STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225431	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bear Mountain at Reading	1364 Main Street Reading, MA 01867

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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was found unresponsive by staff, the Facility failed to ensure that Licensed Nursing Staff had adequate training, and the necessary skill set needed to initiate life saving measures in an effective and efficient manner when responding during an emergency situation.Findings include:The Facility Policy, Emergency Procedure - Cardiopulmonary Resuscitation (CPR), dated February 2018, indicated the chances of surviving a sudden cardiac arrest may be increased if CPR is initiated immediately upon collapse and early delivery of a shock with a defibrillator plus CPR within 3-5 minutes of collapse can further increase chances of survival.The Policy indicated if an individual is found unresponsive, briefly assess for abnormal or absence of breathing. If sudden cardiac arrest is likely, begin CPR and do the following:-Instruct a staff member to activate the emergency response system (Code).-Instruct a staff member to retrieve the automatic external defibrillator (AED).-Initiate the basic life support (BLS) sequence, C-A-B (chest compressions, airway, breathing).-When the AED arrives, assess for need and follow AED protocol as indicated.-Continue with CPR/BLS until Emergency Medical Services (EMS) arrive.Review of the Facility's Internal Investigation's Final Report, dated [DATE], indicated around 2:00 A.M., Nurse #1 found Resident #1 without wearing his/her Bilevel Positive Airway Pressure (BiPAP, helps people to breathe by providing pressurized air through a mask), and Nurse #1 provided education to Resident #1 to leave the BiPAP on. The Report indicated around 4:00 A.M. Resident #1 was found unresponsive, cardiopulmonary resuscitation (CPR) initiated, 911 was called and CPR continued until 4:55 A.M. The Report indicated EMS took over and pronounced Resident #1 dead, while still at the Facility.The Report indicated, per Nurse Practitioner (NP) Resident #1 was hospitalized 25 times since [DATE], Resident #1's death was unavoidable, and NP said the cause of death was Respiratory Failure (lungs cannot properly exchange gases, causing abnormal levels of Carbon Dioxide and/or Oxygen in the arteries) with contributing factor of nonadherence to BiPAP. Resident #1 was admitted to the Facility in [DATE], diagnoses included but was not limited to the following: Chronic Obstructive Pulmonary Disease (a group of lung diseases that block airflow and make it difficult to breathe), Congestive Heart Failure (the heart does not pump blood as well as it should), Pulmonary Hypertension (high blood pressure that affects arteries in the lungs and in the heart), Atrial Fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and Obstructive Sleep Apnea (intermittent airflow blockage during sleep).Resident #1's Advanced Directives indicated he/she was a Full Code (patients has opted for all available life-saving measures to be used if their heart stops beating and/or they stop breathing).During interview on [DATE] at 1:24 P.M. and 4:30 P.M., Nurse #1 said on [DATE], sometime around 4:00 A.M. - 4:30 A.M. (unable to recall exact time), she walked into Resident #1's room, observed Resident #1's head in an upward position, his/her facial skin color was bluish, his/her eyes and mouth were wide open, and his/her skin was warm to touch. Nurse #1 said she also noted that Resident #1, who required the use of a BiPAP (Bilevel Positive Airway Pressure machine), that the BiPAP, was not on his/her face. Nurse #1 said she called Resident #1's name several times and tried shaking him/her, without getting any response. Nurse #1 said she screamed for Certified Nurse Aide (CNA) #1 to retrieve the Code Cart, said she started chest compressions immediately on Resident #1, could not recall how many sets of chest compressions or cycles she completed before leaving Resident #1 to go to the Nursing station to inform Nurse #2, who worked on another unit, that she needed help.Nurse #1 said she called the other Nursing Unit via telephone, spoke to CNA #2 and informed her to tell Nurse #2 immediately that she needed help. Nurse #1 said she ran back to Resident #1's room, started chest compressions again. Nurse #1 said Nurse #2 and CNA #1 arrived, helped place the back board under Resident #1 and then she continued with chest compressions. Nurse #1 said Nurse #2 assisted with performing chest compression, CNA #1 assisted with the Ambu bag, but she was unaware of how many cycles were completed. Nurse #1 said the automatic external defibrillator (AED) was not applied to Resident #1 and said she could not recall if the AED was in Resident #1's room.Nurse #1 said while Nurse #2 and CNA #1 continued performing CPR on Resident #1, she left to call 911 and then returned to Resident #1's room. Nurse #1 said shortly thereafter Emergency Medical Services (EMS) arrived at Resident #1's room and took over the code.During a telephone interview on [DATE] at 3:19 P.M., Certified Nurse Aide (CNA) #1 said on [DATE] she observed Resident #1 sleeping around 3:00 A.M. with his/her BiPAP on his/her face and he/she did not look like he/she was having problems at that time. CNA #1 said she started her safety rounds

