

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 04/29/2026
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)		
F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. Based on record review, and interview, the facility failed to ensure four Residents (#7, #14, #1, and #71) out of a total sample of 29 residents were seen by a Physician at the required regulatory frequency for Physician visits. Specifically, the facility failed to ensure that Residents #7, #14, #1, and #71 were seen by a Physician for alternating visits with the Nurse Practitioner (NP) every 60 days as required, after the Residents were in the facility for 90 days. Findings include: 1. Resident #7 was admitted to the facility in February 2021 with diagnoses including Diabetes Mellitus II with Hyperglycemia, Hypo-Osmolality, Hypernatremia, and Major Depressive Disorder. Review of Resident #7's clinical record on 4/28/26 did not provide any evidence that Resident #7 had been seen by an Attending Physician since January 2025. 2. Resident #14 was admitted to the facility in August 2014 with diagnoses including Paranoid Schizophrenia and Major Depressive Disorder. Review of Resident #14's clinical record on 4/28/26 did not provide any evidence that Resident #14 had been seen by an Attending Physician since December 2024. During an interview on 4/28/26 at 12:15 P.M., the Director of Nursing (DON) said Physician progress notes were documented in the electronic medical record (EMR) under the Practitioner tab. The surveyor and the DON reviewed Resident #7's and Resident #14's electronic medical records and the DON said that there were no Physician progress notes documented in Resident #7's or Resident #14's EMR. The DON also said that she was unsure of when either of the Residents had been seen by the Attending Physician. During a follow-up interview on 4/28/26 at 1:04 P.M., the DON said that all residents should be seen by an Attending Physician every sixty days. The DON said that Resident #7 was last seen by an Attending Physician in January 2025, and Resident #14 was last seen by an Attending Physician in December 2024. The DON did not provide any evidence that Resident #7 or Resident #14 had been seen by an Attending Physician as required. 3. Resident #1 was admitted to the facility in March 2022 with diagnoses including Type 2 Diabetes Mellitus, Undifferentiated Schizophrenia, Chronic Kidney Disease Stage 3A, and Dysphagia. Review of Resident #1's medical record on 4/28/26 did not provide any evidence that Resident #1 had (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 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	been seen by an Attending Physician since May 2025. 4. Resident #71 was admitted to the facility in January 2020 with diagnoses including Idiopathic Aseptic Necrosis of Left Femur, Major Depressive Disorder, Anxiety Disorder, and Elevated [NAME] Blood Cell Count. Review of Resident #71's medical record on 4/28/26 did not provide any evidence that Resident #71 had been seen by an attending physician since May 2025. During an interview on 4/29/26 at 7:50 A.M., the Director of Nursing (DON) said that Physician progress notes were documented under the Practitioner tab in the electronic health records for Residents #1 and #71. The DON said that she reviewed Resident #1 and #71's record and there was no evidence of Physician progress notes. The DON said that Residents #1 and #71 should have Physician visits every thirty to ninety days. The DON said Physician visits were important to ensure that Resident #1 and #71's plan of care was being followed and implemented as ordered. During an interview on 4/29/26 at 12:30 P.M., the Clinical Nurse Specialist (CNS) said that Residents #1 and #71 should have had a Physician visit every ninety days. The CNS said that it was important for the Physician to see Residents #1 and #71 to ensure that treatment and care are being followed as ordered for the Residents.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review, and interview, the facility failed to ensure that one Resident (#3) of five applicable residents sampled for unnecessary medications, out of a total sample of 29 residents, was free from unnecessary psychotropic (medication that affect how the brain works and causes changes in mood, awareness, thoughts, feelings, perception and behaviors) medications. Specifically, for Resident #3, the facility failed to monitor for potential side effects and evaluate the Resident's response to Seroquel (Quetiapine - antipsychotic medication), Klonopin (Clonazepam - benzodiazepam medication), Ativan (Lorazepam - benzodiazepam medication), and Zoloft (Sertraline - antidepressant medication) medications, placing the Resident at risk for unidentified medication side effects and/or complications. Findings include: Review of the facility policy titled Psychotropic Medication, dated April 2015, included but was not limited to: *Each resident's drug regimen will be free from unnecessary drugs. Administration of psychoactive