STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225430	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Patrick's Manor	863 Central Street Framingham, MA 01701

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41601 Based on interviews and records reviewed, for one of three sampled residents (Resident #2), whose primary spoken language was not English, the Facility failed to ensure he/she was free from abuse, when on 4/08/24, during the evening shift, when Resident #2 approached Nurse #1, who was in the hallway at the medication cart, to ask for his/her supplement, Nurse #1 yelled at Resident #2 in a humiliating and verbally aggressive manner saying, you are in America now, you need to learn to speak English! The altercation was witnessed by two other residents, who said Resident #2 was upset and crying after Nurse #1 yelled at him/her. Findings include: Review of the Facility's Policy titled Prevention, Identification, Investigation and Reporting of Abuse, Neglect, Mistreatment or Exploitation of Resident or Misappropriation of Resident Property, dated January 2023, indicated the following: - Employees, consultants, contractors, volunteers, and other caregivers will provide an environment for residents that is safe and free from abuse, neglect, exploitation, mistreatment, and misappropriation, treating each resident with respect, dignity, and the provision of privacy. - Verbal abuse means the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families or within their hearing distance regardless of their age, ability to comprehend, or disability. - Mental abuse includes but is not limited to humiliation, harassment, threats of punishment, deprivation, or abuse and further includes Nursing Home Staff taking, keeping, distributing, or using photographs or recordings of a resident and/or resident's personal space in any manner that would demean or humiliate a resident. Resident #2 was admitted to the Facility in March 2023, diagnoses included Parkinson's disease without dyskinesia, type 2 diabetes mellitus, major depressive disorder, sleep terrors, spinal stenosis, and hypertension. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #2's Annual Minimum Data Set (MDS) Assessment, dated 3/13/24, indicated that he/she was cognitively intact, made his/her own decisions, could speak and understand a limited amount of English, and utilized a translation application on an electronic device (his/her iPad) to communicate his/her needs to staff. The MDS indicated that Resident #2 required moderate assistance from one staff member to meet his/her care needs. Review of the Facility's Investigation, dated 4/11/24, indicated Resident #1 reported he/she heard Nurse #1 state to Resident #2, You are now in America, and you need to learn English because no one is going to understand you! The Investigation also indicated that Nurse #1 made {inappropriate}statements regarding Resident #1, and those statements were confirmed by a second nurse (later identified as Nurse #2) who worked on the same unit on 4/08/24. The Investigation indicated that Nurse #2 reported that while they were charting around 10:00 P.M., Nurse #1 stated, I told the Chinese patient that he/she needs to learn English, and that Nurse #1 went on to say to Nurse #2 and the Certified Nurse Aides (CNA's) who were also present at the nursing station, I came from [NAME], and I learned English, why can't he/she? The Investigation indicated the Administrator received an email on 4/11/24 at 2:40 A.M., from Resident #1's Family Member (FM #1) concerning Nurse #1 being rude to Resident #1 on 4/08/24 (during the evening shift). The Investigation indicated FM #1 also included in the email that Resident #1 reported to her that Nurse #1 was also verbally abusive towards Resident #2. The Investigation indicated that Nurse #1 refused to participate in the Facility's Investigation into the allegations, conducted by the Administrator. Review of Nurse #2's Written Witness Statement, dated 4/08/24, indicated that she spoke to Resident #2's Family Member (FM #2) on the phone on 4/08/24, and that FM #2 told her (Nurse #2) that Resident #2 reported being yelled at by Nurse #1 for asking for his/her supplement. The Statement indicated that FM #2 stated he did not like it that Resident #2 was crying. The Statement indicated Nurse #2 reported the incident to the Nurse Supervisor. Further review of Nurse #2 Written Witness Statement indicated that at 9:15 P.M., while providing care to Resident #1, he/she reported to her (Nurse #2) that he/she had overheard Nurse #1 yelling loudly at Resident #2, and that he/she felt sorry for Resident #2. During an interview on 4/30/24 at 3:02 P.M., Nurse #2 said that on 4/08/24 at approximately 7:30 P.M., Resident #2 approached her, he/she crying and looked sad. Nurse #2 said that when she asked Resident #2 what was wrong, he/she said {using his/her iPad as an interpreter}, that Nurse #1 yelled and screamed at him/her, which scared and humiliated him/her. Nurse #2 said that while Resident #2 was describing the incident, Resident #3 came over and stated that he/she had witnessed Nurse #1 yelling and humiliating Resident #2, and that it also scared him/her. Nurse #2 said she spoke to Resident #2's Family Member (FM #2) that night, who reported receiving a very emotional call from Resident #2, who was crying about being yelled at for asking Nurse #1 for his/her supplement. Nurse #2 said that FM #2 stated that he did not like it that Resident 2 was crying. Nurse #2 said she immediately reported the incident to the Nurse Supervisor after she spoke to FM #2. