STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225009	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hermitage Healthcare (the)	383 Mill Street Worcester, MA 01602

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 45429 Based on observation, interview, and policy review the facility failed to maintain a clean and homelike environment for one Resident (#81) on one unit out of three units observed. Specifically, for Resident #81 who resided on the Sunburst Unit the facility failed to ensure that the Resident's enteral tube feeding (nutritional supplement through a tube to the stomach) equipment consisting of a pump and a pole was maintained in a clean manner. Findings include: Review of the facility policy for Cleaning and Disinfection of Environmental Surfaces, last revised 4/2018, indicated the following: -semi-critical items consist of items that come in contact with mucous membranes or non-intact skin. Such devices should be free from all microorganisms . -housekeeping surfaces will be cleaned on a regular basis, when spills occur and when the surfaces are visibly soiled -environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly soiled. On 5/30/24 at 11:13 A.M., the surveyor observed multiple stains and splattered dried brown material on Resident #81's feeding tube pump and on multiple large areas of the pole that the tube feeding supplies had been hanging from. On 6/03/24 at 8:42 A.M., the surveyor observed Resident #81's tube feeding pump and pole remained stained with multiple areas of dried brown splattered material. During an observation and interview on 6/3/24 at 9:03 A.M., the surveyor and Nurse #1 observed Resident #81's tube feeding pump and pole remained with multiple areas of dried brown splattered material. Nurse #1 said that Resident #81's tube feeding supplies should not have been soiled and should have been cleaned. Nurse #1 also said that the housekeeping staff were responsible for cleaning the surfaces in the Resident's room. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/3/24 at 9:05 A.M., Housekeeping Staff #1 said that she had not been made aware that Resident#81's tube feeding supplies had been soiled. Housekeeping Staff #1 also said that it was the responsibility of both the housekeeping staff and the nursing staff to keep these items clean.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 42761 Based on observation, interviews, and records reviewed, the facility failed to arrange services according to professional standards of practice for one Resident (#42) out of a total sample of 20 residents. Specifically, facility staff failed to arrange services with the Hand Surgeon for Resident #42 to undergo surgery when the Hand Surgeon diagnosed the Resident with Carpal Tunnel Syndrome (CTS: occurs when the median nerve, which runs from your forearm, through your wrist, into the palm of your hand, becomes pressed or squeezed at the wrist) and a trigger finger (condition in which fingers remain in a bent position due to inflammation of tendons that bend the fingers) and recommended surgical intervention. Findings include: Review of the American Society for Surgery of the Hand's document titled Trigger Finger, dated 2020, indicated the following relative to a trigger finger: - Trigger finger is a common and treatable problem. - Trigger finger is diagnosed through review of one's history, symptoms, and by physical exam. - Risk factors for trigger finger include Diabetes. - Trigger finger symptoms include, but are not limited to pain and mechanical symptoms, such as abnormal movements described as popping, catching, or locking while bending or straightening the finger. - Surgical intervention may be recommended. Review of the National Institute of Arthritis and Musculoskeletal and Skin Disease' document titled Carpal Tunnel Syndrome, dated December 2023, indicated the following: - CTS usually occurs in adults. - Contributing factors for CTS include metabolic disorders, such as Diabetes. - Most cases of CTS can be diagnosed through physical exam by one's Physician. - In some cases where one's CTS can not be diagnosed using physical exam alone, other tests may be ordered. - Electromyography (EMG: diagnostic test using one or more small needles one or more small needles inserted through the skin into the muscle) can be used to determine the severity of muscle damage due to CTS. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #42 was admitted to the facility in June 2022 with a diagnosis of Type 2 Diabetes and pain in the right wrist. Review of Resident #42's Document of Resident Incapacity, dated 7/14/22 and signed by the Nurse Practitioner (NP), indicated the Resident lacked the capacity to make or communicate health care decisions related to moderate progressive Dementia and that the probable duration of incapacity was indefinite. Review of Resident #42's Physician's Order, dated 7/15/22, indicated: Health Care Proxy (HCP: person selected by an individual to make health care related decisions if the individual becomes incapacitated) activated. Review of Resident #42's Physician Consultation, dated 10/3/23, indicated the following: - EMG positive for . moderate right CTS. - Follow-up with the hand surgeon was recommended. - The Consultation section titled New Orders/Diagnosis indicated: surgery for R (right) Carpal Tunnel and trigger