STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225444	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blue Hills Health and Rehabilitation Center	1044 Park Street Stoughton, MA 02072

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** Based on interviews and records reviewed, for one of the three sampled residents (Resident #1), who was severely cognitively impaired and dependent on staff for care, the Facility failed to ensure Resident #1 was free from physical abuse when, on 01/14/26 around 7:30 A.M., Certified Nurse Aide (CNA) #1 slapped Resident #1 in the face, which was witnessed by another staff member. Resident #1 was observed to have red marks on his/her face, told staff his/her face hurt and that he/she had been slapped. Based on the reasonable person concept, a cognitively impaired resident would experience emotional upset after being slapped by a caregiver.Findings include:Review of the Facility Policy titled Abuse, Neglect, and Exploitation, dated as last revised 01/2025, indicated the Facility is to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.The Policy indicated the definition of abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. The Policy further indicated that physical abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. Review of the report submitted by the Facility via Health Care Facility Reporting System (HCFRS), dated 01/14/26, indicated that a Certified Nurse Aide (CNA, later identified as CNA #1) had been witnessed slapping Resident #1 in the face. The Report indicated that CNA #1 denied the allegation of slapping Resident #1, however CNA #1 had stated that she had pushed Resident #1. The Report indicated that Resident #1 had red markings to the right side of his/her face, reported pain to his/her face, and received pain medication.The Report indicated that the Police were notified, statements were obtained by the officer and CNA #1 was transported to the Police Department.Resident #1 was admitted to the Facility in September 2025, diagnoses include dementia with behavioral disturbances, major depression, and he/she is legally blind. Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 12/09/25, indicated he/she scored a three (3) out of 15 on his/her Brief Interview for Mental Status (BIMS) (13-15 cognitively intact, 8-12 moderate cognitive impairment and 0-7 severe cognitive impairment), indicating he/she had severe cognitive impairment.During an interview on 01/29/26 at 3:31 P.M., Nurse #1 said while putting Resident #1's clothes away in his/her room, she heard someone say, why did you do that? Nurse #1 said she immediately left the room and went to the area of the incident (small alcove directly to the right of Resident #1's room) to see what was going on.Nurse #1 said when she got there, she observed Resident #1 holding his/her face with both hands, noted a red area on the right side of his/her face, and a scratch near his/her right eyebrow. Nurse #1 said CNA #2 was with Resident #1 and reported to her that CNA #1 had slapped Resident #1 in the face. Nurse #1 said she asked Resident #1 what happened and that Resident #1 said I got hurt. Nurse #1 said that CNA #1 had already left the scene.Nurse #1 said (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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F 0600 Level of Harm - Actual harm Residents Affected - Few	she immediately reported the incident to the Staff Development Coordinator (SDC), who was on Resident #1's Unit at the nurse's station at that time.During an interview on 01/29/26 at 12:51 P.M., the SDC said that she immediately called the Director of Nurses (DON, who was on her way to the Facility) to inform her of the incident, said she also instructed CNA #1 to remain off the resident units, and to wait for the DON to arrive to speak with her.The SDC said she went to assess Resident #1, and he/she was holding his/her head with both hands. The SDC said asked him/her what had happened and Resident #1 said that someone hit him/her in the face. The SDC said she observed a small pink scratch on the right side of his/her face.The SDC said she then interviewed CNA #1. The SCD said that CNA #1 said that Resident #1 was reaching for her glasses, so she pushed him/her away. During an interview on 01/29/26 at 2:28 P.M., the Medical Records employee said on 01/14/26 around 7:35 A.M., she was walking down the corridor on Resident #1's unit, overheard some commotion near the dirty utility room and said she heard what sounded like a slap. During an interview on 01/29/26 at 1:28 P.M., CNA #2 said on 01/14/26 around 7:30 A.M. she was going to the linen closet, located in a small alcove next to the dirty utility room on Resident #1's unit, to get linen for her assignment. CNA #2 said she turned into the alcove and witnessed CNA #1 slap