STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225385	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Christopher House of Worcester	10 Mary Scano Drive Worcester, MA 01605

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observations, interviews, and record reviews, the facility failed to maintain a clean and homelike environment for one Resident (#123), out of a total sample size of 28 residents. Specifically, for Resident #123, the facility staff failed to maintain the Resident's wheelchair in a clean and sanitary manner when the Resident was dependent on the wheelchair use for mobility and the wheelchair was visibly soiled. Findings include: Review of the facility policy titled Wheelchair Cleaning Policy, last reviewed 9/25/24, included but was not limited to:-to ensure the safety, hygiene, and functionality of all wheelchairs in use by maintaining a consistent cleaning schedule and accurate tracking system. -wheelchairs will be cleaned once per week at a minimum until all wheelchairs are completed.-additional cleanings may be performed as needed due to visible soiling, spills, or infection control requirements. -the Housekeeping/Maintenance Department is responsible for ensuring all wheelchairs are cleaned weekly.-the Supervisor or Designated Staff Member will perform weekly audits of the cleaning log for compliance. -areas to be cleaned include: armrests, seat and back cushions, footrests, wheels and brakes, handles and frame. Resident #123 was admitted to the facility in September 2023 with diagnoses including spinal stenosis and cerebral infarction due to embolism of left middle artery. Review of the Resident's Minimum Data Set (MDS) Assessment, dated 6/8/25, indicated Resident #123: -was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) a score of 12 out 15 points. -required supervision to walk 10 feet due to medical condition or safety concern.-used a manual wheelchair. Review of the facility weekly Wheelchair Cleaning Schedules dated:-7/8/25, 7/17/25, 7/24/25, 7/31/25, 8/7/25, 8/18/25 and 8/25/25 failed to indicate that Resident #123's wheelchair had been cleaned weekly or was cleaned since June 2025. During an interview on 8/26/25 at 9:36 A.M., Resident #123 said the staff have not cleaned his/her wheelchair. The surveyor observed the Resident was seated in his/her wheelchair in the [NAME] dining area. The surveyor further observed the wheelchair frame had dried dark browns spots on the frame, the spokes and wheels were covered in flaky white debris, and the armrests were stained with a dark brown/black substance. On 8/27/25 at 9:46 A.M., the surveyor observed Resident #123 sitting in his/her wheelchair in the [NAME] Dining area. The Resident's wheelchair was observed with dried brown/black spots on the frame, the spokes of the wheels remained covered in flaky white debris and the armrests were stained with a dark brown/black substance. During an interview at the time, Resident #123 said that staff has not cleaned his/her wheelchair in a long time, and he/she hoped they did not expect him/her to clean it him/herself. On 8/27/25 at 1:30 P.M., the surveyor and Nurse #1 observed Resident #123's wheelchair. During an interview at the time, Nurse #1 said that Resident #123's wheelchair was dirty, covered in food debris, should have been cleaned and was not cleaned. During an interview on 8/27/25 at 1:57 P.M., Housekeeping Staff #1 said that Resident #123's wheelchair needs to be cleaned and that he would clean the wheelchair. Housekeeping Staff #1 said that the (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Housekeeping Department will have a better system in place so that wheelchairs will not be missed for future cleanings.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, and interviews, the facility failed to complete Minimum Data Set (MDS) Assessments that accurately reflected the status of two Residents (#15 and #142) out of a total sample of 28 Residents.Specifically, for Resident #15, and Resident #142, the facility failed to ensure that the Brief Interview for Mental Status (BIMS) and Patient Health Questionnaire-9 (PHQ-9: questionnaire used to assess for Depression) were completed, placing the Resident's at risk for care that is not Resident driven and unidentified Depression. Findings include:1) Resident #15 was admitted to the facility in July 2025 with diagnoses including BiPolar Disorder and Mood Disorder. Review of the MDS assessment dated [DATE] indicated Resident #15: -was usually understood -usually understood others -BIMS assessment was not attempted -PHQ-9 assessment was not attempted During an interview on 8/26/25 at 9:04 A.M., Resident #15 appropriately understood and answered the surveyor's questions about his/her stay in the facility. Review of Resident #15's medical record failed to indicate that a BIMS assessment or PHQ-9 assessment had been conducted or attempted during the assessment period for the 7/15/25 MDS Assessment. During an interview on 8/28/25 at 12:27 P/M., the MDS Nurse said that Resident #15 should have participated in the assessments because he/she was able to be interviewed, he/she was not assessed, and should have been. The MDS Nurse also said that it is important to capture the Resident's response because the MDS assessment is Resident driven, and if you do not interview the Resident, it does not accurately reflect the Resident. 