finger in November. Review of Resident #42's clinical record included no evidence the facility arranged for the Resident to follow-up with the hand surgeon relative to the recommended surgery for CTS and trigger finger. Review of two Physician's Orders for Resident #42, both dated 4/3/24, indicated: - OT (Occupational Therapy) eval and treat as indicated. - OT required three times per week over 30 days . Review of Resident #42's OT Evaluation, dated 4/3/24, indicated the following: - The Resident was referred for a quarterly evaluation. - One of the Resident's goals was to improve their hand problem. - Active range of motion (AROM) of the Resident's right middle finger was impaired. - Pain was present daily in the Resident's right middle finger at a level of six out of 10 with movement. - The Resident described the pain type as catching. - The Resident's pain limited their ability to open their hand. - The clinical impression indicated: potential right middle trigger finger that appears to catch when bent, requiring use of the Resident's opposite hand to extend the finger. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The focus of the plan of treatment was restoration and compensation. - The Resident reported possibly having hand surgery on the right middle trigger finger. - The Occupational Therapist planned to contact the Resident's hand clinic Physician to determine whether OT treatment would be beneficial for improving active movement and function. Review of Resident #42's clinical record included no evidence any facility staff contacted the Resident's hand clinic Physician as indicated in the OT Evaluation. Review of Resident #42's Minimum Data Set (MDS) Assessment, dated 4/4/24, indicated the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15 total possible points. During an interview on 5/31/24 at 11:00 A.M., Resident #42 said he/she was having trouble with right hand pain and that he/she was right hand dominant. Resident #42 said he/she had no pain when his/her right hand was at rest, but that the pain increased when he/she used their right hand. The Resident also said his/her middle finger got stuck in a bent position when he/she made a fist and then tried to open the hand. At this time, Resident #42 made a fist with his/her right hand, then opened the hand, and the surveyor observed that the Resident's middle finger did not fully open and remained bent at the joint furthest away from the palm. Resident #42 then said facility staff provided pain medicine to treat his/her hand pain, but that the medicine did not fix the problem. Resident #42 also said he/she had seen a hand specialist at a hand clinic and that the hand specialist recommended surgery. Resident #42 further said he/she had asked facility staff about following up with the specialist for surgery, but the Resident had not heard anything back yet. The Resident said he/she just wanted the problem with his/her hand fixed and did not think it was right that it was taking so long. During an interview on 5/31/24 at 1:00 P.M., Nurse #2 said that Resident #42 had gone to see a hand specialist, but she was not aware that surgery was recommended for the Resident. Nurse #2 said that she thought the Resident had been diagnosed with arthritis and that the Resident's pain was treated with medication. Nurse #2 said she thought no other interventions had been recommended for the Resident to correct the problem with his/her hand. During a follow-up interview on 6/4/24 at 9:45 A.M., Nurse #2 said when a resident came back to the facility following an appointment with a specialist, the Nurse was required to receive the recommendations from the specialist and communicate the recommendations to the resident's Physician and HCP, if the HCP was activated. Nurse #2 said the Nurse who received the recommendations for surgery from Resident #42's hand specialist should have communicated the recommendations to the Resident's Physician and HCP, and arranged for the Resident's follow-up services with the hand surgeon. Nurse #2 said the hand clinic had not been contacted until 6/3/24, after the surveyor's inquiry, to arrange follow-up services with the hand surgeon and that the Resident required another examination to be completed to ensure his/her condition had not deteriorated since October 2023 prior to being able to schedule surgery. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/4/24 at 11:55 A.M., the Physician said he could not recall whether facility staff had communicated the recommendation made from the hand specialist on 10/3/23 for Resident #42 to undergo surgery. During an interview on 6/4/24 at 12:12 P.M., Resident #42's HCP said although he/she was activated as Resident #42's HCP, the Resident was very aware of what he/she wanted was able to make his/her own health decisions with the HCP. The HCP said he/she could not recall when facility staff had communicated the recommendation made from the hand specialist on 10/3/23 to him/her for Resident #42 to undergo surgery, but that he/she assumed the surgery never occurred since the Resident was still reporting pain. During an interview on 6/5/24 at 10:40 A.M., following the survey period, the Occupational Therapist said he had evaluated Resident #42 in April 2024 for a quarterly evaluation and that the Resident reported having seen a hand specialist who recommended surgical