STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225438	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Francis Rehabilitation & Nursing Center	101 Plantation Street Worcester, MA 01604

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was severely cognitively impaired and had a history of wandering in his/her wheelchair, the Facility failed to ensure he/she was free from physical abuse by a staff member, when on 07/19/25, Certified Nurse Aide (CNA) #1, after seeing Resident #1 exiting another resident's room with an object in his/her hands, that did not belong to him/her, CNA #1 slapped his/her hand and grabbed the object away from him/her, all of which was captured on video by a visitor.Findings include:Review of the Facility's Policy titled Abuse Prohibition Guideline, dated as revised 10/24/22, indicated the policy was to maintain a zero tolerance for any form of abuse or neglect of a resident. The Policy indicated the Facility would assure that staff uses caring, ethical, and professional behavior in all relationships with residents.Further review of the Policy indicated the definition of Physical Abuse included but was not limited to hitting, slapping, pinching, and kicking.Review of the Facility's Internal Investigation Summary, undated, indicated that on 07/19/25, a visitor video recorded their family member (a resident) during a meal, with their phone. The Summary indicated that a few days later, the Visitor discovered the video had captured an altercation between a resident and a staff member. The Summary indicated the Visitor shared the video footage of the altercation with the Director of Social Services during a meeting on 07/24/25 at approximately 1:02 P.M. The Summary indicated the video footage showed the following:- Resident #1 was sitting in his/her wheelchair in another resident's bedroom doorway, across from where the Visitor was recording with her phone. - CNA #1 approached Resident #1 and made contact with the top of his/her (Resident #1) left hand, using her right hand, and repeatedly told him/her Stop, stop, stop. - CNA #1 took a glass cross from Resident #1's hands. - Resident #1 did not appear to react and instead self-propelled his/her wheelchair away from CNA #1. The Summary indicated that Resident #1 did not have any bruises, marks or pain following the incident, and had full range of motion in his/her hand.The Summary further indicated that CNA #1 told the Director of Nursing (DON) that she tapped Resident #1's hand and then grabbed the glass cross from his/her hands, because he/she had been in another resident's room going through their belongings and she thought the glass cross did not belong to him/her. The Summary indicated CNA #1 was suspended pending investigation on 07/24/25 and later terminated on 07/31/25. Resident #1 was admitted to the Facility in September 2020, diagnoses included moderate unspecified dementia and osteoarthritis of the left hand. Resident #1 resided in the Memory Care Unit. Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 06/26/25, indicated Resident #1 was severely cognitively impaired with a score of 1 out of 15 on the Brief Interview for Mental Status (BIMS, scores indicate: 0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, and 13-15 cognitively intact). The Assessment indicated Resident #1 exhibited wandering behavior 1 to 3 days per week, during the assessment period.Review of Resident #1's Behavior Care Plan, dated as reviewed 07/10/25, indicated Resident #1 had episodes of wandering the halls looking for a new room. Interventions identified for Resident #1 included redirection using a diversional activity when he/she was agitated about his/her room and offering prayer books, visits and musical programs of interest. During an interview on 08/05/25 at 12:58 P.M., Certified Nurse Aide #2 said that she worked full time in the Memory Care Unit and often provided care to Resident #1. CNA #2 said that Resident #1 sometimes wandered into other resident rooms and took their belongings. CNA #2 further said that Resident #1 generally responded well to redirection and would often release objects in his/her hands when engaged or reapproached. Review of Certified Nurse Aide (CNA) #1's Written Witness Statement, dated 07/24/25, indicated that CNA #1 stated she tapped Resident #1's hand and grabbed the cross from him/her. The Surveyor was unable to interview CNA #1 as she did not respond to the Department of Public Health's telephone or letter requests for an interview. During a telephone interview on 08/05/25 at 2:25 P.M., the Director of Social Services said that during a meeting on 07/24/25, a Visitor showed her a video that unknowingly captured an incident that occurred between a staff member and a resident. The Director of Social Services said that when she watched the video, she was able to identify the staff member as CNA #1 and the resident as Resident #1. The Director of Social Services said the video showed Resident #1 sitting in the doorway of another resident's room, holding a glass cross in his/her hands. The Director of Social Services said that CNA #1 came into view, slapped the top of Resident #1's hand and said repeatedly Stop, stop, stop. The Director of Social Services said that CNA #1 then pulled the glass cross from Resident #1's hands. The Director of Social Services said the incident was immediately reported, and the video was shared with the Director of Nursing, the Administrator and Law Enforcement. The Director