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Nurse #2 said later that night, around 9:15 P.M., while providing care to him/her, Resident #1 also reported that he/she overheard Nurse #1 yelling and screaming at Resident #2, telling him/her, You are in America and need to learn English. This is America! Nurse #2 said later that same night when she was at the nursing station doing her charting, Nurse #1 was on the other side of the nursing station, and that two Certified Nurse Aides, were also there. Nurse #2 said Nurse #1 bragged to them and said, I told the Chinese patient that he/she needs to learn English. Nurse #2 said Nurse #1 went on to say, I came from [NAME] and learned English, why can't he/she learn? I am not catering to him/her. Nurse #2 said that as Nurse #1 got up and was passing her, that she (Nurse #1) looked at her and said, Don't let me go ghetto on you. Nurse #2 said Nurse #1 made her uncomfortable, and that she could not imagine how the residents' felt. During an interview on 4/30/24 at 1:05 P.M., Resident #2, due his/her limited English, requested that the Surveyor contact and speak to Family Member #2 about the incident. During a telephone interview on 5/07/24 at 9:00 A.M., Family Member #2 (who spoke on Resident #2 behalf, with his/her permission) confirmed receiving a call from a very emotional Resident #2 on 4/08/24, during which he/she reported that Nurse #1 (whom Resident #2 identified by name) had very aggressively and loudly yelled at him/her that night. FM #2 said that Resident #2 told him that Nurse #2 had yelled at him/her and said Why don't learn English? This is America! FM #2 said Resident #2 told him that he/she had only gone to Nurse #1 to ask for his/her supplement. During an interview on 4/30/24 at 3:40 P.M., Certified Nurse Aide (CNA) #3 said when she was at the nursing station area doing her documentation on 4/08/24 for the evening shift, that Nurse #1 was on the other side of the nursing station bragging about what she (Nurse #1) had done, and that Nurse #1 made the following statements; I told the Chinese patient that he/she needs to learn English, I came from [NAME], and I learned English, why can't he/she? and I am not catering to him/her! During an interview on 4/30/24 at 12:55 P.M., Resident #3 said he/she had witnessed Nurse #1 suddenly snap at Resident #2, that Nurse #1 had been aggressively yelling at Resident #2 in humiliating manner. Resident #3 said he/she could see that Resident #2 was scared and that he/she was crying. Resident #3 said that he/she felt terrible for Resident #2. Resident #3 said he/she was distraught because Nurse #1 was treating Resident #2 that way, and said after witnessing Nurse #1's behavior, he/she was fearful of Nurse #1 and did not interact with her (Nurse #1) the rest of the night. During an interview on 4/30/24 at 1:10 P.M., Resident #1 said he/she had witnessed Nurse #1 yelling and in an aggressive manner at Resident #2. Resident #1 said he/she was in the hallway, had been standing close to Nurse #1's medication cart during the altercation and said that Resident #2 looked scared and was crying. Resident #1 said Nurse #1 was also rude to him/her during the shift. Resident #1 said that the next day, he/she told Family Member #1 about how rude Nurse #1 was throughout the shift. Review of the Facility's Investigation Summary Report, dated 4/11/24, indicated that upon their investigation, Nurse #1 admitted to making inappropriate comments at the nurse's station in the presence of other staff members. The Surveyor was unable to interview Nurse #1 as she did not respond to the Department of Public Health's telephone call or letter requests for an interview. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/30/24, at 1:50 P.M., the Administrator said she received an email from Resident #1's Family Member (FM #1) at 2:40 A.M. on 4/11/24, that alleged Nurse #1 had been verbally inappropriate to Resident #1 and Resident #2. The Administrator said she immediately called the Nursing Supervisor, initiated an investigation, and suspended Nurse #1. The Administrator said Nurse #1 was from the Agency and had been scheduled to work 4/08/24 (3:00 P.M. to 11:00 P.M. & 11:00 P.M. to 7:00 A.M.) which was the unit in which Resident #1 and Resident #2 resided on. The Administrator said Nurse #1 was terminated and would no longer be contracted through the Agency to work at their facility.

