

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225420	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Center for Extended Care at Amherst		STREET ADDRESS, CITY, STATE, ZIP CODE 150 University Drive Amherst, MA 01002	

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)
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>37227</p> <p>Based on records reviewed and interviews, for one of three sampled residents (Resident #1) who was severely cognitively impaired and dependent on staff for care, the Facility failed to ensure he/she was treated in a dignified and respectful manner, when on 10/13/24 at 9:00 A.M., two staff members witnessed Certified Nurse Aide (CNA) #1 directing profanity at Resident #1 and treating him/her in a demeaning, insulting manner during care.</p> <p>Findings include:</p> <p>Review of the Facility Policy titled Resident Rights, dated as revised 02/20/21, indicated that employees shall treat all residents with kindness, respect and dignity.</p> <p>Resident #1 was admitted to the Facility in September 2016, diagnoses included Alzheimer's disease and cognitive communication deficit.</p> <p>Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 10/09/24, indicated Resident #1 was severely cognitively impaired with a score of 0 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). Further review of the MDS indicated Resident #1 was totally dependent on staff for Activities of Daily Living (ADLs) and mobility, and he/she rejected care one to three days per week during the assessment reference period.</p> <p>Review of the Facility's Investigation Summary, undated, indicated CNA #2 said that CNA #1 used fowl language while caring for Resident #1 and accused him/her of being difficult. The Report indicated that CNA #3 said she also witnessed CNA #1 use profanity during Resident #1's care, and that CNA #1 had rolled Resident #1 over during care too fast and was rough. The Report indicated the incident was reported to the Nurse Supervisor, upon completion of Resident #1's care, and CNA #1 was suspended pending investigation.</p> <p>During a telephone interview on 11/08/24 at 12:06 P.M., Certified Nurse Aide (CNA) #1 said that on 10/13/24, while she was providing morning care to Resident #1, CNA #2 was providing care to his/her roommate, and CNA #3 arrived a few moments later to help with Resident #1's mechanical lift transfer.</p> <p>(continued on next page)</p>

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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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>CNA #1 said that she may have used profanity when speaking to CNA #2 when she did not help her with Resident #1's care, and that CNA #2 must have misunderstood and thought her swearing was directed at Resident #1.</p> <p>During an interview on 11/07/24 at 11:40 A.M., Certified Nurse Aide (CNA) #2 (which also included a review of her Written Witness Statement dated 10/13/24) said that while she was providing care to Resident #1's roommate, at 9:00 A.M., CNA #1 was in the room, providing care to Resident #1. CNA #2 said the privacy curtain was drawn and that although she could not see CNA #1, she clearly heard her direct profanity, repeatedly, at Resident #1. CNA #2 said that Resident #1 was calling out during care and that CNA #1 sounded increasingly frustrated. CNA #2 said that Resident #1 had a history of resisting and calling out during care, especially with unfamiliar staff.</p> <p>CNA #2 said that she heard CNA #1 say to Resident #1, [Resident #1] why the fuck are you so difficult?, What the fuck is your problem? and Why won't you fucking roll? CNA #2 said that CNA #1 told her (in the presence of Resident #1) I can't fucking deal with [Resident #1], I don't know why he/she is being so difficult when he/she can fucking help! CNA #2 said that she told CNA #1 that Resident #1 couldn't help his/her behavior. CNA #2 said that she couldn't intervene at that moment because it would have been unsafe to leave the resident she was caring for, so she rang the call light for assistance. CNA #2 said that CNA #3 immediately responded to the call light.</p> <p>Review of Certified Nurse Aide (CNA) #3's Written Witness Statement, dated 10/13/24, indicated that she entered Resident #1's room to assist with his/her care and witnessed CNA #1 roll him/her roughly and too quickly. CNA #3 said that CNA #1 said [Resident #1] is too fucking much!</p> <p>During a telephone interview on 11/07/24 at 1:57 P.M., the Nurse Supervisor (which also included a review of her Written Witness Statement dated 10/13/24) said that when she suspended CNA #1, pending investigation of the incident involving Resident #1, she acted aggressively toward staff and tried to find out who reported her, prior to leaving the facility.</p> <p>During an interview on 11/07/24 at 1:30 P.M., the Director of Nurses (DON) said that based on witness statements and the Nurse Supervisor's interview with CNA #1, she was suspended pending an internal investigation and was terminated.</p>		