

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225443	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/21/2024
NAME OF PROVIDER OR SUPPLIER Blaire House of Worcester		STREET ADDRESS, CITY, STATE, ZIP CODE 116 Houghton 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)
<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15203</p> <p>Based on interviews and records reviewed, for one of three sampled residents (Resident #1) who was alert, disoriented, unable to make his/her needs known and was dependent on staff for transfers between surfaces, dressing and hygiene, the Facility failed to ensure Resident #1 was free from the use of physical restraint when, on 9/24/24 around 7:20 A.M., the Scheduler and the Activity Director observed Resident #1, who was seated in a wheelchair at a table in the dayroom with a gait belt around him/her that was also wrapped around the back of the wheelchair. The gait belt was clasped closed behind the wheelchair, unable to be removed or unlocked by Resident #1 and therefore restraining his/her ability to get up, if desired.</p> <p>Findings include:</p> <p>Review of the Facility Policy titled Device/Restraints Policy & Procedure, effective 10/10/00, indicated the resident has the right to be free from physical restraints imposed for the purposes of discipline and convenience and not required to treat the resident's medical condition. The Policy defined physical restraint to include any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the resident's body, that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.</p> <p>Review of Resident #1's clinical record indicated that he/she was admitted to the Facility during September 2024 and his/her diagnoses included dementia, brief psychotic disorder and generalized anxiety disorder.</p> <p>Review of Resident #1's most recent Admission Minimum Data Set Assessment, dated 9/21/24, indicated his/her cognitive patterns were severely impaired, he/she did not ambulate and he/she was dependent on the assistance of staff members when transferring between surfaces and for dressing and hygiene.</p> <p>Resident #1's Care Plan related to Falls, dated as initiated 9/23/24, indicated that Resident #1's risk for falling and for significant injury would be minimized daily. Additional interventions, dated as initiated 9/23/24, indicated staff were to remind and encourage Resident #1 to call for assist prior to transfer and ambulation.</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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 9/24/24, indicated that a staff member reported that Resident #1 was sitting in a wheelchair restrained with a gait belt.</p> <p>During a telephone interview on 10/22/24 at 1:00 P.M., the Activity Director said that on 9/24/24 around 7:00 A.M. she arrived to the Facility and went to her office which was adjacent to the day room (on the Unit where Resident #1 resided). The Activity Director said that after leaving her belongings in her office, she turned on the television in the day room. The Activity Director said Resident #1 was seated in his/her wheelchair at a table facing the television. The Activity Director said that as she walked closer to Resident #1, she saw that there was gait belt around Resident #1 and his/her wheelchair, and it was latched closed behind the wheelchair back. The Activity Director said that she went closer to Resident #1 and saw that although the gait belt was across Resident #1's torso, his/her shirt was pulled over the belt so that it was not visible from the front. The Activity Director said that she saw the Scheduler in the hallway and asked her to come into the day room.</p> <p>During an interview on 10/21/24 at 11:00 A.M., the Scheduler said that, on 9/24/24, around 7:00 A.M., the Activity Director called her into the day room where Resident #1 was seated in his/her wheelchair at a table. The Scheduler said that the Activity Director showed her that there was a gait belt around Resident #1 and his/her wheelchair and it was latched closed behind the back of the wheelchair. The Scheduler said that she removed the gait belt and reported the incident to Nurse #1, Nurse #2 and the Director of Nursing.</p> <p>During an interview on 10/21/24 at 1:00 P.M., the Director of Nursing said that on 9/24/24 the Scheduler reported that Resident #1 had been found with a gait belt around him/her in a wheelchair, latched closed behind Resident #1's back. The Director of Nursing said that she initiated an internal investigation including obtaining Written Witness Statements from the Facility staff members on duty during the 11:00 P.M. to 7:00 A.M. shift starting on 9/23/24 and ending on 9/24/24 and the staff members on duty during the 7:00 A.M. to 3:00 P.M. shift on 9/24/24.</p> <p>The Director of Nursing said, and review of the Written Witness Statements indicated, that none of the staff members on duty during the 11:00 P.M. to 7:00 A.M. shift starting on 9/23/24 and ending on 9/24/24 saw the gait belt around Resident #1 and the wheelchair, or admitted they had applied it.