

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225390	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Parsons Hill Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 Main Street Worcester, MA 01603	

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)
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41107</p> <p>Based on records reviewed and interviews, for three of three sampled residents (Resident #1, #2, and #3), as well as interviews with several non-sampled residents, the Facility failed to ensure the residents were treated in a dignified and respectful manner by a staff member, when all of the residents reported that Certified Nurse Aide (CNA) #1's behavior toward them was rude and aggressive, that CNA #1 yelled at and could be mean to them, and had stopped asking CNA #1 for assistance in order to avoid having any interaction with her.</p> <p>Findings include:</p> <p>Review of the Facility Policy titled Resident Rights, dated as revised July 2015, indicated that residents have the right to be treated with consideration, respect, and full recognition of their dignity and individuality.</p> <p>Review of the Report submitted Facility via the Health Care Facility Reporting System (HCFRS) on 02/20/25, indicated that during a resident council meeting on 02/13/25, residents expressed concerns about CNA #1's customer service.</p> <p>Review of the Facility's Internal Investigation Report, dated 03/07/25, indicated that following a resident council meeting held on 02/13/25, during which multiple residents raised concerns about a CNA (later identified as CNA #1), an internal investigation was conducted. The Report indicated that the Facility determined CNA #1's actions were inconsistent with the Facility's standards for care and professionalism, and that CNA #1 had been terminated.</p> <p>Review of the Resident Council Meeting minutes, dated 02/13/25, indicated that residents had voiced complaints about CNAs on the 3:00 P.M.-11:00 P.M. shift on the [NAME] Unit and said that they were not attentive to residents' needs and answering call lights.</p> <p>During an interview on 04/01/25 at 10:54 A.M., the Activities Director said during a Resident Council Meeting on 02/13/25, residents voiced general concerns about CNAs on the [NAME] Unit specifically on the 3:00-11:00 P.M. shift. The Activities Director said she notified administration, and that it was initially considered a customer service issue based on what residents reported.</p> <p>(continued on next page)</p>

