STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225720	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care One at Millbury	312 Millbury Avenue Millbury, MA 01527

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review and interviews, the facility failed to provide adequate supervision and assistive devices to ensure one of three sampled residents (Resident #1) remained free from accident hazards during transfers, resulting in Actual Harm. Specifically, for Resident #1, who was assessed as being at high risk for falls and requiring a two-person stand aid for safe transfer, two Certified Nurse Aides (CNAs) attempted a manual transfer after the resident reportedly refused the stand aid, gait belt, and Hoyer lift. The CNAs failed to wait for supervision (Nurse or Rehabilitation staff) to intervene regarding the refusal, which resulted in an unsafe transfer contrary to the resident's care plan, demonstrating a failure to implement safety protocols when an assistive device required by the care plan was refused. Consequently, Resident #1 fell, required transfer to the Hospital Emergency Department for evaluation and was diagnosed with a cervical neck fracture (C7).Findings include:Review of the Facility's policy, titled Using a Mechanical Lifting Machine, dated 07/2017, indicated the following:-At least two trained, competent staff members are needed to safely move a resident with a mechanical lift.-Types of lift that may be available in the facility include sit-to-stand lifts.Review of the Facility's policy, titled Comprehensive Person-Centered Care Plans, dated 03/2022, indicated a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.Resident #1 was admitted to the facility in August 2025, diagnoses included chronic obstructive pulmonary disease (COPD), morbid obesity, and generalized muscle weakness.Review of a report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated10/08/25, indicated that on 10/04/25, Resident #1 sustained a fall during a transfer with two Certified Nurse Aides (CNAs) from his/her bed to his/her wheelchair. Resident #1 hit his/her head on the wall during the fall, and he/she was transferred to the Hospital Emergency Department (ED) for an evaluation and treatment.Further review of the Report indicated Resident #1 sustained a nondisplaced fracture for the seventh vertebra (C7) and was discharged back to the Facility with a hard collar to be worn at all times.Review of Resident #1's admission Minimum Data Set (MDS) assessment, dated 08/29/25, indicated he/she scored a 15 out of 15 (0-7 suggests severe cognitive impairment, 8-12 suggests moderate cognitive impairment, and 13-15 suggests a resident is cognitively intact).Review of Resident #1's Falls Care Plan, indicated he/she was at risk for falls due to impaired balance/poor coordination and unsteady gait.Review of Resident #1's Activities of Daily Living (ADL) Care Plan, included an intervention dated 08/25/25, [for staff] to use a stand aid (a mechanical transfer device used to provide assistance to stand from a seated position) with two person assist for transfers from the bed to the wheelchair.Review of the Facility's investigation for Resident #1's fall on 10/04/25 indicated it included written witness statements, signed and dated 10/04/25, by Certified Nurse Aides (CNAs) #1 and #2.During interviews on 11/19/25 at 1:13 P.M. and 2:56 P.M., (which included review of her written witness statement) Certified Nurse Aide (CNA) #1 said she had taken care of Resident #1 on multiple occasions, and Resident #1 was on her assignment on the day shift (7:00 A.M. through 3:00 P.M.) on 10/04/25. CNA #1 said Resident #1 required the use of a stand aid and two persons assist for transfers. CNA #1 said that on 10/04/25, Resident #1 told (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 0689 Level of Harm - Actual harm Residents Affected - Few	her he/she wanted to get out of bed and when she (CNA #1) told him/her that she needed to go get the stand aid, Resident #1 began to yell and said he/she did not want to use the stand aid.CNA #1 said she offered to use a hoyer lift (a mechanical lift that supports full body weight) instead or a gait belt and Resident #1 refused both. CNA #1 said she left Resident #1's room and went to tell Nurse #1 and Occupational Therapist #1 that Resident #1 was refusing the stand aid. CNA #1 said both told her that Resident #1 had a right to refuse the stand aid and had a right to get out of bed. CNA #1 said at the time she took that information to mean that she needed to transfer Resident #1 out of bed without the stand aid but said she should have asked for clarification.CNA #1 said Resident #1 was in bed and the wheelchair was next to Resident #1's bed, she was on one end of the wheelchair and CNA #2 was on the other, and that she and CNA #2 did the best they could to help transfer Resident #1 out of bed and into his/her chair. CNA #1 said Resident #1 placed his/her feet on the floor and his/her hands on the arms of the