medications will focus on the individual needs of the resident and will be prescribed only when necessary and clinically indicated to treat specific conditions and symptoms as diagnosed and documented. -Obtain Physician order for each psychoactive medication. Ensure that supportive diagnosis and target behaviors are documented and clearly identify the use of the medication is necessary and warranted. -Monitor target behaviors daily for Antipsychotic, Antidepressants, and Anxiolytics using a behavior monitoring tool. -Monitor the resident's response to the medication and for any potential adverse consequences of the medication. -Care plan the psychoactive medication use, supportive diagnosis, goals of therapy, target behaviors and pharmacological and non-pharmacological approaches, inclusive, but not limited to behavioral interventions. -Review the care plan with interdisciplinary team (IDT) when a resident is admitted on psychoactive medications, quarterly, annually and as needed for changes in resident status and revise as necessary. -Review should include verification that adequate indications for use of the psychotropic medication exist, the medications are not being used for extended duration, and residents are free of duplicate therapy and being monitored for adverse consequences, per current professional standards of practice and in accordance with Federal and State guidelines. Review of the facility policy titled Nursing Documentation, dated February 2016, included but was not limited to: *The licensed nursing personnel documents information related to the resident's condition and care provided in the resident's medical record. -Document all untoward reactions related to medications, treatment, therapy. Resident #3 was admitted to the facility in March 2025 with diagnoses including Bipolar Disorder, Depression, Agoraphobia with Panic Disorder, and borderline personality disorder. Review of the Minimum Data Set (MDS) Assessment, dated 3/3/26, indicated Resident #3:-was cognitively intact as evidenced by a Brief Interview of Mental Status (BIMS) score of 15 out of a possible score of 15. -was understood by others and understand others.-received an antipsychotic medication and the antipsychotic was administered on a routine basis. Review of Resident #3's April 2026 Physician orders indicated:-Ativan (Lorazepam) Oral Tablet 0.5 milligrams (mg). Give 1 tablet by mouth every 24 hours as needed for Anxiety for 30 days, initiated 4/23/26.-Clonazepam Oral Tablet 1 mg. Give 1 mg tablet by mouth three times a day for Anxiety, initiated 12/12/25-Clonidine Hydrochloride (HCl) Oral Tablet 0.1 mg. Give 1 mg tablet by mouth at bedtime for Anxiety, initiated 3/10/25-Hydroxyzine HCl Oral Tablet 25 mg. Give 1 tablet by mouth three times a day for Anxiety related to Bipolar Disorder, Unspecified, initiated 2/9/2-Seroquel (Quetiapine Fumarate) Oral Tablet 100 mg. Give 1 tablet by mouth one time a day for mood related to Bipolar Disorder, Unspecified Borderline Personality Disorder, initiated 3/10/25-Seroquel Oral Tablet 400 mg. Give 400 mg by mouth (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at bedtime for mood related to Bipolar Disorder, Unspecified, initiated 3/10/25-Zoloft (Sertraline HCl) Oral Tablet 100 mg. Give 200 mg by mouth one time a day for depression, initiated 3/10/25 Review of Resident #3's medical record failed to indicate Physician orders or nursing interventions to monitor for potential side effects for Ativan, Clonazepam, Clonidine, Hydroxyzine, Seroquel and Zoloft medication use. During an interview on 4/28/26 at 9:30 A.M., Nurse #2 said that Nurses administering psychotropic medications to residents should monitor side effects which include anxiety and depression symptoms such as crying, lack of energy, sleeping too much and refusing to eat. The surveyor and Nurse #2 reviewed Resident #3's medical record and Nurse #2 said that there were no Physician orders or interventions to monitor and document psychotropic medication side effects for Resident #3. Nurse #2 said that it was important that medication side effects were monitored and documented to ensure treatment adherence and prompt intervention. During an interview on 4/28/26 at 10:15 A.M., the Director of Nursing (DON) said her expectation for nursing staff administering psychotropic medications was that nursing staff should monitor and document side effects. The DON said that monitoring for medication side effects ensures that the medication was effective and any side effects could be communicated to the Physician for prompt intervention. The DON also said that Resident #3 should have had a Physician order, care plan and interventions addressing the need for care and services related to psychotropic medication use, but there were none.