STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225216	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fitchburg Healthcare	1199 John Fitch Hwy Fitchburg, MA 01420

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews for one of three sampled residents (Resident #1) who was severely cognitively impaired, the Facility failed to ensure he/she was treated in a respectful and dignified manner, when during the provision of care, two staff members overheard Certified Nurse Aide (CNA) #1 interacting with Resident #1, during which CNA #1 used profanities and spoke to him/her in a raised, very loud tone of voice.Findings include:Review of the Facility's Policy titled, Abuse Investigation and Reporting, dated as last revised February 2024, indicated that every resident in the facility will be treated with respect and dignity. Review of the Facility's Policy titled, Resident Rights, dated as last revised January 2024, indicated all residents have a right to a dignified existence and employees shall treat all residents with kindness, respect, and dignity.Resident #1 was admitted to the Facility in May 2025, diagnoses included Lewy Body Dementia (a type of brain disease characterized by the accumulation of abnormal protein deposits called Lewy bodies in the brain) and Post Traumatic Stress Disorder (PTSD, a mental health condition that can develop after experiencing or witnessing a traumatic event).Review of Resident #1's admission Minimum Data Set Assessment, dated 05/26/25, indicated he/she had severe cognitive impairment as evidenced by a score of 01 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).Further review of the MDS Assessment indicated Resident #1 usually understood others (missed some part/intent of message but comprehended most conversation), experienced hallucinations, physical and verbal behavioral symptoms directed toward others, and a history of rejection of care. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 07/14/25, indicated that on 07/14/25, the Shift Supervisor notified the Director of Nursing (DON) that a Unit Nurse requested the Shift Supervisor's assistance because the Unit Nurse said she heard yelling and cursing coming from the hallway bathroom, which was occupied by a Certified Nurse Aide (later identified as CNA #1) and a resident (later identified as Resident #1). Review of the Facility's Incident Summary indicated the Administrator interviewed CNA #1 who said she told Resident #1, I am sick of this [NAME] and [NAME] shit (Resident's name), come on! The Report also indicated the Administrator asked CNA #1 if she made any additional unprofessional, vulgar, or inappropriate comments and that CNA #1 told him she could not recall exactly what she said but acknowledged she may have used the word dumbass.During an interview on 09/17/25 at 12:07 P.M. (which also included a review of her written witness statement, dated 07/14/25), Nurse #1 said on 07/14/25, just after dinner time (exact time unknown), she was behind the nursing station when she heard yelling coming from the hallway bathroom which was located diagonally across from where she was standing. Nurse #1 said she heard CNA #1 shouting, stop, stop, stop, you fucking dumb ass, coming from behind the closed bathroom door. Nurse #1 said she immediately responded to the shouting by banging on the bathroom door, telling CNA #1 to immediately stop what she was doing and to exit the bathroom. Nurse #1 said CNA #1 told her (through the closed door) she was unable to open the door because Resident #1 was not in a safe position for her to leave his/her side. Nurse #1 said she then summoned two other unit CNAs to stand at the door while she went to the adjacent unit to elicit help from the Shift Supervisor.Nurse #1 said that CNA #1 finally opened the bathroom door, and she and the Shift Supervisor told CNA #1 to leave the Unit, and the two other unit CNAs assumed completion of care for Resident #1.During a telephone interview on 09/17/25 at 1:44 P.M. (which also included a review of her written witness statement, dated 07/14/25), CNA #2 said she was working during the 3:00 P.M. to 11:00 P.M. shift on 07/14/25 and just after dinnertime (exact time unknown) she heard CNA #1 yelling and cursing from behind the bathroom door (near the nursing station). CNA #2 said she heard CNA #1 yell, you fucking stand up and said she also heard CNA #1 use the word dumbass and that CNA #1 was being very loud towards Resident #1.CNA #2 said that Nurse #1 requested that she and another CNA stand at the bathroom door, and said after CNA #1 finally opened the door, she and the other CNA went into the bathroom to assist Resident #1.During a telephone interview on 09/17/25 at 2:04 P.M. (which also included a review of her written witness statement, dated 07/14/25), the Shift Supervisor said Nurse #1 came to request her assistance regarding an incident involving CNA #1 and Resident #1 in the bathroom. The Shift Supervisor said Nurse #1 told her that CNA #1 was yelling profanities at Resident #1, that she tried to get CNA #1 to exit the bathroom, and that CNA #1 was not removing herself from the situation, despite Nurse #1's insistence. The Shift Supervisor said when she arrived on the Unit with Nurse #1, CNA #1 was still in