STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225296	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quabbin Valley Healthcare	821 Daniel Shays Highway Athol, MA 01331

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 - 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 record reviewed and interviews, for two of three sampled residents (Resident #1 who was severely cognitively impaired and required assistance from staff for mobility and Resident #2 who was cognitively intact and dependent on his/her call light to alert staff of his/her needs), the Facility failed to ensure they were free from abuse by a staff member when: A). On 03/28/24 at approximately 6:00 P.M., Certified Nurse Aide (CNA) #1, was witnessed by Visitor #1 as she forcefully transferred Resident #1 to his/her bed. CNA #1 was then witnessed by both Visitor #1 and Nurse #1, as she forcefully pushed Resident #1 down on his/her bed when he/she tried to get up. Resident #1 was visibly upset and trembling after the incident, was fearful during a skin assessment on the following day, and was found to have three new bruises and two reddened areas on his/her left hand and collarbone that were not present, prior to the incident. B). On 04/03/24 (exact times unknown) CNA #3, was witnessed by Nurse Aide #A as she removed the call light, more than once, away from and out of Resident #2's reach and was heard telling Resident #2 that he/she was in a time-out for using the call light too much, leaving him/her without a way to request staff assistance, if needed. Findings include: Review of the Facility Policy, titled Abuse Policy and Procedure, dated as revised in 2024, indicated it is the policy of the Facility to maintain an environment free of abuse, neglect, and exploitation. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, deprivation, and involuntary seclusion. Residents will not be subjected to abuse by anyone including, but not limited to any staff, other residents, consultants, volunteers, staff, or other agencies serving the residents, family members or legal guardians, friends, or other individuals, (caretakers). A) Resident #1 was admitted to the Facility in October 2023 with diagnoses including generalized anxiety disorder, unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225296	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quabbin Valley Healthcare	821 Daniel Shays Highway Athol, MA 01331

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 - Actual harm Residents Affected - Few	Resident #1's most recent Minimum Data Set (MDS) Assessment, dated 03/20/24, indicated his/her cognitive skills for daily decision making were severely impaired. The Assessment also indicated Resident #1 required moderate assistance from staff for transfers and he/she was dependent on staff for activities of daily living (ADLs). Review of Resident #1's Nurses Note, dated 03/28/24, indicated Visitor #1 ran into the day room in distress and said, you need to come right now! The Note indicated Visitor #1 told Nurse #1 that she had witnessed a CNA (later identified as CNA #1) throw Resident #1 onto his/her bed. The Note indicated that as Nurse #1 approached Resident #1's bed, she heard Resident #1 say Stop that! and Don't hit me! The Note indicated that when Nurse #1 entered Resident #1's room she saw a CNA (CNA #1) push the resident[Resident #1] on the shoulder down onto the bed, hard. The Note indicated Nurse #1 dismissed CNA #1 and she took over Resident #1's care. The Note indicated Nurse #1 sat with Resident #1 until he/she calmed down. Review of the Police Department's Report, dated 03/28/24, indicated a Police Officer responded to a 911 call made by the Facility at 6:08 P.M. The Report indicated that Visitor #1 told the Officer that she witnessed CNA #1 abusing her family member's roommate (later identified as Resident #1). The Report indicated that Visitor #1 told the Officer that she witnessed CNA #1 throw Resident #1 onto his/her bed. The Report indicated that Visitor #1 told the Officer that when Resident #1 was laying on his/her bed, CNA #1 picked him/her up and threw him/her back down, causing him/her to bounce slightly on the bed. The Report indicated that Visitor #1 became upset and started crying while describing the incident to the Officer. The Report indicated CNA #1 told the Officer she put Resident #1's wheelchair next to his/her bed and quickly transferred him/her into the bed. The Report indicated that CNA #1 told the Officer that Resident #1 grabbed the back of her arm and pinched her. The Report indicated that CNA #1 told the officer that in response to the pain from being pinched, she