STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225474	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Taunton	68 Dean Street - Rear Taunton, MA 02780

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. 40702 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had severe cognitive impairment, the Facility failed to ensure he/she was free from abuse from a staff member, when on 03/30/25, Resident #1 became combative during care and in response to his/her behaviors, Certified Nurse Aide (CNA) #2, told Resident #1 if he/she hit her again, she would hit him/her back. CNA #2 hit Resident #1 on the top of his/her left hand twice. The incident was witnessed by another staff member who was assisting with Resident #1's care. A cognitively intact person would experience pain and mental anguish after being hit by a caregiver. Findings include: Review of the Facility's Policy titled Abuse Prohibition, dated as revised 3/2025, indicated the following: -each resident has the right to be free from verbal, sexual, physical and mental abuse, neglect, corporal punishment, involuntary seclusion, and misappropriation of their property; every resident in the facility will always be treated with respect and dignity -it is the goal of this facility to foster an environment that recognizes the worth, specialties and uniqueness of all individuals --abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish to a resident -physical abuse includes, but not limited to, hitting, slapping, pinching, kicking and control of behavior through corporal punishment of a resident Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 03/30/25, indicated that Resident #1 was being combative during incontinence care. The Report indicated that during the provision of care to Resident #1, CNA #1 reported that [in response to Resident #1 hitting her] CNA #2 said to Resident #1 If you hit me again, I will hit, you back. The Report further indicated that CNA #1 witnessed CNA #2 forcibly grab Resident #1's left arm and slap the back of his/her left hand two times. (continued on next page)

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 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #1 was admitted to the Facility in May 2021, diagnoses included dementia, anxiety disorder, and major depressive disorder. Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 01/17/25, indicated that he/she had severe cognitive impairment. Although Resident#1's impaired cognition minimized his/her understanding of the incident, an unimpaired individual would have experienced physical pain and mental anguish after being treated by a caregiver in this manner. During an interview on 05/22/25 at 12:29 P.M., (which included review of her written witness statement) CNA #1 said around 5:00 A.M., she and CNA #2 were providing care to Resident #1. CNA #1 said Resident #1 became combative, hit CNA #2 several times and he/she called her (CNA #2) a racial slur. CNA #1 said CNA #2 became frustrated and told Resident #1, If you hit me again, I will hit, you back. CNA #1 said CNA #2 then forcefully grabbed Resident #1 by his/her left wrist, slapped the top of his/her left hand twice and Resident #1 yelled out Ow. CNA #1 said it was not a tap it was a hard slap because she heard the slapping noise when CNA #2 hit Resident #1's left hand. During an interview on 05/28/25 at 9:46 A.M., (which included review of her written witness statement, sent to the facility via email) CNA #2 said around 5:00 A.M., she and another CNA (later identified as CNA #1) were providing care to Resident #1, and he/she became verbally and physically combative. CNA #2 said Resident #1 told her to Get out, get out, I do not want you, and that he/she called her (CNA #2) a racial slur. CNA #2 said Resident #1 hit her right arm and that she told him/her Not to do that! and that she said to him/her If you hit me again, I will hit, you back. CNA #2 said Resident #1 then hit her again, kicked her left breast and said that in response she (CNA #2) tapped the top of Resident #1's left hand. CNA #2 said Resident #1 did not make a sound and moved his/her hand. During an interview on 05/22/25 at 3:19 P.M., (which included review of her written witness statement) Nurse #1 said on 03/30/25 she worked from 3:00 A.M. to 3:00 P.M. and around 5:00 A.M. she heard Resident #1 yelling at staff while they were providing care. Nurse #1 said Resident #1 could be physically and verbally combative with care. Nurse #1 said she was starting her medication pass and said she did not go to Resident #1's room. During an interview on 05/21/25 at 2:44 P.M., the Director of Nursing (DON) said that on 03/30/25 around 9:19 A.M. Nurse #1 notified her that CNA #1 reported that she had witnessed CNA #2 slap Resident #1 on the hand. The DON said she started her investigation, told Nurse #1 to notify the Police, and she notified the scheduler to remove CNA #2 from the schedule pending investigation. The DON said CNA #1 told her Resident #1 was being combative during care, that she (CNA #1) heard CNA #2 tell Resident #1 If you hit me again, I will hit you back, that Resident #1 hit CNA #2 again, and that she (CNA #1) observed CNA #2 grab Resident #1's left arm and slap the back (top side) of his/her left hand twice. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The DON said CNA #2 told her Resident #1 was combative, hitting her, and called her (CNA #2) a racial slur. The DON said CNA #2 said she only tapped the back (top side) of Resident #1's left hand, and that she (CNA #2) had told him/her If you are going to hit me, I am going to hit, you back. The DON said the facility substantiated the allegation of abuse and that CNA #2 was terminated.