2) Resident #142 was admitted to the facility in March 2024 with diagnoses including Dementia and Delusional Disorder. Review of the MDS assessment dated [DATE] indicated Resident #142:-was usually understood-usually understood others-BIMS assessment was not attempted-PHQ-9 assessment was not attempted Review of Resident #142's Nursing Progress Notes indicated the following:-a Nursing Progress Note dated 5/12/25 at 1:17 P.M., indicated the Resident was alert and responsive and denied pain or discomfort.-a Nursing Progress Note dated 5/27/25 at 11:28 P.M., indicated the Resident is alert and able to make needs known. Further review of Resident #142's medical record failed to indicate that a BIMS assessment or PHQ-9 assessment had been conducted or attempted during the assessment period for the 5/27/25 MDS assessment. During an interview on 8/28/25 at 2:15 P.M., the MDS Nurse said there was no evidence that Resident (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#142 had a BIMS assessment or PHQ-9 assessment attempted in the medical record, but the assessments should have been attempted. During an interview on 8/28/25 at 2:34 P.M., the MDS Nurse said that the MDS was meant to be Resident driven and if the Resident was not involved in the assessment that the MDS would not accurately reflect the Resident. The MDS Nurse further said the PHQ-9 assessment was important to be attempted as it assessed the Resident for Depression.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care and services as required for an indwelling urinary/Foley catheter for one Resident (#3) out of a total sample of 28 residents. Specifically, for Resident #3, the facility failed to ensure that a blocked indwelling urinary catheter was replaced with the correct sized catheter balloon as ordered by the Physician. Findings include: Review of the facility policy for Urinary Catheters, last revised 11/1/23, indicated: -to ensure appropriate use of indwelling or intermittent urinary catheters once necessity has been determined .-Catheter Removal: >the Licensed Nurse checks Physician's order for.catheter>documents findings as indicated Resident #3 was admitted to the facility in June 2025 with diagnoses including neurogenic bladder and obstructive uropathy. Review of Resident #3 August 2025 Physician's orders indicated: -Foley catheter care every shift, start date 6/30/25-Foley catheter change as needed for leakage, blockage or wear. Size 16 French (Fr: French scale system used to size catheters) with 30 cc (cc: cubic centimeter = ml balloon), start date 6/30/25 Review of Resident #3's July 2025 Treatment Administration Record (TAR) indicated:-Foley catheter size 16 Fr with a 30 cc (cubic centimeters) balloon.-the Foley catheter had been changed to a size 16 Fr with a 30 cc balloon as needed for a blockage or leakage on 7/31/25. Review of Resident #3's August 2025 TAR failed to indicate that the urinary catheter had been changed. Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #3:-was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of three out of 15. -was dependent for toileting -had an indwelling urinary catheter. Review of Resident #3's Care Plan for indwelling catheter, last revised 8/27/25, indicated:-change catheter per MD (Medical Doctor) order.-provide catheter care every shift. Review of Resident #3's clinical record indicated:-Nursing Progress Note dated 7/31/25 that documented the Resident's Foley catheter had been changed to a 16 Fr with 30 cc balloon due to a leakage. -Nursing Progress note dated 8/9/25 that documented the Resident's Foley catheter had been changed due to blockage. On 8/27/2025 at 10:08 A.M., the surveyor and Nurse #2 observed that Resident #3 had a 16 Fr catheter in place with a 10 cc balloon. During an interview at the time, Nurse #2 said that she had checked the Resident's Physician's orders earlier this morning and the Resident should have a 30 cc balloon in place but did not, and Nurse #2 notified her Unit Manager (UM). During an interview on 8/27/25 at 10:15 A.M., UM #1 said that Resident #3 should have a 30 cc balloon inserted, but he/she did not and must have had the urinary catheter incorrectly changed. UM #1 also said that she had just changed the Resident's Physician's order to a 10 cc balloon after the surveyor had requested to observe the current urinary catheter with Nurse #2 and found a size 10 cc balloon was in place.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on observations, interviews, and record reviews the facility failed to provide trauma-informed care according to professional standards of practice and accounting for the Resident's experiences for one Resident (#6) out of a total sample of 28 residents. Specifically, for Resident #6, the facility failed to:-assess the Resident for a history of trauma when the Resident was newly admitted to the facility.