sped up the transfer and placed Resident #1 onto the bed, harder than usual. Review of Resident #1's Medical Record indicated his/her Health Care Proxy (HCP) was activated on 10/14/23. Review of Resident #1's Skin Assessment, dated 03/28/24, indicated his/her skin was clean and intact. Review of Resident #1's Skin Assessment, dated 03/29/24 indicated the following: - Left shoulder (front) three medium purple areas along the collar bone. The anterior area was the largest (1 cm) and irregularly shaped, the second area was approximately .5 cm and irregular shaped and the third area was approximately .25 cm. - Two small, reddened areas on the left wrist and the back of the left hand, both less than .5 cm with irregular outlines. Review of Resident #1's Skin Assessment, dated 03/31/24 indicated the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225296	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quabbin Valley Healthcare	821 Daniel Shays Highway Athol, MA 01331

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 - Actual harm Residents Affected - Few	- Left shoulder (front) three medium purple areas along the collar bone. - Left, back of hand, erythema (redness of the skin from injury or irritation). Review of the Facility's Internal Investigation Narrative, undated, indicated the Director of Nurses (DON) received a call from the Facility, at approximately 6:04 P.M., notifying her that Visitor #1 was upset and had demanded the police be called to report an abuse allegation. The Narrative indicated the DON arrived at the Facility at 6:10 P.M., at which time CNA #1 had already been removed from the unit and was waiting in a separate room. The Report indicated that CNA #1 told the DON that she did not throw Resident #1 onto the bed but was simply transferring him/her from the wheelchair to the bed and it went quickly because Resident #1 was pinching her. The Narrative indicated that Visitor #1 told the DON that she witnessed CNA #1 forcefully throw Resident #1 onto his/her bed from his/her wheelchair. The Narrative indicated that Visitor #1 told the DON that when Resident #1 tried to sit up from his/her bed, CNA #1 pushed him/her back down onto the bed. The Narrative indicated Nurse #1 responded to Visitor #1's urgent request to go to Resident #1's room. The Narrative indicated that Nurse #1 said she saw CNA #1 push Resident #1 down onto the bed. The Narrative indicated that the Facility's Internal Investigation determined the incident was substantiated as physical abuse and CNA #1 was terminated. During a telephone interview on 05/02/24 at 10:39 A.M., Certified Nurse Aide (CNA) #1 (which also included a review of her written witness statement dated 03/28/24) said that on 03/28/24 during the evening shift, Resident #1 was more disruptive than usual, so she brought him/her to his/her room. CNA #1 said that when she transferred Resident #1 from his/her wheelchair into his/her bed, she (CNA #1) swooped [Resident #1] under the arms to move him/her and he/she pinched the back of her arm. CNA #1 said she plopped Resident #1 onto his/her bed in response to the painful pinch. CNA #1 said that a few minutes later, when Nurse #1 entered the room, Resident #1 popped up in bed and said she (CNA #1) used her right hand on Resident #1's left chest/shoulder area to push him/her back down onto the bed. During a telephone interview on 05/01/24 at 11:23 A.M., Visitor #1 said she was at the Facility visiting family on the evening of 03/28/24, when she went to get her family member a glass of juice, and she saw CNA #1 pushing Resident #1 in his/her wheelchair down the hall. Visitor #1 said that around 5:50 P.M., she saw Resident #1 try to grab the handrail while CNA #1 was pushing his/her wheelchair, and said she saw CNA #1 swat/slap Resident #1's hand away from the handrail. Visitor #1 said that later, at approximately 6:00 P.M., when she walked down the hall, intending to leave the Facility, she had forgotten something, doubled back and re-entered her family member's room (shared with Resident #1) where she saw CNA #1 slam Resident #1 down on his/her bed causing his/her head to bounce on the mattress. Visitor #1 said she immediately ran to get help and quickly returned to the room with Nurse #1. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225296	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quabbin Valley Healthcare	821 Daniel Shays Highway Athol, MA 01331