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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. 41601 Based on records reviewed and interviews for one of three sampled residents (Resident #2), the Facility failed to ensure staff implemented and followed their Abuse Policy, when on 4/08/24 during the evening shift after the Nurse Supervisor received a report of an allegation of abuse from Nurse #2 that Nurse #1 had been verbally abusive towards to Resident #2, the Nurse Supervisor failed to immediately notify the Administrator and Director of Nursing (DON) of the alleged abuse, and did not suspend Nurse #1, as a result Nurse #1 continued to work the overnight shift (11:00 P.M. to 7:00 A.M.) providing care to Resident #2 and other residents, placing them at risk for the potential for further abuse. Findings include: Review of the Facility's Abuse Policy, dated 02/2023, indicated that after ensuring the residents are protected, Nursing Home Staff must immediately report to his or her Supervisor or the Administrator any allegation or suspicion of abuse, neglect, mistreatment, or exploitation, including injuries of unknown source as well as any allegation or suspicion of the misappropriation of resident property. The Supervisor shall immediately notify the Administrator of all reports. Review of the Facility's Abuse Reporting Immediate Response Supervisor Checklist Form, with a revised date of 1/26/23, indicated the Nurse Supervisor or Designee will immediately initiate an Abuse protocol when a report of Abuse, Neglect, Misappropriation is alleged, The Checklist Actions included, but was not limited to the following; -Protect resident immediately from harm. -Remove any threat/potential threat (if resident is upset, staff to stay with resident). -Employee involved in allegation is immediately removed from unit, away from all residents, and with supervision. -Attach suspension form with instructions given to employee and then employee is removed from premises and suspended by Supervisor. -Nurse Supervisor immediately notifies Director of Nursing (DON) or Designee, continue until you reach the DON or Designee, if no answer after three tries approximately five minutes apart, call the Administrator. -Do Not text or Email, Speak Directly with Director or Designee. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility's Internal Investigation, dated 4/11/24, indicated that the management team did not become aware of the incident (allegation of verbal abuse of Resident #2 by Nurse #1 that occurred on 4/08/24 during the evening shift) until 4/11/24 when the Administrator received an email from Resident #1's Family Member (FM #1) that voiced concerns about Nurse #1 being rude at Resident #1. The Investigation indicated that FM #1 also stated in the email that Nurse #1 was also verbally abusive towards Resident #2. The Investigation indicated Nurse #1 was on the schedule on 4/11/24 on different unit and was suspended that day. The Investigation included a written statement from Nurse #2, dated 4/08/24 which indicated that on 4/08/24, at 7:30 P.M., Resident #2 was crying and upset and reported to her (Nurse #2) that Nurse #1 was rude and yelling at him/her. The Investigation indicated that Resident #3 also witnessed and confirmed that Nurse #1 screamed at Resident #2 and made him/her cry. The Investigation indicated Resident #3 was standing beside the medication cart and witnessed the incident, and that it had scared him/her (Resident #3). During an interview on 4/30/24 at 3:02 P.M., Nurse #2 said that at approximately 7:30 P.M., on 4/08/24. Resident #2 approached her, that he/she was crying and sad. Nurse #2 said that when she asked Resident #2 what was wrong, he/she used his/her iPad (as an interpreter) and said that Nurse #1 yelled and screamed at him/her, which scared and humiliated him/her. Nurse #2 said that while Resident #2 was describing the incident, Resident #3 came over and stated that he/she had witnessed Nurse #1 aggressively yelling and humiliating Resident #2, which also made him/her feel scared. Nurse #2 said she immediately reported this to the Nurse Supervisor. Review of the Facility's Nursing Schedule, dated 4/08/24, indicated Nurse #1 worked from 3:00 P.M. to 11:00 P.M. (for the entire shift) and continued to work on the overnight shift (11:00 P.M. to 7:00 A.M.) on the same unit, and therefore continued to provide care to Resident #2 and other residents on that unit. During a telephone interview on 5/01/24 at 10:30 A.M., the Nurse Supervisor said that on 4/08/24 during the evening shift Nurse #2 reported to her that Resident #2 was upset about how Nurse #1 had treated him/her. The Nurse Supervisor said it was unclear to her if it was abuse. The Nurse Supervisor said she did not recall if she sent a text that night to notify the Administrator, of the incident. The Nurse Supervisor said she was aware of the Facility's Abuse Policy. During an interview on 4/30/24 at 1:50 P.M., the Administrator said the Nurse Supervisor had not followed facility policy after becoming aware on 4/08/24 of an alleged incident of abuse of Resident #2 by Nurse #1. The Administrator said an investigation should have been initiated, Nurse #1 should have been suspended and the Director of Nurses and Administrator should have been notified, per the Facility's Abuse Policy.