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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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #1 was admitted to the Facility in November 2023, diagnoses included chronic obstructive pulmonary disease, major depressive disorder, post-traumatic stress disorder, and generalized anxiety disorder.</p> <p>Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 02/10/25 indicated he/she was cognitively intact and dependent on staff for care.</p> <p>During an interview on 04/01/25 at 11:58 A.M. (which included a review of his/her Written Interview documented by Director of Social Services (SS), dated 02/19/25), Resident #1 said CNA #1 was rude and treated residents as less than. Resident #1 said CNA #1 was aggressive when she threw sugar packets onto his/her bedside table and slammed his/her cup of milk down onto his/her bedside table hard enough that it spilled. Resident #1 said he/she just stopped talking to CNA #1 and avoided her.</p> <p>Resident #2 was admitted to the Facility in October 2023, diagnoses included non-traumatic intracerebral hemorrhage (brain bleed) and seizures.</p> <p>Review of Resident #2's Quarterly MDS Assessment, dated 01/16/25, indicated he/she was cognitively intact and required supervision from staff for all care.</p> <p>During an interview on 04/01/25 at 12:03 P.M. (which included a review of his/her Written Interview documented by Director of SS, dated 02/19/25), Resident #2 said CNA #1 yelled at him/her when he/she asked her for more milk. Resident #2 said CNA #1 also slammed his/her cup down onto his/her bedside table hard enough that liquid spilled onto his/her computer, and she (CNA #1) would not help him/her clean it up. Resident #2 said CNA #1 was mean and very short with him/her so he/she would ask other CNAs for help in order to avoid her.</p> <p>Resident #3 was admitted to the Facility in January 2023, diagnoses included anoxic brain injury (due to lack of oxygen) and anxiety disorder.</p> <p>Review of Resident #3's Quarterly MDS Assessment, dated 01/16/25, indicated he/she was cognitively intact and dependent on staff for all care.</p> <p>During an interview on 04/01/25 at 12:11 P.M. (which included a review of his/her Written Interview documented by Director of SS, dated 02/19/25), Resident #3 said CNA #1 yelled a lot and was rude to residents. Resident #3 said CNA #1 was a bitch and made him/her wait for care.</p> <p>During an interview on 04/01/25 at 12:57 P.M. (which included a review of his/her Written Interview documented by Director of SS, dated 02/19/25), Resident #4 said he/she didn't like the way CNA #1 treated him/her, and that she was disrespectful and angry all of the time and did not want to help him/her.</p> <p>During an interview on 04/01/25 at 1:11 P.M. (which included a review of his/her Written Interview documented by Director of SS, dated 02/19/25), Resident #5 said CNA #1 is like a Pitbull, she is very unfriendly and has a bad attitude. Resident #5 said he/she stopped asking CNA #1 for help because she was so rude and demeaning.</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/01/25 at 1:26 P.M. (which included a review of his/her Written Interview documented by Director of SS, dated 02/19/25), Resident #6 said CNA #1 yelled at him/her every time he/she had to go to the bathroom and yelled that she did not give out bedpans. Resident #6 said CNA #1 was mean and angry, so he/she was afraid to ask her for help sometimes</p> <p>During an interview on 04/01/25 at 2:29 P.M. (which included a review of his/her Written Interview documented by Director of SS, dated 02/19/25), Resident #7 said CNA #1 was moody, grumpy, and yelled that he/she (Resident #7) could not have a snack because it was not time yet. Resident #7 said he/she did not want to ask CNA #1 for anything, so he/she would avoid her at all cost.</p> <p>Review of Resident #8's Written Interview (documented by the Director of SS, dated 02/19/25), indicated that Resident #8 said CNA #1 had a very negative attitude and if he/she asked her to push his/her wheelchair, she (CNA #1) would tell him/her (Resident #8) No! Resident #8 was not available to be interviewed by the Surveyor.</p> <p>During an interview on 04/01/25 at 12:57 P.M., Resident #9 said he/she was the Resident Council President and during the Resident Council Meeting held on 02/13/25, several residents voiced concerns about the CNAs on the [NAME] Unit that worked the 3:00-11:00 P.M. shift. Resident #9 said the residents said one of the CNAs (later identified as CNA #1) was mean, rude, complained about the residents, and would not provide care when asked.</p> <p>During an interview on 04/01/25 at 11:37 A.M., the Director of SS said that the Administrator asked her to interview residents on the [NAME] Unit about their interactions with CNA #1. The Director of SS said she received several complaints about CNA #1 and brought the interviews back to the Administrator.</p> <p>During an interview on 04/01/25 at 3:35 P.M., CNA #4 said CNA #1 was rough, abrupt, and yelled for residents to stop ringing their call lights.</p> <p>During a telephone interview on 04/04/25 at 2:27 P.M., Nurse #2 said CNA #1 spoke rudely to residents and that she (Nurse #1) had redirected her (CNA #1) several times. Nurse #2 said CNA #1 raised her voice, was abrasive, and did not want to do what residents asked her to do.</p> <p>During an interview on 04/01/25 at 1:49 P.M., the Assistant Director of Nurses (ADON) said that when the Activities Director brought the Resident Council's concerns to administration, it was considered a customer service concern but then determined to be a reportable incident after the Director of SS conducted individual resident interviews specific to CNA #1's behavior.</p> <p>During an interview on 04/01/25 at 3:43 P.M., the Administrator said that the Activities Director told her that during a Resident Council meeting residents complained that 3:00 P.M.-11:00 P.M. CNAs on the [NAME] Unit were being rude. The Administrator said the complaints involving the CNAs were initially determined to be customer service related, but later identified CNA #1 specifically as a concern, so she had the Director of SS interview [NAME] residents specific to CNA #1's behavior. The Administrator said based on the results of the resident interviews, she determined that this was an abuse allegation. The Administrator said that based on the Facility's investigation, and CNA #1's abusive behavior, she terminated CNA #1's employment at the Facility.</p>		