-recognize the Resident's experiences of traumatization when, during the Resident's stay at the facility, contracted Psychological Services identified that the Resident had a history of trauma, putting the Resident at risk for re-traumatization. Findings include: Review of the facility's policy titled Trauma Informed Care, last reviewed 9/6/22, indicated the following:-It is the policy of the facility to ensure residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice.-Care will be provided while considering the residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. -Trauma-informed care is a holistic, person-centered approach to treatment that understands and incorporates the biological, psychological, neurological, and social impact of trauma on an individual.-Without screening, trauma histories and related symptoms often go undetected, and we may provide services for symptoms and disorders that may only partially explain the individuals' distress.-Universal screening for trauma history and trauma-related symptoms can identify individuals at risk for developing more pervasive and severe symptoms of traumatic stress.-All new admissions will be assessed for a history of traumatic events through interviews with the resident/resident representative, review of medical records, and observations .-Any resident with a history of a traumatic event . will have a person-centered comprehensive care plan developed with interventions implemented from a collaborative interdisciplinary team approach.-The goal is to decrease the risk of inadvertent re-traumatization of individuals who have experienced trauma .-On an ongoing basis, residents will be observed for changes in condition and/or behavior that may be indicative of trauma . such as: -Fearfulness. -Isolation. -Difficulty sleeping or nightmares. -Lack of interest. -Negative thoughts about themselves. -Feeling detached from family/friends. -Feelings of hopelessness. Resident #6 was admitted to the facility in August 2024 with diagnoses including Complete Paraplegia, Major Depressive Disorder, Anxiety Disorder, family history of other psychoactive substance abuse and dependence, Insomnia, and history of bilateral below the knee amputations (BKA). Review of Resident #6's clinical record indicated:-The Resident's 48-Hour Baseline Care Plan's section relative to trauma screening was not completed.-No evidence a trauma assessment had been completed by the facility staff for the Resident when the Resident was newly admitted to the facility. Review of the Minimum Data Set (MDS) Assessment, dated 1/29/25, indicated Resident #6:-was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 total possible points.-exhibited no behavioral symptoms during the observation period for the Assessment.-required substantial/maximal assistance to dependence on staff for bathing, dressing, toilet hygiene, and bed mobility. Review of the Psychological Services Evaluation, dated 3/4/25, indicated Resident #6:-was being evaluated for a medication review at the request of the facility due to concerns of increased depression, medical decision-making capacity.-Physician reported the Resident had been making questionable choices related to his/her care.-was alert and oriented.-stated that he/she felt traumatized every time he/she goes to the hospital.-stated every time he/she went in [to the hospital] something always went wrong, or [they] find something else wrong with him/her. -stated that he/she knew the risk of refusing treatment was death.-said that he/she did not want to die but did not feel the trauma, psychological effects of being in the hospital were worth it. Review of Resident #6's Care Plan dated 8/1/24 (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	through 8/28/25, failed to indicate any evidence a person-centered care plan had been developed relative to the Resident's reported traumatic experiences relative to hospitalizations. On 8/26/25 at 1:32 P.M., the surveyor observed Resident #6 in his/her room, sitting up approximately 60 degrees in bed. The surveyor observed that the Resident was awake, and there was no natural light or lights on in the room.At this time, Resident #6 declined to speak with the surveyor. During an interview on 8/28/25 at 5:00 P.M., Social Worker (SW) #1 said Resident #6 was newly admitted to the facility in August 2024. SW #1 said she reviewed the Resident's record and there was no evidence a trauma assessment had been completed for the Resident when he/she was admitted to the facility. SW #1 said all new admissions were required to be assessed for a history of trauma and that a trauma assessment should have been completed for Resident #6 when he/she was admitted to the facility. The surveyor and SW #1 reviewed Resident #6's 3/4/25 Psychological Services Evaluation and SW #1 said the facility should have developed a care plan for the Resident, for trauma and triggers for trauma related to hospitalizations.