STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225219	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bear Mountain at Worcester	59 Acton Street Worcester, MA 01604

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 0693 Level of Harm - Actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - 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 had a gastrostomy tube (G tube, placed through the abdomen into the stomach, for feedings, liquids and medications) in place to meet his/her nutritional and fluid intake needs, and whose physician's orders included formula feeds, water flushes and medication administration through the G tube, the Facility failed to ensure that Resident #1 was provided with appropriate treatment and services when his/her G tube was replaced by a Facility Nurse, and formula feeding and water flushes were administered into the incorrectly positioned G tube resulting in a change in Resident #1's condition, with subsequent need for transfer and admission to the Hospital. Findings include:Review of the Facility policy titled Enteral Feedings, undated, indicated the procedures for administering enteral feed formulas and flushes, changing administration set tubing and verification of tube placement. Review of the policy indicated there was no evidence to support that nursing staff were allowed to insert a gastrostomy tube. The Facility was also unable to provide any documentation to support the nurses had received clinical training on G tube insertion. Review of the Covidien Kangaroo Gastrostomy Feeding Tube manufacturer's instructions, dated as revised 12/2018, provided by the Facility, indicated the device should only be inserted by a trained clinician. Resident #1 was admitted to the Facility in [DATE], diagnoses included but not limited to acute respiratory failure with hypoxia (low oxygen), dependence on respirator (ventilator), cerebral infarct (stroke-damage to brain from interruption in blood supply), dysphagia (difficulty swallowing) and gastrostomy. Review of Resident #1's Nutrition Care Plan, date initiated [DATE], indicated the following:Tube feedings will provide 100% of estimated needs for nutrition/hydration. Check placement and patency of tube prior to initiating tube feeding. Review of Resident #1's Physician's orders for the month of [DATE], related to G tube feeds and water flushes indicated it included orders for, but not limited to the following:Enteral Feed Order-Vital 1.5 at 50 milliliters per hour (ml/hr) via PEG (gastrostomy) tube daily, start date [DATE].Water flushes 400 ml via PEG every six hours, start date [DATE].Document tube feed/water intake every shift, start date [DATE]. Review of Resident #1's Medication Administration Record (MAR) for the month of [DATE] indicated the following was documented as administered:[DATE]-Day Shift-Enteral Feed Order-Vital 1.5 at 50 ml/hr, documented as administeredXXX[DATE]-Day Shift-Water flushes 400 ml via PEG every six hours, documented as administeredXXX[DATE]-Day Shift-Document tube feed/water intake every shift-documented as administered: feed-400, water 400. Review of Resident #1's Nurse Progress Note, dated [DATE], indicated the following:Guardian updated on (Resident #1) removing his/her PEG tube today and that we replaced it with a G-tube. He/she now has 18 French (Fr) 20 milliliter (ml) (size of gastrostomy tube) and orders changed to support that and changing times.Review of Resident #1's Provider Progress Note, dated [DATE], indicated that the Nurse Practitioner was informed by the Unit Manager that Resident #1's PEG tube fell out this morning and that we replaced it with a G-tube, so it will need to be replaced every three months now. The Provider Progress Note indicated that at approximately 3:30 P.M., Resident #1 was examined by his/her Physician and observed to have abdominal distention after bedside G Tube replacement and that Resident #1 was to be sent to the Hosptial Emergency Department (ED).During a telephone interview on [DATE] at 10:00 A.M., the Physician said that on [DATE] at approximately 3:30 P.M., she was made aware that a facility nurse had inserted a G-tube into Resident #1. The Physician said she then assessed Resident #1, found his/her abdomen to be distended, that she was unable to withdraw gastric contents to verify placement of the G tube, ordered the feeding stopped and ordered Resident #1 to be transferred to the hospital. The Physician said that G tube placement should have been checked with Gastrografin (a contrast medium injected into a tube followed by an X ray that is used to confirm proper G tube placement after insertion), prior to the G tube being used. Review of Resident #1's Hospital Record indicated the following:The Hospital Emergency Department (ED) Report, dated [DATE], indicated Resident #1 was transferred to the ED for PEG (gastrostomy tube) study when he/she was found to be significantly hypotensive by Emergency Medical Services (EMS). On arrival at the Emergency Department (ED) Resident #1 had no pulse and cardiopulmonary resuscitation (CPR) was initiated. Resident #1 achieved return of spontaneous circulation after one round of CPR. The Critical Care History and Physical, dated [DATE], indicated Resident #1 had his/her PEG tube replaced with a G-tube at [nursing facility], on [DATE] at around 12:00 P.M., at which time tube feeds were continued. Computed Tomography (CT) scan of the abdomen and pelvis, dated [DATE], indicated that the gastrostomy tube was mal-positioned