intervention for the Resident's hand. The Occupational Therapist said he planned to contact the hand specialist to determine whether non-surgical intervention through occupational therapy could be beneficial for the Resident's hand condition. The Occupational Therapist said he reviewed Resident #42's clinical record and located no consultation from a hand specialist, so he made inquiries to the Nursing staff and the Resident's family members relative to which hand specialist had examined the Resident. The Occupational Therapist said the facility's Nursing staff and Resident #42's family members did not know who the specialist was or how to contact them. The Occupational Therapist further said that he as unable to obtain any information relative to the hand specialist prior to his last day of work at the facility which was 4/11/24.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45429 Based on interview, policy and record review, the facility failed to ensure that residents who are trauma survivors receive culturally competent and trauma-informed care for one Resident (#86) out of a total sample of 20 residents. Specifically, the facility staff failed to develop and implement a trauma informed care plan for Resident #86's past history of trauma and/or triggers which may cause re-traumatization. Findings include: Review of the facility policy for Trauma Informed Care last revised October 2019, indicated: -to implement universal screening of residents for trauma -as part of the comprehensive assessment, identify history of trauma or interpersonal violence when such information is provided to the facility. Resident #86 was admitted to the facility in February 2024 with diagnoses including unspecified adult maltreatment (used for confirmed cases of adult maltreatment when clinical information is unknown or not available about a particular condition. It falls under the range of injury, poisoning, and certain other consequences of external causes), cognitive impairment and depression. Review of Resident #86's hospital discharge paperwork dated 2/7/24, indicated that the Resident had been a victim of nonconsensual sexual intercourse prompting the hospital to file an Elder At-Risk report with the local Elder Services organization. Further review of the hospital discharge paperwork indicated diagnoses of a Right Humerus fracture and multiple rib fractures. Review of Resident #86's Physician Admission Progress note dated 2/15/24, indicated that the Resident had reported physical and sexual abuse by his/her (significant other), a Right humerus fracture and multiple rib fractures. Review of the Resident #86's Minimum Data Set (MDS) assessment dated [DATE], indicated that the Resident a Brief interview of Mental Status (BIMS) score of 3 out of a possible score of 15, indicating cognitive impairment. Further review of the MDS revealed that the Resident had a diagnosis of unspecified adult maltreatment subsequent encounter (routine care for the same condition) as well as exhibited physical behaviors, verbal behaviors, wandering and care rejection. Review of Resident #86's care plans did not indicate that a care plan had been initiated for trauma informed care. Further review of Resident #86's care plans indicated a Behavior care plan, last revised 2/20/24, that indicated that the Resident had been struggling with wandering, exit seeking, screaming, anger, disruptive sounds and refusing care. Review of Resident #86's Medication Administration Records indicated that the facility staff had attempted interventions for the Resident's behaviors without efficacy on the following dates: (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Wandering: 3/6/24- 3/7/24, 3/10/24, 3/12/24, 3/21/24-3/22/24, 3/24/24, 3/28/24, 3/30/24 -Screaming: 3/8/24, 3/13/24-3/15/24, 3/17/24, 3/20/24, 3/24/24, 3/31/24, 4/2/24-4/5/24, 4/7/24, 4/10/24-4/11/24, 4/13/24, 4/17/24, 4/19/24, 4/21/24, 4/27/24-4/28/21, 4/30/24, 5/1/24, 5/5/24-5/6/24, 5/9/24-5/15/24, 5/17/24, 5/20/24, 5/22/24-5/23/24, 5/25/24-5/28/24 -Pacing: 3/9/24 -Disruptive Sounds: 3/29/24 -Refusing Care: 4/14/24-4/17/24, 4/20/24-4/21/24, 4/24/24-4/26/24, 4/28/24, Review of Resident #86's Social Services Evaluation dated 5/7/24 indicated the following: -that the Resident had an experience so upsetting that they thought it had changed them emotionally, spiritually, physically or behaviorally. -that the Resident thought that these problems bothered them now -that the Resident had experienced a serious accident at home, work or during recreational activity -that the Resident had experienced physical assault and sexual assault -that the Resident had witnessed life threatening illness or injury -that a trauma informed care plan had not been initiated. During an interview on 6/03/24 at 3:12 P.M., Social Worker (SW) #1 said that a trauma informed care plan should have been completed for Resident #86, that it had not been and that it was an oversight on her part.