STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225749	A. Building B. Wing	01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lee Healthcare	620 Laurel Street Lee, MA 01238

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. Based on records reviewed and interviews, for one of three sampled residents (Resident #1) who was moderately cognitively impaired and prone to agitation, the Facility failed to ensure he/she was treated in a dignified and respectful manner, when on 12/20/25, despite Resident #1 verbally objecting and telling staff not to touch his/her hat, Certified Nurse Aide (CNA) #1 taunted Resident #1 by touching his/her hat twice, provoking him/her, instead of respecting his/her request.Findings include:Review of the Facility Policy titled Resident Rights and Responsibilities, dated as revised January 2024, indicated employees shall treat all residents with kindness, respect, and dignity.Resident #1 was admitted to the Facility in August 2023, diagnoses included moderate vascular dementia with mood disturbance and anxiety disorder.Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 09/30/25, indicated Resident #1 was moderately cognitively impaired with a score of 9 out of 15 on the Brief Interview for Mental Status (BIMS, scores indicate: 0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, and 13-15 cognitively intact). Review of Resident #1's Mood and Behavioral Care Plan, dated as reviewed 12/03/25, indicated he/she had vascular dementia with mood disturbance and agitation. Further review of the Care plan indicated his/her mood could change on dime and he/she had a history of hitting, kicking, grabbing, spitting, screaming or threatening others. Further review of the Care Plan indicated that interventions identified for Resident #1 included assessing triggers for aggression or agitation and providing de-escalation strategies (quiet environment, reassurance).Review of a Facility Investigation Report, dated 12/20/25, indicated that an altercation occurred between Certified Nurse Aide (CNA) #1 and Resident #1. The Report indicated that staff witnessed CNA #1 provoke Resident #1 by touching his/her hat, twice, after he/she had loudly objected, resulting in Resident #1 becoming increasingly agitated, shouting profanities and physically destructive toward facility property. During an interview on 01/13/26 at 1:02 P.M., Nurse #1 said that Resident #1 became easily agitated and had a history of altercations with other residents. Nurse #1 said that he witnessed an altercation between Certified Nurse Aide (CNA) #1 and Resident #1 around 1:00 P.M. on 12/20/25. Nurse #1 said that while he was on the phone addressing a medical emergency, Resident #1 was seated in his/her wheelchair at the nurses' station, directly in front of him. Nurse #1 said that CNA #1 and CNA #2 were also in the immediate area. Nurse #1 said that CNA #2 approached Resident #1 and touched his/her hat while bending forward to speak with him/her. Nurse #1 said that when CNA #2 touched Resident #1's hat, he/she loudly objected and verbally stated that he/she did not want his/her hat touched. Nurse #1 said that then CNA #1, despite Resident #1's verbal objection, approached and provoked Resident #1 by touching his/her hat. Nurse #1 said that Resident #1 became increasingly agitated and demanded that CNA #1 stop touching his/her hat, and despite his/her demand to stop, CNA #1 touched his/her hat a second time.Nurse #1 said that after CNA #1 touched Resident #1's hat the second time, his/her agitation escalated further, and he separated CNA #1 from Resident #1. Nurse #1 said he had to leave the nurses' station area for about 15 minutes to attend (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	to another resident, and that when he returned Resident #1 was still very agitated, cursing and kicking a medication cart. Nurse #1 said that he directed CNA #3 to bring Resident #1 to a quiet area and sit with him/her until he/she de-escalated. Nurse #1 said CNA #1 was sent home and the Director of Nurses was notified of the incident. During an interview on 01/13/26 at 3:30 P.M., Certified Nurse Aide (CNA) #2 said that on 12/20/25 around 1:00 P.M., she was near the nurses' station with Resident #1 and CNA #1. CNA #2 said that she leaned forward to speak with Resident #1 and briefly touched the top of his/her hat. CNA #2 said that Resident #1 immediately yelled and told her to stop touching his/her hat, and that she stopped as soon as he/she objected. CNA #2 further said that CNA #1 then taunted and provoked Resident #1 by touching his/her hat. CNA #2 said that Resident #1 loudly objected to CNA #1 touching his/her hat, however, CNA #1 touched his/her hat again despite the objection. CNA #2 said she left the nurses' station immediately following the altercation to attend to another resident. CNA #2 said that when she returned around 15 minutes later, Resident #1 was still agitated, yelling, swearing, and kicking a medication cart near the nurses' station. During a telephone interview on 01/14/26 at 11:11 A.M., CNA #1 said that while she was working the day shift on 12/20/25, she touched Resident #1's hat, despite having witnessed him/her loudly objecting to CNA #2 touching his/her hat. CNA #1 said that she immediately apologized to Resident #1 before Nurse #1 intervened. During an interview on 01/13/26 at 1:36 P.M., the Director of Social Services said that she was not present in the Facility on Saturday, 12/20/25, at the time of the altercation between CNA #1 and Resident #1, and that she was notified by the Director of Nurses (DON) about the incident. The Director of Social Services said that she arrived at the Facility around 2:30 P.M. to check on Resident #1. The Director of Social Services said that Resident #1 was a bit revved up noting that this type of behavioral presentation from Resident #1 occurred at times. The Director of Social Services further said that Resident #1 had no recollection of the altercation and was easily redirected and calmed with one-to-one conversation. During an interview on 01/13/26 at 3:39 P.M., the Director of Nurses (DON) said that Resident #1 had a history of agitation and angry outbursts. The DON said that on 12/20/25, Certified Nurse Aide #1 had teased and provoked Resident #1 by touching his/her hat, despite his/her objections. The DON said that CNA #1 worked for a staffing agency, and that due to the altercation with Resident #1, she notified the agency that CNA #1 was no longer allowed to work at the Facility.