse #2 also said she could not hear an audible bell when we activated the call system in room [ROOM NUMBER]-A. During an environmental tour of Unit 4 on 10/01/24 at 3:00 P.M., Surveyor #1 observed the following: - room [ROOM NUMBER]-B - Call light did not work. Non-Sampled (NS) Resident # 13 said if he/she needed a nurse, he/she just went into the hall and called for one and that he/she did not have a hand bell. - room [ROOM NUMBER]-A and 403-B - call light did not work - room [ROOM NUMBER]-A and 406-B - call light did not work - room [ROOM NUMBER]-A and 408-B - call light did not work - room [ROOM NUMBER]-A - call light did not work, hand bell on nightstand did not have a striker inside. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- room [ROOM NUMBER]-B - there was no call light connected to the wall panel at all. NS Resident #12 said he/she had no idea where it was, that he/she was not given a hand bell and when he/she needed help, he/she yelled for it. - room [ROOM NUMBER]-A - call light did not work. 37086 During an environmental tour on Unit 2 on 10/01/24 at 7:53 A.M., Surveyor #2 observed: -Non-functioning call light system for the entire unit. During an environmental tour on Unit 3 on 10/01/24 at 8:40 A.M., Surveyor #2 observed: -No call lights ringing and several resident rooms with non-functional call lights. -During an interview on 10/01/24 at 8:10 A.M., NS Resident #2 said his/her call light did not work, that he/she had a hand bell which did not work either and if he/she needed staff assistance he/she would go to the hallway and call for help. -During an interview on 10/01/24 at 8:24 A.M., NS Resident #3 said his/her call light did not work and if he/she needed staff assistance he/she would get out of bed and find a staff member to help him/her. -During an interview on 10/01/24 at 8:40 A.M., NS Resident #5 said his/her call light did not work and he/she had to use the hand bell when he/she needed staff assistance. -During an interview on 10/01/24 at 2:07 P.M., NS Resident #6 said his/her call light did not work and he/she would yell out when he/she needed assistance from staff. -During an interview on 10/01/24 at 2:10 P.M., NS Resident #7 said his/her call light did not work and if he/she needed something from staff he/she would leave his/her room to find help. During a group interview on 10/02/24 at 1:20 P.M., with the Administrator, the Plant Manager and the Director of Housekeeping, the Surveyors asked about their non-functioning call light system which has been a known issues since before March 2024. The Administrator said they had received a quote for replacement and the company required a 50 percent down payment. Surveyor #1 asked about their previous plan of correction to replace the system completely with a quote in March 2024 and inquired why the call light system was still non-functional. The Administrator shrugged his shoulders and said they had just received a new quote. The Administrator said the call lights were a real problem for the Facility and had been an on-going issue sometimes they work, sometimes they do not. The Administrator said that not all residents with a non-functional call light had a hand bell to use because the hand bells were easily broken and in constant need of replacement. The Administrator said the entire call light system for Units 2, 3 and 4 were in need of replacement.

