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	11/14/2025

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 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. (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	Based on interviews and records reviewed, for one of four sampled residents (Resident #2), who was alert oriented and able to make his/her needs know, the Facility failed to ensure he/she was treated in a dignified and respectful manner, when it was reported that during an overnight shift (8/20/25 into 8/21/25) that Certified Nurse Aide (CNA) #2, while interacting with Resident #2, roughly grabbed him/her by wrist, was rude and disrespectful while providing care and when Resident #2 asked CNA #2 for his name, CNA #2 laughed at him/her and walked out of the room. Findings include:Review of the Facility's policy titled Resident Rights, revised dated January 2025, indicated all residents will be treated with kindness, respect, and dignity based on established Resident Rights. Our facility will make every effort to assist each resident in exercising his/her rights to assure that the residents are always treated with respect, kindness and dignity. Resident #2 was admitted to the Facility in July 2025, diagnoses included multiple sclerosis, paraplegia, colostomy, chronic wounds, anxiety, and depression. Review of Resident #2's Minimum Data Set (MDS) Assessment, dated 07/11/25, indicated he/she scored a 15 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. The Facility's Internal Investigation, dated 08/21/25, indicated that during early morning care, Resident #2 reported to Nurse #1 that he/she was roughly handled during care by a male CNA (on the overnight shift). The Investigation indicated Resident #2 reported that at approximately 5:30 A.M., he/she put the call light on to be changed, a male staff member (later identified as Certified Nurse Aide #2) came into the room, and he/she told CNA he/she needed to be changed. The Investigation indicated Resident #2 reported that male aide (CNA #2) grabbed him/her by the left wrist and squeezed. The Investigation indicated that Resident #2 reported that when CNA #2 asked him/her to turn, he/she informed CNA #2 that he/she could not turn, that CNA #2 again asked Resident #2 to turn, and he/she pointed his/her right-hand index finger in the air and asked CNA #2 if he did not hear him/her. The Investigation indicated that Resident #2 said that CNA #2 responded by grabbing his/her left wrist and said to him/her You do not talk to people that way! You do not point your finger at people! The Investigation indicated that Resident #2 reported when he/she asked CNA #2 what his name was, he laughed at him/her and when he/she asked CNA #2 a second time for his name, CNA #2 laughed again as he left the room. The Investigation indicated that Resident #2 reported that CNA #2 was angry when he came into the room. During an interview on 09/29/25 at 2:00 P.M., Resident #2 said that early in the morning (during the overnight shift) on 08/21/25, when CNA #2 asked him/her to turn, he/she informed CNA #2 that he/she could not turn, and he ignored him/her. Resident #2 said that he/she pointed his/her right-hand index finger in the air and asked CNA #2 if he did not hear him/her, and that CNA #2 responded by grabbing his/her left wrist and stated You do not talk to people that way! You do not point your finger at people! Resident #2 said that CNA #2 raised his voice and continued to being rude and disrespectful. Resident #2 said when he/she asked CNA #2 his name was, he laughed at him/her and when he/she asked for his name a second time, CNA #2 laughed again as he left the room. Resident #2 said who speaks to people like that disrespectful manner.During an interview on 09/29/25 at 3:30 P.M., Nurse #1 said on 08/21/25 she received a report from the 11:00 P.M. to 7:00 A.M. shift (during change of shift report) Nurse that Resident #2 had just made allegations during her final round check at 7:00 A.M. that CNA #2 was rough and rude during care. Nurse #1 said she immediately assessed Resident #2, and he/she reported to her that CNA #2 had been rough with him/her around 5:30 A.M., while providing care, and squeezed his/her left wrist. Nurse #1 said she immediately reported the allegation to the Unit Manager and Administrator. During an interview on 09/29/25 at 1:30 P.M., the Director of Social Services (DSS) said that Resident #2 reported that CNA #2 was rough and rude when he was providing care. The DSS said Resident #2 reported that when he/she complained to CNA #2 that he was being too rough and was hurting him/her, that CNA #2 responded by continuing to squeeze his/her left wrist and said, You do not talk to people that way! and when he/she asked for his name, CNA #2 started laughing at him/her and walked of his/her room. The Director of Social Services (DSS) said that Resident #2 requested that CNA #2 not provide care to him/her. The DSS said she validated Resident #2's feelings and provided support, and Resident #2 told her that he/she feels safe. During a telephone interview on 10/02/25 at 12:47 P.M., Nurse #2 said that at the time of the incident, she was the Unit Manager, and Nurse #1 reported Resident #2's allegation on 08/21/25 in the morning. Nurse #2