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 - Actual harm Residents Affected - Few	Visitor #1 said that when she re-entered the room with Nurse #1, she saw Resident #1 sit up in bed and CNA #1 forcefully pushed him/her back down onto the bed. Visitor #1 said CNA #1's actions were forceful and stern when she shoved [Resident #1] down on the bed. Visitor #1 said CNA #1's face was red and she appeared frustrated and overwhelmed during her interactions with Resident #1. During an interview on 05/01/24 at 3:40 P.M., Nurse #1 said that when she worked the evening shift on 03/28/24, Visitor #1 came running up to her and said, You to need to come with me, now! Nurse #1 said that as they hurried toward Resident #1's room, Visitor #1 told her that she had witnessed CNA #1 throw Resident #1 on his/her bed. Nurse #1 said that, from the hallway, she heard Resident #1 say stop hitting me and don't hit me, stop that! Nurse #1 said that Resident #1 sometimes repetitively called out for help when he/she was anxious, but said when she heard Resident #1 call out stop hitting me, she felt it was different from his/her normal behavior. Nurse #1 said as she rounded Resident #1's privacy curtain, she saw Resident #1 trying to get up from the bed and said she saw CNA #1 push him/her back down onto the bed, forcefully. Nurse #1 said she heard CNA #1 tell Resident #1, in an angry tone, You need to lay down! as she pushed Resident #1 down with her hand around his/her left upper chest/shoulder area. Nurse #1 described CNA #1's actions as angry and forceful and said CNA #1 appeared impatient, flustered and frustrated. Nurse #1 said that when she dismissed CNA #1 from the room and took over Resident #1's care, she noticed Resident #1 was visibly upset. Nurse #1 said Resident #1 snuggled against her and he/she was trembling. Nurse #1 said she stayed with Resident #1 for over an hour before he/she calmed down. Nurse #1 said she completed Resident #1's care after the incident and said there were no bruises or reddened areas present at that time. During an interview on 05/01/24 at 1:10 P.M., the Unit Manager said Resident #1 was often apprehensive and sometimes fearful during care, therefore, he/she required reassurance and a calm approach. The Unit Manager said Resident #1 becomes frightened and may resist care if the right approach is not used. The Unit Manager said that on 03/29/24 (the day after the incident), when she and Nurse #2 performed Resident #1's skin assessment, he/she was frightened and more jumpy than usual whenever they touched or moved him/her. The Unit Manager said that while performing a skin assessment, they noticed Resident #1 had bruises that were not present prior to the incident on 03/28/24. During an interview on 05/01/24 at 1:20 P.M., Nurse #2 said he performed a skin assessment on Resident #1, on 3/29/24 and noted three purple areas along his/her collar bone that were irregular in shape. Nurse #2 said he also noted red areas on the back of his/her hand. Nurse #2 said all of Resident #1's bruises, red areas were new and were not there prior to the incident on 3/28/24. Nurse #2 said that during the assessment, Resident #1 was more frightened and jumpy with repositioning, than he/she usually is. During an interview on 05/01/24 at 4:10 P.M., the Director of Nurses (DON) said that skin assessments conducted on Resident #1 by nursing after the incident showed new bruising, consistent with the witness accounts of Resident #1 being pushed on at his/her left shoulder. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225296	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quabbin Valley Healthcare	821 Daniel Shays Highway Athol, MA 01331

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 - Actual harm Residents Affected - Few	The DON said that based on statements from witnesses, Resident #1's bruising and CNA #1's unwillingness to participate any further with the Facility's internal investigation, the Facility substantiated the allegation of physical abuse and CNA #1 was terminated. 37086 B. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated as submitted on 04/04/24 at 8:16 A.M., indicated that on 04/03/24 during Resident #2's morning care (exact time unknown), Nurse Aide #A reported that Certified Nurse Aide (CNA) #3 placed Resident #2's call light out of his/her reach and heard CNA #3 say to Resident #2 that he/she was in a time-out. Resident #2 was admitted to the facility in May 2023, diagnoses included cerebral infarction (stroke) and adjustment disorder with depressed mood. Review of Resident #2's Quarterly Minimum Data Set (MDS) Assessment, dated 03/06/24, indicated he/she scored a 13 out of 15 on his/her Brief Interview for Mental Status (BIMS) Assessment (0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired cognition, and 12-15 suggests a resident is cognitively