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were stored and secured in accordance with State and Federal requirements on one unit (Brookside unit) medication carts, out of total of four units and that medications were stored in a safe and secure manner for one Resident (#3) out of a total sample of 28 residents.Specifically, the facility failed to:1. ensure that one medication cart on the Brookside Unit was locked while the Nurse walked away from the medication cart multiple times and the unlocked medication cart was out of her sight, providing ready access of medications in the medication cart to unauthorized personnel and residents.2.For Resident #3, ensure that a prescribed inhaler was secured and not left on the Resident's nightstand table that was readily accessible to other residents and/or unauthorized individuals. Findings include: Review of the facility policy titled Storage of Medications, revised 2024, included but was not limited to:-Medications and biologicals are stored safely, securely, and properly, following manufacturers' recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.-Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) are permitted to access medications. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access.Review of the facility policy titled Medication Administration, revised 3/3/20, included but was not limited to:-Medications are administered by Licensed Nursing Staff only.-Medication carts are supplied on each unit in the facility for the storing and passing of medications.-During a medication pass, the cart is visible at all times. If more than 5 feet away, the medication cart is locked with the wheels locked also. 1. On 8/27/25 at 8:11 A.M. to 8:21 A.M., the surveyor observed the following during a medication pass administration with Nurse #2 on the Brookside Unit (Dementia Unit):-Nurse #2 said that she was in the process of assessing a resident's blood glucose finger stick.-Nurse #2 was observed to remove a plastic container from the medication cart and said that she needed to get more supplies from the supply room.-Nurse #2 left the plastic container with glucometer, lancets, and alcohol wipes on top of the medication cart and stepped away from her medication cart to walk into a supply room and close the door.-The surveyor observed that the Medication cart was unlocked, that residents were sitting in wheelchairs in close proximity of the medication cart, and other residents and staff members were walking by the medication cart.-Nurse #2 returned to the medication cart, placed supplies from the supply room on top of the medication, walked away from the medication cart a second time without securing the medication cart and entered the dining room, and had her back to the medication cart. -The surveyor observed a resident walking by the medication cart at the time and staff members in the area where the medication cart was positioned attempted to redirect the resident back to the dining room. -Nurse #2 returned to the medication cart with a resident, picked up the plastic container from the top of the medication cart with the glucose supplies and propelled the resident sitting in his/her wheelchair down the hall to the resident's room located at the end of the hall. The surveyor observed that the medication cart remained unlocked.-The surveyor and Nurse #2 entered the resident room located at the end of the hallway where Nurse #2 assessed the resident's blood glucose finger stick and was out of sight of the unlocked medication cart. -Nurse #2 returned to the medication cart after completing the finger stick, cleaned the glucometer and placed it inside the medication cart, and walked away from the medication cart to return the resident (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	back to the dining room without securing the medication cart. -At 8:23 A.M., Nurse #2 was observed to return to the medication cart and locked the medication cart. During an interview on 8/27/25 at 8:54 A.M., Nurse #2 said she should lock the medication cart each time she walks away from the medication cart for safety. Nurse #2 said by not locking the medication cart, residents and other staff members walking by the medication cart can have access or remove medications from the medication cart. During an interview on 8/27/25 at 1:00 P.M., the Director of Nursing (DON) said that it was standard practice for nursing staff to ensure that medication carts are locked each time the Nurse stepped away from his/her medication cart. 2.Resident #3 was admitted to the facility in June 2025 with diagnoses including Dementia, Major Depressive Disorder and Chronic Obstructive Pulmonary Disease (COPD). Review of Resident #3's Minimum Data Set (MDS) assessment dated [DATE], indicated that the Resident was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of three out of possible score of 15. On 8/27/25 at 8:25 A.M., the surveyor observed the following during a blood glucose assessment on Resident #3 completed by Nurse #2:-Spiriva Handihaler (tiotropium bromide) capsule and inhalation device labeled with the Resident's name, in a clear plastic zip lock bag on the Resident's nightstand table.