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	03/28/2024

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 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37086 Based on records reviewed and interviews for one of three sampled residents (Resident #1), whose comprehensive plan of care indicated he/she required the use of a Hoyer lift (mechanical mobility aid that supports a person's body weight to allow movement from one surface to another) with assistance of two staff members for all transfers, the Facility failed to ensure staff implemented and followed interventions in his/her care plan, when on 03/12/24, Certified Nurse Aide (CNA) #1 transferred Resident #1 from his/her wheelchair into bed with a Hoyer lift, without another staff member present to assist him. Resident #1 fell to the floor onto his/her knees then fell forward landing on his/her face. Resident #1 was transferred to the Hospital Emergency Department (ED) and diagnosed with a laceration, head injuries and fractures. Findings include: Review of the Facility's Policy, Care Planning and Assessment of Resident, with a reviewed date of 11/14/19, indicated the purpose of the assessment is to identify the resident's current health status, needs, and to develop an individualized interdisciplinary plan of care to address those needs and facilitate continuity of care. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS) dated 03/19/24, indicated that on 03/12/24 at approximately 9:00 P.M., Resident #1 was observed lying in bed with a bloody nose and a large purple hematoma on his/her forehead with a 0.5 centimeter (cm) laceration. The Report indicated that during a transfer from Resident #1's wheelchair to the bed, the mechanical sling came loose, and Resident #1 fell on his/her knees, falling face forward (on the floor). The Report indicated that he/she was transferred to the Hospital Emergency Department (ED) and was found to have a small acute subdural hematoma (a pool of blood between the brain and the skull), small acute subarachnoid hemorrhage (bleeding in the space between the brain and the tissue covering the brain), and bilateral [NAME] II fractures (a pyramid shaped fracture along the nasal bridge which causes separation of the midface from the skull base). Review of Resident #1's Hospital ED Report, dated 03/12/24, indicated Resident #1 sustained the following injuries from a fall at the Facility: -small subdural hematoma -small subarachnoid hemorrhage (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0656 Level of Harm - Actual harm Residents Affected - Few	-bilateral [NAME] II fracture with fracture line passing through the frontal nasal sutures (cranial suture between the frontal and nasal bones), bilateral nasal bones, lateral walls of maxillary sinus (part of nasal cavity), and inferior orbital rim (bone behind the lower eye lid) -extensive scalp edema in the frontal region (forehead), frontal scalp hematoma at the midline with overlying laceration Resident #1 was admitted to the Facility in December 2018, diagnoses included Alzheimer's Disease and unspecified (location of) osteoarthritis. Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 03/06/24, indicated he/she had long and short-term memory impairments, significant impairment for decision making ability, was dependent for chair/bed-to-chair transfers with the assistance of two or more staff members, and had sustained no falls in the previous quarter. Review of Resident #1's Falls Care Plan, with an edited date of 03/04/24, indicated he/she required a Hoyer lift with the assistance of two staff members for all transfers. Review of Resident #1's care Kardex (used by the CNAs to determine individual care needs) indicated he/she required a Hoyer lift with the assistance of two staff members for all transfers and was non-ambulatory. Review of the Facility Investigation, which included written statements provided by staff, indicated that at approximately 9:00 P.M. on 03/12/24, CNA #1 reported to Nurse #1 that Resident #1 was in bed with a bloody nose. The Investigation indicated Nurse #1 observed Resident #1 lying in bed with a bloody nose and a large purple hematoma on his/her forehead with a 0.5 cm laceration. The Investigation indicated that Nurse #1 applied a cold pack to Resident #1's forehead and pressure to stop the bleeding (nose) and notified the Nursing Supervisor who called 911 to transfer Resident #1 to the Hospital ED. The Investigation also indicated that on 03/12/24 at approximately 9:30 P.M., the Director of Nurses (DON) conducted a telephone interview with CNA #1 who said that during Resident #1's transfer (from the wheelchair to the bed), the mechanical lift pad became loose and Resident #1 fell on his/her knees, face forward. Furthermore, the Investigation indicated that CNA #1 said he had not known that Resident #1 was injured before he transferred him/her off the floor and put him/her in bed. Review of a Nurse Progress Note, dated 03/12/24 at 10:39 P.M., (written by Nurse #1), indicated that he was called to Resident #1's room (by CNA #1) at approximately 9:10 P.M. The Note indicated he observed him/her with a bloody nose and a forehead hematoma with a laceration. The Note indicated Nurse #1 called for a supervisor immediately, 911 was called and Resident #1 was transferred to the Hospital ED. (continued on next page)

