STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225318	A. Building B. Wing	03/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mill Town Health and Rehabilitation	22 Maple Street Amesbury, MA 01913

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. 15024 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was severely cognitively impaired and dependent on staff to meet his/her care needs, the Facility failed to ensure he/she was free from physical abuse when two staff members witnessed Certified Nurse Aide (CNA) #1 slap Resident #1 on his/her left thigh, in response to him/her being combative during care. A reasonable person with intact cognitive functioning would have experienced mental anguish as a result of being hit by a caregiver. Findings include: Review of the Facility Policy and Procedure titled, Investigation of Resident Abuse, Neglect, Mistreatment, Misappropriation of Resident Property Complaints/Allegations, dated as revised June 2022, indicated when abuse is is observed, suspected, or reported to any facility employee, the employee will immediately notify the Unit Manager/Supervisor and they will immediately report the issue to the Administrator or Director of Nurses (DON) in his/her absence. Review of the Facility Policy and Procedure titled, Resident Protection During Abuse Investigation, dated as revised June 2022, indicated any employee who is accused of resident abuse will be suspended pending further investigation. The Policy and Procedure indicated if abuse is suspected or substantiated, the employee will be immediately sent home. Resident #1's medical history included diagnoses of Dementia with behavioral disturbances and Encounter for Palliative Care. Review of Resident #1's Significant Change in Status Minimum Data Set (MDS) Assessment, dated 01/13/23, indicated he/she had severe cognitive impairment, required a two person extensive assist with transfers, extensive assist with activities of daily living, and displayed physical and verbal behavioral symptoms directed toward others. Review of Resident #1's Care Plan related to Behaviors, dated 01/13/23, indicated his/her behavioral problem included yelling out, screaming at others, resisting care, physical aggression, and grabbing at others. The Care Plan interventions included for caregivers to provide opportunity for positive interaction, to approach and speak in a calm manner, to divert attention, remove from situation, and take to alternate location as needed. (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	During an interview on 03/01/23 at 11:05 A.M., Certified Nurse Aide (CNA) #2 said on 01/21/23 at approximately 7:30 P.M. she entered Resident #1's bedroom after hearing a commotion, and saw CNA #1 and CNA #3 transferring Resident #1 into a reclining chair. CNA #2 said she went in the room, stood in back of the reclining chair, and said CNA #3 was standing to the side of the chair, and CNA #1 was bent down in front of Resident #1, facing him/her. CNA #2 said Resident #1 tried to swat off CNA #1's glasses. CNA #2 said CNA #1 reacted instantly, and with an open hand, slapped Resident #1's left thigh. CNA #2 said she saw and heard the sound of the slap. CNA #2 said CNA #1 then looked at her and said words to the effect of you didn't see that! CNA #2 said CNA #1 appeared angry and frustrated at the time of the incident. CNA #2 said she immediately removed Resident #1 from the room into the hallway and reported the incident to Nurse #1. Review of CNA #3's written statement, dated 01/21/23, indicated as she and CNA #1 were putting Resident #1 back onto the reclining chair, CNA #2 walked into the room. The Statement indicated had Resident #1 pulled, scratched and pinched them. The Statement indicated after CNA #1 slapped Resident #1's leg, CNA #1 said to her (CNA #3) and CNA #2, that didn't happen! The Surveyor was unable to interview CNA #3, as she did not respond to the Department of Public Health's telephone or letter requests for an interview. Review of CNA #1's written statement, (undated), indicated on the evening of 01/21/23, she and a coworker (later identified as CNA #3) stopped transferring Resident #1 for a few minutes when Resident #1 was physically and verbally abusive. The Statement indicated Resident #1 calmed down, they explained what they were doing and told Resident #1 to stop. The Statement indicated they (CNA #1 and CNA #3) attempted again to transfer Resident #1 and when Resident #1 sat down, he/she pulled her coworker's (CNA #3's) hair and aggressively hit CNA #1 on the head knocking her glasses to the floor. The Statement indicated she (CNA #1) reacted quickly by slapping Resident #1's leg. The Surveyor was unable to interview CNA #1, as she did not respond to the Department of Public Health's telephone or letter requests for an interview. During an interview on 03/02/23 at 10:20 A.M., Nurse #1 said on 01/21/23, CNA #2 approached her sometime between 7:00 P.M. and 7:30 P.M. to report that she saw CNA #1 slap Resident #1's (left) leg. Nurse #1 said she spoke to CNA #1, and CNA #1 admitted to her that she slapped Resident #1. Nurse #1 said she assessed Resident #1, and there was no signs of physical injury and Resident #1 had no recollection of the incident due to cognitive impairment. During an interview on 03/01/23 at 12:30 P.M., the Director of Nurses (DON) said she was notified in the morning on 01/22/23 that CNA #1 allegedly abused Resident #1. The DON said during an interview with CNA #1, CNA #1 told her that while bent down, Resident #1 smacked her glasses off, and that was when she (CNA #1) hit Resident #1's shin. The DON said CNA #1 admitted to saying words to the effect of you didn't see that to CNA #1 and CNA #3. A reasonable person with intact cognitive functioning would have experienced mental anguish as a result of being hit by a caregiver.