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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 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. 40702 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had severe cognitive impairment, the Facility failed to ensure staff implemented and followed their Abuse Identification and Reporting Policy, when on 03/30/25 during the night shift, Certified Nurse Aide (CNA) #1 witnessed CNA #2 slap Resident #1's hand while providing care to him/her. CNA #1 did not immediately report the allegation of physical abuse to the nurse on duty as required and did not do so, until four hours after witnessing the incident. Findings include: Review of the Facility's Policy titled Abuse Identification and Reporting, dated as revised 3/ 2022, indicated the following: -identify any event that may be potential abuse, neglect, involuntary seclusion, or misappropriation of resident property -any suspected allegation of abuse shall be immediately reported to the administrator or his/her designee Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 03/30/25, indicated that on 03/30/25 Resident #1 was being combative during incontinence care. During the provision of care to Resident #1, CNA #1 reported that [in response to Resident #1 hitting her] CNA #2 stated to Resident #1 If you hit me again, I will hit, you back. The Report further indicated that CNA #1 witnessed CNA #2 forcibly grab Resident #1's left arm and slap the back of his/her left hand two times. Resident #1 was admitted to the Facility in May 2021, diagnoses included dementia, anxiety disorder, and major depressive disorder. Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 01/17/25, indicated that he/she had severe cognitive impairment. During an interview on 05/22/25 at 3:19 P.M., (which included review of her written statement) Nurse #1 said on 03/30/25 she worked from 3:00 A.M. to 3:00 P.M. and around 5:00 A.M. she heard Resident #1 yelling at staff while they were providing care. Nurse #1 said she was not aware of any physical abuse by CNA #2 at that time. Nurse #1 said after CNA #1's shift ended (7:00 A.M.), she (CNA #1) came back to the Facility around 9:00 A.M. Nurse #1 said CNA #1 reported to her (Nurse #1) then that CNA #2 had hit the back of Resident #1's hand (could not recall which hand) during care. Nurse #1 said she immediately notified the Director of Nursing (DON). (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/22/25 at 12:29 P.M., (which included review of her written statement) CNA #1 said around 5:00 A.M., her and CNA #2 were providing care to Resident #1. CNA #1 said Resident #1 became combative, hit CNA #2 several times and called her (CNA #2) a racial slur. CNA #1 said CNA #2 became frustrated and told Resident #1, If you hit me again, I will hit, you back. CNA #1 said CNA #2 then forcefully grabbed Resident by his/her left wrist, slapped the top of his/her left hand twice and Resident #1 yelled out Ow. CNA #1 said she became anxious about what she saw and that she did not report the incident to the Nurse on duty. CNA #1 said she went home after the end of her shift (7:00 A.M.) but knew that she was supposed to report what she had observed. CNA #1 said she went back to the Facility around 9:00 A.M. and told Nurse #1 that CNA #2 had slapped Resident #1's left hand while she (CNA #1) and CNA #2 were providing care to him/her. During an interview on 05/21/25 at 2:44 P.M., the Director of Nursing (DON) said that on 03/30/25 around 9:19 A.M. Nurse #1 notified her that CNA #1 reported that she had witnessed CNA #2 slap Resident #1's hand. The DON said she started her investigation, told Nurse #1 to notify the Police, and she notified the scheduler to remove CNA #2 from the schedule pending investigation. The DON said CNA #1 did not immediately report the incident to Nurse #1 per Facility Policy. The DON said her expectation is that all staff immediately report any concern for potential abuse, and that they should notify the Administrator or DON.