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was found unresponsive by staff, and required staff to initiate a Code Blue, the Facility failed to ensure that Licensed Nursing Staff were competent in process of calling and responding in the event of a Code Blue situation. Findings include:According to the Board of Registration in Nursing, 244 CMR9.00: Standards of Conduct, competency is defined as the application of knowledge and the use of affective, cognitive, and psychomotor skills required for the role of a Nurse Licensed by the Board and for the delivery of safe Nursing care in accordance with accepted Standards of Practice.Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully.Resident #1 was admitted to the Facility in [DATE], diagnoses included Chronic Obstructive Pulmonary Disease (a group of lung diseases that block airflow and make it difficult to breathe), Congestive Heart Failure (the heart does not pump blood as well as it should), Pulmonary Hypertension (high blood pressure that affects arteries in the lungs and in the heart), Atrial Fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and Obstructive Sleep Apnea (intermittent airflow blockage during sleep).During interview on [DATE] at 1:24 P.M. and 4:30 P.M., Nurse #1 said on [DATE], sometime around 4:00 A.M.- 4:30 A.M., she walked into Resident #1's room, observed Resident #1's head in an upward position, his/her facial skin color was bluish, his/her eyes and mouth were wide open, and his/her skin was warm to touch. Nurse #1 said Resident #1's BiPAP was not on his/her face. Nurse #1 said she called Resident #1's name several times and shaking him/her without getting a response.Nurse #1 said that she was unaware of the Facility's Emergency Procedure-Cardiopulmonary Resuscitation Procedure and Policy. Nurse #1 said she has never seen the Facility's Emergency Documentation Record (located on the Code Cart) to be completed during a Code Blue. Nurse #1 said she has not participated in a Code Blue or any Mock Code Blue Drills, since she has worked at the Facility (approximately 3 years).Nurse #1 said she has never used the Facility's overhead paging system and therefore did not know how to use it, so she called the other Nursing Unit via telephone (located at the Nursing Station) spoke to CNA #2 and told CNA #2 to let Nurse #2 she needed help.Nurse #1 said she could not recall if the Facility's automatic external defibrillator (AED) was in Resident #1's room during the Code Blue. Nurse #1 said the AED was not applied to Resident #1 and said she was unaware if it was part of the Facility's Policy to bring the AED to a Code Blue along with the Code Cart. Nurse #1 said once cardiopulmonary resuscitation (CPR) was initiated, she left to call for help and left again once the other nurse arrived to call 911.During a telephone interview on [DATE] at 8:19 A.M., Nurse #2 said there has not been any staff development personnel at the Facility for a while. Nurse #2 said the Facility has not provided any Mock Code Blue Drills or trainings since she has worked at the Facility (approximately 6 months). Nurse #2 said there has been no education provided to staff regarding Policy and Procedures related to Emergent Events, Code Blue, CPR, the AED and the Code Carts. Nurse #2 said she was unaware her CPR certification had expired on 01/2025, until the Facility called her on [DATE] (the day of the survey) to inform her she needed to renew it. Nurse #2 said the Facility does not provide CPR classes and that she immediately completed a CPR course on [DATE] after receiving Facility's phone call.During interview on [DATE] at 3:48 P.M., the Unit Manager said she could not recall any Facility education provided to staff relating to Policy and Procedures for Emergent Events, Code Blue, CPR, and AED. The Unit Manager said there has not been any Mock Code Blue Drills or trainings conducted since she has worked at the Facility (approximately 1 year). The Unit Manager said employees are only provided information during their orientation.The Unit Manager said if a Code Blue is initiated, Nursing will document the event in the residents' Progress Note and said staff do not use the Facility's Emergency Documentation Record form (located on the Code Cart) which indicates it needs to be completed during the Code Blue.The Unit Manger said on [DATE], she was informed of the Resident #1's Code Blue but said she had not reviewed the Code Blue event and did not speak to the nursing staff who had responded, regarding the incident. The Unit Manger said that she usually speaks with the nursing staff and reviews the documentation but said she had not. The Unit Manager said when she arrived at the Facility on [DATE], Resident #1 had already been transported to the Funeral Home.During interview on [DATE] at 11:53 A.M., the Director of Nursing (DON) said the Facility Staff on 11:00 P.M. to 7:00 A.M. shift are responsible daily to check the Code Cart to ensure all the required Code equipment is on the Code Cart, locked and to ensure on the 15th of every month the