-Nurse #2 performed the blood glucose finger stick assessment on Resident #3, walked to the bathroom, removed her gloves and washed her hands. The surveyor observed the Spiriva Handihaler remained on the Resident's nightstand table in the zip lock bag. During an interview on 8/27/25 at 8:56 A.M., Nurse #2 said the Spiriva inhaler should not be left on Resident #3's nightstand without the Nurse present. Nurse #2 said she brought the Spiriva inhaler into Resident #3's room when she was administering Resident #3's Albuterol inhaler and left the Spiriva inhaler in the room. Nurse #2 said she did not remove the Spiriva medication when she exited the room and should have removed the Spiriva medication at the time she exited the room to prevent other residents access to the medication. Nurse #2 said that Resident #3 was unable to self-administer his/her Spiriva inhaler and Licensed Staff administers the Resident's medication. During an interview on 8/27/25 at 1:00 P.M., the Director of Nursing (DON) said that it was standard practice for nursing staff to ensure that there was no medication left unattended on a resident nightstand table for other residents' safety.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interviews, and record reviews, the facility failed to maintain complete and accurately documented medical records relative to fluid intake and urinary output for one Resident (#5) out of a total sample of 28 residents.Specifically, the facility failed to maintain complete and accurate documentation of:1. Resident #5's fluid intake when the Resident was identified to have Congestive Heart Failure (CHF), required the use of diuretic medication, and was placed on fluid restriction.2.Resident #5's urine output when the Resident was identified to have CHF, was placed on fluid restriction, and the Resident had an indwelling urinary catheter, putting the Resident at risk for inadequate monitoring of his/her medical condition and fluid-related complications. Findings include:Review of the facility's policy titled Intake and Output Assessment/Documentation, last revised 12/1/24, indicated the following:-The objective was to maintain adequate fluid balance.-The nursing staff will document intake and output in the EHR (electronic health record). Resident #5 was admitted to the facility in May 2024 with diagnoses including CHF, Stage Four Chronic Kidney Disease, and Neuromuscular Dysfunction of Bladder. Review of the Minimum Data Set (MDS) Assessment, dated 8/13/25, indicated Resident #5:-was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15 total possible points.-had an indwelling urinary catheter.-was dependent upon facility staff for toilet hygiene. 1. Review of Resident #5's Dehydration Risk Care Plan, initiated 6/6/24 and last edited 8/12/25, indicated:-The Resident was at risk for dehydration.-Monitor fluid intake with meals. Review of Resident #5's Nurse Practitioner (NP) Progress Note, dated 8/15/25, indicated:-The Resident had altered mental status.-The Resident had retention of urine.-The Resident's chest x-ray results revealed pulmonary vascular congestion (condition where there is an excessive accumulation of fluid in the blood vessels of the lungs that can be caused by heart failure).-The Resident had acute on chronic systolic (congestive) heart failure.-Give extra dose of Bumex (diuretic medication) today.-Continue Bumex 5 milligrams (mg) q (every) day.-Add fluid restriction. Review of Resident #5's Physician orders, dated 8/15/25, indicated:-1.5 L (liter) fluid restriction.-Every shift: (days) 7:00 A.M. - 3:00 P.M., (evenings) 3:00 P.M. - 11:00 P.M., (nights) 11:00 P.M. - 7:00 A.M. Review of Resident #5's clinical record indicated the following documented fluid intake between 8/15/25 and 8/26/25:>8/15/25: -Medication Administration Record (MAR) indicated 420 mL (milliliters) total fluid intake over all three shifts. -Fluid intake recorded in the Vitals section of the electronic health record (EHR) indicated 600 mLs. -Paper Meal Intake Record indicated 240 mL of fluid intake for the supper meal. Breakfast and lunch columns indicated R (refused).>8/18/25: -MAR indicated 660 mL total fluid intake over all three shifts. -Fluid intake recorded in the Vitals section of the EHR indicated 720 mLs. -Paper Meal Intake Record indicated 480 mL fluid intake at breakfast and 480 mL fluid intake at supper (total = 960 mL). The lunch meal fluid intake was blank.>8/21/25: -MAR indicated 280 mL total fluid intake over all three shifts. -Fluid intake recorded in the Vitals section of the EHR indicated 220 mLs. -Paper Meal Intake Record indicated 480 mL fluid intake for breakfast. The lunch and supper meal fluid intakes were blank.>8/22/25: -MAR indicated 300 mL fluid intake over all three shifts. -Fluid intake recorded in the Vitals section of the EHR indicated 360 mLs. -Paper Meal Intake Record indicated 360 mL fluid intake at breakfast, 240 mL fluid intake at lunch, and 360 mL fluid intake at supper (Total = 960 mL).>8/26/25: -MAR indicated 440 mL total fluid intake over all three shifts. -Fluid intake recorded in the Vitals section of the EHR indicated 620 mLs. -Paper Meal Intake Record indicated 220 mL fluid intake at supper. The breakfast and lunch meal fluid intakes were blank. On 8/26/25 at 10:58 A.M., the surveyor observed Resident #5 lying in bed with the bed covers over the (continued on next page)

