STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225747	A. Building B. Wing	05/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Somerset Ridge Center	455 Brayton Avenue Somerset, MA 02726

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41107 Based on records reviewed and interviews for one of three sampled Residents (Resident #1), who was severely cognitively impaired and required physical assistance of one staff person to meet his/her care needs, the Facility failed to ensure he/she was free from physical abuse by staff, when on 03/29/23 at approximately 5:50 A.M., Certified Nurse Aide (CNA) #2 witnessed CNA #1 grab Resident #1's face and push his/her head backward onto the bed, hold his/her arms down, and squeeze/pinch his/her arms. 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. Findings include: Review of the Facility's Policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated as revised April 2021, indicated the following: -residents have the right to be free from abuse, -the resident abuse, neglect, and exploitation prevention program consists of a facility-wide commitment to protect residents from abuse by anyone, including staff, and -the facility will establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive, and emotional problems. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 03/29/23, indicated that on 3/29/23 at approximately 6:00 A.M., a Certified Nurse Aide (later identified as CNA #2), witnessed another CNA (later identified as CNA #1) grab a resident (later identified as Resident #1). The Report indicated CNA #2 reported the abuse to a nurse (later identified as Nurse #1). (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
	225747	A. Building B. Wing	05/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Somerset Ridge Center	455 Brayton Avenue Somerset, MA 02726

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	Review of the Facility's Investigation Report, undated, indicated that on 03/29/23 at 6:24 A.M., Nurse #1 called the Administrator and said CNA #2 reported to her that she had witnessed CNA #1 grab a resident. The Report indicated that CNA #2 reported to Nurse #1 that CNA #1 pushed Resident #1's face backward then pinched his/her arms as she was forcefully holding down Resident #1's arms. The Report indicated that CNA #2 said Resident #1 was combative and CNA #1 grabbed Resident #1's face really hard and slapped his/her arms. The Report indicated that CNA #2 said when she saw the situation, she told CNA #1 No, no. no! to intervene, and CNA #1 stopped. Resident #1 was admitted to the Facility in July 2020, diagnoses included Alzheimer's Disease, depression, and anxiety disorder. Review of Resident #1's Minimum Data Set (MDS) Quarterly Assessment, dated 02/02/23, indicated that Resident #1 had severe cognitive impairment and required physical assistance of one staff to meet his/her care needs. Review of Nurse #1's Written Witness Statement, dated 03/29/23 at 6:15 A.M., indicated that Nurse #1 said that on 03/29/23, CNA #2 came to her visibly upset, shaking, and crying, and told her that CNA #1 assaulted one of the residents (later identified as Resident #1) during care. The Statement indicated Nurse #1 said CNA #2 told her that CNA #1 pushed Resident #1's face backward, pinched his/her arms and forcefully held his/her arms down. The Statement indicated that Nurse #1 said she immediately assessed Resident #1 and said Resident #1 told her, You have [NAME] working here, and she did this to me .as Resident #1 motioned with his/her hand pushing his/her own face and head backward. The Surveyor was unable to interview Nurse #1, as she did not respond to the Department of Public Health's telephone or letter requests for an interview. During an interview on 05/16/23 at 11:02 A.M., and review of CNA #2's Written Witness Statement, dated 03/29/23, CNA #2 said on 03/29/23, at approximately 5:50 A.M., CNA #1 asked her to help with Resident #1 because Resident #1 was being combative. CNA #2 said when she entered Resident #1's room, she saw Resident #1 in bed and he/she was pushing and kicking CNA #1. CNA #2 said CNA #1 grabbed Resident #1's face and pushed his/her head back onto his/her bed. CNA #2 said Resident #1 screamed when CNA #1 pushed his/her face. CNA #2 said CNA #1 also squeezed/pinched and held Resident #1's arms really hard. CNA #2 said she yelled, No, no, no!, and then CNA #1 stopped and left Resident #1's room. CNA #2 said she was so upset and nervous after she saw CNA #1 physically abuse Resident #1 and said she ran out to tell Nurse #1. Review of a Written Interview Report conducted by the Director of Nurses (DON) and the Chief Nursing Officer, dated 03/30/23, indicated that the nurse on duty (Nurse #1) said that CNA #2 reported an alleged incident to her, and said she identified the alleged victim to be Resident #1. The Report indicated that Nurse #1 said CNA #2 approached her, that CNA #2 was very upset and reported to her that she witnessed CNA #1 physically assault Resident #1 during care. The Report indicated that Nurse #1 said CNA #2 told her that CNA #1 pushed Resident #1's face backward and squeezed/pinched his/her arms as she forcefully held Resident #1's arms down. The Report indicated that CNA #2 said Resident #1 was being combative when CNA #1 grabbed Resident #1's face really hard and slapped his/her arms. The Report indicated that CNA #2 said when she saw this, she told CNA #1 No, no, no! as a way to intervene in the situation and then CNA #1 stopped. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225747	A. Building B. Wing	05/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Somerset Ridge Center	455 Brayton Avenue Somerset, MA 02726