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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 0656 Level of Harm - Actual harm Residents Affected - Few	During an interview on 03/27/24 at 3:13 P.M., (which included review of his written statement), Nurse #1 said that on 03/12/24 at approximately 9:00 P.M., CNA #1 told him that Resident #1 had a bloody nose. Nurse #1 said that he went to Resident #1's room and observed him/her lying in bed with blood coming out of both nostrils. Nurse #1 said he also observed a small cut on Resident #1's forehead along with a purple bruise that went over his/her eyes, down the front of his/her nose, and under his/her eyes. Nurse #1 said he applied pressure to Resident #1's nose but could not get the bleeding to stop. Nurse #1 said he also applied an ice pack to his/her forehead. Nurse #1 said that he noticed blood on the floor in Resident #1's room. Review of a Nurse Progress Note dated 03/12/24 at 10:29 P.M., (written by the Nursing Supervisor), indicated that once Resident #1 left the Facility, the Nursing Supervisor interviewed CNA #1. The Note indicated that CNA #1 told the Nursing Supervisor that when he transferred Resident #1 from the wheelchair to the bed, he/she fell forward onto the floor face down. During an interview on 03/27/24 at 3:32 P.M., the Nursing Supervisor (which included review of her written statement), said she interviewed CNA #1 and he told her that he used the Hoyer lift by himself, to transfer Resident #1 from the wheelchair to bed, and that while he was lifting him/her, Resident #1 fell to the floor face first. The Nursing Supervisor said that CNA #1 told her that he then put Resident #1's bed in the lowest position and moved him/her (did not specify how) from the floor back into the bed without any assistance and without getting a nurse to assess Resident #1 immediately following the fall. The Nursing Supervisor said that she observed smeared dried blood on Resident #1's floor, between the wall and his/her bed. Review of the CNA #1 written Witness Statement, dated 03/12/24, indicated that on 03/12/24 at 8:30 P.M., he transferred Resident #1 from the wheelchair to the bed using the Hoyer lift. The Statement indicated as he (CNA #1) lifted Resident #1, the Hoyer pad became loose and Resident #1 fell on to his/her knees and hit his/her head. The Statement indicated that CNA #1 did not think Resident #1 appeared injured and he transferred him/her into bed (from the floor). During telephone interviews on 03/28/24 at 8:29 A.M. and 3:49 P.M., CNA #1 said that Resident #1 was on his assignment for the 3:00 P.M. to 11:00 P.M. shift on 03/12/24. CNA #1 said he was familiar with Resident #1, had often taken care of him/her and knew he/she required the use of a Hoyer lift for all transfers. CNA #1 said that he usually gets another staff member to assist him with Resident #1 during transfers, but had not that night. CNA #1 said he transferred Resident #1 by himself that night, both before and after the fall. CNA #1 said he knew he was supposed to have another staff member with him for assistance with mechanical lift transfers, but said he had not done so. CNA #1 said he was putting Resident #1 to bed and as he transferred him/her from the wheelchair with the Hoyer lift, the straps to the Hoyer pad became loose and Resident #1 fell forward knees first, then hit his/her head. CNA #1 said he had only lifted Resident #1 a few inches off the wheelchair before he/she fell to the floor. CNA #1 said after the fall, he then used the Hoyer lift to transfer Resident #1 off the floor and put him/her back into bed. (continued on next page)

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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 0656 Level of Harm - Actual harm Residents Affected - Few	During an interview on 03/28/24 at 10:55 A.M., the Director of Nurses (DON) said that her investigation indicated that CNA #1 had not gotten assistance from another staff member to help transfer Resident #1 from the wheelchair to the bed and then from the floor to the bed (after the fall). The DON said that CNA #1 should have followed Resident #1's care plan and should have requested and obtained assistance from another staff member to transfer Resident #1. The DON said that all mechanical lift transfers required two person assists.