wheelchair and then threw him/herself toward the wall, resulting in a fall.CNA #1 said she had transferred Resident #1 without the use of a stand aid prior to this incident, because he/she often refused the stand aid. CNA #1 said the reason she went to the rehabilitation department was because Resident #1 had been refusing the stand aid a lot.During a telephone interview on 11/19/25 at 1:53 P.M., (which included review of her written witness statement) Certified Nurse Aide (CNA) #2 said she was on duty during the day shift of 10/04/25. CNA #2 said that she was familiar with Resident #1 but that she had never previously transferred or helped to assist another staff member to transfer Resident #1. CNA #2 said CNA #1 came to her and asked her to help transfer Resident #1 out of bed. CNA #2 said they did not use a stand aid for his/her transfer out of bed because Resident #1 refused the stand aid, the gait belt and that Resident #1 told them (CNAs #2 and #1) he/she could get up on his/her own.CNA #2 said that she and CNA #1 were trying to help get Resident #1 out of bed. CNA #2 said she was on one side of the wheelchair and CNA #1 was on the other side, then Resident #1 got out of the bed and then twisted him/herself and went into the side of the wall. CNA #2 said she did not know if Nurse #1 knew of Resident #1's refusal to use the stand aid prior to them transferring him/her out of bed.During a telephone interview on 11/19/25 at 2:36 P.M., Nurse #1 said she was on duty during the day shift of 10/04/25 and Resident #1 was on her assignment. Nurse #1 said she was not notified by the CNAs [#1 and #2] that Resident #1 had refused all assistive devices for transferring out of bed until after he/she fell. Nurse #1 said if she had been notified of the refusals, her directive to the CNAs would have been to keep Resident #1 in bed because the transfer could not be done safely.During an interview on 11/19/25 at 3:42 P.M., Occupational Therapist (OT) #1 said that on 10/04/25 the day of the incident, he had not been notified by the CNAs [#1 or #2] that Resident #1 had been refusing to use the stand aid to transfer out of bed. OT #1 said that none of the nursing staff on Resident #1's unit, nurses or CNAs, came to him specifically about Resident #1 refusing to use the stand aid for transfers. OT #1 said if a resident required the use of a stand aid for transfers and refused to use it, the resident should be offered a hoyer lift and if they refused the hoyer lift, they would have to stay in bed. OT #1 said it was the facility's responsibility to keep the residents safe during transfers.During an interview on 11/19/25 at 3:25 P.M., the Staff Development Coordinator (SDC) said that if a resident required an assistive device to aid in transfers and refused to use it, she expected the CNAs to ask a supervisor for help or seek advice from the rehabilitation department. The SDC said CNAs should not make their own decisions in the moment.The SDC said there should be ample documentation in a residents' medical record if education, including risks, was provided to a resident who refused the use of assistive devices and that the provider should be notified of refusals. The SDC said that if education is given verbally to a resident, the staff [nursing and rehabilitation] are responsible to write a progress note indicating education was completed.During a telephone interview on 11/19/25 at 4:05 P.M., the Director of Rehabilitation said when Resident #1 was discharged from skilled therapy on 09/20/25 the discharge plan included using two person staff assist with use of the stand aid for transfers, to maintain the safety of both Resident #1 and the staff. The Director of Rehabilitation said she had not been notified of Resident #1's refusals to use the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	stand aid prior to his/her fall on 10/04/25, and if she had been notified, the therapists would have re-evaluated him/her because refusing to use the required assistive devices for transfers becomes a safety issue.Review of Resident #1's medical record indicated that prior to the incident on 10/04/25, there was no documentation to support that nurses or rehab staff were made aware of Resident #1's refusals to use the stand aid or that education was provided to him/her regarding the risks of not using the stand aid.During an interview on 11/19/25 at 4:17 P.M, the Director of Nurses (DON) said when Resident #1 refused to use the stand aid the CNAs should have kept him/her in bed to maintain patient safety and let the supervisor know. The DON said no one had told her that Resident #1 had refused the stand aid prior to his/her fall on 10/04/25. The DON said if Resident #1 had been educated about the risks of not using the stand aid it would have been documented in the nursing progress notes. The DON said she thought the CNAs had brought the stand aid into Resident #1's room to transfer him/her out of bed on 10/04/25, she said she did not realize that was not the case.