STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225402	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clifton Rehabilitation Nursing Center	500 Wilbur Avenue Somerset, MA 02725

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on records reviewed and interviews, for two of three sampled residents (Resident #1 and Resident #2), who were alert, oriented, and able to make their needs known, the Facility failed to ensure both residents were treated in a dignified and respectful manner when Certified Nurse Aide (CNA) #1 was witnessed by other staff members engaging in a verbal confrontation with both residents, during which CNA #1 became increasingly angry, raised his/her voice, spoke disrespectfully to Resident #1, and while questioning Resident #2, CNA #1 was heard using profane language.Findings include:Review of the Facility's Residents Rights Policy, dated 11/2021, indicated residents have the right to be treated with respect and dignity.Resident #1 was admitted to the Facility in January 2026, with diagnoses including lumbar disc disease/spinal stenosis, cerebral infarct, facial weakness, hemiplegia, dysarthria, dysphagia, intertrochanteric fracture of the right femur, and anxiety.Review of Resident #1's Minimum Data Set (MDS) Assessment, dated 02/09/26, indicated he/she had intact cognition, was able to communicate his/her needs, was his/her own decision-maker, and required assistance from staff members for care needs.Resident #2 was admitted to the Facility in February 2026, with diagnoses including hypertension, chronic obstructive pulmonary disease, peripheral vascular disease, and polycythemia vera.Review of Resident #2's MDS Assessment, dated 03/01/26, indicated he/she had intact cognition, was able to communicate his/her needs, was his/her own decision-maker, and required supervision for activities of daily living.Review of the Facility's Internal Investigation, dated 03/15/26, indicated that Resident #1 reported that CNA #1 yelled at him/her and pulled his/her hair. The Investigation indicated that while CNA #2 assisted Resident #1 with toileting, Resident #1 was tearful, upset and CNA #2 heard Resident #1 state, She was mean to me.The Investigation indicated CNA #1 overheard their (CNA #2 and Resident #1's) discussion, entered the bathroom, and asked Resident #1 why he/she was upset. The Investigation indicated that CNA #1 reported that Resident #1's back was turned toward her [so to get his/her attention] and she tapped Resident #1 on the shoulder. The Investigation indicated Resident #1 was unable to fully turn around, and CNA #1 moved in front of Resident #1 and questioned him/her about what she (CNA #1) had done.The Investigation indicated CNA #1 then approached Resident #2 and questioned him/her about whether he/she had observed her (CNA #1) while providing care [to Resident #1] earlier that morning, and that Resident #2 responded, I have not seen you today. The Investigation indicated CNA #1 responded angrily, stating, You did not see my fucking face make your bed? The Investigation indicated that Resident #2 said he/she responded back to CNA #1 and said, Don't you dare talk to me like that. The Investigation indicated CNA #1 was immediately removed from the unit and suspended.During a telephone interview on 04/22/26 at 10:23 A.M., Resident #1(who since the date of the incident, had been discharged from the Facility) said on 3/15/26 he/she was uncomfortable when CNA #1 came over his/her shoulder and spoke loudly to him/her while CNA #2 was assisting him/her with toileting. Resident #1 said he/she felt CNA #1 was in a bad mood and did not like him/her.During a telephone interview on 04/16/26 at 11:15 A.M., Resident #2 (who since the date of the incident, had been discharged from the Facility) said on 03/15/26 CNA #1 came into his/her room stood in the doorway, and loudly stated, You did not see my fucking face make your (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed? Resident #2 said he/she responded, Don't you dare talk to me like that. Resident #2 said CNA #1's conduct was disrespectful and unprofessional toward residents and staff.During an interview on 04/14/26 at 11:06 A.M., CNA #2 said that on 03/15/26 at around 7:00 A.M., while assisting Resident #1 with morning care, she observed Resident #1 to be tearful and upset. CNA #2 said Resident #1 stated CNA #1 was mean to him/her. CNA #2 said CNA #1 then entered the bathroom while Resident #1 was holding the bathroom grab bars and facing the wall. CNA #2 said CNA #1 tapped Resident #1 on the shoulder and stated in a loud voice, I did something to you? CNA #2 said she did not witness CNA #1 grab Resident #1's shoulder or pull his/her hair.CNA #2 said CNA #1 exited the bathroom, appeared upset, spoke loudly in Portuguese, and stated, I did nothing. CNA #2 said she then overheard CNA #1 speaking with Resident #2 and heard CNA #1 use the word fuck.During a telephone interview on 04/22/26 at 12:00 P.M., CNA #3, Lead CNA Coordinator, said on 03/15/26 she overheard a commotion and observed CNA #1 exiting the bathroom where Resident #1 and CNA #2 were located. CNA #3 said Resident #1 identified CNA #1 and stated, She does not like me. CNA #3 said CNA #1 appeared angry, was speaking loudly to Resident #2, and used the word fuck. CNA #3 said she immediately removed CNA #1 from the unit and reported the incident to the Supervisor.During a telephone interview on 04/22/26 at 9:22 A.M., CNA #1 said on 3/15/26, she overheard Resident #1 and CNA #2 discussing that she (CNA #1) had been rude to Resident #1. CNA #1 said she lost her temper, used profanity and was disrespectful towards residents and her coworkers. CNA #1 said she wished she had walked away instead of arguing.During an interview on 04/14/26 at 1:00 P.M., the Administrator said initial staff statements indicated CNA #1 yelled at Resident #1 and pulled his/her hair; however, Resident #1 later reported CNA #1 had not pulled his/her hair but had stated, She does not like me. The Administrator said interviews with staff and Resident #2 confirmed that CNA #1 spoke loudly and used profanity. The Administrator said the Facility terminated CNA #1's employment.On 04/14/26, the Facility was found to be in Past Non-Compliance and presented the Surveyor with a Plan of Correction with an effective date of 04/01/26 which addressed the identified area(s) of concern, as evidenced by:A. On 03/15/26, Resident #1 and Resident #2 were immediately assessed for signs of injury or emotional distress. No concerns were identified, and both residents were monitored by staff with support provided as needed. Resident #1 and Resident #2 no longer reside at the facility.B. On 03/15/26, all residents assigned to Certified Nurse Aide (CNA) #1 were immediately assessed for the potential of adverse effects related to the identified area of concern, no other care issues or concerns were identified,C. On 03/15/26, Clinical and Management staff conducted resident interviews to ensure the resident felt safe, that they were treated in a dignified and respectful manner by all staff, and to potentially identify any additional concerns. No additional concerns were identified.D. From 03/15/26 through 03/31/26, the Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC), and Nursing Supervisor provided re-education to all staff on the following: - The definition of the Abuse Prohibition, Resident Rights, and Customer Services. - Interaction with residents should be appropriate and professional. E. Clinical and Management staff will continue to monitor (conduct random observations) to ensure residents are treated in a dignified and respectful manner.F. During the March 2026 monthly Quality Assurance and Performance Improvement (QAPI) meeting, the committee reviewed and discussed the incident related to the identified an area of concern and developed a corrective action plan. G. The QAPI committee will continue to monitor this issue for a period of two months to ensure continued substantial compliance.H. The Director of Nursing and/or designee is responsible for ongoing compliance.