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	09/15/2025

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interviews and records reviewed, for one of three sampled residents (Resident #1) who reported an allegation of verbal abuse to a staff member, the Facility failed to ensure staff implemented and followed the Facility Abuse Prohibition Policy, when the staff member did not immediately report the allegations to the shift supervisor/charge nurse/manager or the Administrator/designee. Findings include: The Facility Policy titled Administration, last reviewed 10/2022, indicated that the Facility prohibited abuse, that all staff would notify the shift supervisor/charge nurse/manager immediately if suspected abuse occurred, that the incident would be reported to the Director of Nursing and the Administrator and to the DPH within two hours. Resident #1's medical record indicated he/she was admitted to the Facility during May of 2025. Resident #1's most recent Minimum Data Set (MDS) Assessment, dated 5/22/25, indicated his/her cognitive patterns were moderately impaired.Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 7/16/25, indicated Resident #1 reported that the Social Worker screamed at him/her and called him/her a crackhead.During a telephone interview on 9/23/25 at 12:51 P.M., the Nurse Practitioner (NP) said that on 7/15/25 Resident #1 told her that the Social Worker screamed at him/her and called him/her a crackhead. The Nurse Practitioner said that she did not report Resident #1's statement to the shift supervisor/charge nurse/manager immediately or to the Administrator or Director of Nursing. The Nurse Practitioner said that she documented Resident #1's comments in a Progress Note.Review of the Nurse Practitioner's Progress Note, dated 7/15/25, indicated Resident #1 told this writer (the NP) that the Social Worker screamed at him/her, told him/her that he/she should go and kill him/herself and called him/her a crackhead.During an interview on 9/15/25 at 2:00 P.M. the Director of Nursing said that on 7/16/25, she learned that on 7/15/25, the Nurse Practitioner documented in a Progress Note that Resident #1 alleged that the Social Worker screamed at him/her, told him/her that he/she should go and kill him/herself and called him/her a crackhead. The Director of Nursing said that the Nurse Practitioner had not informed her or the Administrator of the allegation on 7/15/25, in accordance with the Facility Policy.On 9/15/25, the Facility was found to be in Past Non-Compliance and presented the Surveyor with a plan of correction, with an effective date of 7/25/25, which addressed the area(s) of concern as evidenced by:A) On 7/16/25, the Nurse Practitioner was suspended and subsequently terminated.B) On 7/16/25 and on-going until his/her discharge in August 2025, Resident #1 received support and counseling from the Behavioral Health Service.C) Between 7/16/25 and 7/22/25, the Director of Nursing/designee trained all Facility staff members on the Facility Abuse Policy.D) Between 7/16/25 and 7/24/25, the Director of Nursing/designee interviewed all Facility residents without identifying further allegations which had not been reported.E) On 7/25/25, the Facility held an ad hoc meeting of the Quality Assurance Committee to review the correction plan.F) On 7/16/25 and on-going, the Facility leadership (Administrator, Director of Nursing and Regional Staff) initiated a process for daily interviews of a sampled of direct care staff in order to assess their understanding of the Facility Abuse Policy.G) In July 2025 and on-going, Facility leadership (Administrator, Director of Nursing and Regional) initiated monthly meetings with the Ombudsman and Resident Council to ensure relevant concerns had been reported timely in accordance with the Facility Abuse Policy.H) On 7/16/25 and on-going, Facility leadership (Administrator, Director of Nursing and Regional Staff) initiated a daily review of all Progress Notes to ensure relevant concerns had been reported timely in accordance with the Facility Abuse Policy.I) The Administrator/designee are responsible for overall compliance.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interviews and records reviewed, for one of three sampled residents (Residents #1), the Facility failed to ensure that after being made aware on 6/02/25 of an allegation of verbal abuse by a staff member, that the incident was reported to the Department of Public Health (DPH), within two hours, as required. Findings include: The Facility Policy titled Administration, last reviewed 10/2022, indicated that the Administrator would report allegations to the DPH within two hours. Resident #1's medical record indicated he/she was admitted to the Facility during May of 2025. Resident #1's most recent Minimum Data Set (MDS) Assessment, dated 5/22/25, indicated his/her cognitive patterns were moderately impaired.Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 7/16/25, indicated Resident #1 reported the Social Worker screamed at him/her and called him/her a crackhead. During an interview on 9/15/25 at 2:00 P.M. the Director of Nursing said that on 7/16/25 she learned that Resident #1 had told the Nurse Practitioner on 7/15/25 that the Social Worker screamed at him/her, told him/her that he/she should go and kill him/herself and called him/her a crackhead. The Director of Nursing said during that investigation into Resident #1's allegation, she learned that another allegation had previously been reported to the Former Administrator. The Director of Nursing said that a Written Witness Statement (dated 6/02/25) from the Behavioral Department Staff Member was found on the Former Administrator's desk. Review of the Written Witness Statement from the Behavioral Staff Member, dated 6/02/25, indicated the Behavior Staff Member witnessed the Social Worker and Resident #1 having a discussion and during the discussion, the Social Worker called Resident #1 a crack addict and berated and taunted him/her.During a telephone interview on 9/16/25 at 3:20 P.M., the Behavioral Department Staff Member said that he witnessed the Social Worker argue with and yell at Resident #1 and call him/her a drug seeking crackhead. The Behavioral Department Staff Member said that he reported his observation to the immediate supervisor and the Former Administrator.The Surveyor was unable to interview the Former Administrator as he did not respond to the DPH's telephone or email requests for an interview.The Director of Nursing said that the Former Administrator told her that he handled the Behavior Department Staff Member's report as a grievance and did not report the allegation that the Social Worker verbally abused Resident #1 to the DPH, as required.The Director of Nursing said that she submitted a report via the HCFRS on 7/16/25, (regarding the 6/02/25 incident) about six weeks after the allegation had been reported to the Former Administrator.On 9/15/25, the Facility was found to be in Past Non-Compliance and presented the Surveyor with a plan of correction, with an effective date of 7/25/25, which addressed the area(s) of concern as evidenced by: A) On 7/16/25, the Former Administrator was suspended and subsequently terminated. B) On 7/16/25 and on-going until his/her discharge in August 2025, Resident #1 received support and counseling from the Behavioral Health Service. C) Between 7/16/25 and 7/22/25, the Director of Nursing/designee trained all Facility staff members on the Facility Abuse Policy. D) Between 7/16/25 and 7/24/25, the Director of Nursing/designee interviewed all Facility residents without identifying further allegations which had not been reported. E) On 7/25/25, the Facility held an ad hoc meeting of the Quality Assurance Committee to review the correction plan. F) On 7/16/25 and on-going, the Facility leadership (Administrator, Director of Nursing and Regional Staff) initiated daily interviews of a sample of staff members to assess their understanding of the Facility Abuse Policy. G) In July 2025 on-going Facility leadership (Administrator, Director of Nursing and Regional Staff) initiated monthly meetings with the Ombudsman and Resident Council to ensure relevant concerns had been reported timely in accordance with the Facility Abuse Policy. H) On 7/16/25 and on-going, Facility leadership (Administrator, Director of Nursing and Regional Staff) initiated a daily review of all Progress Notes to ensure relevant concerns had been reported timely in accordance with the Facility Abuse Policy. I) The Administrator/designee is responsible for overall compliance.