intact). The MDS also indicated that he/she was dependent for bathing, dressing, hygiene, transfers, incontinent care, and was non-ambulatory. Review of Nurse Aide #A's (nurse aide in training) Written Witness Statement, signed and dated 04/03/24, indicated she (Nurse Aide #A) was assigned to work with CNA #3 on 04/03/24 and upon completion of Resident #2's morning care, CNA #3 told Resident #2 that he/she was in a time-out and CNA #3 took away his/her call light and placed the call light next to his/her bed (out of Resident #2's reach). The Statement indicated that when Nurse Aide #A and CNA #3 re-entered Resident #2's room (exact time unknown), Resident #2 had his/her call light and CNA #3 told Resident #2 that she did not know who gave the call light back to him/her because he/she was still in a time-out and was not supposed to have it, and that CNA #3 took Resident #2's call light away from him/her again. The surveyor was unable to interview Nurse Aide #A as she did not respond to the Department of Public Health's telephone and letter requests for an interview. During a telephone interview on 05/02/24 at 2:37 P.M., Certified Nurse Aide (CNA) #3 said she had been terminated from the Facility and was not comfortable speaking about the incident on 04/03/24 regarding Resident #2. Review of Resident #2's Witness Statement, dated 04/03/24 and signed by the Director of Nurses (DON), indicated that the DON met with Resident #2 at 5:10 P.M. and he/she identified CNA #3 by name and said that she was the CNA who took care of him/her that day. The Statement indicated that Resident #2 said that sometimes CNA #3 took his/her call light away when he/she was in a time-out and that CNA #3 took his/her call light away that day because she said he/she used the call light too much. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225296	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quabbin Valley Healthcare	821 Daniel Shays Highway Athol, MA 01331

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 - Actual harm Residents Affected - Few	During an interview on 05/01/24 at 3:09 P.M., Resident #2 said that he/she used the call light when he/she was wet and needed to be changed, or when he/she needed to be repositioned in bed or needed something from staff. Resident #2 said that CNA #3 took care of him/her on the morning of 04/03/24 and that CNA #3 told him/her that she was taking the call light away because he/she used it too much. Resident #2 said he/she always holds onto the call light in his/her hand. Resident #2 said that it did not make me feel good, and he/she was upset when CNA #3 took his/her call light away. Resident #2 said he/she did not recall if CNA #3 said he/she was in a time-out. However, Resident #2's statement on the day of the incident to the DON included that Resident #1 had said he/she was told he/she was in a time-out. During an interview on 05/01/24 at 1:41 P.M. Certified Nurse Aide (CNA) #4 said that she was familiar with and provided care for Resident #2. CNA #4 said that Resident #2 used his/her call light to alert staff if he/she needed to be changed or repositioned. CNA #4 said that Resident #2 often held a tight hand grip on the call light and appeared afraid to let go of it. During an interview on 05/01/24 at 3:55 P.M., the Director of Nurses (DON) said that on the afternoon of 04/03/24, she received a report from Nurse Aide #A that following the completion of Resident #2's morning care with CNA #3, CNA #3 placed Resident #2's call light out of his/her reach and told him/her that he/she was in a time-out. The DON said Nurse Aide #A reported that CNA #3 told Resident #2 that he/she used the call light too much and needed a time-out. The DON said that Nurse Aide #A reported that once CNA #3 left Resident #2's room, she (Nurse Aide #A) gave the call light back to Resident #2. The DON said that she conducted an interview with Resident #2 on 04/03/24 at 5:10 P.M. and that he/she identified CNA #3 by name and told her that CNA #3 sometimes took his/her call light away when he/she was in a time-out. The DON said that Resident #2 indicated to her that this was not the first time CNA #3 had taken his/her call light away. The DON said the Facility substantiated the abuse allegation and CNA #3 was terminated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225296	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quabbin Valley Healthcare	821 Daniel Shays Highway Athol, MA 01331