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview, and record review, the facility failed to provide care and services consistent with professional standards of practice for one Resident (#147), of one applicable resident receiving dialysis (process that filters wastes, salts and fluid from your blood when the kidneys are unable to work adequately) services, out of a total sample of 29 residents. Specifically, for Resident #147, the facility failed to ensure:-medications were administered timely when the Resident attended regularly scheduled dialysis treatments. -that the facility staff administered the Mircera Injection Solution Prefilled Syringe Medication (a long-acting medication used to treat anemia) as ordered and notified the Physician when the medication was unavailable from the pharmacy, placing the Resident at risk for low blood count.-that the facility staff administered the Romiplostim (used to increase platelet counts to reduce the risk of bleeding) as ordered and notified the Physician when the medication was unavailable from the pharmacy, placing the Resident at risk for low platelet count.-that Sevelamer (medication to lower phosphorus levels in the blood) medication was administered as ordered by the Physician with meals, causing the Resident to miss the scheduled Sevelamer doses at breakfast on Tuesdays, Thursdays, and Saturdays.-that the facility staff accurately monitored the total daily fluid intake, placing him/her at risk for complications related to fluid overload. Findings include:Review of the facility policy titled, Hemodialysis, revised April 2015, indicated:-If resident is placed on fluid restriction, monitor intake. Resident #147 was admitted to the facility in April 2026 with diagnoses including cirrhosis of liver, End Stage Renal Disease (ESRD), Thrombocytopenia, Diabetic Retinopathy and Major Depressive Disorder.Review of Resident #147's April 2026 Physician orders indicated:-Hemodialysis every Tuesday, Thursday and Saturday at 5:30 A.M.-Micera Injective Solution Prefilled Syringe, inject 225 micrograms (mcg) subcutaneously in the morning every Monday, and Friday related to Anemia, start date 4/17/26.-Romiplostim Subcutaneous Solution reconstituted 250 mcg, inject 0.5 milliliters (ml) in the morning every Monday related to Thrombocytopenia, start date 4/20/26.-Insulin Lispro Injection Solution 100 Unit/ml, inject 5 units subcutaneously with meals related to Type 2 Diabetes, start date 4/14/26.-Sevelamer Carbonate Oral Tablet 800 mg, give 4 tablets by mouth with meals related to End Stage Renal Failure, start date 4/14/26.-Fluid Restriction 1500 ml, start date 4/14/26. Review of Resident #147's April 2026 Medication Administration Record (MAR), indicated:>Micera Injective Solution Prefilled Syringe, inject 225 mcg subcutaneously in the morning every Monday, and Friday related to Anemia, start date 4/17/26. At 10:00 A.M., the Micera medication was documented as (9) - indicating see progress notes on the following dates:-Friday, 4/17/26.-Monday, 4/20/26.-Friday, 4/24/26.>Romiplostim Subcutaneous Solution reconstituted 250 mcg, inject 0.5 milliliters (ml) in the morning every Monday related to Thrombocytopenia, start date 4/20/26.At 10:00 A.M., the Romiplostim medication was documented as (9) - indicating see progress notes on 4/20/26.>Insulin Lispro Injection Solution 100 Unit/ml, inject 5 units subcutaneously with meals related to Type 2 Diabetes, start date 4/14/26.At 8:00 A.M., the Insulin medication was documented as (3) - indicating Resident #147 was not available on the following dates:-Thursday 4/16/26.-Tuesday, 4/21/26.-Saturday, 4/25/26.>Sevelamer Carbonate Oral Tablet 800 mg, give 4 tablets by mouth with meals related to End Stage Renal Failure, start date 4/14/26.At 8:00 A.M., the Sevelamer medication was documented as (3) - indicating Resident #147 was not available on the following dates:-Tuesday, 4/21/26.-Saturday, 4/25/26.-Monday, 4/27/26.Further Review of Resident #147's April 2026 MAR indicated:-Fluid Restriction 1500 ml.-Total Fluid Intake every shift.Review of the MAR and the 24-hour total fluid intake for 4/13/26 to 4/26/26 indicated:-4/13/26: MAR - 480 ml/ 24-HR total - 1800 ml -4/14/26: 700 (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ml/ 840 ml/4/15/26: 1080 ml/ 1200 ml/4/16/26: 880 ml/ 120 ml/4/17/26: 310 ml/ (no documentation) 4/18/26: 820 ml/ 120 ml/4/19/26: 1140 ml/ 480 ml/4/20/26: 600 ml/ 240 ml/4/21/26: 1320 ml/ 1200 ml/4/22/26: 1880 ml/ 680 ml/4/23/26: 840 ml/ 600 ml/4/24/26: 1320 ml/1200 ml/4/25/26: 860 ml/ 1200 ml/4/26/26: 1610 ml/960 ml Review of Resident #147's April 2026 Order Administration Notes in the progress notes indicated:-4/17/26,11:04 A.M., Micera medication - not available.-4/20/26, 11:34 A.M., Micera medication - pending delivery.-4/20/26, 11:34 A.M., Romiplostim subcutaneous medication - pending delivery.