Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/01/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225338	A. Building B. Wing	04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cape Regency Rehabilitation & Health Care Center	120 S Main Street Centerville, MA 02632

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 48362 Based on a resident group meeting, staff interviews, and document review, the facility failed to ensure grievances and concerns from the Resident Council were documented to ensure they were acted upon timely and included the facility response and rationale for review with the Resident Council. Findings include: Review of the facility's policy titled Resident Council, last revised 10/2015, indicated the following: - It is the policy of this home that the Recreation Department will provide support and assistance in the formation of a Resident Council. - The residents will have an opportunity to express their concerns or grievances, contribute ideas and make recommendations regarding the operation of the home. - Resident Council will meet monthly. - Maintain written minutes including residents in attendance, opening, adjournment times, discussions and/or actions that take place. - Notify Department Heads in writing of concerns that come up during the meeting. - Retain a copy of the resolutions that address each concern. - Retain minutes on file for a minimum of one (1) year. - Review Residents Rights through Resident Council meetings. During the entrance conference on 3/26/24 at 8:56 A.M., the surveyor requested three months of Resident Council minutes, with the approval from the Resident Council President. (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: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 S Main Street Centerville, MA 02632	

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/27/24 at 11:00 A.M., the surveyor held a group meeting with 15 residents in attendance. The residents said they prefer to hold Resident Council monthly. The Resident Council said facility staff attend to document any of their concerns. The residents said similar concerns are brought forward monthly. The Resident Council said they are unsure of what happens to concerns once they are brought forward, and little follow up on concerns is brought back to the group monthly. Review of the Resident Council Meeting Minutes, dated 1/19/24, indicated but was not limited to the following unresolved concerns: - Call lights on first and second floor units; - Staff not wearing name tags or wearing name tags where they can be seen; - Staff wearing ear buds or on their phones; and - Staff speaking in different languages. Review of the Resident Council Meeting Minutes, dated 2/26/24, indicated but was not limited to the following unresolved concerns: - Third shift name tags are still a concern; - Call lights are being answered better on day shifts, but still a concern on evening shift; and - Staff using cell phones in resident care areas. Review of the Resident Council Meeting Minutes, dated 3/2024, indicated but was not limited to the following unresolved concerns: - Name tags are not being worn by staff or in visible areas. Further review of the Resident Council Meeting Minutes provided failed to indicate a resolution to group concerns were reviewed and discussed with the group. Review of the Resident Council Meeting Minutes failed to include group grievance or resolution forms related to on-going concerns brought forward by the group. During an interview on 3/27/24 at 2:11 P.M., the Social Worker said Resident Council concerns are brought forward to her by the Recreation Director. The Social Worker said she documents concerns from the group in the grievance log. The Social Worker said once a resolution has been completed, she brings the information forward to the Recreation Director to review with the group. Review of the Grievance Log Binder failed to indicate any grievances/concerns brought forward by the Resident Council for the previous three months. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cape Regency Rehabilitation & Health Care Center	120 S Main Street Centerville, MA 02632

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/27/24 at 3:27 P.M., the Recreation Director said after the Resident Council meeting any concerns are brought forward to the Administrator and Director of Nurses. The Recreation Director said she reviews concerns the next morning during the interdisciplinary team meeting with all department heads. The Recreation Director said she verbally reviews concerns and does not provide the interdisciplinary team with information in writing. The Recreation Director said concerns are addressed by the department affected. The Recreation Director said she did not have anything in writing related to resolution of concerns from the previous three months. The Recreation Director said she does not document the Resident Council group or individual concerns brought forward in the meeting in writing. The Recreation Director said she typically just tells the department head they affect. The Recreation Director said she does not review resolution plans with the Resident Council. During an interview on 3/28/24 at 11:14 A.M., the Administrator said issues/concerns brought forward by the Resident Council are brought forward to him by the Recreation Director after each meeting. The Administrator said he receives the meeting minutes from the Recreation Director and brings forwards the information to each department head. The Administrator said he expects each department head to follow up with a resolution to any specific concerns related to them. The Administrator said if an individual resident brings forward a concern in the Resident Council meeting, he would expect a grievance form to be completed. The Administrator said when the Resident Council group brings forward a concern, then those would be addressed by each department for resolutions. The Administrator said the Recreation Director should review resolutions to the Resident Council concerns at the start of each meeting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 S Main Street Centerville, MA 02632	

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49424 Based on observation and interview, the facility failed to ensure the residents' environment was clean, comfortable, and homelike. Specifically, the facility failed to ensure the residents' rooms and environment were maintained in good repair and homelike on 1 of 3 resident care units. Findings include: Review of the facility's policy titled Preventative Maintenance, undated, indicated but was not limited to: -The facility's physical plant and equipment will be maintained through a program of preventative maintenance and prompt action to identified areas/items in need of repair. The Maintenance Director will follow all policies regarding routine periodic maintenance. On 3/22/24 at 10:00 A.M., the surveyor observed the window screens on the first floor at the end of both hallways to be broken and did not fit correctly in the window leaving gaps where the screen was bent between the glass and screen. On 3/27/24 at 1:56 P.M, the surveyor observed the first floor resident sitting area with wall molding separating approximately 12 inches from the bottom exposing flaking pieces of wall. From 3/22/24 through 3/26/24, the surveyor observed the resident rooms not being homelike as follows: -room [ROOM NUMBER], multiple areas in the wall were patched and unpainted, other areas scratched and dented, and the baseboard was separating from the wall. -room [ROOM NUMBER], the corner of the wall was scratched, dented, and cracked exposing dry wall at the bottom of the wall. -room [ROOM NUMBER], the glass of the window and the windowsill were broken and there was a hole approximately 14 inches wide exposing plaster and dry wall. -room [ROOM NUMBER], the wall had an approximately seven inch wide hole with pieces of plaster exposed. The wall had multiple scratches and dents. -room [ROOM NUMBER], three bathroom ceiling tiles were stained brown and dirty. The walls in the room had holes, stains, and were unpainted in areas. -room [ROOM NUMBER], the bathroom wall behind the toilet was unpainted, and the molding was separating from the wall exposing unpainted areas. -room [ROOM NUMBER], multiple areas of the wall with holes, dents, and scratches with pieces of the wall coming off and falling into the molding which was separating from wall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 S Main Street Centerville, MA 02632	

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-room [ROOM NUMBER], the bureau was in disrepair with multiple drawers not closing and crooked. -room [ROOM NUMBER], areas of the wall were scratched with deep marks and areas of the wall were scraped causing a dark mark. -room [ROOM NUMBER], the molding was being held up by tape and was peeling away from wall leaving a gap between the taped molding and wall area. During an interview on 3/27/24 at 2:43 P.M., a family member said the room had been in disrepair since the Resident moved into the room about six months prior. The family member said the facility could do a better job at maintaining the building and improving the appearance of the resident rooms. He/She said the Maintenance Director was aware of the issues and had attempted to sand and patch some of the holes in the wall. During an interview with observation on 3/28/24 at 8:40 A.M., the Maintenance Director said he checks the maintenance log books on the unit and rounds on the floors daily. After rounding the unit with the surveyor, he said he had not identified these issues prior to the surveyor identifying them. He said that he has a book of preventative maintenance tasks and frequencies but resident areas and rooms were not identified on the list for completion.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 S Main Street Centerville, MA 02632	