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. 37086 Based on records reviewed and interviews, for one of three sampled residents (Resident #2), who was dependent on staff for all aspects of personal care including bed mobility and transfers, the Facility failed to ensure staff implemented and followed their Abuse Policy related to the need to immediately report an allegation of abuse to the Administrator and/or designee, when on 04/03/24, during the provision of morning care, Nurse Aide #A witnessed Certified Nurse Aide (CNA) #3 place Resident #2's call light out of his/her reach, and then tell Resident #2 that he/she was in a time-out however, Nurse Aide #A did not report the incident to the Director of Nurses (DON) until the end of his/her shift, at approximately 4:30 P.M. that day (approximately eight hours after witnessing the incidents). Findings include: Review of the Facility Policy titled Abuse Policy and Procedure, with a revision date of 2024, indicated the Facility will maintain an environment free of abuse, neglect and exploitation. The Policy indicated the following definitions of: - Neglect: means failure of the facility, its employees or service providers to provide goods and services necessary to avoid physical harm, pain, mental anguish or emotional distress. -Mental Abuse: includes, but is not limited to, humiliation, harassment and threats of punishment or deprivation. Further review of the Policy indicated employees, volunteers, and contractors must report any knowledge of abuse to the facility administration immediately. Resident #2 was admitted to the facility in May 2023, diagnoses included cerebral infarction (stroke) and adjustment disorder with depressed mood. Review of Resident #2's Quarterly Minimum Data Set (MDS) Assessment, dated 03/06/24, indicated he/she scored a 13 out of 15 on his/her Brief Interview for Mental Status (BIMS) Assessment (0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired cognition, and 12-15 suggests a resident is cognitively intact). The MDS also indicated that he/she was dependent for bathing, dressing, hygiene, transfers, incontinent care, and was non-ambulatory. Review of Nurse Aide #A's (nurse aide in training) Written Witness Statement, signed and dated 04/03/24, indicated she (Nurse Aide #A) was assigned to work with CNA #3 on 04/03/24 and upon completion of Resident #2's morning care, CNA #3 told Resident #2 that he/she was in a time-out and CNA #3 placed his/her call light next to his/her bed (out of Resident #2's reach). The Statement indicated that when she (Nurse Aide #A) and CNA #3 re-entered Resident #2's room (exact time unknown), Resident #2 had his/her call light and CNA #3 told Resident #2 that she did not know who gave the call light back to him/her because he/she was still in a time-out, was not supposed to have it, and that CNA #3 took Resident #2's call light away from him/her again. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225296	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quabbin Valley Healthcare	821 Daniel Shays Highway Athol, MA 01331

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	The surveyor was unable to interview Nurse Aide #A as she did not respond to the Department of Public Health's telephone and letter requests for an interview. Review of Resident #2's Witness Statement, dated 04/03/24 and signed by the Director of Nurses (DON), indicated that the DON met with Resident #2 at 5:10 P.M. and that he/she identified CNA #3 by name and said she was the CNA who took care of him/her that day. The Statement indicated that Resident #2 said that sometimes CNA #3 took his/her call light away when, according to her (CNA #3) he/she was in a time-out. The Statement indicated that Resident #2 said that CNA #3 took his/her call light away because she said he/she used the call light too much. During an interview on 05/01/24 at 3:09 P.M., Resident #2 said that he/she used the call light when he/she was wet and needed to be changed, or when he/she needed to be repositioned in bed or needed something from staff. Resident #2 said that CNA #3 took care of him/her on the morning of 04/03/24 and that CNA #3 told him/her that she was taking the call light away because he/she used it too much. Resident #2 said he/she always holds onto the call light in his/her hand. Resident #2 said it did not make me feel good, and that he/she was upset when CNA #3 took his/her call light away. Resident #2 said he/she did not recall if CNA #3 said he/she was in a time-out. However, Resident #2's statement on the day of the incident to the DON, included that Resident #2 said he/she was told he/she was in a time-out. During an interview on 05/01/24 at 3:55 P.M., the Director of Nurses (DON) said that on the afternoon of 04/03/24 she received a report from Nurse Aide #A that following the completion of Resident #2's morning care with CNA #3, CNA #3 placed Resident #2's call light out of reach and told him/her that he/she was in a time-out. The DON said Nurse Aide #A reported that CNA #3 told Resident #2 that he/she used the call light too much and needed a time-out. The DON said that she conducted an interview with Resident #2 on 04/03/24 at 5:10 P.M. and that he/she identified CNA #3 by name and told her that CNA #3 sometimes took his/her call light away when he/she was in a time-out. The DON said that Nurse Aide #A should have reported the incident to Facility administration immediately, and should not have waited until the end of the shift to do so.