-4/24/26, 3:38 P.M., Micera medication - will follow-up. During an interview on 4/26/26 at 8:15 A.M., Nurse #5 said Resident #147 leave the facility for dialysis on Tuesdays, Thursdays, and Saturdays around 5:30 A.M. and return to the facility around 10:30 A.M. Nurse #5 said no medications from the facility were sent to dialysis with Resident #147, and the medications scheduled to be administered in the morning at 8:00 A.M., and 10:00 A.M., when the Resident was out at dialysis, would be administered when he/she returned from dialysis treatment between 10:15 A.M. to 10:30 A.M. Nurse #5 said the Resident's MAR should reflect the times that the Resident's medications were administered and currently the MAR was not accurate relative to the medication administration times. Nurse #5 said she would document the scheduled 8:00 A.M., medication as a (3) to indicate that the Resident was not available for the days when the Resident was out to dialysis. Nurse #5 said she had documented that the Micera medication was pending delivery from the pharmacy and not available but had not notified the Physician about the medications that were not available, but she should have. During an interview on 4/27/26 at 10:08 A.M., the Director of Nursing (DON) said Resident #147 started dialysis treatments after admission to the facility, and that his/her medication administration times should have been adjusted based on his/her dialysis schedule. The DON further said she would have to investigate the Sevelamer, Micera and Romiplostim medications administration. On 4/27/26 at 10:35 A.M., the surveyor and the Assistant Director of Nursing (ADON) reviewed Resident #147's April 2026 fluid intake documented on the MAR shift totals and the 24-hour fluid total intake. The ADON said the documented total fluid intake per shift from 4/13/26 to 4/26/26 was calculated inaccurately. The ADON said that accuracy of monitoring and recording of fluid restrictions was important so that residents are provided with what is ordered by the Physician. The ADON said the 24-hour intake totals of Resident #147's fluid intake did not match every shift fluid intake documented by the Nurses. During a follow-up interview on 6/25/25 at 11:23 A.M., the DON said she was unsure if the Provider was made aware that morning medications scheduled for 8:00 A.M. and 10:00 A.M. on dialysis days were given after the Resident's return from dialysis prior to the surveyor interviews or that the Sevelamer medication (scheduled for 8:00 A.M. with breakfast) was not being administered as ordered for the breakfast meal on the days (Tuesday, Thursday and Saturday) Resident #147 was at dialysis. During a follow-up interview on 4/27/26 at 3:15 P.M., the Regional Nurse said the facility policy should have been followed relative to dialysis and medication timing for Resident #147. The Regional Nurse said the facility should have coordinated with the Resident's dialysis clinic relative to his/her medications and should have adjusted the medication administration times on dialysis days. The Regional Nurse further said the Physician should have been notified when the medications were held and were not available for administration, but they had not.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, interviews, and record review, the facility failed to maintain accurate records of controlled substances (drugs or chemicals that the government regulates for its manufacture, possession, and use, that are classified into schedules based on their potential for abuse) for one Controlled Substance Book on the Greendale Unit, out of three controlled substance books reviewed. Specifically, for the Greendale Unit, the facility failed to maintain a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation in the Controlled Substance Book (Narcotic Book). Findings include: Review of nurse in-service titled How to do a Narcotic Count, undated, included: -As soon as the count is completed, both nurses should sign as count done. At this point the narcotic keys are transferred to oncoming nurse Review of nurse in-service titled Controlled Substance Book Documentation, undated, included: -The narcotic count should not be signed off in advance-Count should be performed at the beginning and end of your work shift-This count requires both nurses to be present at the med (medication) cart with the narcotic book opened to the index page and the narcotic drawer opened-At the end of the narcotic count, both nurses are then to sign the signature entries. Document the date, time and answer if count was correct On 4/27/26 at 9:45 A.M., the surveyor and Nurse #4 reviewed the Controlled Substance Book for the Greendale Unit. Review of the signature log in the back of the book failed to provide evidence of two licensed nurses signing to verify the accuracy and reconciliation of the controlled medication count at the change of each shift on the following dates and times: -4/26/26 at 7:00 A.M.-4/26/26 at 3:00 P.M.-4/26/26 at 11:00 P.M.