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 43935 Based on record review, policy review, and interview, the facility failed to ensure a baseline care plan was developed for two Residents (#257 and #259) for their history of substance abuse, out of a total sample of 21 residents. Findings include: Review of the facility's policy titled Care plan - Baseline, dated as revised in November 2017, indicated but was not limited to the following: - a baseline care plan is developed within 48 hours of admission based on information obtained during the admission process as a guide for care until the comprehensive care plan is developed. 1. Resident #257 was admitted to the facility in March 2024 with a diagnosis of alcohol abuse. Review of the most recent Brief Interview for Mental Status (BIMS), dated 3/12/24, indicated Resident #257 was cognitively intact with a score of 15 out of 15. Review of the baseline care plans and current comprehensive care plans as of 3/27/24 failed to indicate a baseline care plan was developed to assist the Resident in managing his/her substance use disorder. 2. Resident #259 was admitted to the facility in March 2024 with a history of cocaine abuse. Review of the most recent BIMS, dated 3/12/24, indicated Resident #259 was cognitively intact with a score of 13 out of 15. Review of the baseline care plans and current comprehensive care plans as of 3/27/24 failed to indicate a baseline care plan was developed to assist the Resident in managing his/her substance use disorder. During an interview on 3/27/24 at 2:11 P.M., Social Worker #1 said residents are evaluated and a care plan is developed at the time of admission for their substance use disorder, prior to the comprehensive care plan being developed. She reviewed the care plans for both Resident #257 and #259 and said there was no baseline care plan or care plan in place at all at the time of the surveyor's inquiry and it was missed in the absence of the facility having a stable substance use disorder counselor. She said there should have already been care plans in place and they were not. During an interview on 3/28/24 at 10:58 A.M., Consulting staff #2 said a baseline care plan is supposed to be developed for residents with substance use disorders or a history of substance use at the time of admission and during their initial assessment and meeting with their substance use disorder counselor at the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER: Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 120 S Main Street, Centerville, MA 02632	

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/28/24 at 4:18 P.M., the Director of Nurses said both Resident #257 and Resident #259 should have had baseline care plans created for their substance use disorder and they were not in place until the surveyor brought the information to the attention of the Social Worker on 3/27/24. Refer to F740

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cape Regency Rehabilitation & Health Care Center	120 S Main Street Centerville, MA 02632

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 43935 Based on record review, policy review, and interview, the facility failed to develop individualized, person-centered care plans regarding pain management for two Residents (#257 and #259), out of a total sample of 21 residents. Findings include: Review of the facility's policy titled: Comprehensive Care Plans, dated as revised November 2017, indicated but was not limited to the following: - the facility is committed to providing residents with all necessary care and services to enable them to achieve their highest quality of life - recognizing each resident as an individual, the facility will identify and meet those needs in a resident-centered environment - care plans are oriented toward preventing avoidable decline in clinical and functional levels, maintaining a specific level of function and reflect resident preferences - care plans are a combination of data from the hospital discharge record, physician data, evaluations performed by professionals, resident goals of treatment and acute/chronic events, behaviors and/or illnesses. - comprehensive care plans are developed by the interdisciplinary team (IDT) for each resident that includes measurable objectives and timelines to accommodate resident preferences, special medical, nursing and psychosocial needs as identified by the IDT and through the resident assessment instrument (RAI). 1. Resident #257 was admitted to the facility in March 2024 with diagnoses including: pressure ulcer of the sacral region stage four (full thickness wound to the lower back/buttocks area where muscle or bone is exposed), sepsis, and alcohol abuse. Review of the most recent Brief Interview for Mental Status (BIMS), dated 3/12/24, indicated Resident #257 was cognitively intact with a score of 15 out of 15. Review of the most recent pain evaluation for Resident #257, dated 3/8/24, indicated but was not limited to the following: - Resident is able to vocalize pain - Resident experiences pain in the sacral area - pain is continuous in nature (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER: Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 120 S Main Street Centerville, MA 02632	

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- pain limits Residents day to day activity and makes it hard for the Resident to sleep at night - worst pain gets is a 9 on a 0-10 verbal numeric pain scale (0 being no pain and 10 being the worst pain of their life) - acceptable level of pain is 5 out of 10 on a 0-10 scale - pain quality is nagging - triggers to the pain is movement - things that relieve pain include: pain medication and off-loading pressure from the sacral area - proceed to care plan - No Review of the current comprehensive care plans for Resident # 257 indicated but were not limited to the following: Focus: Resident has pain/potential for pain related to impaired mobility and sacral wound (3/8/24) Goal: Resident will report relief of pain with treatment/medications as ordered with each occurrence until review (3/8/24) Interventions: Administer pain medications as ordered; assess characteristics of pain: location and severity on a 0-10 scale; assist with position changes as needed to achieve optimal level of comfort; discuss factors that precipitate pain and what may reduce it; discuss the need to request pain medication before pain becomes severe; offer non-pharmacological interventions to reduce pain (3/8/24) During an observation with interview on 3/26/24 at 12:48 P.M., the surveyor observed the Resident lying in bed on an air mattress with a pillow behind his/her head and one pillow underneath each hip on his/her left and right side. Resident #257 said their pain is pretty constant and usually around a 5 on a 0-10 scale and a five is their goal and an acceptable level of pain for them to manage. The Resident said their pain worsens typically with therapy or wound treatment dressing changes. During an interview on 3/27/24 at 11:55 A.M., Nurse #6 said there are no non-pharmacological interventions documented to use in lieu of pain medication for Resident #257 and she is unaware of what helps the Resident alleviate pain except for the use of his/her pain medications and has not ever offered any non-medicinal interventions to the Resident when he/she has complained of pain or requested pain medication. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER: Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 120 S Main Street Centerville, MA 02632	

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/27/24 at 12:20 P.M., Certified nurse assistant (CNA) #1 said Resident #257 will request assistance with repositioning when necessary. She said the Resident frequently complains of pain and when that happens she notifies the nurses to assess and medicate the Resident. She said she is unaware of any other interventions or techniques to help alleviate the Resident's pain that are not medication related. During an interview on 3/28/24 at 10:08 A.M., Nurse #2 said when she assesses or evaluates the Resident's pain, she typically just offers the Resident whatever pain medication is available to him/her. She said she is not aware of any non-medicinal interventions that the Resident uses to help alleviate pain and could not recall ever offering any to the Resident. During an observation with interview on 3/28/24 at 3:47 P.M., the surveyor observed Resident #257 lying in bed with a wedge cushion tucked underneath his/her right side. The surveyor observed the Resident reposition the cushion to their left side. The Resident said the wedge cushion was new and provided to him/her by the skilled rehab team to assist them with repositioning to help alleviate their pain. He/she said this is the first time they have been offered anything other than medication to assist them with pain management. During an interview on 3/28/24 at 4:00 P.M., Unit Manager (UM) #2 reviewed Resident #257's pain care plan and said the care plan is generic and not specific to the Resident's needs, goals or pain management and does not provide the staff with any non-medicinal pain interventions to attempt for the Resident prior to administering pain medications. She said the care plan should be more specific to this Residents needs and goals and was not. During an interview on 3/28/24 at 4:21 P.M., the Director of Nurses (DON) said care plans should be specific to an individual Resident's needs and goals and Resident #257's pain care plan was not. She said it should reflect the Resident's use of the wedge cushion, skilled rehab involvement and modalities and the Resident's personal goal of a 5 on a 0-10 pain scale and did not. She said the care plan was generic and did not meet the resident-centered goal of the care plan policy as it should. 2. Resident #259 was admitted to the facility in March 2024 with diagnoses including: sepsis, discitis (an inflammation in between the bones of the spine), osteomyelitis (an inflammation of bone caused by infection), lower back pain, and cocaine abuse. Review of the most recent BIMS, dated 3/12/24, indicated Resident #259 was cognitively intact with a score of 13 out of 15. Review of the most recent pain evaluation for Resident #259 dated: 3/8/24, included but was not limited to the following: - Resident is able to vocalize pain - location, duration and quality of pain was blank - Resident's present pain 10 (on a 0-10 pain scale) - worst pain gets is 10 verbal numeric pain scale (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 S Main Street Centerville, MA 02632	

