STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225305	A. Building B. Wing	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Mary Health Care Center	39 Queen Street Worcester, MA 01610

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for 5 of 5 sampled residents (Residents #1, #2, #3, #4 and #5), who were alert and able to made their needs known, the Facility failed to ensure they were treated in a dignified and respectful manner, when they all reported that Nurse #1 responded to their request for assistance with yelling, rudeness and disrespect. Findings include: Review of the Facility Resident Rights Policy, undated, indicated residents had the right to be treated with dignity and respect in full recognition of their individuality and to receive services with reasonable accommodations to individual needs and preferences. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 6/13/25, indicated that 5 residents (Residents #1, #2, #3, #4 and #5) reported that Nurse #1 withheld medications, used a curt or aggressive tone of voice, threw medications on the resident's table and/or yelled at them. Resident #1 was admitted to the Facility in June of 2023 and his/her diagnoses included Alzheimer's Disease, osteoarthritis and vertigo. Resident #1's Quarterly Minimum Data Set Assessment (MDS), dated [DATE] indicated his/her cognitive patterns were intact, with a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15 (13-15 suggest intact cognition, 8-12 suggests moderate impairment, and 0-7 suggests severe impairment). Resident #2 was admitted to the Facility in February of 2023 and his/her diagnoses included dementia and generalized anxiety disorder. Resident #2's Quarterly MDS, dated [DATE] indicated his/her cognitive patterns were intact, with a BIMS score of 15 out of a possible 15. Resident #3 was admitted to the Facility in April of 2025 and his/her diagnoses included dementia, major depressive disorder and anxiety disorder. (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #3's admission MDS, dated [DATE] indicated his/her cognitive patterns were moderately impaired, with a BIMS score of 10 out of a possible 15. Resident #4 was admitted to the Facility in August of 2022 and his/her diagnoses included hemiparesis and hemiplegia following subarachnoid hemorrhage and anxiety disorder. Resident #4's Quarterly MDS, dated [DATE] indicated his/her cognitive patterns were intact, with a BIMS score of 15 out of a possible 15. Resident #5 was admitted to the Facility in July of 2024 and his/her diagnoses included major depressive disorder and anxiety disorder. Resident #5's Quarterly MDS, dated [DATE] indicated his/her cognitive patterns were intact, with a BIMS score of 15 out of a possible 15. During in-person interviews on: - 6/23/25 at 11:20 A.M. with Resident #4, - 6/23/25 at 11:35 A. M with Resident #3, - 6/23/25 at 11:46 A. M with Resident #5, - 6/23/25 at 11:56 A. M with Resident #1, and - 6/23/25 at 1:55 P.M with Resident #2, they said the following: The residents' all said when they requested assistance from Nurse #1 during the 11:00 P.M. to 7:00 A.M., she yelled at them and was rude. Resident #1 said that when he/she asked Nurse #1 for things, Nurse #1's tone of voice in response was sharp, brusque and dismissive. Resident #2 said Nurse #1 was awful to deal with, yelled at him/her and always responded to requests for medication by stating it was not time. Resident #3 said he/she recalled an incident in which Nurse #1 screamed and yelled at him/her and was mean in response to his/her request for medications. Resident #4 said Nurse #1 hollered at him/her, spoke to him/her with disrespect and made him/her feel afraid to ask for things. Resident #4 said that Nurse #1 routinely yelled at another resident in the hallway for taking off their clothes, loud enough for him/her (Resident #4) to hear. Resident #3 and Resident #4 said that when Nurse #1 brought them their medications, she threw them or banged them on the bedside table, instead of placing them in their hand. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #5 said that he/she had an incident in which Nurse #1 interrupted two CNAs providing care to him/her following an episode of incontinence and that Nurse #1 lashed out at him/her, telling him/her that he/she needed to use the bed pan, and that Nurse #1 did so in an angry tone of voice. During an interview on 6/25/25 at 3:35 P.M. by telephone, Nurse #3 said that residents had spoke to him about Nurse #1 coming on too strong and raising her voice. Nurse #3 said although residents had not specifically told him that Nurse #1 was disrespectful or rude, he said she thought Nurse #1 was strong willed and didn't realize when she crossed the line in her interactions with residents. During an interview on 6/25/25 at 3:45 P.M. by telephone, Nurse #4 said that Residents #2 and #4 told her that Nurse #1 yelled and wasn't very approachable. During a telephone interview on 6/27/25 at 12:46 P.M., the Nurse Supervisor said that she only worked alongside Nurse #1 at 11:00 P.M., for the change of shift. The Nurse Supervisor said that routinely, Nurse #1 would arrive and would remove Resident #6 from the nurses' station where she (Nurse Supervisor) had positioned him/her for supervision and monitoring. The Nurse Supervisor said that as soon as Nurse #1 arrived, she would grab Resident #6's wheelchair and abruptly move it from the nurses station, stating you don't belong here, in a reprimanding, loud tone of voice. During an interview on 6/30/35 at 11:28 A.M. by telephone, Certified Nurse Aide (CNA) #5 said that she worked during the 11:00 P.M. to 7:00 A.M. shift with Nurse #1. CNA #5 said that Nurse #1 lacked compassion, was annoyed by any resident's request and spoke rudely and condescendingly to residents. During an interview on 7/02/25 at 12:00 P.M. Nurse #1 said that she did not yell at, speak rudely to or disrespect residents. Nurse #1 said she thought resident's complaints may have been influenced by her strict adherence to medication times. Nurse #1 said that she spoke in a loud tone of voice because her voice was low and resident's were hard of hearing. Although Nurse #1 said she was not disrespectful, her statement seems suspect given the consistent corroborating statements of residents and staff. On 6/23/25 the Facility was found to be in past non-compliance and provided the Surveyor with a plan of correction which addressed the area of concern as evidenced by: A. The Facility terminated Nurse #1 on 6/18/25. B. On 6/15/25, the Director of Social Services met with Residents #1, #2, #3, #4 and #5 to offer support and reassurance, and continue to meet with them as needed. C. On 6/15/25, the Director of Social Services and Clinical Manager conducted interviews of residents capable of being interviewed who were cared for by Nurse #1 to assess for other impacted residents. D. On 6/20/25 and on-going, the Facility Staff Development Coordinator initiated training of all staff on Resident Rights and mechanisms for reporting concerns. E. The Facility recognizes that all residents have the potential to be effected by the Rights Rights concern area identified, they will continue to offer support to residents and additional staff education as needed. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. On 6/19/25, the Facility Leadership initiated a Quality Improvement Project to improve staff knowledge regarding reporting and resident rights, which was presented during the QAPI meeting and will continue to be discussed until substantial compliance is met. G. The Administrator and/or Designee are responsible for overall compliance.