STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225525	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Harwich	111 Headwaters Drive Harwich, MA 02645

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on records reviewed and interviews, for one of three sampled residents (Resident #1), the Facility failed to ensure he/she was treated in a dignified and respectful manner by a staff member when 07/27/25, Certified Nurse Aide (CNA) #1 teased Resident #1 and sat on his/her lap. Findings include:Review of the Facility Policy titled Resident Rights, dated as revised April 2022, indicated that employees shall treat all residents with kindness, respect, and dignity. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS) dated 07/28/25, indicated that Resident #1's family (Family Member #1) was concerned with CNA #1's interaction with Resident #1, and that Family Member #1 thought his (CNA #1) behavior was bizarre in nature. During an interview on 08/28/25 at 7:22 A.M., Family Member #1 said she went to the Facility to visit Resident #1 and did not see him/her in his/her room, but could hear Resident #1 yelling, don't! Family Member #1 said she followed Resident #1's voice to Resident #2's room, opened the door, and saw CNA #1 sitting on Resident #1's lap. Family Member #1 said Resident #1 was upset and ran to her (Family Member #1). Family Member #1 said that CNA #1 and CNA #2 followed her and Resident #1 back to Resident #1's room, where CNA #1 apologized and said it was a joke. Review of the Facility's Internal Investigation Report Summary, undated, indicated that on 07/27/25, Resident #1 followed CNA #1 and CNA #2 into Resident #2's room. The Summary indicated that while Resident #1 was seated on an unoccupied bed in Resident #2's room, CNA #1 briefly engaged Resident #1 in a lighthearted interaction in an apparent attempt to redirect and comfort him/her. The Summary indicated that during this exchange, Family Member #1 arrived and misinterpreted CNA #1's behavior as inappropriate, specifically noting that it appeared that CNA #1 was sitting on Resident #1's lap. Resident #1 was admitted to the Facility in March 2024, diagnoses included dementia and psychotic disorder with delusions. Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 06/05/25, indicated that Resident #1 had severe cognitive impairment, was independent with ambulation, and dependent on staff for self-care. During an interview on 08/28/25 at 3:01 P.M. (which included a review of his Written Witness Statement, dated 07/28/25), CNA #2 said that Resident #1 followed him and CNA #1 into Resident #2's room, and sat on an unoccupied bed. CNA #2 said CNA #1 joked around with Resident #1 and bent forward to sit on his/her lap. CNA #2 said that Resident #1 yelled each time CNA #1 moved to sit on his/her lap. CNA #2 said that CNA #1 moved to sit on Resident #1's lap three times, and after each time he/she told him (CNA #1) to stop, but he did not. CNA #2 said that Family Member #1 walked into Resident #2's room and asked why CNA #1 was sitting on Resident #1's lap. During an interview on 08/28/25 at 12:48 P.M. (which included a review of his undated Written Witness Statement), Nurse #1 said that Family Member #1 reported to him that she went room to room looking for Resident #1 and could hear him/her screaming from behind Resident #2's room door. Nurse #1 said that Family Member #1 told him that when she opened the door, she saw Resident #1 in Resident #2's room and was upset because she saw CNA #1 sitting on Resident #1's lap. During an interview on 08/28/25 at 3:19 P.M., the Director of Nurses (DON) said that during her investigation, CNA #2 told her that Resident #1 followed him and CNA #1 into Resident #2's room where he/she sat on an unoccupied bed. The DON said that CNA #2 told her that CNA #1 was pretending to sit on Resident #1's lap and that when Family Member #1 opened the door to Resident #2's room, she became very upset and said, what if this was your parent? The DON said that she suspended CNA #1 and CNA #2 pending an internal investigation and then determined that this incident was a customer service and professionalism issue.