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- acceptable level of pain is 10 out of 10 on a 0-10 scale - pain effects of function was blank - triggers to the pain was blank - things that relieve pain was blank - proceed to care plan - No Review of the current comprehensive care plans for Resident # 259 indicated but were not limited to the following: Focus: Resident has pain/potential for pain related to back pain (3/11/24) Goal: Resident will report relief of pain with treatment/medications as ordered with each occurrence until review (3/11/24) Interventions: Administer pain medications as ordered; assess characteristics of pain: location and severity on a 0-10 scale; assist with position changes as needed to achieve optimal level of comfort; discuss factors that precipitate pain and what may reduce it; discuss the need to request pain medication before pain becomes severe (3/11/24) During an observation with interview on 3/26/24 at 8:35 A.M., the surveyor observed Resident #259 lying in bed. The Resident said they suffer from chronic back pain and their pain is usually pretty bad and they seem to never get full relief. During a follow up interview on 3/27/24 at 11:03 A.M., Resident #259 said that his/her personal pain goal is for their pain not to exceed a 3 on a 0-10 scale. During an interview on 3/28/24 at 9:03 A.M., Nurse #3 said Resident #259 can reposition and transfer themselves from bed to chair. She said the Resident is working with skilled rehab and uses narcotic and non-narcotic medication for his/her pain which is frequent. She said she was not aware of any non-medicinal interventions to offer the Resident in lieu of pain medications and typically just administers Resident #259 pain medication when they complain of pain. Review of the medical record indicated Resident #259 was seen by his/her physician on 3/26/24 and a new order was received for a pain clinic consult. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER: Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 120 S Main Street Centerville, MA 02632	

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/28/24 at 4:01 P.M., UM #2 reviewed the pain care plan for Resident #259 and said the care plan is generic and not individualized to the Resident's specific needs. She said the Resident has a complicated history with pain and the care plan should indicate the attempts to manage pain and what does and does not work for the Resident and the initiation of the pain clinic referral. She said the care plan does not include the Resident's individual pain goal or identify that he/she is working with skilled rehab. She said the care plan should be specific to the Resident's needs and it is not and needs more work to be resident centered. During an interview on 3/28/24 at 4:21 P.M., the DON reviewed Resident #259's pain care plan and said the care plan should be more Resident specific including things like the Resident's preference to decline the use of non-narcotic pain medication and refusal to attempt any non-medicinal interventions. She said the care plan should speak to the Resident's individual pain goal, the quality and severity of the pain and modalities that skilled rehab may be using while working with the Resident and the referral to a pain clinic since the Resident has a complicated history with pain management but it does not. She said the care plan is not individualized for Resident #259 as it should be. Refer to F697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cape Regency Rehabilitation & Health Care Center	120 S Main Street Centerville, MA 02632

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 43935 Based on observation, policy review and interview, the facility failed to ensure one Resident (#41) was administered their medications in accordance with professional standards and the facility policy. The total sample was 21 residents. Findings include: Review of the facility's policy titled Medication Administration - Oral, dated June 2015, indicated but was not limited to the following: - drugs for oral administration are available in tablets, capsules, syrups, elixirs, oils, liquids, suspensions, and powders. - the nurse is to stay with the resident until he/she has swallowed the medication. Resident #41 was admitted to the facility in July 2023 with diagnoses including stroke, hypertension, and diabetes mellitus. On 3/27/24 at 7:56 A.M., the surveyor observed Nurse #1 pour liquid protein 30 milliliters (mls) into a cup for Resident #41 as part of his/her morning medications. The nurse then left the cup of medication with the Resident after informing him/her what the medication was. She did not observe the Resident ingest the medication to ensure it was consumed by the Resident. Review of the Self-Administration of Medication Informed Consent and Assessment for Resident #41 in the medical record indicated but was not limited to the following: - the Resident signed he/she wished to have their medications administered by the nurse - the back of the form which indicated an assessment of the Residents ability to self-administer was blank Review of the Self-Administration of Medications Assessment for Resident #41, dated 3/21/24, indicated the Resident did not desire to self-administer their own medications. Review of the current Physician's Orders and Medication Administration Record (MAR), dated 3/27/24, failed to indicate the physician had authorized that the Resident could self-administer medications. During an interview on 3/27/24 at 8:00 A.M., Nurse #1 said she typically will leave medications with Residents who are with it and assumes they know enough to take them. She said this is against the standard of practice and she should have stayed with Resident #41 and watched him/her actually take his/her medication. She said the Resident does not self-administer medications that she is aware of. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225338	A. Building B. Wing	04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cape Regency Rehabilitation & Health Care Center	120 S Main Street Centerville, MA 02632

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/28/24 at 12:51 P.M., the Regional Nurse said Nurse #1 should not have left any medications at the Resident's bedside and should have remained with the Resident to ensure the medication was taken as ordered. She said the nurse did not follow the standard of practice or policy for medication administration at the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER: Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 120 S Main Street Centerville, MA 02632	

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 0695

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide safe and appropriate respiratory care for a resident when needed.

49425

Based on observation, interview, and record review, the facility failed for two Residents (#33 and #65), out of a total sample of 21 residents, to ensure staff provided the necessary respiratory care and services in accordance with professional standards of practice. Specifically, the facility failed:

1. For Resident #33, to ensure continuous positive airway pressure (CPAP) mask and tubing were stored properly in a sanitary manner to prevent potential contamination from germs and environmental debris; and

2. For Resident #65, to ensure CPAP mask and tubing were stored in a sanitary manner to decrease the risk of potential contamination.

Findings include:

Review of Lippincott's Manual of Nursing Procedures 9th edition, dated 2023, indicated but was not limited to the following:

-When the CPAP therapy has been completed, follow these steps:

-Clean and disinfect the equipment using a facility-approved disinfectant according to the manufacturer's instructions

-Store it properly

1. Resident #33 was admitted to the facility in September 2022 with diagnoses including acute and chronic respiratory failure and chronic obstructive pulmonary disease (lung disease that blocks airflow and makes it difficult to breathe).

On 3/26/24 at 9:14 A.M., the surveyor observed Resident #33 sleeping on their bed with his/her CPAP mask and tubing inside the open top drawer of the bedside table, uncovered, not stored in a sanitary manner, exposed to environmental elements, and increased risk of contamination.

Throughout the surveyor, the surveyor made additional observations of Resident #33's CPAP mask and tubing:

- 3/26/24 at 2:06 P.M., mask and tubing, not stored in a sanitary manner, inside open top drawer of the bedside table, exposed to environmental elements and increased risk of contamination.

- 3/27/24 at 8:18 A.M., mask and tubing, not stored in a sanitary manner, inside open top drawer of the bedside table, exposed to environmental elements and increased risk of contamination.