-4/27/26 at 7:00 A.M. During an interview on 4/27/26 at 9:58 A.M., Nurse #4 said she did conduct the controlled medication count at 7:00 A.M. on 4/27/26 for the Greendale medication cart with the off-going Nurse. Nurse #4 said the controlled medication count was accurate, but she must have forgotten to sign her name in the log at the back of the Narcotic Book as required. During an interview on 4/27/26 at 10:57 A.M., Nurse #3 said she had worked a double shift on the Greendale Unit on 4/26/26 from 7:00 A.M. until 11:00 P.M. and had possession of the medication cart keys during that time. Nurse #3 said she did conduct a count of the controlled medication with the off-going licensed Nurse on 4/26/26 at 7:00 A.M. and then again on 4/26/26 at 11:00 P.M. with the oncoming licensed Nurse. Nurse #3 said the controlled medication count was accurate during both counts, but she must have forgotten to sign her name in the log at the back of the Narcotic book as required. During an interview on 4/27/26 at 11:00 A.M., the Director of Nursing (DON) said there was an expectation that the count of all controlled medications stored in the medication cart would occur at the change of each shift, by the licensed Nurse coming on duty with the licensed Nurse going off duty. The surveyor and the DON reviewed the back of the Controlled Substance Book on the Greendale medication cart and the DON said that there were no signatures indicating that a count of the controlled medications stored in the Greendale medication cart was conducted by two Nurses on the following dates and times: -4/26/26 at 7:00 A.M.-4/26/26 at 3:00 P.M.-4/26/26 at 11:00 P.M.-4/27/26 at 7:00 A.M. The DON said the licensed Nurses should have conducted the controlled medication count and then signed the back of the Controlled Medication Book together as required, but they had not done so.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews, the facility failed to ensure all drugs and biologicals were stored in accordance with accepted professional standards of practice, as required, for one (Greendale Unit) medication cart, out of three medication carts reviewed. Specifically, for the Greendale Unit medication cart, the facility failed to properly secure medications and ensure the medication cart was sanitary and free of debris. Findings include: Review of facility policy titled Medication Storage Room/Medication Cart Policy, dated February 2018, included: -All licensed personnel are responsible for ensuring the cleanliness of the medication cart/med room at all times and at the end of the shift. -Medications are stored primarily in a locked mobile medication cart which is accessible only to licensed nursing personnel. -The medication cart is to be kept locked at all time(s) when not in use by the nurse. -The medication cart is to be locked when stored in the medication room or some other location. -Medication carts will be cleaned at least weekly and daily as needed. On 4/27/26 at 9:45 A.M., the surveyor observed an unlocked and unattended medication cart in the Greendale Unit hallway. The surveyor observed a resident in a wheelchair pass in close proximity to the front of the medication cart. The surveyor observed the top drawer of the medication cart with medications stored was easily accessible to unauthorized persons. The surveyor remained at the medication cart until Nurse #4 returned. During an interview at the time, Nurse #4 said she had not noticed the surveyor standing by her medication cart. The surveyor and Nurse #4 reviewed the medication cart and removed over 25 assorted loose pills and paper debris from the bottom of the resident specific medication card drawer. Nurse #4 said she left the medication cart to go into an adjacent room to give a resident their medication. Nurse #4 said she must have forgotten to lock the medication cart, but she usually does lock the medication cart when she steps away. Nurse #4 said the correct thing to do when she stepped away from the medication cart was to lock the cart, but she had not done so. Nurse #4 said that there should not be loose pills in the drawer. Nurse #4 said that it was the responsibility of all Nurses to keep the medication cart clean and to remove any pills that drop into the drawer. Nurse #4 said the expectation was that the drawers would be clean, but they were not. During an interview on 4/27/26 at 11:00 A.M., the Director of Nursing (DON) said that the medication cart should be secured at all times when the responsible Nurse steps away from the cart, and that it was the responsibility of all licensed Nurses accessing the medication cart to keep the cart clean and free of debris. Please Refer to F842		