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37086 Based on records reviewed and interviews for one of three sampled residents (Resident #1), who on 03/12/24, experienced a fall to the floor during a transfer with the Hoyer lift (mechanical mobility aid that supports a person's body weight to allow movement from one surface to another), the Facility failed to ensure he/she was provided with quality of care that met acceptable standards of practice, when after the fall despite noting that while Resident #1 was on the floor he/she was bleeding from his/her nose, Certified Nurse Aide (CNA) #1 transferred Resident #1 off the floor and put him/her in bed, before notifying nursing so Resident #1 could be assessed for injuries. Resident #1 was transferred that evening to the Hospital Emergency Department (ED) for an evaluation and was diagnosed with a laceration, head injuries and fractures. Findings include: Review of the Facility's policy, Fall Procedure, with a revision date of 09/08/21, indicated the objective was to provide appropriate intervention, evaluation, documentation, and care plan adjustment and in the event of a fall the Licensed Nurse will conduct a physical assessment of the resident. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS) dated 03/19/24, indicated that on 03/12/24 at approximately 9:00 P.M., Resident #1 was found with a bloody nose and a large purple hematoma on his/her forehead with a 0.5 centimeter (cm) laceration. The Report indicated that during a transfer from his/her wheelchair to the bed, the mechanical lift sling came loose, and Resident #1 fell on his/her knees, falling face forward (to the floor). The Report indicated that he/she was transferred to the Hospital Emergency Department (ED) and was found to have a small acute subdural hematoma (a pool of blood between the brain and the skull), small acute subarachnoid hemorrhage (bleeding in the space between the brain and the tissue covering the brain) and bilateral [NAME] II fractures (a pyramid shaped fracture along the nasal bridge which causes separation of the midface from the skull base). Resident #1 was admitted to the Facility in December 2018, diagnoses included Alzheimer's Disease and unspecified (location of) osteoarthritis. Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 03/06/24, indicated he/she had long and short-term memory impairments, significant impairment for decision making ability, was dependent for chair/bed-to-chair transfers with the assistance of two or more staff members, and had sustained no falls in the previous quarter. Review of Resident #1's Hospital ED Report, dated 03/12/24, indicated Resident #1 sustained the following injuries from a fall at the Facility: -small subdural hematoma -small subarachnoid hemorrhage -bilateral [NAME] II fracture with fracture line passing through the frontal nasal sutures, bilateral nasal bones, lateral walls of maxillary sinus, and inferior orbital rim. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-extensive scalp edema in the frontal region, frontal scalp hematoma at the midline with overlying laceration Review of a Nurse Progress Note, dated 03/12/24 at 10:39 P.M., (written by Nurse #1), indicated that he was called to Resident #1's room (by CNA #1) at approximately 9:10 P.M. because Resident #1 had a bloody nose. The Note indicated he (Nurse #1) observed Resident #1 with a bloody nose and a forehead hematoma with a laceration. The Note indicated Nurse #1 called for a supervisor immediately, 911 was called and Resident #1 was transferred to the Hospital ED. During an interview on 03/27/24 at 3:13 P.M., (which included review of his written statement), Nurse #1 said that on 03/12/24 at approximately 9:00 P.M., CNA #1 told him that Resident #1 had a bloody nose. Nurse #1 said that he went to Resident #1's room and observed him/her lying in bed with blood coming out of both nostrils. Nurse #1 said he also observed a small cut on Resident #1's forehead along with a purple bruise that went over his/her eyes, down the front of his/her nose, and under his/her eyes. Nurse #1 said that he also noticed blood on the floor in Resident #1's room. Nurse #1 said he asked CNA #1 what happened, but that CNA #1 did not respond. Review of a Nurse Progress Note dated 03/12/24 at 10:29 P.M., (written by the Nursing Supervisor), indicated that she was called to Resident #1's room at approximately 9:10 P.M. and she observed him/her lying in bed on his/her back with an active bloody nose and a moderate amount of fresh blood. The Note indicated that she also observed him/her to have a large purple hematoma to the center of his/her forehead and slight bruising around both of his/her eyes and that his/her nose appeared swollen and tender to touch. Further review of the Note indicated that once Resident #1 left the Facility, the Nursing Supervisor interviewed CNA #1. The Note indicated that CNA #1 told her that when he transferred Resident #1 from the wheelchair to the bed, he/she fell forward onto the floor face down. During an interview on 03/27/24 at 3:32 P.M., the Nursing Supervisor (which included review of her written statement), said on the evening of 03/12/24, that once Resident #1 was transferred to the Hospital ED, she started her investigation. The Nursing Supervisor said she interviewed CNA #1, and he told her that he used the Hoyer lift by himself, to transfer Resident #1 from the wheelchair to bed, and that while he was lifting him/her, he/she fell to