| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225763 | A. Building<br>B. Wing | 12/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Palmer Healthcare Center | 250 Shearer Street<br>Palmer, MA 01069 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.<br><br>(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 0557<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had severe cognitive impairment and was dependent on staff to meet his/her healthcare needs, the Facility failed to ensure he/she was treated in a respectful and dignified manner, when after eliciting the attention of Activity Aide #1, Activity Aide #2 used his fingers to jiggle the loose skin under Resident #1's neck while laughing and saying, [NAME], [NAME]. Activity Aide #2 did this in the presence of other residents and staff members.Findings include:Review of the Facility's policy titled, Resident Rights, dated 05/28/21, indicated Federal and state laws guarantee certain basic rights to all residents of this facility, including the right to be treated with respect, kindness, and dignity.Review of the Facility's policy titled, Dignity, dated 05/28/21, indicated the following:-Residents are treated with dignity and respect at all times.-Demeaning practices and standards of care that compromise dignity are prohibited.Resident #1 was admitted to the Facility in October 2025, diagnoses included unspecified dementia with anxiety, restlessness, and agitation.Review of Resident #1's Minimum Data Set (MDS) Assessment, dated 10/30/25, indicated that he/she had severe cognitive impairment and was dependent on staff to meet his/her care needs.Resident #1 was unable to be interviewed due to his/her severe cognitive impairment.During a telephone interview on 12/16/25 at 11:00 A. M., which included review of her written witness statement, dated 12/01/25, Activity Aide (AA) #1 said on 11/30/25 at around 5:30 P.M., (exact time unknown), both she and AA #2 were in the Facility's Dining/Activity room with several residents, including Resident #1.AA #1 said that she was standing in the corner of the room and AA #2 was seated at a table with Resident #1. AA #1 said that AA #2 called out her (AA #1) name and asked her to look. AA #1 said when she looked over to see what AA #2 wanted, she saw AA #2 flicking the loose skin under Resident #1's neck while laughing and saying, [NAME], [NAME]. AA #1 said she immediately told AA #2 to stop it, told him he was being rude, and AA #2 stopped what he was doing.Review of Certified Nurse Aide (CNA) #2's witness statement, obtained via telephone interview by the Director of Nursing (DON) on 12/05/25 at 10:40 A.M., indicated CNA #2 was taking a resident out of the Dining/Activity room, saw that AA #2 was with Resident #1, and that she heard AA #2 make a comment about and started playing with his/her (Resident #1's) neck.Review of CNA #3's written witness statement, dated 12/05/25, indicated that while she did not witness AA #2 flick the loose skin under Resident #1's neck, the statement indicated that she had heard AA #1 tell AA #2, that is not funny.The surveyor was unable to interview CNA #2 or CNA #3 as they did not respond to the Department of Public Health's request for an interview.Review of AA #2's witness statement (sent via an email), dated 12/02/25 timed stamped 10:19 A.M., indicated that on 11/30/25, he was in the activity room with Resident #1, that he attempted to be playful and keep him/her engaged in conversation and that he tickled the loose skin on his/her neck. AA #2's statement indicated Resident #1 did not ask him to stop and that he (AA #2) did not perceive this interaction as inappropriate.The surveyor was unable to interview AA #2 as he was unreachable by telephone, and he did not respond to the Department of Public Health's letter request for an interview. During an interview on 12/16/25 at 12:55 P.M., (which included a review of her written statement, dated 12/02/25), the Activity Director said that on 12/01/25 at around 2:30 P.M., (exact time unknown), AA #1 reported to her that AA #2 had behaved inappropriately towards Resident #1 on 11/30/25 around dinner time.The Activity Director said AA #1 told her that AA #2 called out to her (AA #1) to get her attention on both himself and Resident #1 and that AA #1 told her that she saw AA #2 jiggling Resident #1's loose neck skin with his fingers while saying, [NAME], [NAME]. The Activity Director said based on what AA #1 told her, she felt the situation needed to be reported to the DON right away, and they immediately began an internal investigation.The Activity Director said both she and a representative from Human Resources called AA #2, and they asked him if anything unusual happened during his shift on 11/30/25 and informed him that an abuse allegation was made against him.The Activity Director said when AA #2 said he had no knowledge of any incident, so they asked him specifically about his interaction with Resident #1. The Activity Director said AA #2 told them he was playing with Resident #1's chin flap and that he/she did not tell him to stop.The Activity Director said AA #2 sent his witness statement via email to her, he was suspended immediately pending investigation and was terminated at the conclusion of the investigation for violating Resident #1's rights.During an interview on 12/16/25 at 1:35 P.M., the Director of Nurses (DON) said the Activity Director came to her office on 12/01/25 at around 2:30 P.M. (exact time unknown) and told her that one of the Activity Department employees had concerns over the weekend |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>(continued on next page) |