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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 0726 Level of Harm - Actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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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 0726 Level of Harm - 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 had a gastrostomy tube (G tube, placed through the abdomen into the stomach, for feedings, liquids and medications) in place to meet his/her nutritional and fluid intake needs, the Facility failed to ensure nursing staff were competent related to gastrostomy tubes (G tube) and appropriate actions to take when dislodged, when after Resident #1's G Tube became dislodged, nursing inserted a new G Tube and restarted his/her tube feeding without verifying tube placement, resulting in a change in Resident #1's condition, he/she subsequently required transfer and admission to the Hospital. Findings include:Review of the Facility policy titled Enteral Feedings, undated, indicated the procedures for administering enteral feed formulas and flushes, changing administration set tubing and verification of tube placement. Review of the policy indicated there was no evidence to support that nursing staff were allowed to insert a gastrostomy tube. The Facility was also unable to provide any documentation to support the nurses had received clinical training on G tube insertion. Review of the Covidien Kangaroo Gastrostomy Feeding Tube manufacturer's instructions, dated as revised 12/2018, provided by the Facility, indicated the device should only be inserted by a trained clinician. Review of Nurse #1's Required Competency, dated [DATE] indicated there was no documentation to support that Nurse #1 had been trained or was competent to insert G Tubes. Resident #1 was admitted to the Facility in [DATE], diagnoses included but not limited to acute respiratory failure with hypoxia (low oxygen), dependence on respirator (ventilator), cerebral infarct (stroke-damage to brain from interruption in blood supply), dysphagia (difficulty swallowing) and gastrostomy.Review of Resident #1's Hospital Record indicated the following:The Emergency Department (ED) Report, dated [DATE], indicated Resident #1 was being transferred to the Hospital for PEG (gastrostomy tube) study when he/she was found to be significantly hypotensive by Emergency Medical Services (EMS). On arrival at the Emergency Department (ED) Resident #1 had no pulse and cardiopulmonary resuscitation (CPR) was initiated. Resident #1 achieved return of spontaneous circulation after one round of CPR. The Critical Care History and Physical, dated [DATE], indicated Resident #1 had his/her PEG tube replaced with a G-tube at [nursing facility], on [DATE] at around 12:00 P.M., at which time tube feeds were continued. Computed Tomography (CT) scan of the abdomen and pelvis, dated [DATE], indicated that the gastrostomy tube was malpositioned (not in the stomach) with the balloon and tip within the peritoneum (membrane that lines the abdominal cavity) with associated moderate free air and moderate free ascites (accumulation of fluid). During a telephone interview on [DATE] at 10:00 A.M., the Facility Physician said that on [DATE] at approximately 3:30 P.M., she was made aware that a Facility nurse had inserted a G-tube into Resident #1. The Physician said she assessed Resident #1, found his/her abdomen to be distended, that she was unable to withdraw gastric contents to verify placement of the G tube, ordered the feeding stopped and ordered Resident #1 to be transferred to the hospital. The Physician said that G tube placement should be checked with Gastrografin (a contrast medium injected into a tube followed by an X ray that is used to confirm proper placement of a G tube after insertion), prior to the G tube being used. Review of Nurse #1's written statement, undated, indicated that Nurse #1 had notified Unit Manager #1 that Resident #1's G tube had been dislodged. The statement indicated that Unit Manger #1 had notified the Provider, and that Nurse #1 had replaced the G tube, administered medication and restarted the tube feeding. The Surveyor was unable to interview Nurse #1, as she did not respond to the Department of Public Health's request for an interview. During an interview on [DATE] at 12:35 P.M., Unit Manager #1 said that on [DATE], she instructed Nurse #1 to insert a G tube into Resident #1. Unit Manager #1 said she did not assess Resident #1 or review the Facility policy prior to giving Nurse #1 instructions to insert a G tube into Resident #1.During an interview on [DATE] at 2:00 P.M., the Director of Nurses (DON) said Nurse #1 should not have inserted a G tube into Resident #1 and that the Facility did not have a policy or protocol to support this practice.On [DATE], the Facility was found to be in Past Non-Compliance and presented the Surveyor with a plan of correction, with an effective date of [DATE], which addressed the areas of concern as evidenced by:a) Resident #1 was transferred and admitted to the hospital on [DATE] for treatment.b) Nurse #1 and Unit Manager #1 have received disciplinary actions for not following Facility policy related to G tube insertion.c) The Facility has revised the Enteral Feedings policy (effective 05/2025) to include a statement that no licensed professionals (Nurses/Physicians, Nurse Practitioners etc.) will replace or insert any enteral tube at the facility. Any replacement/insertion of enteral tubes will be performed at the