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 42761 Based on observation, interviews, and records reviewed, the facility failed to provide two Residents (#49 and #48), who were diagnosed with Dementia, with appropriate treatment to attain or maintain their highest practicable mental and psychosocial well-being, out of a total sample of 20 residents. Specifically, facility staff failed to adequately monitor Resident #48's verbal behaviors and implement effective behavior interventions to prevent Resident #48 from directing verbal behaviors towards Resident #49 when Resident #49 was receiving personal care from facility staff, which resulted in an undignified experience for both Residents. Findings include: Review of the facility's policy, titled Resident Rights, dated November 2017 and last revised January 2024, indicated Federal and State laws guarantee certain basic rights to all residents of the facility, including the resident's right to: - a dignified existence. - be treated with respect, kindness, and dignity . a. Resident #49 was admitted to the facility in October 2017 with diagnoses including: left knee pain, left elbow contracture (permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen), history of traumatic brain injury (TBI: damage to the brain caused by external mechanical force), major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest), and pseudobulbar affect (condition where one may have sudden uncontrollable laughing or crying and can be a result of neurological conditions such as a stroke or TBI), and Dementia (group of symptoms affecting memory, thinking and social abilities). Review of Resident #49's Psychosocial Care Plan, initiated 10/3/17 and revised 3/5/24, indicated: - The Resident yelled and screamed during all care and transfers. - Getting up to a chair was a process of verbal noise, resistive . at times. - The goal was for the Resident to maintain psychosocial well-being throughout the next review date (target date identified as 7/24/24). Review of Resident #49's Activities of Daily Living (ADL) Care Plan, initiated 10/4/17 and revised 8/14/18, indicated the Resident was dependent on two staff for transfers using a mechanical lift. Review of Resident #49's Cognitive Deficit Care Plan, initiated 10/19/18 and revised 7/30/20, indicated the Resident was dependent on staff for meeting emotional . and social needs related to cognitive deficits. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #49's Minimum Data Set (MDS) Assessment, dated 4/25/24, indicated the Resident was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of eight out of 15 total possible points. Review of Resident #49's Behavior Visit Note, dated 5/7/24, indicated the following: - The Resident's baseline status was noted to be agitated with care, yell, scream at others, and exhibit tearfulness. - The Resident's current status included a labile (tendency to fluctuate quickly and abruptly between distinct emotional states) mood with episodes of agitation and resistance to care. - The Resident was noted to yell out frequently during care. b. Resident #48 was admitted to the facility in January 2020 with diagnoses including: Dementia with agitation. Review of Resident #48's Cognition Care Plan, initiated 1/3/20 and revised 4/9/21, indicated the Resident was alert and oriented, and had a diagnosis of Dementia. Review of Resident #48's Psychosocial Care Plan, initiated 3/11/20 and revised on 2/9/24, indicated: - The Resident had altered psychosocial well-being and coping mechanisms. - The Resident was quick to anger, specifically when the words no, don't, or stop. - Staff were to help the Resident to cope by suggesting possible solutions to conflict. Review of Resident #48's Behavior Care Plan, initiated 2/23/21 and revised 2/9/24, indicated: - The Resident had behaviors of yelling, screaming, and swearing at . residents. - One of the triggers for Resident #48's behavior was when staff verbally redirected the resident from engaging in negative behaviors. Review of Resident #48's Dementia with Behavioral Disturbance Care Plan, initiated 12/14/20 and revised 8/23/23, indicated the Resident had been involved in a previous resident to resident altercation and that staff were to: - encourage the Resident to go to a quiet environment with increased stimulation on the Unit. - offer activities of interest. Review of Resident #48's MDS Assessment, dated 2/15/24, indicated the Resident was moderately cognitively impaired as evidenced by a BIMS score of 10 out of 15 total possible points. On 5/30/24 between 2:52 P.M. and 3:14 P.M., the surveyor observed the following: (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident #48 and Resident #49 in their shared room. Resident #48 was lying in bed, looking at the television (TV) and Resident #49 was positioned in his/her wheelchair beside the bed. Resident #49 was crying loudly and Resident #48, in a loud voice said, [He/she] expects everyone to wait on [him/her] just because [his/her] elbow and bum hurt. Resident #48 then turned his/her head toward Resident #49 and said, You just have to wait!. - At this time, the surveyor observed Resident #48 pull the privacy curtain between the two beds forcefully toward a closed position, then said, I'm not talking to you anymore. - The surveyor observed Resident #49 continue to cry out loud and stated loudly that his/her elbow hurt. - The surveyor then observed Resident #48 yell out, You are being a baby!. - The surveyor then alerted Nurse #2, who was at the Nurses' station, that Resident #49 was crying, expressing pain, and that Resident #48 was raising his/her voice at Resident #49. At this time, Nurse #2 said staff offered to assist Resident #49 to bed earlier that afternoon, but the Resident declined. Nurse #2 