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	10/21/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on records reviewed and interviews for one of three sampled residents (Resident #1), who had an unwitnessed fall and an episode of emesis (vomiting) during the 11:00 P.M. to 07:00 A.M. shift, and then experienced a decline in condition, the Facility failed to ensure nursing notified the Provider in a timely manner, as required.Findings include: Review of the Facility's policy titled, Acute Condition: Significant Change, dated April 2015 indicated: - The nurse will notify the residents' attending physician or physician on call when there has been a significant change in the resident's condition. Resident #1 was admitted to the Facility in July 2024, diagnoses included diabetes, difficulty walking, sleep apnea and schizoaffective disorder. Review of the Facility's Investigation Report, dated 9/22/25, indicated that Resident #1 was found by Nursing staff on the floor of his/her room lying in emesis at approximately 2:00 A.M., was assessed by Nurse #1 and found to be at his/her baseline with no complaints of pain and was placed back into bed. The Report further indicated that Resident #1 had a decline in his/her condition in the morning when Nurse #1 assessed him/her and he/she was non-rousable but breathing. During a telephone interview on 10/21/25 at 1:30 P.M., Certified Nurse Aide (CNA) # 2 said on 9/22/25, around 6:00 A.M., Resident #1 had told her he/she was not feeling well, wasn't his/her usual self, was weak, and that she reported what Resident #1 said to the Nurse.During a telephone interview on 10/21/25 at 11:38 A.M., Nurse #1 said that on 9/22/25 around 2:00 A.M., CNA staff called her into Resident #1's room and he/she was on the floor by the bathroom lying on his/her side in emesis. Nurse #1 said she assessed Resident #1, found him/her at baseline, with no complaints of pain and he/she denied hitting his/her head. Nurse #1 said since the fall was unwitnessed, she started the Neurological Documentation Record per facility protocol. Nurse #1 said at 8:00 A.M., she re-assessed Resident #1, he/she was unrousable and breathing. Nurse #1 said she continued to monitor Resident #1 and said she notified the Nursing Supervisor around 9:00 A.M., who at that time did an assessment of Resident #1 and notified the Provider, who provided orders to send him/her to the Hospital Emergency Department (ED). Nurse #1 said she did not notify Resident #1's Provider or the On-Call Provider of his/her condition change in the morning or of the previous night's fall with emesis and she should have. Review of the Neurological Documentation Flow Sheet dated 9/22/25, indicated Resident #1 became lethargic and unrousable at approximately 8:00 A.M.Review of Resident #1's medical record indicated there was no documentation to support nursing notified the Provider timely on 9/22/25 of his/her fall and episode of vomiting [that had occurred around 2:00 A.M. during the overnight shift]. There was no documentation to support nursing notified the Provider after CNA #2 reported Resident #1 complaints of not feeling well and not feeling like him/herself to Nurse #1 around 6:00 A.M., or of the decline in his/her condition noted by Nurse #1 around 8:00 A.M., when the Provider was not notified until around 9:00 A.M., by the Nursing Supervisor. During a telephone interview on 10/21/25 at 11:13 A.M., the Nurse Practitioner (NP) said she was notified by nursing staff around 9:00 A.M., on 9/22/25 that Resident #1 had a fall during the overnight night shift, that he/she slipped on his/her own vomit and had a change in condition. The NP said she gave orders to send him/her to the Hospital Emergency Department. The NP said there is an On -Call Provider on overnight until 08:00 A.M., and that the nursing staff should have called the On- Call Provider. During an interview on 10/21/25 at 10:34 A.M., the Nursing Supervisor said she was notified by Nurse #1 at approximately 9:00 A.M. on 9/22/25 that Resident #1 had an episode of emesis with an unwitnessed fall during the night and had a decline in condition in the morning and said she (Nursing Supervisor) called the Provider and received an order to send him/her to the Hospital ED. During a telephone interview on 10/21/25 at 2:00 P.M., the Director of Nursing (DON) said there was no documentation to support that Nurse #1 notified the On-Call Provider during the overnight shift to report that Resident #1 had an unwitnessed fall, emesis and a decline in condition in a timely manner. The DON said that it is the facility's expectation that nursing staff assess for acute changes in the resident's condition, notify the resident's Provider, and the DON and in this case, it was not done. On 10/21/25, the Facility presented the Surveyor with a Plan of Correction with an effective date of 10/01/25, that addressed the areas of concern identified in this survey; the Plan of Correction provided is as follows: A. Resident #1 no longer resides at the facility. B. On 9/22/25, a Facility wide audit was initiated by the Nursing Administration on residents with acute condition changes to ensure Facility policy was followed. C. Starting on 9/22/25, audits were conducted daily by the DON/designee with a 30 day lookback period on documentation to ensure that the provider had been notified of any residents with changes in condition, and will be reviewed at the daily morning report until substantial compliance is met and