STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225262	A. Building B. Wing	10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bear Mountain at West Springfield	42 Prospect Avenue West Springfield, MA 01089

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 37227 Based on interviews and records reviewed, for one of three sampled residents (Resident #1), who was cognitively intact and had the potential to be verbally aggressive, the Facility failed to ensure he/she was free from physical abuse by a staff member, when on 10/02/24 at approximately 12:30 P.M. (exact time unknown), Nurse #1 engaged in a verbal altercation with Resident #1 during which she grabbed his/her chin and reprimanded him/her for his/her behavior. Nurse #1 admitted to physically touching Resident #1 during the altercation. Findings include: Review of the Facility's policy titled Abuse Prohibition, dated as revised 02/20/23, indicated residents will not be subject to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers, and staff of other agencies serving the resident, family members or legal guardians, friends or other individuals. The Policy indicated that physical abuse included hitting, slapping, pinching, scratching, spitting, holding roughly, kicking etc. The Policy indicated that physical abuse also included controlling behavior through corporal punishment. Resident #1 was admitted to the Facility in March 2023, diagnoses included Parkinsonism, bipolar disorder, anxiety disorder and major depressive disorder. Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 09/22/24, indicated that Resident #1 was cognitively intact, with a score of 15 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). The Assessment indicated Resident #1 exhibited verbal and other behaviors 4 to 6 days per week, during the assessment period. Review of Resident #1's Behavior Care Plan, reviewed and renewed with the Quarterly MDS completed 09/22/24, indicated he/she exhibits persistent requests, becomes easily anxious and easily agitated when he/she does not get immediate gratification therefore he/she can be accusatory and hypercritical of others and verbally abusive toward staff. The Care Plan interventions identified for Resident #1 included the following: (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Provide one-to-one with Resident #1 and allow him/her to express his/her frustrations and fears. Let Resident #1 know if any of his/her requests are beyond the reach of the Facility and attempt to problem solve ways that would work to fulfill his/her requests. -When Resident #1 becomes agitated, intervene before agitation escalates, guide away from source of distress, and engage calmly in conversation. If the response is aggressive, staff should walk calmly away and reapproach later. Review of Resident #1's Behavioral Health Note, dated 10/01/24, indicated Resident #1 requested a medication evaluation. The Note indicated Resident #1 reported that he/she wanted his/her medication adjusted so that he/she was not so angry and verbally aggressive. The Note indicated that Resident #1 said he/she was distressed by his/her behavior. The Note indicated there was a plan to check labs and to consider continuing Depakote (anticonvulsant, used as a mood stabilizer) 500 milligrams (mg) twice a day (BID) given at 8:00 A.M. and 8:00 P.M., and add Depakote 250 mg, at 2:00 P.M. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 10/02/24, indicated that during an altercation, Nurse #1 grabbed Resident #1's chin and Resident #1 slapped her, and threw water at her. The Report indicated the Facility substantiated the allegation of abuse when Nurse #1 admitted to grabbing Resident #1 by the chin, and Nurse #1 was terminated. Review of a text message sent from Nurse #1 to Administrator #2, dated 10/02/24 at 2:53 P.M., indicated Nurse #1 admitted to grabbing Resident #1's chin [during the altercation earlier that day] and that she had resigned from her position at the Facility. During an interview on 10/15/24 at 10:35 A.M., Resident #1 said that prior to the incident on 10/02/24, he/she had recognized a change in his/her mood and said he/she had felt anger and rage at times. Resident #1 said he/she felt bad for expressing his/her anger by saying mean things to staff. Resident #1 said that on Friday [09/27/24] he/she had communicated his/her change in mood to the nursing staff. Resident #1 said his/her medications were evaluated by a Behavioral Health Practitioner [on 10/01/24, the day before the incident] and that the Practitioner had recommended adding an additional 250 mg of [Depakote] his/her mood stabilizer medication. Resident #1 said that on 10/02/24, around lunch time (exact time unknown), Nurse #1 entered his/her room to administer his/her medications and that he/she asked for a mood stabilizer. Resident #1 said that he/she yelled and swore at Nurse #1 when she told him/her that an extra dose of a mood stabilizer had not yet been approved by the physician. Resident #1 said that Nurse #1 grabbed him/her, roughly, by the chin, and yelled at him/her, in response to his/her outburst. Resident #1 said that Nurse #1 yelled and said to him/her she was sick and tired of his/her acting out when she was only trying to help him/her, and that she was trying her best. Resident #1 said that he/she responded by pushing Nurse #1's hand away from his/her chin and that he/she threw a cup of water in Nurse #1's direction, as she turned and walked away. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 10/16/24 at 10:14 A.M., Nurse #1 said that she went to administer Resident #1's medication on 10/02/24 at approximately 12:30 P.M., and Resident #1 requested a mood stabilizer. Nurse #1 said that when she told Resident #1 that the physician had not yet ordered the extra dose of the mood stabilizer, he/she became angry and started yelling. Nurse #1 said that Resident #1 directed profanity at her and told her she was a lousy nurse. Nurse #1 said that Resident #1 slapped her hand and threw a cup of water at her. Nurse #1 said that as she stepped away from Resident #1, she slipped in the water and landed on the floor. Nurse #1 said that she grabbed and held Resident #1's chin as you would do to a little child to get his/her attention and told him/her that his/her behavior needed to stop, right now! During a telephone interview on 10/22/24 at 8:17 A.M., the Licensed Clinical Social Worker (LICSW) said she visited with Resident #1 at 1:00 P.M. on 10/02/24, shortly after the incident with Nurse #1. The LICSW said that when she entered Resident #1's room, he/she appeared irritated and was yelling loudly. The LICSW said that Resident #1 told her that Nurse #1 grabbed his/her face during an altercation. The LICSW said that Resident #1 told her that he/she pushed Nurse #1's hand from his/her chin, and he/she inadvertently made contact with (Nurse #1's) face, but denied intentionally slapping her. The LICSW said that Resident #1 told her that he/she threw water at Nurse #1. The LICSW said that Resident #1 usually had a good rapport with Nurse #1, and that his/her moods had been deregulated leading up to the incident, and that Behavioral Health Services had been actively involved with Resident #1's behavioral health treatment plan. Nurse #1 said that grabbing Resident #1's chin during the altercation was wrong. Nurse #1 said she reported her actions to the Social Worker, before she left the Facility to seek medical care, and that she reported her actions to the Administrator, via text message. During an interview on 10/15/24 at 12:19 P.M., the Social Worker said she first learned about the altercation between Resident #1 and Nurse #1 on 10/02/24, when she (Nurse #1) interrupted the At-Risk Meeting around 1:30 P.M., and asked to be relieved so that she could seek medical care for a fall in Resident #1's room. The Social Worker said there was no abuse allegation at that time, when she spoke with Nurse #1. The Social Worker said that around 2:00 P.M., when she returned to her office after the At-Risk Meeting, Nurse #1 told her that she had grabbed Resident #1 by the chin during the altercation. During an interview on 10/15/24 at 12:00 P.M., the Case Manager said that on 10/02/24 sometime between 1:30 and 2:00 P.M., Nurse #1 told her that Resident #1 became angry during medication pass and said that he/she (Resident #1) slapped her (Nurse #1) and threw water at her. The Case Manager said Nurse #1 told her that she grabbed Resident #1 by his/her chin to get him/her to listen. During a telephone interview on 10/16/24 at 12:47 P.M., Administrator #2 said that on 10/02/24 Nurse #1 told him that around 12:30 P.M., she slipped and fell after Resident #1 had thrown water at her. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator #2 said the Social Worker told him that Nurse #1 had admitted to grabbing Resident #1's chin during the altercation. The Administrator said Nurse #1 sent him a text message that said she had grabbed Resident #1's chin during the altercation and that she wished to resign from her position at the Facility. Administrator #2 said the outcome of the Facility's Internal Investigation was that the allegation of physical abuse was substantiated and that Nurse #1's last day of employment at the Facility was 10/02/24.