- 3/27/24 at 3:48 P.M., mask and tubing, not stored in a sanitary manner, inside open top drawer of the bedside table, exposed to environmental elements and increased risk of contamination.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 S Main Street Centerville, MA 02632	

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 3/28/24 at 2:03 P.M., mask and tubing, not stored in a sanitary manner, inside open top drawer of the bedside table, exposed to environmental elements and increased risk of contamination. During an interview with observation on 4/1/24 at 7:27 A.M., Nurse #5 said she changes all the oxygen tubing weekly on Sundays during the 11-7 shift, and as needed if soiled. She said she labels and dates all the tubing and supplies the residents with a new bag for storage when not in use. She said all CPAP masks and tubing should be placed in a bag when not in use to keep it clean. Nurse #5 observed Resident #33 utilizing her mask and tubing and could not locate a storage bag in the room. She said Resident #33 did not have a storage bag for his/her mask and tubing to store the mask and tubing appropriately when not in use. During an interview on 4/1/24 at 8:30 A.M., the Assistant Director of Nursing (ADON) said all residents using Oxygen should have a storage bag to place their mask and tubing in, when not in use, to reduce the risk of contamination from germs and dust particles. 43935 2. Resident #65 was admitted to the facility in November 2023 with diagnoses including chronic pulmonary embolism (a blockage of the pulmonary artery by blood clots) and sleep apnea (a sleeping disorder in which breathing repeatedly stops and restarts). Review of the most recent Brief Interview for Mental Status (BIMS), dated 12/5/23, indicated the Resident was cognitively intact with a score of 15 out of 15. On 3/26/24 at 8:57 A.M., the surveyor observed Resident #65 sitting on the edge of their bed with his/her CPAP mask and tubing on top of the bedside table, not stored in a bag but left open to potential germs and environmental debris. Resident #65 said he/she was unaware of what the facility expectation is for storing their CPAP mask and tubing when it was not in use and he/she typically puts it next to the machine for use the next night. He/she said they were not offered a bag to store the CPAP tubing and mask in when not in use and the surveyor did not observe one in the Resident's room. Throughout the survey, the surveyor made additional observations of Resident #65's CPAP mask and tubing: - 3/27/24 at 9:46 A.M., mask and tubing laying exposed to potential germs and environmental debris, not stored in a sanitary manner, resting against the bedside tabletop - 3/27/24 at 10:56 A.M., mask and tubing, not secured in a bag or storage container, resting against the base of the lamp on the bedside table exposed to potential germs and environmental debris - 3/27/24 at 12:56 P.M., mask and tubing, not secured in a bag or storage container, resting against the base of the lamp on the bedside table exposed to potential germs and environmental debris - 3/28/24 at 8:22 A.M., mask and tubing laying on bedside table touching the tabletop, not stored in a sanitary manner to protect it from potential contamination from germs or environmental debris (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER: Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 120 S Main Street Centerville, MA 02632	

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/27/24 at 10:19 A.M., the Assistant Director of Nurses said the expectation for storing CPAP mask and tubing is to store it in a labeled respiratory equipment bag when not in use by the resident to protect it from being exposed to germs. She said she does not believe the facility policy indicates this but it is the expectation of the facility that all respiratory equipment and tubing is stored in a sanitary manner in a respiratory storage bag when not in use by the residents. During an interview with observation on 3/28/24 at 10:21 A.M., Unit Manager #2 observed Resident #65's CPAP mask and tubing exposed to potential germs and environmental debris resting on the bedside table, not secured in a respiratory equipment storage bag. She said the CPAP mask and tubing should be stored in a labeled respiratory storage bag when not in use by Resident #65 to decrease the risk of contamination by germs in the air. She said the mask and tubing should be in a storage bag and was not stored appropriately as it should have been. During an interview on 3/28/24 at 12:48 P.M., the Regional Nurse said the expectation is for the facility to store all respiratory tubing and CPAP masks in respiratory storage bags when not in use by the residents to prevent possible contamination of the mask and tubing from germs and environmental debris. She said based on the surveyors' observations that expectation was not met and it was a breech in the infection control standard.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 S Main Street Centerville, MA 02632	

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 43935 Based on record review, interview, and policy review, the facility failed to maintain an effective resident-centered pain management program to assist one Resident (#257) in meeting their individual pain goals, out of a total sample of 21 residents. Findings include: Review of the facility's policy titled Pain Management, dated April 2015, indicated but was not limited to the following: - the facility is committed to assisting each resident attain or maintain their highest practicable well-being, by evaluating pain and using interventions to prevent pain from interfering with overall quality of life - in the evaluation the resident's perception of pain is always considered reality and the resident's goal of pain for pain management will be honored - the resident's acceptable level of pain will be determined by resident interview and evaluation - the facility will: assess potential for pain, recognize the onset or presence of pain, assess using a standardized scale, develop and implement interventions to pain management both pharmacological and non-pharmacological, use pain medications judiciously (with good judgement or sense) to balance the resident's desired pain level and avoid adverse reactions; monitor for effectiveness and adverse reactions, modify approaches as necessary Resident #257 was admitted to the facility in March 2024 with diagnoses including pressure ulcer of the sacral region stage four (full thickness wound to the lower back/buttocks area where muscle or bone is exposed), sepsis, and alcohol use disorder. Review of the most recent Brief Interview for Mental Status, dated 3/12/24, indicated Resident #257 was cognitively intact with a score of 15 out of 15. During an observation with interview on 3/26/24 at 12:48 P.M., the surveyor observed Resident lying in bed on an air mattress with a pillow behind his/her head and one pillow underneath each hip on his/her left and right side. Resident #257 said their pain is pretty constant and usually around a 5 on a 0-10 scale and a 5 is their goal and an acceptable level of pain for them to manage. The Resident said the pain worsens typically with therapy or wound treatment dressing changes. Review of the most recent pain evaluation for Resident #257, dated 3/8/24, indicated but was not limited to the following: - Resident is able to vocalize pain - Resident experiences pain in the sacral area (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER: Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 120 S Main Street Centerville, MA 02632	

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- pain is continuous in nature - pain limits Resident's day to day activity and makes it hard for the Resident to sleep at night - worst pain gets is a 9 on a 0-10 verbal numeric pain scale (0 being no pain and 10 being the worst pain of their life) - acceptable level of pain is 5 out of 10 on a 0-10 scale - pain quality is nagging - triggers to the pain is movement - things that relieve pain include: pain medication and off-loading pressure from the sacral area - proceed to care plan - No Review of the most recent Minimum Data Set (MDS) assessment for Resident #257, dated 3/15/24, indicated but was not limited to the following: Section J - health conditions: J0100. Pain management: A. Yes, Resident received scheduled pain medication regimen B. Yes, Resident received as needed (PRN) pain medication or was offered and declined C. No, Resident did not receive non-medication intervention for pain J0200. Pain Assessment Interview: Yes, interview should be conducted with Resident J0300. Yes, pain in the last five days J0410. Pain occurs frequently J0510. Pain effects sleep frequently J0520. Pain interferes with therapy activities frequently J0530. Pain interferes with day to day activities frequently J0600. Worst pain in the last five days on a 0-10 verbal numeric scale was 3 out of 10 Review of the current Physician's Orders for Resident #257 indicated but were not limited to the following active orders: - Monitor pain every shift using 0-10 pain scale (3/8/24) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 S Main Street Centerville, MA 02632	