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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 observation and interviews, the facility failed to keep confidential information contained in the resident's record secure, in accordance with accepted professional standards and practice for one (Greendale Unit) medication cart computer screen, out of three medication cart computer screens reviewed. Specifically, for the Greendale Unit medication cart computer screen, the facility failed to properly secure the computer screen containing confidential resident specific medication administration information when the computer screen was left unlocked and unattended, leaving the information readily viewed by unauthorized persons. Findings include: Review of the facility policy titled Information Technology Policy, dated 2/9/24, included: >Examples of Confidential Data-Medical and healthcare information>Storage-Confidential information must be removed from desks, computer screens, and common areas unless it is currently in use. Confidential information should be stored under lock and key (or keycard/keypad), with the key, keycard, or code secured. On 4/27/26 at 9:45 A.M., the surveyor observed an unlocked and unattended medication cart in the Greendale Unit hallway. The surveyor further observed that the computer screen on the medication cart was unlocked and confidential resident information was clearly visible. The surveyor remained at the medication cart until Nurse #4 returned. During an interview at the time, Nurse #4 said she had not noticed the surveyor standing by her medication cart. The surveyor and Nurse #4 reviewed the medication cart and observed that the medication computer screen was left open displaying confidential resident information. Nurse #4 said she left the medication cart and went into an adjacent room to give a resident their medication. Nurse #4 said she forgot to secure the computer resident information screen before she stepped away from the medication cart, but she usually does lock the computer information screen. Nurse #4 said that the correct thing to do when she steps away from the medication cart was to lock the cart, and to hide the computer information screen but she had not done so. During an interview on 4/29/26 at 12:30 P.M., the Director of Nursing (DON) said the expectation would be that computer screens containing confidential resident information were hidden, before the assigned licensed Nurse leaves the medication cart unattended, to preserve the residents' privacy. The DON said Nurse #4 should have hidden the computer information screen before walking away from the medication cart.		

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 04/29/2026
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, interviews, and record review, the facility failed to implement infection control practices to prevent transmission of infections for one Residents (#136) out of a total sample of 29 residents. Specifically, for Resident #136, the facility failed to ensure that staff implemented Enhanced Barrier Precautions (EBP- the use of protective equipment such as gowns and gloves to prevent the spread infection from one person to another) during high contact care activities for the Resident, placing the Resident, other residents, and staff at risk for the spread of infection. Findings include: Review of the facility policy titled Enhanced Barrier Precautions Policy, undated, included but was not limited to the following: -It is the policy of this facility to implement enhanced barrier precautions for preventing transmission of novel or targeted multidrug -resistant organisms (MRDOs-bacteria or microorganisms that are difficult to treat, easily spread, and resistant to one or more antimicrobial agents [antibiotics]). -MRDOs may include >Methicillin Resistant Enterococcus (MRSA- a specific type of staphylococcus bacteria that has developed resistance to many common antibiotics) -EBPs require the use of gown and gloves for certain residents during specific high contact care activities. High contact resident care activities include bathing, providing hygiene, dressing, transferring, linen changes, toileting, device care and wound care. Resident #136 was admitted to the facility in April 2019 with diagnoses including obstructive and reflux uropathy, history of MRSA, and immunodeficiency. Review of Resident #136's April 2026 Physician orders indicated: -Foley Catheter 14 French/10 milliliter balloon (a specific type of soft, flexible tube that is inserted into one's bladder to drain urine). -EBP related to Foley, History (Hx) of MRSA, every shift, effective 3/21/25 Review of Resident #136's person-centered care plan indicated the following: -Infection with a Resistant Micro-Organism history of MRSA, revised 8/10/25. >Interventions: Precautions as ordered. On 4/26/26 at 7:45 A.M., the surveyor observed Resident #136's doorway to have the following signage posted: -STOP Enhanced Barrier Precautions STOP -EVERYONE MUST: >Clean their hands, including before and after entering and when leaving the room. -PROVIDERS AND STAFF MUST ALSO: >Wear gloves and a gown for the following high contact Resident Care Activities: --Dressing, Bathing --Transferring --Changing Linens --Providing Hygiene --Device care or use: urinary catheter, feeding tube, central line, tracheostomy --Wound Care On 4/26/26 at 9:12 A.M., the surveyor observed Nurse #1 sitting on Resident #136's bed and assisting him/her to eat oatmeal. The surveyor observed Nurse #1's left leg and shoe making direct contact with Resident 136's Foley catheter tubing and drainage bag. Nurse #1 was observed not wearing a gown or gloves at the time. Nurse #1 then exited the Resident's room and said