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	225385	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Christopher House of Worcester	10 Mary Scano Drive Worcester, MA 01605

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident's lower body. The surveyor observed a section of clear catheter tubing exiting from under the Resident's bed covers, leading to a urinary catheter collection privacy bag. The surveyor did not observe any urine in the catheter tubing and the contents of the urinary catheter collection bag were not visible. During an interview at the time, Resident #5 said he/she used to have a urinary catheter and that he/she no longer had a urinary catheter in place. 2. Review of Resident #5's Indwelling Urinary Catheter Care Plan, initiated 8/28/24 and last edited 8/12/25, indicated:>Resident had an indwelling urinary catheter related to urinary retention and neurogenic bladder.>Document urinary output every shift. >Record: -amount. -type. -color. -odor. Review of Resident #5's Nurse Practitioner (NP) Progress Note, dated 8/15/25, indicated:-Continue Foley catheter.-The Resident had acute on chronic systolic (congestive) heart failure. Review of Resident #5's clinical record failed to indicate any evidence that the Resident's urine output, including amount, type, color, and odor was documented every shift from 8/15/25 through 8/26/25. On 8/27/25 at 10:40 A.M., the surveyor observed Resident #5 sitting up in a wheelchair in his/her room and drinking a cup of coffee. During an interview at the time, Resident #5 said he/she had just returned from an appointment and that while he/she was out, his/her Resident Representative bought him/her a cup of coffee. Resident #5 said he/she loved coffee and that he/she was not aware of any restriction on the amounts of fluids he/she could drink. During an interview on 8/27/25 at 2:40 P.M., Certified Nurse Aide (CNA) #2 said she was responsible to provide care for Resident #5 on 8/27/25. CNA #2 said that she was not aware of Resident #5 requiring a fluid restriction. CNA #2 said that Resident #5 did not usually ask for drinks in addition to the fluids provided throughout the day and that the Resident usually drank all of the fluids that were provided to him/her. CNA #2 also said that Resident #5 had an indwelling urinary catheter and that staff were required to document the amount of urine output the Resident had every shift into the EHR. During an interview on 8/27/25 at 4:56 P.M., Nurse #4 said Resident #5 was on a fluid restriction and that the Resident had an indwelling urinary catheter. Nurse #4 said that she was responsible to document the total amount of fluid the Resident consumed during her shift, and that the total amount consumed would include all fluids the Resident was provided by all staff members. Nurse #4 also said that the CNAs were responsible to empty Resident #5's indwelling urinary catheter collection bag and report the total urine output to the Nurse responsible for the Resident's care. Nurse #4 said that the CNAs would empty Resident #5's urinary catheter collection bag on the current shift and would be required to tell Nurse #4 how much urine output the Resident had on the shift. Nurse #4 said the CNAs were responsible to document the exact amount of urine output for Resident #5 in the Resident's EHR. Nurse #4 said she was responsible to ensure the CNAs documented the urinary output in the EHR, and it was important to accurately record Resident #5's fluid intake and urine output as recording these measurements were ways to help monitor the Resident's fluid balance maintenance and urinary catheter function. During an interview on 8/28/25 at 2:33 P.M., Nurse #5 said that she was helping to cover the role of Staff Development Coordinator (SDC). Nurse #5 said that anytime a Resident was placed on fluid restriction and/or had an indwelling urinary catheter, fluid intake and urine output monitoring would be implemented. Nurse #5 said that nursing staff were responsible to document total fluid intake and urine output for a Resident on a fluid restriction. Nurse #5 said nursing staff were required to document exact measurements, in milliliters, of urine output for a Resident with an indwelling urinary catheter. Nurse #5 said that Nurses and CNAs responsible to care for Resident #5 were required to accurately record the Resident's fluid intake and urine output as the Resident had been placed on fluid restriction and had an indwelling urinary catheter. Nurse #5 said accurately recording the amount of fluid intake and urine output for Resident #5 was required as this was one (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	way the facility staff would monitor the Resident's fluid balance.