the floor face first. The Nursing Supervisor said that CNA #1 told her that he then put Resident #1 back into bed without getting a nurse to assess Resident #1 immediately following the fall. The Nursing Supervisor said that she had observed smeared dried blood on Resident #1's floor, between the wall and his/her bed. Review of CNA #1 written Witness Statement, dated 03/12/24, indicated that at 8:30 P.M., he (CNA #1) transferred Resident #1 from the wheelchair to the bed using the Hoyer lift. The Statement indicated as he (CNA #1) lifted Resident #1, the Hoyer pad became loose and he/she fell on to his/her knees and hit his/her head. The Statement indicated that CNA #1 did not think Resident #1 appeared injured and he transferred (did not specify how) him/her into bed (from the floor). (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During telephone interviews on 03/28/24 at 8:29 A.M. and 3:49 P.M., CNA #1 said that Resident #1 was on his assignment for the 3:00 P.M. to 11:00 P.M. shift on 03/12/24. CNA #1 said he was familiar with Resident #1 and often took care of him/her. CNA #1 said he was putting Resident #1 to bed and as he transferred him/her from the wheelchair with the Hoyer lift, the straps to the Hoyer pad became loose and Resident #1 fell forward, knees first, then hit his/her head. CNA #1 said he had lifted Resident #1 a few inches off the wheelchair before he/she fell to the floor. CNA #1 said that he noticed Resident #1 was bleeding when he/she was on the floor, and said he transferred Resident #1 off the floor by himself and put him/her in bed because no other staff members were around. CNA #1 said he knew he was supposed to call the nurse immediately after a resident fell , and that he knew a resident should not be moved until the nurse assesses them. CNA #1 said he used the the Hoyer lift to transfer Resident #1 off the floor and put him/her into bed. CNA #1 said that he then cleaned the blood off Resident #1's floor before he went and notified Nurse #1 that Resident #1 had a bloody nose and had fallen. Review of the Facility Investigation, including written statements by staff, indicated that at approximately 9:00 P.M. on 03/12/24, CNA #1 reported to Nurse #1 that Resident #1 was in bed with a bloody nose. Nurse #1 observed Resident #1 lying in bed with a bloody nose and a large purple hematoma on his/her forehead with a 0.5 cm laceration. The Investigation indicated that Nurse #1 applied a cold pack to Resident #1's forehead and pressure to stop the bleeding (from his/her nose) and notified the Nursing Supervisor who called 911 to transfer Resident #1 to the Hospital ED. The Investigation also indicated that on 03/12/24 at approximately 9:30 P.M., the Director of Nurses (DON) conducted a telephone interview with CNA #1, who said that during Resident #1's transfer (from the wheelchair to the bed), the mechanical lift sling (pad) became loose, and Resident #1 fell on his/her knees, face forward. Furthermore, the investigation indicated CNA #1 said he did not know that Resident #1 was injured before he transferred him/her from the floor to the bed and when asked why he transferred Resident #1 off the floor before notifying a nurse, CNA #1 did not respond. However, the statement made by CNA #1 to the DON during the facility's investigation, that he did not know Resident #1 was injured before transferring him/her off the floor after the fall and putting him/her in bed, conflicted with what CNA #1 said during an interview with the surveyor, in which CNA #1 said he noticed Resident #1 was bleeding when he/she was on the floor and he cleaned the blood off Resident #1's floor before he went to notify the nurse. During an interview on 03/28/24 at 10:55 A.M., the Director of Nurses (DON) said that she was notified on 03/12/24 by the Nursing Supervisor that Resident #1 sustained injuries which included a bloody nose and bruise to the forehead and around his/her eyes. The DON said that she conducted a telephone interview with CNA #1 on 03/12/24 following the incident and said CNA #1 was tight lipped and told her that the Hoyer pad came loose and that was how Resident #1 fell to the floor. The DON said that her investigation indicated that CNA #1 did not get assistance from another staff member to transfer Resident #1 from the wheelchair to the bed and then from the floor to the bed. The DON said that CNA #1 should have requested assistance of another staff member to transfer Resident #1 and that staff were not supposed to transfer a resident off the floor who had fallen, until a nurse assessed him/her for injury.