Resident #1 in the face. CNA #2 said I saw her slap him/her so hard. CNA #2 said Resident #1 held his/her face with both hands, and she saw a red mark and little cut on the right side of his/her face. CNA #2 said she had never seen anything like that before and told CNA #1 that she cannot put her hands on any resident like that and that it was abuse. CNA #2 said Nurse #1 arrived almost immediately after the incident occurred and that she told Nurse #1 what she saw.During a telephone interview on 01/29/26, CNA # 1 said she was attempting to put dirty linen in the solid utility room (located in an alcove next to Resident #1's room) and Resident #1 was in front of her not allowing her to move forward to enter the dirty utility room.CNA #1 said Resident #1 refused to move and was grabbing for her face/glasses and she said that she pushed him/her away, with her hands on his/her shoulders.Review of the Police Report, dated 01/14/26, indicated that Resident #1 said that he/she had got into a tussle. The Police Report indicated that Resident #1 pointed to his/her right eye and stated he/she was hit in the eye. The Police Report indicated that Resident #1 said he/she was just sore and did not wish to go to the Hospital for evaluation.The Police Report indicated the Police Officer observed on the right side of Resident #1's head, near his/her eye that there were two (2) small red marks. The Police Report indicated that CNA #1 said that she had pushed Resident #1 on his/her shoulders.The Police Report further indicated that CNA #1 was placed under arrest and charged with assault and battery on a disabled person over the age of 60. During an interview on 01/29/26 at 2:59 P.M., the Director of Nurses (DON) said when she arrived at the Facility on 1/14/26, she immediately went to interview CNA #1, and that CNA #1 stated Resident #1 was trying to reach for her glasses and she had pushed him/her away.The DON said she also assessed Resident #1, and he/she reported to her that someone had slapped him/her in the face but could not remember who it was. The DON said she observed a red scratch mark on the right side of his/her face.The DON said it is the Facility's expectation that all residents remain free from any type of abuse, including physical, and all staff had been educated per the Facility Abuse Policy.On 01/29/26, the Facility presented the Surveyor with a plan of correction with an effective date of 01/26/26 that addressed the area of concern identified in this survey, as follows:A) Resident #1 was immediately assessed following the incident and was observed to have a small scratch and red marks to the right side of his/her face, and B) The Resident #1, declined offer to be transferred to the Hospital ED for evaluation, was administered medication for complaints of pain as needed for comfort and continues to be monitored and provided emotional supported by staff.C) Resident #1's Physician and Health Care (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Agent (HCA) notified and were made aware of the incident and injury.D) The Administrator and the Director of Nurses (DON) reviewed/submitted an internal investigation and personnel record review indicated that CNA #1 was immediately suspended following the alleged incident and subsequently terminated.E) On 01/14/26, the DON and other management staff began interviewing all residents able to be interviewed to elicited feedback regarding care and treatment provided by facility staff members. F) On 01/14/26, the DON and other management staff began monitoring residents that are unable to be interviewed for signs and symptoms of behavior, physical and/or functional changes for indicators of potential concerns of abuse.G) On 01/16/26 the Staff Development Coordinator (SDC) initiated mandatory staff training on the Facility Patient Abuse Policies and Caring for residents with Dementia.H) The Facility Educator and/or designee will conduct random validation quizzes for up to ten (10) employees to ensure comprehension of the Abuse Policy three times per week for three (3) weeks, then monthly for two (2) months to ensure compliance. I) The Facility Staff Educator and/or designee will conduct random interviews for residents able to be interviewed for up to 10 residents to ensure satisfaction and safety three times per week for three weeks, then for two months to ensure compliance. J) The areas of concerns were discussed by administration and management staff, related to the need for an Ad [NAME] Quality Assurance and Performance Improvement (QAPI) meeting to implement immediate corrective action.K) The results/data from the staff training and the resident's interviews will be presented at the next monthly QAPI meeting and quarterly reporting will continue.L) The DON and/or designee are responsible for overall compliance.