

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225216	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/30/2025
NAME OF PROVIDER OR SUPPLIER Fitchburg Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observation, interviews and records reviewed, for one of three sampled residents (Resident #1), who resides on a secured Dementia unit, has a known behavior that includes physical aggression and has been involved in multiple resident to resident physical and verbal altercations, the Facility failed to ensure that they provided him/her with an adequate level of staff supervision on the unit to maintain residents safety in an effort to prevent resident to resident altercations, therefore placing him/her and other residents on the unit at risk for injury. Findings include: Review of the Facility policy titled, Care Plan, comprehensive Person-centered, revised 01/2024, indicated a comprehensive, person-centered care plan will be developed for each resident. The policy indicated a care plan will include objectives that meet the residents' physical, psychosocial and functional needs. The policy indicated that the resident comprehensive care plan will identify problem areas and their causes as warranted and develop interventions that are targeted and meaningful to each resident. Review of the report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 02/26/25, indicated there was a resident-to-resident altercation involving Resident #1 and Resident #3, when Resident #1 put his/her hand on Resident #3's neck, resulting in a skin tear (laceration) to Resident #1. Review of the report submitted by the Facility via the HCFRS, dated 06/16/25, indicated a resident-to-resident altercation involving Resident #1 and Resident #2 had occurred when Resident #1 went into Resident #2's room and stood over him/her resulting in scratches to Resident #1. Review of the report submitted by the Facility via the HCFRS, dated 08/13/25, indicated a resident-to-resident altercation was witnessed by staff in which Resident #1 was observed to have pinched another Resident. Review of the report submitted by the Facility via the HCFRS, dated 09/15/25, indicated a resident-to-resident altercation involving Resident #1 and Resident #2 had occurred while Resident #1 was standing in Resident #2's room doorway. Review of the report submitted by the HCFRS, dated 12/12/25, indicated a resident-to-resident altercation involving Resident #1 and Resident #2 had occurred, on when Resident #1 removed the STOP sign and entered Resident #2's room resulting in a laceration to Resident #1. Review of the report submitted by the Facility via the HCFRS, dated 12/20/25, indicated a resident-to-resident altercation involving Resident #1 and Resident #2 had occurred when Resident #1 removed the STOP sign and approached Resident #2 while he/she was in bed resulting in a bruise to Resident #1. Resident #1 was admitted to the Facility October 2023, diagnoses included Alzheimer's dementia, dementia with unspecified severity with other behavioral disturbance, generalized anxiety disorder and insomnia. Review of Resident #1's Minimum Data Set (MDS) Assessment, dated 10/06/25, indicated he/she was severely cognitively impaired and wandered, placing the resident at significant risk of getting into a potentially dangerous place, was dependent for activities of daily living (eating, toileting, hygiene, dressing) and required supervision for ambulation. Review of Resident #1's Behavior Care Plan, dated as initiated 04/12/2024 and reviewed/revised on 12/26/25, indicated Resident #1 wanders on the unit, refuses/resists care, rummages, paces and throws/smears food, finds furnishings and will attempt and be successful at taking them apart or destroying items, enters other residents' rooms and is difficult to redirect at times, takes his/her personal belongings such as blankets, clothes, activity items, decorations etc. and throw/places them into trash receptacles, is aggressive towards [Spouse] at times and puts non-food items in his/her mouth and will refuse to allow staff to remove. Resident #1's Behavior Care Plan Interventions included; encourage [spouse]/health care proxy to not try and force resident to do things that he/she is showing signs of not wanting to do, invite and encourage activity programs consistent with established interests, offer snacks or drinks as a redirection tactic, provide non-confrontational environment for care, when agitated reapproach at a later time when resident is less agitated. Resident #2 was admitted to the Facility in July 2022, diagnoses included unspecified dementia with other behavior disturbance, cerebral infarction (stroke), diabetes mellitus and Schizophrenia (brain disorder that disrupts how a person thinks, feels and behaves). Review of Resident #2's Minimum Data Set (MDS) Assessment, dated 12/08/25, indicated he/she was cognitively intact, exhibited physical, verbal, and other behavior symptoms, rejected care, was dependent on staff for toileting, hygiene, dressing and required supervision for ambulation. Review of Resident #2's Behavior Care Plan, dated as initiated 04/29/25 and reviewed/revised 12/26/25, indicated he/she rejected/refused care, was sexually inappropriate, had angry outburst, and had a history of assaultive behaviors. Resident #2's Behavior Care Plan intervention included; encourage to call for assistance if someone enters his/her room, encourage to keep the STOP sign on his/her door at all times, when agitated reapproach at a later time when he/she is</p>		