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Put firmly secured handrails on each side of hallways. 37086 Based on observations and interview, for one of four resident units (Unit 3) the Facility failed to ensure the handrail in the corridor between the Nurse's Station and the Nourishment Kitchen, was secured to the wall. Finding include: During an environmental tour on 10/02/24 at 12:10 P.M., Surveyor #2 observed the handrail in the corridor on Unit 3, between the Nurses Station and Nourishment kitchen was loose and unattached from the wall, which created a gap between the end of the railing and the wall, posing a potential safety hazard to residents. During an interview on 10/02/24 at 1:25 P.M. the Administrator said all handrails should be secured to the wall.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44129 Based on observations, records reviewed and interviews, the Facility failed to ensure they maintained an effective pest control program, when from the end of May 2024 to the beginning of August 2024, despite having a known active, ongoing infestation of mice and German Cockroaches (one of the most stubborn and difficult species to eliminate) in several resident care areas of the Facility, Pest Control Service visits and treatments were not conducted at the Facility during that time. Findings include: The Facility was unable to provide the surveyors with any policies related to the maintenance of a clean, homelike environment or pest control. Review of the Pest Control Service Reports indicated visits to the Facility were made on the following dates: 05/02/24, 05/16/24, 08/06/24, 08/23/24, 09/03/24, 09/17/24 and 10/01/24 (date of survey). Review of the Pest Control Service Report, dated 05/02/24, indicated the following: -five dead mice were found in the kitchen food preparation area -three dead mice were found in the kitchen stove/oven line. Review of the Pest Control Service Report, dated 05/16/24, indicated the following: -10 live German Cockroaches were found in the bathrooms (location not specified). -two dead mice were found in the bathrooms (location not specified). -four dead mice were found in the kitchen food preparation area -four dead mice were found in the kitchen stove/oven line. There were no Pest Control Service visits conducted from 05/16/24 through 08/06/24 despite the Facility having an on-going, active infestation of mice and a newly identified problem with cockroaches. Review of the Pest Control Service visit on 08/23/24 indicated the following: -four dead mice found in the kitchen food preparation area -four dead mice found in the kitchen stove/oven line. Review of the Pest Control Service visit on 09/17/24 indicated the following: (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-14 dead German cockroaches found in the bathrooms (location not specified). -3 dead mice found in the bathrooms (location not specified). -2 dead mice found in the kitchen food preparation area. During an environmental tour of Unit 5 on 10/01/24, Surveyor #1 observed the following: - 7:50 A.M., room [ROOM NUMBER], Non-Sampled (NS) Resident #10 showed the surveyor a Mouse and Insect Glue Board and said that Maintenance gave this to him/her to catch the numerous mice that have been in his/her room. NS Resident #10 said he/she was not comfortable torturing the mice and wished the facility would take care of this problem once and for all. - 8:59 A.M., room [ROOM NUMBER], NS Resident #14 said he/she sees both mice and cockroaches in his/her room and that it made him/her uncomfortable. During an environmental tour of Unit 4 on 10/01/24, Surveyor #1 observed the following: - 3:09 P.M., room [ROOM NUMBER] - small black gnat-like flying insects throughout the room, nearer Bed A, a small, approximately one-half-inch sized orange colored, six-legged insect crawling on the wall, a larger approximately one inch sized, orange colored, six-legged insect with antennae crawling on the wall next to the call light housing. - 3:30 P.M., room [ROOM NUMBER] - a large, approximately two-inch-long orange colored six-legged insect with antennae crawling on the floor next to the wall between the bathroom and Bed A. - 3:42 P.M., room [ROOM NUMBER] - numerous small black gnat-like flying insects throughout the entire room. During an environmental tour of Unit 2 on 10/01/24, Surveyor #2 observed the following: -8:10 A.M., room [ROOM NUMBER] B, mice droppings inside of NS Resident #2's top drawer of both his/her bedside table and bureau, and ripped edges along the bottom of a cloth bag which held snacks, next to NS Resident #2's bed. NS Resident #2 said he/she had seen more than 50 mice in his/her room within the last year, and presented a tally sheet of mice caught, and said the mice situation was only getting worse. NS Resident #2 said the ripped edges on the cloth bags were from mice trying to bite through them to get to the food. -8:30 A.M., room [ROOM NUMBER] B, NS Resident #4 said he/she had mice in the room nightly. During an environmental tour of Unit 2 on 10/02/24, Surveyor #2 observed the following: -2:10 P.M., room [ROOM NUMBER] B, NS Resident #7 said the Facility had a lot of mice and cockroaches and when he/she turned on the bathroom light at night, he/she would see cockroaches scatter. NS Resident #7 said the cockroaches come out of there like crazy and pointed to the heater in his/her room that was detached from the wall, causing a space between the wall and the heater. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-10:15 A.M., room [ROOM NUMBER] A, NS Resident #8 said there were too many mice in the Facility and the cockroaches came out of the wall vents in his/her room. NS Resident #8 shook his/her picture frames and clock which were all on the wall, and said cockroaches came out from behind them at night. During an environmental tour of Unit 3, on 10/01/24, Surveyor #2 observed the following: -8:40 A.M., room [ROOM NUMBER] A, several small black gnat-like bugs flying around the bedside table area. During an environmental tour of Unit 3, on 10/02/24, Surveyor #2 observed the following: -10:40 A.M., room [ROOM NUMBER] A, a dead brownish insect with several legs on Resident #2's closet floor. Resident #2 said there was a cockroach in his/her pile of linen a few days prior. Resident #2 said he/she heard rats in the ceiling at night. During an observation of the main kitchen dish room on 10/02/24 at 8:30 A.M., Surveyor #1 observed several small black gnat-like flying insects hovering over the floor drain and a large amount of small black gnat-like flying insects surrounding the area underneath the sink centered around the garbage disposal, as well as flying around throughout the dish room. During an interview on 10/02/24 at 8:40 A.M., the Food Service Director (FSD) said he was aware of the flying insects around the dish room, and he thought the exterminator was aware of them, as well. During an interview on 10/02/24 at 9:11 A.M., the Administrator, Surveyor #1 asked the Administrator if he was aware of the flying insect problem both in the kitchen and on the nursing units, and if the exterminator was addressing this problem. Initially, the Administrator said that the exterminator was treating for the flying insects, however Surveyor #1 referred him to the most recent exterminator report, that they had provided to the surveyors, which only addressed mice and roaches. The Administrator then said the exterminator was not aware of the flying insects, therefore they were not treating the infestation. Surveyor #1 and Surveyor #2 informed the Administrator of the multiple observations of flying insects on the nursing units and the Administrator said residents have complained to him about fruit flies and he said his response to them was to make sure they did not keep food, specifically fruit in their rooms. The Surveyors asked the Administrator if he was certain the flying insects were fruit flies and not drain flies, as they were observed congregating around the drains in the kitchen. The Administrator said he did not know. Immediately following the interview, Surveyor #1 and the Administrator went to the dish room and observed a small number of small, black gnat-like flying insects hovering over the floor drain and a large amount of small, black gnat-like flying insects flying around the garbage disposal under the sink and all around the sink area, in general. The Administrator then said the insect problem in the dish room was bad. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225199	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Worcester Rehabilitation & Health Care Center	119 Providence Street Worcester, MA 01604

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a follow-up observation and interview with the FSD on 10/02/24 at 9:45 A.M., Surveyor #1 observed numerous small black gnat-like flying insects all around the dish room. The FSD said when the exterminator visited, the exterminator did not seek him out to provide any information as to what their findings were and what their recommendations might have been, and that the exterminator reports directly to the Plant Manager. The FSD said he attended Quality Assurance and Performance Improvement (QAPI) meetings monthly and while pest control is discussed at each meeting, he said there was nothing discussed specifically relative to the kitchen, just an overall general report that pest control is being addressed. The FSD said he was not aware of the most recent report that identified how many and where any dead mice were found in the kitchen and was not aware that the exterminator was not treating the flying insects in the kitchen. 37086 During a group interview on 10/02/24 at 1:15 P.M. with the Administrator, Director of Housekeeping, and the Plant Manager, the Director of Housekeeping said he was responsible for the pest control in the Facility. The Director of Housekeeping said he accompanied the exterminator when they came in and he did not know why the exterminator did not make visits to the Facility in June or July 2024. The Director of Housekeeping said he did not do much with the end of visit reports the exterminator provided and said What else can I do? I just keep cleaning. The Administrator said he was unaware that the Pest Control Services did not make visits to the Facility in July and August 2024 and said they were supposed to come to the Facility at least monthly. The Administrator said the Facility needed to do more to combat the pest problems.