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37086 Based on records reviewed and interviews for one of three sampled residents (Resident #1), who required the use of a Hoyer lift (mechanical mobility aid that supports a person's body weight to allow movement from one surface to another) with assistance of two staff members for all transfers, the Facility failed to ensure he/she was provided with the necessary level of staff assistance to maintain his/her safety and prevent an incident/accident resulting in an injury, when on 03/12/24, while Certified Nurse Aide (CNA) #1 transferred Resident #1 from his/her wheelchair into bed without another staff member present to assist him. Resident #1 fell to the floor onto his/her knees then fell forward landing on his/her face. Resident #1 was transferred to the Hospital Emergency Department (ED) and diagnosed with a head laceration, head injuries and multiple facial fractures. Findings include: Review of the Facility's Policy, titled Mechanical Lifts, with a revision date of 1/25/22, indicated the following: -To provide safe transfers for residents. -With two assists, inspect and obtain appropriate sling (pad) for the type of mechanical lift. -Place a sling under the resident in bed and attach all four sling points. -Slowly raise resident off the bed, position over the seating device and slowly lower the resident to the seating device for proper positioning. -Follow the same procedure to return the resident to bed. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 03/19/24, indicated that on 03/12/24 at approximately 9:00 P.M., Resident #1 was observed lying in bed with a bloody nose and a large purple hematoma on his/her forehead with a 0.5 centimeter (cm) laceration. The Report indicated that during a transfer from Resident #1's wheelchair to the bed, the mechanical sling came loose, and Resident #1 fell on his/her knees, falling face forward (to the floor). The Report indicated that he/she was transferred to the Hospital Emergency Department (ED) and was found to have a small acute subdural hematoma (a pool of blood between the brain and the skull), small acute subarachnoid hemorrhage (bleeding in the space between the brain and the tissue covering the brain), and bilateral [NAME] II fractures (a pyramid shaped fracture along the nasal bridge which causes separation of the midface from the skull base). (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Facility Investigation, which included written statements provided by staff, indicated that at approximately 9:00 P.M. on 03/12/24, CNA #1 reported to Nurse #1 that Resident #1 was in bed with a bloody nose. The Investigation indicated Nurse #1 observed Resident #1 lying in bed with a bloody nose and a large purple hematoma on his/her forehead with a 0.5 cm laceration. The Investigation indicated that Nurse #1 applied a cold pack to Resident #1's forehead and pressure to stop the bleeding (from his/her nose) and notified the Nursing Supervisor, who called 911, to transfer Resident #1 to the Hospital ED. Review of Resident #1's Hospital ED Report, dated 03/12/24, indicated Resident #1 sustained the following injuries from a fall at the Facility: -small subdural hematoma -small subarachnoid hemorrhage -bilateral [NAME] II fracture with fracture line passing through the frontal nasal sutures (cranial suture between the frontal and nasal bones), bilateral nasal bones, lateral walls of maxillary sinus (part of nasal cavity), and inferior orbital rim (bone behind the lower eye lid) -extensive scalp edema in the frontal region (forehead), frontal scalp hematoma at the midline with overlying laceration Resident #1 was admitted to the Facility in December 2018, diagnoses included Alzheimer's Disease and unspecified (location of) osteoarthritis. Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 03/06/24, indicated he/she had long and short-term memory impairments, significant impairment for decision making ability, was dependent for chair/bed-to-chair transfers with the assistance of two or more staff members, and had sustained no falls in the previous quarter. Review of Resident #1's Falls Care Plan, with an edited date of 03/04/24, indicated he/she required a Hoyer lift with the assistance of two staff members for all transfers. Review of Resident #1's care Kardex (used by the CNAs to determine individual care needs) indicated he/she required a Hoyer lift with the assistance of two staff members for all transfers and he/she was non-ambulatory. Review of a Nurse Progress Note, dated 03/12/24 at 10:39 P.M., (written by Nurse #1), indicated that he was called to Resident #1's room (by CNA #1) at approximately 9:10 P.M. The Note indicated he observed Resident #1 with a bloody nose and a forehead hematoma with a laceration. The Note indicated Nurse #1 called for a supervisor immediately, 911 was called and Resident #1 was transferred to the Hospital ED. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 03/27/24 at 3:13 P.M., (which included review of his written statement), Nurse #1 said that on 03/12/24 at approximately 9:00 P.M., CNA #1 told him that Resident #1 had a bloody nose. Nurse #1 said that he went to Resident #1's room and observed him/her lying in bed with blood coming out of both nostrils. Nurse #1 said he also observed a small cut on Resident #1's forehead along with a purple bruise that went over his/her eyes, down the front of his/her nose, and under his/her eyes. Nurse #1 said he applied pressure to Resident #1's nose but could not get the bleeding to stop. Nurse #1 said he also applied an ice pack to his/her forehead. Nurse #1 said that he noticed blood on the floor in Resident #1's room. Review of a Nurse Progress Note dated 03/12/24 at 10:29 P.M., (written by the Nursing Supervisor), indicated that she was called to Resident #1's room at approximately 9:10 P.M. and she observed him/her lying in bed on his/her back with an active bloody nose and a moderate amount of fresh blood. The Note indicated that she also observed him/her to have a large purple hematoma to the center of his/her forehead and slight bruising around both of his/her eyes and that his/her nose appeared swollen and tender to touch. The Note indicated that Nurse #1 provided first aid and she (the Nursing Supervisor) called 911. Further review of the Note indicated that once Resident #1 left the Facility, the Nursing Supervisor interviewed CNA #1. During an interview on 03/27/24 at 3:32 P.M., the Nursing Supervisor (which included review of her written statement), said on the evening of 03/12/24 she received a call from Nurse #1 that there was an emergency on his unit. The Nursing Supervisor said she immediately went to Nurse #1's unit and then to Resident #1's room where she observed Resident #1 lying in bed with a bloody nose and a hematoma that covered most of his/her forehead with a small laceration in the center of the hematoma. The Nursing Supervisor said she also observed bruising under both Resident #1's eyes and swelling in the nasal area. The Nursing Supervisor said that once Resident #1 was transferred to the Hospital ED, she started her investigation. The Nursing Supervisor said she interviewed CNA #1 and he told her that he used the Hoyer lift by himself, to transfer Resident #1 from the wheelchair to bed, and that while he was lifting him/her, he/she fell to the floor face first. The Nursing Supervisor said that CNA #1 told her that he then put Resident #1's bed in the lowest position and moved him/her (did not specify how) from the floor into the bed without any assistance and without getting a nurse to assess Resident #1 immediately following the fall. The Nursing Supervisor said that she observed smeared dried blood on Resident #1's floor, between the wall and his/her bed. Review of the CNA #1 written Witness Statement, dated 03/12/24, indicated that on 03/12/24 at 8:30 P.M., he transferred Resident #1 from the wheelchair to the bed using the Hoyer lift. The Statement indicated as he (CNA #1) lifted Resident #1, the Hoyer pad became loose and Resident #1 fell on to his/her knees and hit his/her head. The Statement indicated that CNA #1 did not think Resident #1 appeared injured and he transferred him/her back into bed (from the floor). During telephone interviews on 03/28/24 at 8:29 A.M. and 3:49 P.M., CNA #1 said that Resident #1 was on his assignment for the 3:00 P.M. to 11:00 P.M. shift on 03/12/24. CNA #1 said he was familiar with Resident #1 and had often taken care of him/her. CNA #1 said he knew he was supposed to have someone else with him while doing the mechanical lift transfer, and said he usually got another staff member to assist when transferring Resident #1, but said he had not that night. (continued on next page)

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	03/28/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	CNA #1 said as he transferred Resident #1 from the wheelchair with the Hoyer lift, the straps to the Hoyer pad became loose and Resident #1 fell forward knees first, then hit his/her head. CNA #1 said he had only lifted Resident #1 a few inches off the wheelchair before he/she fell to the floor. CNA #1 said that he forgot to add to his written statement, which he provided to the Facility, that after the fall he used the Hoyer lift (by himself) to transfer Resident #1 up off the floor and put him/her into the bed. CNA #1 said that he noticed Resident #1 was bleeding when he/she was on the floor and said he transferred Resident #1 off of the floor by himself because no other staff members were around. CNA #1 said that he cleaned the blood off Resident #1's floor before he notified Nurse #1 that Resident #1 had fallen and had a bloody nose. During an interview on 03/28/24 at 10:55 A.M., the Director of Nurses (DON) said that she was notified on 03/12/24 by the Nursing Supervisor that Resident #1 sustained injuries which included a bloody nose and bruise to the forehead and around his/her eyes. The DON said that she conducted a telephone interview with CNA #1 on 03/12/24 following the incident and that CNA #1 was tight lipped and said that the Hoyer pad came loose and that was how Resident #1 fell to the floor. The DON said that her investigation indicated that CNA #1 had not gotten assistance from another staff member to help transfer Resident #1 from the wheelchair to the bed and then from the floor to the bed (after the fall). The DON said that CNA #1 should have requested assistance from another staff member to transfer Resident #1. The DON said that all mechanical lift transfers required two person assists.