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interviews, and record reviews, the facility failed to maintain an effective infection control and prevention program to stop the spread of organisms and infections for one Resident (#52) out of a total sample of 28 residents. Specifically, for Resident #52, the facility failed to ensure that staff performed appropriate hand hygiene during glove changes while providing wound care for Resident #52 who was on Enhanced Barrier Precautions (EBP: infection prevention practice of wearing gown and gloves to reduce transmission of multi-drug-resistant organisms [MDRO's - bacteria that are resistant to three or more types of antimicrobial drugs]) during high contact resident care), placing the Resident at risk for contracting healthcare-associated infections. Findings include: Review of the facility's policy titled, Wound Care, last revised 2/9/24, included but was not limited to: -to protect our residents, our staff follow evidenced-based infection prevention practices to minimize pathogen transmission during wound care.-The following practices should be incorporated into all wound care procedures: 1. perform hand hygiene before and after wound care, even if gloves are worn.2. after removal of PPE (Personal Protective Equipment), including of gloves are changed during the procedure. -prevent contamination of wound care supplies.-place supplies on a clean surface in the resident room or treatment area.-maintain separation between clean and dirty supplies. Review of the facility policy for Enhanced Barrier Precautions (EBP), last revised 4/8/24, indicated: -EBP is used in conjunction with standard precautions and expands the use of PPE to don gowns and gloves during high contact resident care activities that provide opportunities for transferring MDRO's to staff hands and clothing.-EBP is indicated for wounds and indwelling medical devices even if the resident is not known to be infected or colonized with an MDRO. Resident #52 was admitted to the facility in March 2025 with diagnoses including Vascular Dementia, Pressure Ulcer of Unspecified Part of the Back - Stage II, and Unspecified Severe Protein Calorie Malnutrition. Review of Resident #52's August 2025 Physician's orders indicated: -measure wound to mid back every Monday, start date 8/22/25.-maintain enhanced barrier precautions every shift, start date 8/26/25.-stage II wound to spine: wash wound with soap and water, pat dry, then apply Calcium Alginate, superabsorbent pad. Please include wound measurements when ordering for accurate dosing, once an evening, start date 8/27/25. On 8/27/25 at 3:48 P.M., the surveyor observed the following as Nurse #3 performed wound care, while CNA #1 assisted with positioning Resident #52, who was lying in bed:-3:51 P.M., Nurse #3 and CNA #1 doffed (removed) gloves and donned (put on) new gloves without performing hand hygiene between the glove change and continued caring for the Resident. -4:02 P.M., Nurse #3 doffed her gloves and donned new gloves without performing hand hygiene and continued providing wound treatment.-4:07 P.M., Nurse #3 doffed her gloves and donned new gloves without performing hand hygiene and continued with providing wound treatment.-4:11 P.M., Nurse #3 doffed her gloves and donned new gloves without performing hand hygiene and continued with providing wound treatment.-4:12 P.M., Nurse #3 doffed her gloves and donned new gloves without performing hand hygiene and continued with providing wound treatment.-4:22 P.M., Nurse #3 doffed her gloves and donned new gloves without performing hand hygiene and continued with providing wound treatment.-4:24 P.M., Nurse #3 doffed removed her gloves and donned new gloves without performing hand hygiene and continued with providing wound treatment. Nurse #3 removed a pen from her pant pocket below her gown with soiled gloves and wrote the date of the dressing on tape. -4:27 P.M., Nurse #3 doffed her gloves and donned new gloves without performing hand hygiene and continued to the conclusion of providing wound treatment to the Resident. During an interview on 8/27/25 at 4:36 P.M., Nurse #3 said that she should have performed handwashing after she removed her gloves and she did not. Nurse #3 also said that she should have used a clean pen to date the wound dressing, rather than use the pen (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that had been inside of her pant pocket. During an interview of 8/27/24 at 4:47 P.M., the Director of Nursing (DON) said that Nurse #3 should have sanitized her hands after removing her gloves and putting on new gloves. The DON also said Nurse #3 should have used a sanitary writing implement to date the wound dressing.