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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. 15024 Based on records reviewed and interviews for one of three sampled residents (Resident #1) who was severely cognitively impaired and was dependent on staff to meet his/her care needs, the facility failed to ensure: 1) that staff implemented and followed their abuse policy related to the need to immediately report an allegation of potential abuse to the Administrator and/or Director of Nurses, and 2) that a staff member suspected of abuse was immediately suspended, in an effort to protect other residents from potential abuse, and 3) that a Massachusetts Nurse Aide Registry (NAR) background check was conducted on Certified Nurse Aide #2, upon hire. Findings include: 1) Review of the Facility Policy and Procedure titled, Investigation of Resident Abuse, Neglect, Mistreatment, Misappropriation of Resident Property Complaints/Allegations, dated as revised June 2022, indicated when abuse is is observed, suspected, or reported to any facility employee, the employee will immediately notify the Unit Manager/Supervisor and they will immediately report the issue to the Administrator or Director of Nurses (DON) in his/her absence. During an interview on 03/01/23 at 11:05 A.M., Certified Nurse Aide (CNA) #2 said at on 1/21/23 at approximately 7:30 P.M. she saw CNA #1 slap Resident #1's left thigh with an open hand, after Resident #1 tried to swat CNA #1's glasses off her face. CNA #2 said she immediately removed Resident #1 from the room into the hallway and reported the alleged incident of abuse to Nurse #1. CNA #2 said the following morning, 01/22/23 at approximately 7:00 A.M. she decided to report the allegation to the Nursing Supervisor on-call, who stated she had not been made aware of the alleged incident. During an interview on 03/02/23 at 10:20 A.M., Nurse #1 said CNA #2 approached her sometime between 7:00 P.M. and 7:30 P.M. on 01/21/23 to report that she saw CNA #1 slap Resident #1's leg. Nurse #1 said she requested and reviewed a written statement from CNA #3 said which indicated she also saw CNA #1 slap Resident #1's leg. Nurse #1 said she spoke to CNA #1, and CNA #1 admitted to her that she slapped Resident #1. Nurse #1 said she did not report the allegation of abuse to a nurse supervisor, the Administrator or Director of Nurses. Nurse #1 said she should have immediately reported the allegation of abuse when it was initially reported by CNA #2. Nurse #1 said she thought she had 72 hours to report allegations of abuse. During an interview on 03/01/23 at 12:30 P.M., with the Director of Nurses (DON), in which the Administrator was also present, the DON said Nurse #1 did not notify them that there was an allegation of abuse reported on 01/21/23 during the 3:00 P.M. to 11:00 P.M. shift. The DON said they were unaware of the allegation that CNA #1 slapped Resident #1's leg until it was reported to her by the Nursing Supervisor in the morning on 01/22/23 after she was reached by CNA #2. The DON said Nurse #1 was incorrect when she thought she had a few days to report an allegation of abuse to herself (DON) or the Administrator. 2) Review of the Facility Policy and Procedure titled, Resident Protection During Abuse Investigation, dated as revised June 2022, indicated any employee who is accused of resident abuse will be suspended pending further investigation. The Policy and Procedure indicated if abuse is suspected or substantiated, the employee will be immediately sent home. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of CNA #1's Time Sheet dated 1/21/23, indicated she punched out and left the Facility at 11:11 P.M. (which was approximately 3 to 3.5 hours after Nurse #1 was made aware of the incident involving Resident #1 and CNA #1). CNA #2 said that on 1/21/23, after reporting to Nurse #1 that CNA #1 slapped Resident #1's thigh, CNA #1 remained on the Unit and provided care for residents until approximately 11:00 P.M. (which was the end of the shift). Nurse #1 said CNA #1 remained on the unit through the remainder of the shift (11:00 P.M.) to provide care for other residents, while Resident #1 was supervised by staff at the nursing desk. Nurse #1 said she should have immediately sent CNA #1 home after CNA #2 reported the allegation of abuse to her, but did not. The DON said upon being notified of the allegation of abuse in the morning on 01/22/23, immediate action was taken which included suspending CNA #1's employment. The DON said CNA #1's employment should have been suspended immediately when the allegation of abuse was initially reported in the evening on 01/21/23. 3) Review of the Facility Policy titled, Abuse Program Policies and Procedures, dated as revised June 2022, indicated screening of potential employees will include verifying information with appropriate licensing boards and certification registries. Review of CNA #2's Personnel File indicated she was hired on 11/07/22. Further review of CNA #2's Personnel File indicated there was no documentation to support that a Massachusetts NAR background check was conducted for CNA #2 upon hire. During an interview on 03/01/23 at 3:45 P.M., the Administrator said the Facility was unable to provide any documentation to support that a Massachusetts NAR check for CNA #2 had been conducted.