STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225500	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Side House Ltc Facility	35 Fruit Street Worcester, MA 01609

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15203 Based on interviews and records reviewed, for two of three sampled residents (Residents #1 and #2), who were severely cognitively impaired and had court ordered legal guardianships in place, the Facility failed to ensure that staff implemented and followed the Facility Abuse Prohibition Policy when, on 10/17/24, although Nurse #1 and Nurse #2 were made aware of an allegation of abuse, that Resident #1 was at Resident #2's bedside engaged in a sexual act, neither of them reported the allegation to the Director of Nursing or Administrator, and as a result, they were not made aware until more than 12 hours later, when Nurse #3 became aware and reported the allegation. Findings include: Review of the Facility Policy titled Abuse Prevention Policies and Procedures, revised 4/2017, indicated that all staff members are responsible for reporting incidents that may constitute or lead to any form of resident abuse, neglect, mistreatment, exploitation or misappropriation. The Policy indicated that upon observation of potential/alleged resident abuse, the observing staff member is required to intervene, stop the potential/alleged abuse, and report to their supervisor. Review of the Facility Reporting Resident Neglect/Abuse Policy, dated 4/2017, indicated that when notified that a staff member believes that a Facility resident has been abused, the supervisor will notify the Administrator/Director of Nursing Services. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 10/18/24, indicated that staff members reported that on 10/17/24 around 7:00 P.M., Resident #2 was observed lying in bed with his/her pants and underwear pulled down and Resident #1 was sitting in his/her wheelchair at the bedside, resting his/her head in the area of Resident #2's exposed genitalia. Resident #1's clinical record indicated he/she was admitted to the Facility during March of 2019 and his/her diagnosis included dementia, traumatic brain injury and depression. Review of Resident #1's Minimum Data Set (MDS) Assessment, dated 10/03/24 indicated that his/her cognitive patterns were severely impaired. Resident #1's clinical record indicated that the court appointed a legal guardian for him/her in June of 2019. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2's clinical record indicated he/she was admitted to the Facility during May of 2023 and his/her diagnosis included metabolic encephalopathy, traumatic brain injury, depression and HIV. Review of Resident #2's MDS Assessment, dated 10/03/24 indicated that his/her cognitive patterns were moderately impaired. Resident #2's clinical record indicated that the court appointed a legal guardian for him/her in March of 2024. During a telephone interview on 11/15/24 at 1:20 P.M., Certified Nurse Aide (CNA) #1 said that on 10/17/24 around 7:00 P.M., she entered Resident #2's room via the adjoining bathroom and saw Resident #2 on his/her bed with his/her pants and underwear pulled down and his/her genitalia was exposed. CNA #1 said Resident #1 was seated in his/her wheelchair next to Resident #2's bed with his/her head on Resident #2's genitalia moving up and down. CNA #1 said that when she entered the room, Resident #1 moved his/her head away from Resident #2 and Resident #2 pulled his/her shirt down. CNA #1 said that she went back through the adjoining room and told CNAs #2 and CNA #3 what she saw. During telephone interviews on 11/16/24 at 10:40 A.M. with CNA #2 and 11/20/24 at 3:10 P.M. with CNA #3 they said the following: On 10/17/24 around 7:00 P.M., CNA #1 told them that something sexual was going on between Residents #1 and #2 in Resident #2's room. They went into Resident #2's room and saw Resident #2 in his/her bed and Resident #1 seated in his/her wheelchair next to Resident #2's bed. CNA #2 and CNA #3 said Residents #1 and #2 told them that they were watching television. CNAs #1, #2 and #3 said that they told Nurse #1 what CNA #1 witnessed between Residents #1 and #2. During an interview on 11/20/24 at 8:10 A.M. by telephone, Nurse #1 said that on 10/17/24 after dinner, CNA #2 told her that CNA #1 said Resident #1 was in Resident #2's room. Nurse #1 said that when Resident #1 came to the nurses' station she asked him/her what he/she had been doing in Resident #2's room and he/she said that they were playing cards. Nurse #1 said that later on during the 3:00 P.M. to 11:00 P.M. shift, CNA #2 told her that although Resident #2 had been in bed and covered by blankets when staff saw Resident #1 beside his/her bed, when staff later pulled back Resident #2's blankets, they saw that Resident #2 was naked. Review of Nurse #1's Written Witness Statement, dated 10/18/24, indicated that on 10/17/24 around 7:00 P. M., CNA #1 told her that she went into Resident #2's room and saw a sexual act taking place. Nurse #1's Written Witness Statement indicated that Resident #1 was invited to the nurses' station and reported that he/she and Resident #2 were playing cards. Nurse #1 said that CNAs #1, #2 and #3 did not tell her that a sexual act taking place between Resident #1 and Resident #2 on 10/17/24, however when she came to the facility on [DATE] she learned that there was an allegation that there had been sexual contact between Resident #1 and Resident #2 on 10/17/24 and she wrote about that in her Written Witness Statement. Although Nurse #1 said CNAs #1, #2 and #3 did not tell her that a sexual act took place between Residents #1 and #2, her statement contradicts the statements made by CNAs #1, #2 and #3 and her (Nurse #1's) Written Witness Statement. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 11/18/24 at 11:00 A.M., Nurse #2 said that on 10/17/24 around 9:00 P.M., CNA #1 told her that she had gone into Resident #2's room and seen Resident #1 performing oral sex on Resident #2. Nurse #2 said that CNA #1 told her that she had already reported the incident to Nurse #1. Nurse #2 said that she did not report CNA #1's statement to the Director of Nursing or the Administrator. During an interview on 11/06/24 at 9:30 A.M., the Director of Nursing said that around 12:00 P.M. on 10/18/24, Nurse #3 reported to her that staff members were discussing an incident (an alleged sexual act between Residents #1 and #2) which had taken place during the 3:00 P.M. to 11:00 P.M. shift on 10/17/24. The Director of Nursing said that she initiated an investigation and determined that there had been an incident in which CNA #1 observed an interaction between Residents #1 and #2 which may have been sexual in nature. The DON said that although CNAs #1 and #2 reported the incident to Nurse #1 and Nurse #2 during the 3:00 P.M. to 11:00 P.M. shift, they did not immediately notify her or the Administrator. The Director of Nursing said that when she became aware of the alleged incident more than 12 hours later, she reported it to the Administrator.