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225296	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quabbin Valley Healthcare	821 Daniel Shays Highway Athol, MA 01331

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 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. 37086 Based on records reviewed and interviews, for one of three sampled residents (Resident #2), the Facility failed to ensure that an allegation of abuse, was reported to the Department of Public Health (DPH) within two hours, as required, per Federal Regulations and Facility Policy. When on 04/03/24 at approximately 4:30 P.M. the Director of Nurses (DON) became aware of an incident that occurred earlier that day on the 7:00 A. M. to 3:00 P.M. shift, where the call light was deliberately removed from Resident #2's reach by Certified Nurse Aide (CNA) #3 who told Resident #2 that he/she could not have it because he/she was in a time-out, however the incident was not reported by the facility to the DPH until the following day on 04/04/24 at 8:16 A. M., more than 16 hours after they became aware of the allegation. Findings include: Review of the Facility Policy titled Abuse Policy and Procedure, with a revision date of 2024, indicated the Facility will maintain an environment free of abuse, neglect, and exploitation. The Policy indicated the following definitions of: - Neglect: means failure of the facility, its employees or service providers to provide goods and services necessary to avoid physical harm, pain, mental anguish or emotional distress. -Mental Abuse: includes, but is not limited to, humiliation, harassment and threats of punishment or deprivation. Further review of the Policy indicated if abuse is suspected or confirmed, a report will be made within two hours to the DPH via the DPH portal. Resident #2 was admitted to the Facility in May 2023, diagnoses included cerebral infarction (stroke) and adjustment disorder with depressed mood. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated as submitted on 04/04/24 at 8:16 A.M., indicated that the DON reported an incident to the DPH, that had occurred on 04/03/24 during morning care (exact time unknown) with Resident #2, when Nurse Aide #A reported that CNA #3 placed Resident #2's call light out of his/her reach and told him/her that he/she was in a time-out. The Report indicated that later when Nurse Aide #A and CNA #3 re-entered Resident #2's room (exact time unknown), Resident #2 had his/her call light and CNA #3 told Resident #2 that she did not know who gave the call light back to him/her because he/she was still in a time-out, was not supposed to have it, and that CNA #3 took Resident #2's call light away from him/her again. Further review of the Report indicated the DON submitted the incident report to the DPH greater than 16 hours after initially being made aware of the incident on 04/03/24, when she interviewed Nurse Aide #A at 4:30 P.M. that day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225296	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quabbin Valley Healthcare	821 Daniel Shays Highway Athol, MA 01331

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/01/24 at 3:55 P.M., the Director of Nurses (DON) said that on the afternoon of 04/03/24 she received a report from Nurse Aide #A that following the completion of Resident #2's morning care with CNA #3, CNA #3 placed Resident #2's call light out of his/her reach and the CNA #3 told him/her that he/she was in a time-out. The DON said Nurse Aide #A reported that CNA #3 told Resident #2 that he/she used the call light too much and needed a time-out. The DON said that she conducted an interview with Resident #2 on 04/03/24 at 5:10 P.M. and that he/she identified CNA #3 by name and told her that CNA #3 sometimes took his/her call light away when he/she was in a time-out. The DON said that she substantiated the abuse allegation and reported the incident to the DPH the following morning (04/04/24).