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Acetaminophen (APAP) 325 milligrams (mg) give two tablets to equal 650 mg dose every six hours as needed for pain (3/8/24) - Oxycodone hydrochloride (HCL) (a narcotic pain medication) 5 mg give one tab every six hours as needed for pain (3/8/24) During an interview on 3/27/24 at 11:55 A.M., Nurse #6 said Resident #257 frequently complains of pain. She said she provided the Resident with Oxycodone 5 mg tablet this morning at about 9:10 A.M., for a pain level of 4 on a 0-10 scale. She said the Resident will typically request the Oxycodone and decline the use of the APAP. She reviewed the medication administration record (MAR) for Resident #257 and said there is no indication of which prescribed PRN pain medication to give for which pain level and although usually those orders are specific when there are multiple PRN pain medications this Resident's orders do not specify. She said the nurses are supposed to document a pain score, as provided by the Resident prior to administering the medication and then return to the Resident and document the medications effectiveness. She said this Resident's orders do not specify which pain medication to give for pain based on the Resident's perception of pain; the nurse can provide the Resident with whatever he or she requests or whichever medication the nurse decides to provide. She said there is nowhere that the nurses would document non-pharmacological pain interventions and she is not aware of any non-pharmacological pain interventions for this Resident. She said she has not ever offered anything to the Resident other than pain medication. Review of the progress notes for Resident #257 failed to indicate any non-pharmacological interventions were attempted for Resident #257 or that the Resident has a history of declining the use of the non-narcotic APAP to manage his/her pain. During an interview on 3/27/24 at 12:20 P.M., Certified Nurse Assistant (CNA) #1 said the Resident is assisted with repositioning as needed and will frequently complain of pain to the CNA during this process. She said she believes the Resident is on skilled rehab, but is unaware of any pain interventions or techniques to be used except for the nurses providing the Resident pain medications. CNA #1 said when the Resident complains of pain, she informs the nurses. Review of the March 2024 MAR for Resident #257 from March 1 through March 27 indicated but was not limited to the following: - Out of 57 pain monitoring opportunities, the Resident provided a pain rating of zero 45 times; a score of 1 four times; a score of 4 three times; a score of two, three, five six and seven once each - Resident received PRN APAP 16 times throughout the month for a pain scale score ranging from 3 to 7, on a 0-10 scale - Resident received PRN Oxycodone 38 times throughout the month for a pain scale score ranging from 0 to 10, on a 0-10 scale The MAR failed to indicate any consistency in what medication the Resident was receiving to help alleviate their pain, and indicated they received a narcotic pain medication for a pain level of zero on one occasion. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER: Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 120 S Main Street Centerville, MA 02632	

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/28/24 at 8:07 A.M., Resident #257 said when they complain of pain they provide the nurse a number, but then the staff will administer them whichever pain medication they want at the time and he/she was not limited to accepting APAP even when their pain is at or below their goal of 5 on a 0-10 scale. He/She said they have not ever been offered any non-medicine alternative or interventions to help manage their pain and just takes a pill each time. During an interview on 3/28/24 at 10:08 A.M., Nurse #2 said the nurses will provide the Resident with whichever pain medication he/she requests typically regardless of the pain level the Resident reports. She reviewed the medical record and said if the Resident's pain goal is a 5 on a 0-10 scale then the Resident should not be receiving Oxycodone for a pain level below a 5 and should be offered APAP and if declined, that should be documented. She reviewed the March MAR indicating she had administered the Resident Oxycodone 5 mg for a pain score of 0 and said she should not have given the Resident an Oxycodone pain pill for a pain level of 0 and believes it was likely administered as a preventative before skilled rehab or a wound dressing change but did not document that anywhere so she cannot be sure. She said providing the Resident with an Oxycodone for a pain rating of 0 was an error and not in line with the standard of care for pain management or the facility policy for using medications judiciously. She said she cannot recall ever offering the Resident any non-pharmacological pain interventions or modalities and is unaware of what non-pharmacological interventions may benefit the Resident in managing their pain. Review of the progress notes for Resident #257 failed to indicate why the Resident was administered Oxycodone pain medication for a pain scale score of 0 on a 0-10 scale. Review of the current comprehensive care plans for Resident #257 indicated but were not limited to the following: Focus: Resident has pain/potential for pain related to impaired mobility and sacral wound (3/8/24) Goal: Resident will report relief of pain with treatment/medications as ordered with each occurrence until review (3/8/24) Interventions: Administer pain medications as ordered; assess characteristics of pain: location and severity on a 0-10 scale; assist with position changes as needed to achieve optimal level of comfort; discuss factors that precipitate pain and what may reduce it; discuss the need to request pain medication before pain becomes severe; offer non-pharmacological interventions to reduce pain (3/8/24) The care plan failed to indicate which non-pharmacological interventions the staff should attempt to help alleviate the Resident's pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER: Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 120 S Main Street Centerville, MA 02632	

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/28/24 at 10:10 A.M., Unit Manager #2 said typically when residents have multiple PRN pain medication orders, the orders will include a pain scale score to differentiate which medication should be offered or administered to the resident based on their pain level. She reviewed the medical record for Resident #257 and said the Resident's orders do not provide guidance to the staff to help them determine which pain medication to offer or provide the Resident based on their reported pain level and they should. She said since the Resident's pain goal is a 5 on a 0-10 scale the Resident should be offered APAP for a pain level of 5 or less and Oxycodone for a pain level above 5 in an effort to not over-medicate the Resident and eliminate the possibility of side effects. She said it was clear that the staff required more education on individualized pain management to consistently provide the Resident with enough medication to keep them comfortable but prevent potential side effects and that any refused attempts at medicating the Resident should be documented in the medical record, as well as any non-pharmacological interventions to assist the Resident with their pain management. During an interview on 3/28/24 at 12:38 P.M., the Regional Nurse reviewed the pain management information for Resident #257 and said the Resident should not have received any pain medication with their current orders for a pain scale score of 0 and their two ordered PRN pain medications should have pain scales built into them to better help the Resident achieve their individual pain management goals without the risk of overmedicating or unnecessary side effects. She said all residents should be offered and provided non-medicinal pain interventions that should be documented by the staff in the progress notes or the individualized care plan. She said staff are not providing the right medication for the right situations and it is clear there is a lack of knowledge on the staff's part when managing this Resident's pain in accordance with their goals and needs. She said the expectation and facility policy for using pain medications judiciously and providing residents with non-pharmacological interventions to assist with their pain management was not met.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 S Main Street Centerville, MA 02632	

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 43935 Based on interview, record review, and policy review, the facility failed to consistently provide substance use disorder counselling and services for two Residents (#257 and #259), out of a total sample of 21 residents. Findings include: Review of the facility's policy titled Treatment Options for Residents with Substance Use Disorder, dated March 2024, included but was limited to: - the facility will offer appropriate individualized treatment for all residents living with the disease of addiction or with a history of substance use disorder - newly admitted residents with substance use disorder will be assessed by licensed substance use clinicians, or designee, and offered appropriate referrals as indicated, warranted, feasible and agreed upon - substance use clinicians, or designee, will provide resources to residents who request and/or accept referral to substance use treatment and will support/assist with initiating treatment - residents with substance use disorder and actively being treated as well as residents with a history of substance use disorder, will be offered behavioral health services and continued counseling - residents with substance use disorder and actively being treated as well as residents with a history of substance use disorder, will have substance use disorder evaluations completed on admission and an individualized care plan completed by the interdisciplinary team (IDT) 1. Resident #257 was admitted to the facility in March 2024 with diagnoses including alcohol use disorder. Review of the most recent Brief Interview for Mental Status (BIMS), dated 3/12/24, indicated Resident #257 was cognitively intact with a score of 15 out of 15. The most recent PHQ-9 (patient health questionnaire that scores depression levels), completed on 3/12/24 indicated a score of 8 indicating mild depression. Review of the Preadmission Screening and Resident Review (PASRR) Level 1 screening for Resident #257 indicated but was not limited to the following: Section B: screening for serious mental illness (SMI) - yes, applicant has a documented diagnosis of mental illness and disorder of Mood (bipolar disorder, major depression) - yes, the applicant has a substance use disorder (SUD) that may lead to chronic disability (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 S Main Street Centerville, MA 02632	

