STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225390	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parsons Hill Rehabilitation & Health Care Center	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)
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 records reviewed and interviews, for one of three sampled residents (Resident #1), whose treatment orders included daily wound care, the facility failed to ensure they maintained a complete and accurate medical record, when nursing documentation related to his/her wound care treatments on multiple days in the month of June 2026, was found to be incomplete and/or inaccurate.Findings include:Review of the Facility policy titled, Nursing Documentation, dated February 2016, indicated the following:-The licensed nursing personnel documents information related to the resident's condition and care provided in the resident's medical record.-Treatments: The type and resident/patient response.Resident #1 was admitted to the Facility March 2026, with diagnoses including but not limited to hypothermia (low body temperature), superficial frostbite of hand and foot, and severe sepsis with septic shock (life threatening infection that leads to low blood pressure and acute organ damage).Review of Resident #1's Minimum Data Set (MDS) admission Assessment, dated 04/06/26, indicated he/she was dependent on staff assistance for bathing, dressing, transfers and mobility, had open lesions and had the application of nonsurgical dressings.Review of Resident #1's Physician's orders for the Month of June 2026 indicated he/she had treatment orders related to wound care for the following:-Treatment Order: Location: Right toes 1-3, Vashe (or similar antibacterial wound cleanser), Alginate (absorbent wound dressing) and DPD (dry protective dressing). Change every day shift. Put Lambs wool in between toes.-Treatment Order: Location: Left toes 1-5, Vashe (or similar antibacterial wound cleanser), Iodosorb (antimicrobial gel) and DPD. Change daily on day shift.-Treatment Order: Location: Right second finger, Vashe (or similar antibacterial wound cleanser), Iodasorb and DPD. Change daily on day shift.1. Review of Resident #1's Treatment Administration Record (TAR) for the month of June 2026, indicated for the following dates there was no nursing documentation related to the description or characteristics of the wounds and/or nursing observations or findings related to the completion of these treatments. -6/12/26, 06/15/26 and 06/17/26-day shift: Left toes 1-5, Vashe (or similar antibacterial wound cleanser), Iodosorb and DPD. -6/12/26, 06/15/26 and 06/17/26-day shift: Right second finger, Vashe (or similar antibacterial wound cleanser).Review of Resident #1's Nurses Notes, dated 06/12/26 through 06/17/26, indicated there was no nursing documentation related to his/her wounds specific to the dressing changes that had been completed on 6/12/26, 06/15/26 and 06/17/26 as ordered by the Physician.During an interview on 06/30/26 at 4:10 P.M., Nurse #1 said that Resident #1 (who was on her assignment on 06/12/26, 06/15/26 and 06/17/26, day shift) had refused to have his/her dressings changed. Nurse #1 said that she should have documented Resident #1's refusal but said that she forgot.During a telephone interview on 07/01/26 at 8:00 A.M., the Facility Wound Nurse said that on 06/15/26 she had accompanied the Wound Care Consultant for wound rounds and had documented Resident #1's wound assessment. The Wound Care Nurse said that after Resident #1's wound assessment was completed a temporary dressing was applied. The Wound Care Nurse said she did not administer the prescribed treatment order to Resident #1 on 06/15/26 and that it was the responsibility of his/her assigned unit nurse.During an interview on 06/30/26 at 3:30 P.M., the Director of Nursing said that she expected the nurses to perform dressing changes as ordered by 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician, document any refusals and notify the Provider of the refusal, but that this had not been done on 06/12/26, 06/15/26 and 06/17/26.2. Further review of Resident #1's Treatment Administration Record (TAR) for the month of June 2026, indicated that for the following dates, although the wound care treatment was signed off on by nursing as having been completed, per staff member interview (with Nurse #4, whose initials were on the TAR) the treatments had actually not been completed and had been signed off on in the TAR in error. -06/17/26: Right toes 1-3, Vashe (or similar antibacterial wound cleanser), Alginate and DPD (dry protective dressing). Documented as completed by Nurse #4.-06/18/26: Right toes 1-3, Vashe (or similar antibacterial wound cleanser), Alginate and DPD (dry protective dressing). Documented as completed by Nurse #4.During a telephone interview on 07/01/26, Nurse #4 said that she worked the 3:00P.M. to 11:00P.M. and 11:00 P.M. to 7:00 A.M. shifts on 06/17/26 and 06/18/26. Nurse #4 said she had never changed Resident #1's dressing on his right toes and did not know why the electronic medical record indicated that she had performed the dressing changes on 06/17/26 and 06/18/26. During a telephone interview on 07/02/26 at 12:00 P.M., the Director of Nurses (DON) said that she had called Nurse #4 and confirmed that she had not changed Resident #1's right foot dressing. The DON said Nurse #4's documentation was supposed to be for monitoring the dressing and not for performing the dressing change but that there was a problem with the electronic medical record. The DON said there was no additional documentation in the medical record to support that Resident #1 's right toe dressing change had been completed on 06/17/26 and 06/18/26, by nursing.