</p> <p>During interviews on:</p> <ul style="list-style-type: none"> -10/21/24 at 11:45 A.M. with Nurse #1, -10/21/24 at 1:55 P.M. with Certified Nurse Aide (CNA) #1, and -10/21/24 at 3:30 P.M. with CNA #2, they said the following: <p>Nurse #1, CNA #1 and CNA #2, said they were the staff working on Resident #1's unit during the 11:00 P.M. to 7:00 A.M. starting on 9/23/24 and ending on 9/24/24. They said Resident #1 was restless during the shift and CNA #1 spent much of the shift seated in the doorway of his/her room monitoring him/her. CNA #1 and CNA #2 said that they provided incontinence care to Resident #1 between 5:30 A.M. and 6:00 A.M. and left him/her seated in his/her room in his/her wheelchair. CNA #1, CNA #2 and Nurse #1 said they did not see the gait belt around Resident #1 or the wheelchair, they all denied putting it there, and said they did not know who applied it.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Director of Nursing said that while interviewing staff members about the gait belt found around Resident #1's wheelchair, she learned that, on 9/24/24 around 6:30 A.M., CNA #3 had dressed Resident #1 at his/her bedside and brought him/her from his/her bedroom to the day room.</p> <p>During an interview on 10/21/21 at 1:30 P.M., CNA #3 said that she arrived to the facility on [DATE] around 6:30 A.M. and one of her first tasks was to dress Resident #1 and bring him/her to the day room. CNA #3 said that when she entered Resident #1's room, she found Resident #1 in his/her wheelchair, at the foot of his/her bed. CNA #3 said that Resident #1 was dressed in pants, one sock and a johnny. CNA #3 said that because the johnny was knotted in the back, she lifted it over Resident #1's head to remove it rather than untying it. CNA #3 said that she dressed Resident #1 in loose blouse and wheeled him/her to the day room in his/her wheelchair.</p> <p>CNA #3 said that later in the morning she learned that Resident #1 had been found in the day room with a gait belt around him/her and latched closed behind the back of the wheelchair. CNA #3 said that she did not apply the gait belt around Resident #1. CNA #3 said that she did not see the gait belt around Resident #1 and the wheelchair when she changed Resident #1's shirt. CNA #3 said that because Resident #1 had been provided with incontinence care and was already dressed in pants and transferred to the wheelchair by staff members on the 11:00 P.M. to 7:00 A.M. shift, she did not have to transfer or position Resident #1 in the wheelchair. CNA #3 said it was possible that the gait belt was around Resident #1 and the wheelchair and latched closed behind the back of the wheelchair when she changed Resident #1 from the johnny into a blouse and she did not see it.</p> <p>Although Nurse #1, CNA #1, CNA #2 and CNA #3 all denied putting the gait belt around Resident #1 in the wheelchair, thereby restricting his/her movement, they were the staff members working on the unit during that time and were assigned to his/her care, Resident #1 was totally dependent on staff for care and physically incapable of doing it.</p> <p>On 10/21/24 the Facility was found to be in past non-compliance. The Facility provided the Surveyor with a plan of correction which addressed the concern as evidenced by:</p> <p>A. On 9/24/24, skin and pain assessments were completed by the Unit Manager for Resident #1 without findings of injury related to the alleged incident.</p> <p>B. On 9/24/24, the Administrator/Director of Nursing suspended CNAs #1, #2 and #3 pending the outcome of their investigation and requested that the Agency no longer assign Nurse #1 shifts at the Facility.</p> <p>C. Between 9/24/24 and 10/02/24, nursing staff reviewed and updated Resident #1's care plan concerns regarding behavioral symptoms and falls prevention, to include interventions such as use of gerichair or Broda chair.</p> <p>D. On 9/24/24, Resident #1 was evaluated by Behavioral Health Services with recommendations made and on 9/27/24, Resident #1 was examined by the Physician.</p> <p>E. On 9/25/25, the Facility Social Worker met with Resident #1 to offer on-going support.</p> <p>F. Between 9/24/24 and 9/27/24, all Facility staff were trained on the Facility Patient Abuse Policy and prohibitions on restraints.</p> <p>(continued on next page)</p>		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	G. The Director of Nursing, Unit Manager and Case Manager continue to make rounds of the Facility Units 3 to 5 times daily, on all shifts, observing for proper uses of devices and equipment. Observation findings are reviewed with clinical team members during the daily clinical meeting. H. Results of the Internal Investigation and observations made during rounds will be reviewed during the the Facility QAPI Meetings. I. The Administrator/designee are responsible for overall compliance.		