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- substances known: alcohol, Fentanyl - most recent use occurred less than 90 days ago - yes, in the past two years applicant has required treatment - SUD treatment SMI screening results: - Positive SMI screen Section C: exempted hospital discharge: the applicant is: - being admitted to a nursing facility following an acute hospitalization after receiving inpatient acute medical care - in need of nursing facility services to treat the same medical condition treated while in acute hospital - not a current risk to self or others, and behavioral symptoms, if present are stable - expected to stay in a nursing facility for less than 30 calendar days as certified by the hospital's attending or discharging practitioner Applicant screened positive for SMI only. However, level 2 PASRR for SMI is not indicated at this time due to exempt hospital discharge Review of the Substance and/or Abuse Evaluation, completed 3/11/24, for Resident #257 indicated but was not limited to the following: - Yes, history of substance use and/or alcohol abuse - history of abusing alcohol - resident will be offered SUD services Review of the SUD progress notes indicated there was only one note available in the medical record, dated 3/11/24, which indicated but was not limited to the following: - substance abuse counselor (SAC) met with Resident and made introductions. Resident initially declined SUD services as he/she has already stopped drinking months ago and does not need help. Resident stated he/she does not have transportation to participate in SUD treatment. SAC educated Resident on available programs and Resident was open to a list of resources and weekly one to one (1:1) visits. Resident became tearful speaking about his/her desire to drink and depression. SAC will meet with Resident weekly for emotional support and to build rapport and SUD services. Further review of the medical record failed to indicate Resident #257 had the weekly follow up visits with the SAC after 3/11/24, as planned. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER: Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 120 S Main Street Centerville, MA 02632	

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the current care plans indicated that, as of 3/27/24, no care plan had been developed to assist the Resident in managing his/her substance abuse or the treatment and support the SAC was to provide to the Resident in their journey to maintain their sobriety. Review of the initial Social Services Summary for Resident #257, dated 3/12/24, indicated but was not limited to the following: - Resident has documented history of alcohol use - Resident denied substance use history, and indicated he/she has been sober for 6-8 months and declined SAC referral - Resident reports depression and agreeable to referral to psych services for 1:1 support During an interview on 3/27/24 at 2:11 P.M., Social Worker #1 said the SAC was on a leave until the middle of April and residents were seeing a SAC from another facility but that person has recently left as well. She said Social Services provides support to SUD residents by referring them to psych services, the SAC or whichever they choose. She said otherwise, unless it is requested, the Social Worker is not involved with the support or treatment of substance use disorder residents. She said the SUD counselors will have an initial meeting with the residents and formulate a care plan that is individualized to the resident's needs at the time of the initial meetings. She reviewed the medical record for Resident #257 and said the Resident was missing visits from his/her SAC and had only been seen once and was on SUD services with the SAC. She said there should be a person-centered detailed care plan on the Resident's SUD use and supports to help them maintain their sobriety but there was not. She said the process of offering SUD services and supporting SUD residents could be improved upon since Resident #257 was missing visits, and a care plan for their SUD needs. Review of the Psychiatric Evaluation and Consultation notes for Resident #257 indicated but were not limited to the following: - 3/11/24: Alcohol abuse, uncomplicated - patient alert and appropriate, mood and affect are appropriate. Denies increase depression or anxiety. Remains stable, declines SUD services - 3/18/24: Mood and behavior follow up. Alcohol abuse, uncomplicated - patient alert and appropriate, calm, and cooperative, no agitation. Denies increase anxiety or depression, reports staying positive, no acute changes in mood follow up as needed. During an interview on 3/27/24 at 4:13 P.M., Resident #257 said he/she did meet with the SAC in the facility and agreed to continue to see them weekly to help keep their spirits up and manage his/her sobriety while they are in the facility and get referrals for when they are discharged home. The Resident said the counselor only came once, even though they said they would see him/her weekly. The Resident was unsure of why the counselor has not returned but said, Maybe they didn't have anything else to offer me and added that he/she would like to continue seeing the SAC. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 S Main Street Centerville, MA 02632	

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/28/24 at 10:10 A.M., Unit Manager #2 reviewed the medical record of Resident #257 and said the Resident accepted SUD services and was seen by the SAC once on 3/11/24. She said the Resident should have been seen weekly and has missed SUD counseling sessions and there was no documentation in the record that indicated why the SAC had not returned to the Resident as the Resident desired. She said the facility has a covering SAC in the building and she will have them see Resident #257 today to get them back on track. She said there should have been an SUD care plan in place at the time of admission that was developed by the SAC to help the staff work through any issues that are specific to the Resident's goals with the SUD, but one was not developed until 3/27/24. She said she does not know who oversees the SUD program, but their normal SAC has not been available and that is likely why the weekly visits were missed and the care plan was not developed. 2. Resident #259 was admitted to the facility in March 2024 with diagnoses including cocaine abuse, major depressive disorder, and generalized anxiety disorder. Review of the most recent BIMS, dated 3/12/24, indicated Resident #259 was cognitively intact with a score of 13 out of 15. Review of the most recent PHQ-9 for Resident #259, dated 3/12/24, indicated a score of 15, indicating severe depression. Review of the Substance and/or Abuse Evaluation, completed 3/11/24, for Resident #259 indicated but was not limited to the following: - Yes, history of substance use and/or alcohol abuse - history of opioids and cocaine - resident will be offered SUD services Review of the SUD progress notes indicated there was only one note available in the medical record, dated 3/11/24, which indicated but was not limited to the following: - SAC met with Resident bedside and made introductions. Resident reported he/she participated in SUD services outpatient, however, endorses cocaine use recently. SAC will continue to build rapport and let Resident settle into the facility, will continue to meet with Resident weekly to further assess needs. Further review of the medical record failed to indicate Resident #259 had any weekly follow up visits with the SAC after 3/11/24 to further assess the Resident's needs and build rapport. Review of the current care plans indicated that, as of 3/27/24, no care plan was developed to assist Resident #259 in managing his/her substance abuse or the treatment and support the SAC was to provide to the Resident in their journey to maintain their sobriety. Review of the initial Social Services Summary for Resident #259, dated 3/12/24, indicated but was not limited to the following: - Resident has documented history of cocaine abuse and carries diagnoses of anxiety, major depressive disorder, and opioid use disorder (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER: Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 120 S Main Street Centerville, MA 02632	