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	Review of a Written Interview Report conducted by the DON and the Chief Nursing Officer, dated 03/30/23, indicated that CNA #1 said on the morning of 03/29/23, she was trying to change Resident #1's brief when he/she started fighting back, and was grabbing at her (CNA #1's) hands. The Report indicated that CNA #1 said she went to get CNA #2 to help her get Resident #1 out of bed, and that he/she continued to fight her, so she told the nurse, and they left Resident #1 in bed. During an interview on 05/22/23 at 11:04 A.M., and review of CNA #1's Written Witness Statement, dated 03/29/23, CNA #1 said Resident #1 tried to scratch her up all over the place and grabbed the skin on her arms. CNA #1 said she tried to get her own skin out of Resident #1's grip, so she held Resident #1's hands. CNA #1 said Resident #1 was fighting her so she had asked CNA #2 for help. CNA #1 said she was not familiar with Resident #1 or CNA #2. During an interview on 05/17/23 at 9:46 A.M., and review of a Written Witness Statement, dated 03/29/23, Social Worker (SW) #1 said she was Resident #1's primary SW, she knew him/her well, and spoke with Resident #1 at least four times per week. SW #1 said she asked Resident #1 what happened and said Resident #1 told her he/she had been in a fight, and said the other person was heavy set and dressed like that as he/she pointed to someone in scrubs. SW #1 said as Resident #1 pointed to another staff member wearing scrubs, and told her, hers had flowers on them. SW #1 said Resident #1 also told her that the person was pulling at his/her clothes. SW #1 said Resident #1 did not typically talk about fights and/or anything related to complaints about staff, even though he/she was frequently combative with care. SW #1 said Resident #1's complaint about being in a fight was out of the ordinary for him/her. During an interview on 05/16/23 at 2:01 P.M., Unit Manager #1 said Resident #1 was disoriented and had uncontrolled anxiety. Unit Manager #1 said when she arrived to the facility on [DATE], the Administrator had already interviewed Resident #1. Unit Manager #1 said the Administrator told her CNA #2 said that CNA #1 pushed Resident #1's head back, held his/her arm and possible pinched his/her arm, while providing care. During an interview on 05/17/23 at 12:45 P.M., the Director of Nurses (DON) said she was notified on 03/29/23 at 6:30 A.M. that CNA #2 saw CNA #1 push Resident #1's head backward, and said both CNA #1 and CNA #2 had said that Resident #1 was agitated. The DON said CNA #1 had left the Facility by the time she got there. The DON said she interviewed CNA #2 via phone on the 03/29/23, and said she re-interviewed CNA #1 and CNA #2 on 03/30/23 because she needed to clarify what they had written in their statements. During an interview on 05/17/23 at 1:14 P.M., the Administrator said on 03/29/23, early in the morning (exact time unknown), Nurse #1 reported to him that CNA #2 told her that CNA #1 pushed Resident #1, and said later he read that Nurse #1's statement indicated CNA #1 pushed Resident #1's face. The Administrator said he suspended CNA #1 immediately during their investigation. However, the facility was unable to provide any documenation to support that all staff were in-serviced or re-educated related to resident abuse, or that any other additional corrective actions were implemented