she thought the EBP signage in the Resident's doorway was old and that nobody living in the room had wounds. Nurse #1 further said she would double check why the signage for EBP was posted. On 4/26/26 at 3:31 P.M., the surveyor observed Certified Nurse Aide (CNA) #1 changing the bed linens on Resident #136's bed. CNA #1 was observed to be wearing gloves but not a gown while changing the Resident's linens. The surveyor then observed CNA #1 exit the Resident's room. During an interview at the time, CNA #1 said Resident #136 was on EBP and that she should have worn gown and gloves when changing the Resident's linens. CNA #1 said a gown and gloves should be used to protect the Resident from getting an infection. During a follow-up interview on 4/26/26 at 3:54 P.M., Nurse #1 said Resident #136 had a history of MRSA in the urine and had a Foley catheter. Nurse #1 said that she should have been wearing a gown and gloves when sitting on the Resident's bed linens because she could have spread infection to the Resident or from the Resident to other residents on the unit. During an interview on 4/26/26 at 4:30 P.M., the infection Preventionist (IP) said Resident #136 required EBP because the Resident had a history of MRSA in (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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NAME OF PROVIDER OR SUPPLIER Parsons Hill Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 Main Street Worcester, MA 01603	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his/her urine but was contained in the Foley catheter and not an active infection, and EBP would protect the staff from transmitting the MRSA to themselves and the other residents in the facility. The IP said Resident #136 also needed EBP to protect the Resident from getting infections because the Resident's Foley catheter device made it easier for the Resident to get infections. The IP said CNA #1 should have worn both gown and gloves while changing the Resident's linens and Nurse #1 should not have been sitting on the Resident's bed without having a gown and gloves on nor made contact with the Resident's Foley catheter. The IP said the Resident was at higher risk to contract and spread infection when the staff did not wear a gown and gloves.		

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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 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review, and interview, the facility failed to provide written notification of a hospital transfer to the Resident's Responsible Party for one Resident (#2) out three closed records sampled. Specifically, for Resident #2, the facility failed to provide written notice of transfer to the Resident's Responsible Party when the Resident was emergently transferred to the hospital for respiratory distress. Findings include: Review of the facility policy titled Emergency Transfers to Acute Care Hospitals and Psychiatric Hospitals, undated, included but was not limited to the following: -Emergency transfers to acute care hospital .and the facility has developed the following procedures to comply with this requirement. >A notice of immediate emergency transfer to a hospital must be completed and sent with the resident. >A copy must also be sent to the resident's responsible party. Resident #2 was admitted to the facility in November 2025 with diagnoses including Acute and Chronic Respiratory Failure and Chronic Obstructive Pulmonary Disease (COPD). Review of Resident #2's medical record included the following: -A Nursing Progress Note dated 2/5/26, which indicated Resident #2 had stated he/she could not breathe, had a pulse oximetry (measure of the oxygen saturation level in the blood) reading of 70% (normal level 95 - 100%), and was ordered to be transferred to the hospital by the Nurse Practitioner (NP). -A Less than 30-Day Notice of Intent to Transfer Resident Form dated 2/5/26, addressed to the Resident and signed by Social Worker (SW) #1. -No evidence that the Resident's Responsible Party was notified, in writing, relative to the Resident's hospital transfer on 2/5/26. During an interview on 4/29/26 at 8:52 A.M., SW #1 said Resident #2's Responsible Party had not been notified of the Resident's hospital transfer on 2/5/26. SW #1 said Resident #2's Responsible Party should have been notified of Resident's transfer to the hospital. During an interview on 4/29/26 at 9:03 A.M., Nurse #1 said she had called 911 to transfer Resident #2 to the hospital because the Resident could not breathe, had a low pulse oximetry reading, and the Resident's condition was emergent. Nurse #1 said she did not contact the Resident's Responsible Party at the time of hospital transfer because the Social Worker was responsible for notifying the Resident's Responsible Party. During an interview on 4/29/26 at 11:52 A.M., the Administrator said it was the responsibility of the transferring Nurse to notify the Resident's Responsible Party when Resident #2 was transferred to the hospital.		