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Records indicate Resident is involved with a community recovery navigator - Resident endorses a referral for 1:1 support. Social worker will refer to psych services who will remain available for support. During an interview on 3/27/24 at 2:11 P.M., Social Worker #1 said the SAC was on a leave until the middle of April and residents were seeing a SAC from another facility but that person has recently left as well. She said Social Services provides support to SUD residents by referring them to psych services, the SAC, or whichever they choose. She said otherwise, unless it is requested, the Social Worker is not involved with the support or treatment of substance use disorder residents. She said the SUD counselors will have an initial meeting with the residents and formulate a care plan that is individualized to the resident's needs at the time of the initial meetings. She reviewed the medical record for Resident #259 and said the Resident was missing visits from his/her SAC and had only been seen once and was on SUD services with the SAC. She said there should be a person-centered detailed care plan on the Resident's SUD and supports to help them maintain their sobriety but there was not. She said the process of offering SUD services and supporting SUD residents could be improved upon since Resident #259 was missing visits and a care plan for their SUD needs. Review of the Psychiatric Evaluation and Consultation notes for Resident #259 indicated but were not limited to the following: - 3/11/24: Generalized anxiety disorder: patient is anxious, tearful and complaining of pain; Cocaine abuse uncomplicated: declines SUD services at this time, said he/she is in pain and does not wish to further discuss; Major depressive disorder recurrent: reporting increase depression symptoms, staff report increase anxiety; recommend increasing antidepressant and schedule a medication for mood - 3/18/24: Follow up due to medication changes: Generalized anxiety disorder: alert and verbally appropriate, denies increase anxiety, reports mild improvement; Cocaine abuse uncomplicated: declines SUD services at this time; Major depressive disorder recurrent: reporting he/she remains depressed about their current situation, encouraged to remain positive and focus on what he/she can control. Continue with current medications. - 3/25/24: Follow up of mood/behavior. Resident went to emergency room over the weekend and returned the same day. Generalized anxiety disorder: alert and verbally appropriate, denies increase anxiety; Cocaine abuse uncomplicated: declines SUD services at this time; Major depressive disorder recurrent: reports feeling optimistic about returning home in the next three weeks. Follow up as needed. During an interview on 3/27/24 at 11:03 A.M., Resident #259 said he/she saw a substance use counselor at the facility and said he/she informed the counselor he/she had a very recent relapse and used cocaine. He/She said the SAC agreed to see him/her again in about a week and discuss further strategies to help him/her feel better about their current situation and offer support services to maintain his/her sobriety, but he/she has not seen them again. He/she laughed quietly and said, Maybe she thought I couldn't do it, or I'm not a priority, I don't know. Resident #259 said he/she does see psych services but they do not discuss or assist him/her with their substance abuse history. During a follow up interview on 3/28/24 at 9:23 A.M., Resident #259 said maintaining his/her sobriety is a struggle everyday especially in their current medical situation and he/she is trying their best to figure it out on their own. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 S Main Street Centerville, MA 02632	

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/28/24 at 10:09 A.M., Unit Manager #2 reviewed the medical record for Resident #259 and said the Resident was seen by the SAC once on 3/11/24 and was supposed to be seen weekly from there. She said there was no evidence in the record as to why the SAC did not return to see the Resident and no care plan that entails what the Resident's goals and needs are to help manage his/her SUD. She said she does not know why or how SUD sessions were missed or who coordinates or oversees the SUD program with the facility SAC unavailable. She said a SAC was in the facility on this day and she would hope they would see Resident #259 to help him/her with their complicated situation. During an interview on 3/28/24 at 10:58 A.M., the Consulting SAC said they were covering the facility to provide services to the residents today and were new to the facility. He said any resident with a history or diagnosis of SUD is seen by the SAC initially and from there a care plan is created, if the resident is agreeable, and treatment and support visits begin, usually weekly, but sometimes more often. He said the care plans should be specific to the resident's individual needs and the substance they have struggled with and their goals to maintain their sobriety and services they have been offered, referred to and the amount of support offered by the SAC. He said once the SAC meets with the resident and develops a schedule of support (such as weekly) it is imperative to maintain the schedule to ensure the residents don't feel forgotten or dismissed in some way which could cause a delay in their progress in their sobriety journey. He said building a trusting relationship and allowing the resident to speak freely about their struggles with substances is a key factor in assisting them. He said he did meet with both Residents #257 and #259 today (3/28/24) who were happy to see him and accepting of continued services, referrals, and support by the SAC while they are in the facility, and the Residents will be seen ongoing, as per the original plan, weekly. During an interview on 3/28/24 at 12:13 P.M., the Administrator said residents with a diagnosis or history of SUD are referred for SUD services with a SAC. He said the facility SAC has been out on medical leave and the facility has been attempting to ascertain assistance from sister facilities in the area to maintain the services for the residents. He said he was unaware that Residents #257 and #259 had missed SAC support sessions or care plans had not been developed for the Resident's SUD services until the issue was brought to the facility's attention by the surveyor the previous day. He said the SUD program is a good program that usually runs pretty smoothly, but since the facility SAC has been unavailable providing all of the program pieces has been challenging and the IDT would have to look into how to track and pick up those pieces to better serve the Residents. During an interview on 3/28/24 at 12:40 P.M., the Regional Nurse said the facility has not fully implemented all the pieces of the SUD program since their SAC counselor has not been available and it is clear the program is not in place based on the missing weekly visits for both Residents #257 and #259 and the lack of SUD care plan development until the survey team brought it to the facility's attention. She said the policy for treatment options for residents with substance use disorder was not being followed by the facility at this time as it should be. During an interview on 3/28/24 at 4:18 P.M., the Director of Nurses said the SUD program is not in place as it should be since the facility's SAC has been unavailable. She said vital pieces of the program have not had oversight and been fully implemented as they should have been for Residents #257 and #259; the facility needed to work on ensuring the program was in place and fully implemented in accordance with the Resident's needs as determined by the SAC and the facility policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER: Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 120 S Main Street Centerville, MA 02632	

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49425 Based on observation, interview, and policy review, the facility failed to safely store medications on one out of three units observed. Specifically, the facility failed to ensure medication carts were secure when not in view of the licensed nurse. Findings include: Review of the facility's policy titled Medication Storage Room/Medication Cart, dated February 2018, indicated but was not limited to the following: -The facility provides pharmaceutical services that are conducted in accordance with accepted ethical and professional standards of practice and that meet applicable Federal, State and Local Laws, rules and regulations -Medications are stored primarily in a locked mobile medication cart which is accessible only to licensed nursing personnel On 03/26/24 at 9:05 A.M., the surveyor observed the medication cart on first floor south side, in the hallway outside of room [ROOM NUMBER], the cart was unlocked, the medications were unsecured, and there was no licensed nurse in the area. On 3/26/24 at 9:07 A.M., the surveyor observed a resident self-propelling in a wheelchair past the unlocked, unsecured medication cart. On 3/26/24 at 9:08 A.M., the surveyor observed a resident ambulating in front of the unlocked, unsecured medication cart. During an observation with interview on 3/26/24 at 9:10 A.M., the surveyor observed Nurse #1 approach the medication cart and lock it. Nurse #1 said the medication cart should have been locked when unattended, she had walked away to assist another nurse, and forgot to lock the cart. On 3/26/24 at 2:18 P.M., the surveyor observed a medication cart, unlocked, on first floor located at the nursing station, the medications were unsecured, and there was no licensed nurse in the area. On 3/26/24 at 2:22 P.M., the surveyor observed a resident ambulating past the unlocked, unsecured medication cart. During an observation with interview on 3/28/24 at 2:25 P.M., the surveyor observed Nurse #1 approach the medication cart and lock it. Nurse #1 said the medication cart should have been locked when she left it unattended.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cape Regency Rehabilitation & Health Care Center	120 S Main Street Centerville, MA 02632