further said she would ask staff to assist Resident #49 to a more comfortable position, back to bed. Nurse #2 did not address Resident #48's verbal behaviors directed toward Resident #49 at this time. - At 3:03 P.M., the surveyor observed three staff members enter the room, one staff pushed a mechanical lift, and closed the door. - The surveyor heard Resident #49 repeatedly yell that his/her elbow hurt,and while Resident #49 yelled out, Resident #48 yelled, You are an [expletive]! . Now everyone knows about you . Would you be quiet! . I am trying to watch TV! . shut up please and be quiet! . You are crazy!. - The surveyor observed one staff member leave the room pushing the mechanical lift and two staff members remained in the room. The surveyor heard on staff member say, It's okay, we are almost there while Resident #49 yelled loudly. - At this time, the surveyor heard Resident #48 yell, Cover [his/her] face! . You are crazy! . Put some tape on [his/her] mouth! . Nobody likes you anymore! . You're an idiot! - At this time, the surveyor heard Resident #49 yell out, I am not an idiot! . - The surveyor again alerted Nurse #2 that Resident #49 was crying and Resident #48 was raising his/her voice at Resident #49. - By the time the surveyor and Nurse #2 returned to the Residents' room at 3:14 P.M., neither Resident was yelling, Resident #49 was in bed and no longer crying, and no staff were in the room. - At this time, Nurse #2 said Resident #49 yelled a lot during personal care and that he/she would stop yelling as soon as personal care was completed. (continued on next page)

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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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/30/24 at 3:22 P.M., Certified Nurse Aide (CNA) #1 said she was familiar with and had provided care for Resident #48 and Resident #49. CNA #1 said Resident #49 yelled and cried frequently during personal care and that Resident #48 became upset and would yell frequently at Resident #49 during these times. CNA #1 further said that when Resident #48 was yelling at Resident #49 during the surveyor's observation, staff in the room asked Resident #48 to stop and not say the things he/she was saying, but Resident #48 did not listen and did not stop. CNA #1 also said that Resident #48 was trying to watch TV while Resident #49 was yelling during care provided by staff, and that when Resident #48 was distracted from something he\she enjoyed, he/she would get upset and yell. During an interview on 5/31/24 at 2:17 P.M., CNA #4 said Resident #48 frequently got upset and began to yell when he/she saw staff enter the room with the mechanical lift and when Resident #49 yelled during care. Review of Resident #48's May 2024 Medication Administration Record indicated the Resident exhibited no verbal behaviors towards others during any shift on 5/30/24. Review of Resident #48's May 2024 Behavior Monitoring and Interventions CNA Flow Sheet indicated the Resident exhibited no behaviors toward others during any shift on 5/30/24. During a follow-up interview on 6/4/24 at 9:43 A.M., Nurse #2 said she did not record any behaviors on the MAR for Resident #48 on 5/30/24 because she did not directly observe the behavior, even though the behavior was reported to her. Nurse #2 further said the CNAs were supposed to record the Resident's verbal behavior toward Resident #49 because they were the staff to observe the behavior and intervene. Nurse #2 also said all behaviors were entered into the electronic medical record and there was no other location behaviors were recorded for residents. During a follow-up interview on 6/4/24 at 11:41 A.M., CNA #1 said she did not record Resident #48's verbal behavior toward Resident #49 on 5/30/23 because the behavior occurred from the day (7:00 A.M.-3:00 P.M.) shift into the evening (3:00 P.M.-11:00 P.M.) shift, so she thought the evening CNAs would record the behavior. During an interview on 6/4/24 at 10:40 A.M., the Director of Nursing (DON) said staff who observed resident behaviors and provided interventions for behaviors were to record the behaviors and interventions provided on the residents' behavior monitoring records in the electronic health record. The DON said that recording residents' behaviors, interventions provided, and the effectiveness of the interventions was the facility's process for behavior monitoring. The DON also said the other process to assist with behavior monitoring and identifying effective interventions was to discuss residents' behaviors at the facility's weekly Risk Meeting. The DON said staff who had observed Resident #48's verbal behaviors toward Resident #49 on 5/30/24 should have recorded the behaviors, interventions, and effectiveness of the interventions on Resident #48's electronic health record, but they did not. The DON also said Resident #48's verbal behaviors directed toward others had not been discussed at the facility's weekly Risk Meeting. The DON said staff had not made him aware that Resident #48 reacted with verbal behaviors towards Resident #49 when staff brought the mechanical lift into the Residents' room and that staff should think about offering an alternate activity to Resident #48 when Resident #49 was going to receive care in order to minimize the risk for verbal behaviors directed toward Resident #49.