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|---|---|
| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had severe cognitive impairment and was dependent on staff to meet his/her care needs, the Facility failed to ensure staff implemented and followed their Abuse Policy, when on 11/30/25, Activity Aide (AA) #1 witnessed a potential incident of verbal and physical abuse and did not immediately report the incident as required, therefore placing Resident #1 and other residents at risk for abuse.Findings include:Review of the Facility policy titled Abuse Prevention Program, dated as revised March 2022, indicated that all employees are responsible to immediately report any violation or alleged violations.Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 12/01/25, indicated that on 12/01/25, Activity Aide (AA) #1 reported to the Activity Director that on 11/30/25, she witnessed AA #2 making a comment mimicking a [NAME] sound while touching the loose skin under Resident #1's chin, as well as calling him/her a jackass for knocking a tablet over and calling him/her childish after Resident #1 verbalized being scared but was unable to answer when AA #2 asked him/her why.Review of the Facility's Incident Report, dated 12/01/25, indicated these alleged incidents occurred the previous evening (on 11/30/25).Resident #1 was admitted to the Facility in October 2025, diagnoses included unspecified dementia with anxiety, restlessness and agitation.Review of Resident #1's Minimum Data Set (MDS) Assessment, dated 10/30/25, indicated that he/she had severe cognitive impairment and was dependent on staff to meet his/her care needs.Resident #1 was unable to be interviewed due to his/her severe cognitive impairment. During a telephone interview on 12/16/25 at 11:00 A.M., which included review of her written witness statement, dated 12/01/25, Activity Aide (AA) #1 said on 11/30/25 at around 5:30 P.M., (exact time unknown), both she and AA #2 were in the Facility's Dining/Activity room with several residents, including Resident #1.AA #1 said that she was standing in the corner of the room and AA #2 was seated at a table with Resident #1. AA #1 said that AA #2 called out her name, asked her to look, and when she looked over to see what AA #2 wanted, she saw AA #2 flicking the loose skin under Resident #1's neck while laughing and saying, [NAME], [NAME]. AA #1 said she immediately told AA #2 to stop it, said she told him he was being rude, and AA #2 stopped what he was doing.AA #1 said a little while later, AA #2 asked her to get a tablet for another resident seated at the same table as Resident #1. AA #1 said she obtained the tablet, and as AA #2 was setting it up for the other resident, Resident #1 knocked the tablet out of AA #2's hand and she heard AA #2 call Resident #1 a jackass in response. AA #1 said not long after that incident, she heard Resident #1 say he/she was scared, heard AA #2 ask him/her why, and heard him/her reply to AA #2 that he/she did not know why. AA #1 said she heard AA #2 tell Resident #1 he/she was childish and not making sense.AA #1 said she did not report the incident to anyone until the next day. AA #1 said although she told the Activity Director the next morning (12/01/25) that she needed to speak to her, AA #1 said she did not share full details of the incident until around 2:30 P.M. AA #1 said after she reported the incident, the Activity Director told her that this needed to be reported to the DON right away.AA #1 said that she knew the entire interaction between AA #2 and Resident #1 was not right but said she did not think to report it right away.During an interview on 12/16/25 at 12:55 P.M., the Activity Director said that on 12/01/25 at 2:30 P.M., AA #1 reported to her that on 11/30/25 (around 5:30 P.M.) she observed AA #2 laughing and jiggling Resident #1's neck skin while saying, [NAME], [NAME] and reported to her that AA #2 also called Resident #1 a jackass and childish.The Activity Director said AA #1 should have reported these incidents immediately after it happened.During an interview on 12/16/25 at 1:35 P.M., the Director of Nurses (DON) said that on 12/01/25, the Activity Director notified her of an interaction that occurred between AA #2 and Resident #1 on 11/30/25 at around 5:30 P.M. The DON said they immediately conducted an interview with AA #1. The DON said AA #1 reported that she and AA #2 were in the Dining/Activity room the prior evening with several residents, and AA #1 reported she observed AA #2 jiggling Resident #1's neck skin while saying, [NAME], [NAME] and that she heard AA #2 call Resident #1 a jackass and childish.The DON said although she was unable to substantiate an allegation of verbal abuse, she said that AA #1 should have reported these interactions between AA #2 and Resident #1 immediately (on 11/30/25) and should not have waited until the following day.On 12/16/25, the Facility was found to be in Past Non-Compliance and presented the Surveyor with a plan of correction, with an effective date of 12/10/25 which addressed the areas of concern as evidenced by:A) Resident #1 was assessed, and he/she showed no signs of distress or change in behavior as a result of the incident and will continue to be |