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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 36542 Based on interview and record review, the facility failed to ensure laboratory (lab) services were obtained for one Resident (#89), out of a total sample of 21 residents. Specifically, the facility failed to follow the physician's plan to obtain a CBC (complete blood count), CMP (comprehensive metabolic panel), HgbA1c (hemoglobin A1C), lipid panel, and TSH (thyroid-stimulating hormone). Findings include: Resident #89 was admitted to the facility in October 2023 with diagnoses of diabetes and a history of a stroke with left sided hemi-paresis. Review of the medical record indicated Resident #89 was seen by the physician on 1/18/24 for generalized weakness and slow progressive decline. The Physician's Progress Note included a plan to check the CBC, CMP, HgbA1c, lipid panel and TSH. Review of the Physician Interim Orders indicated orders for the following labs were written: 1/18/24: Keppra level 2/12/24: Digoxin level, CBC, CMP, EKG Review of the medical record failed to indicate the CBC, CMP, HgbA1C, lipid panel or TSH were completed. During an interview on 3/28/24 at 10:17 A.M., Nurse #4 said she reviewed the medical record and was unable to find the labs being ordered in the electronic lab system. She reviewed the Physician's Interim orders and the Physician's Progress Note and said the labs should have been ordered when the Physician's Progress Note was received. She said the Physician's Interim Order for the labs of CBC and CMP on 2/12/24 should have been ordered. She said she would need to clarify with the physician. During an interview on 3/28/24 at 2:46 P.M., Nurse #4 said she had spoken with the Physician Assistant, who did want all labs completed for Resident #89 and ordered a CBC, CMP, Digoxin level, Keppra level, TSH and HgbA1c on this date. During an interview on 3/28/24 at 7:40 A.M., the Assistant Director of Nurses said the nurse who received the 1/18/24 Physician's Progress Note, generated on 1/24/24, should have verified the plan and contacted the physician to clarify the additional labs. She said the nurse who took the Physician's Interim Order on 2/12/24 should have entered the CBC and CMP in the electronic lab system.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER: Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 120 S Main Street Centerville, MA 02632	

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 36542 Based on observation and interview, the facility failed to follow professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to maintain safe and clean microwaves in three out of three kitchenettes. Findings include: Review of the 2022 Food Code, a model for safeguarding public health and ensuring food is safe for consumption, indicated: 4-201.11 Equipment and Utensils. Equipment and utensils must be designed and constructed to be durable and capable of retaining their original characteristics so that such items can continue to fulfill their intended purpose for the duration of their life expectancy and to maintain their easy cleanability. If they cannot maintain their original characteristics, they may become difficult to clean, allowing for the harborage of pathogenic microorganisms . Equipment and utensils must be designed and constructed so that parts do not break and end up in food as foreign objects or present injury hazards to consumers. On 3/27/24 at 4:04 P.M., the surveyor observed the microwave in the first-floor kitchenette. The inside of the microwave was observed to have paint/plastic peeling off the top with exposed metal the size of a hand. On 3/27/24 at 4:14 P.M., the surveyor observed the microwave in the second-floor kitchenette. The inside of the microwave door was observed to have areas of exposed metal and a large area of brown substance the length of the door. On 3/27/24 at 4:18 P.M., the surveyor observed the microwave in the third-floor kitchenette. The inside of the microwave was observed to have white paint/plastic bubbling on the top, with small specks of exposed metal. During an interview on 3/28/24 at 11:10 A.M., the Food Service Director said the housekeeping staff were responsible for cleaning the microwaves in the kitchenettes. The Food Service Director observed the first-floor microwave and said the microwave had peeling paint and should not be in use because the paint could fall onto the food. She said the housekeeping staff should have notified their manager for the microwaves to be replaced. During an interview on 3/28/24 at 1:58 P.M., the Food Service Director said she had observed the third-floor microwave to have internal paint coming off the top and the microwave needed to be removed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 S Main Street Centerville, MA 02632	

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/28/24 at 2:05 P.M., the Director of Housekeeping said her staff had notified her about concerns with all three of the kitchenette microwaves over the previous two or three weeks. She said she had reported the concern to one of the maintenance assistants for the microwaves to be replaced. During an interview on 3/28/24 at 2:11 P.M., the Director of Maintenance said he did not know about the concerns with the microwaves and new ones had not been ordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 S Main Street Centerville, MA 02632	

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 0838 Level of Harm - Potential for minimal harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 48362 Based on document review and interview, the facility failed to accurately update the nurse staffing plan to reflect the current needs of the facility upon completion of their annual assessment. Findings include: Review of the Facility Assessment, dated as last revised 1/12/2024, indicated but was not limited to the following: - Persons involved in completing the assessment: + Administrator + Director of Nurses (DON) + Medical Director + Governing Body Representative + Director Physical Plant + Director of Activities + Staff Development Coordinator (SDC) + Admissions Director - Resident Profile: + Number of residents licensed to provide care for: 120 beds + Average daily census: 80-85 + First Floor: 40 beds; long-term care + Second Floor: 40 beds; short term rehabilitation, COVID-19 isolation/quarantine + Third Floor: 40 beds; secure unit, memory care - Staffing Plan: + Licensed Nurses: one DON, one Assistant Director of Nurses (ADON), four Unit Managers/Supervisors, one SDC, one Infection Preventionist Nurse (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER: Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 120 S Main Street Centerville, MA 02632	

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 0838 Level of Harm - Potential for minimal harm Residents Affected - Some	+ 1:20 Licensed Nurse ratio Days and Evenings + 1:40 Licensed Nurse ratio Nights Review of the Daily Nurse Staffing logs from 3/26/24 through 4/1/24 indicated the following: - 3/26/24: + 1 nurse worked alone on the 1st floor unit on the evening shift (as scheduled) + 1 nurse worked alone on the 3rd floor unit on day shift (as scheduled) and the evening shift (as scheduled) - 3/27/24: + 1 nurse worked alone on the 1st floor unit on the evening shift (as scheduled) + 1 nurse worked alone on the 3rd floor unit on day shift (as scheduled) and the evening shift (as scheduled) - 3/28/24: + 1 nurse worked alone on the 1st floor unit on the evening shift (as scheduled) + 1 nurse worked alone on the 3rd floor unit on day shift (as scheduled) and the evening shift (as scheduled) - 3/29/24: + 1 nurse worked alone on the 1st floor unit on day shift (as scheduled) and the evening shift (as scheduled) + 1 nurse worked alone on the 3rd floor unit on the evening shift (as scheduled) - 3/30/24: + 1 nurse worked alone on the 1st floor unit on the evening shift (as scheduled) + 1 nurse worked alone on the 3rd floor unit on the evening shift (as scheduled) - 3/31/24: + 1 nurse worked alone on the 1st floor unit on day shift (as scheduled) + 1 nurse worked alone on the 3rd floor unit on day shift (as scheduled) and the evening shift (as scheduled) - 4/1/24: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cape Regency Rehabilitation & Health Care Center	120 S Main Street Centerville, MA 02632

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 0838 Level of Harm - Potential for minimal harm Residents Affected - Some	+ 1 nurse worked alone on the 3rd floor unit on day shift (as scheduled) and the evening shift (as scheduled) During an interview on 3/28/24 at 1:36 P.M., the Nurse Scheduler said the facility utilizes an electronic scheduling program. The Nurse Scheduler said she can update the daily census for the building and the electronic scheduling system indicates the total number of nurses per day needed. The Nurse Scheduler said typically there is one nurse for day and evening shifts on the first and third floors. The Nurse Scheduler said she tries to schedule a nurse to cover at least half shifts on the first floor, but it is not always possible. The Nurse Scheduler said there is a unit manager on the first and second floor units. The Nurse Scheduler said unit managers try to assist with morning medication and treatment passes during the day shift on the first and third floor units. The Nurse Scheduler said the census on the first and third floor units have more than 20 residents. During an interview on 3/28/24 at 1:59 P.M., Unit Manager (UM) #1 said she will try to assist the nurses on the first-floor unit with daily medication and treatment passes. UM #1 said she typically asks the nurse on the cart what they would like her to assist them with on that shift. UM #1 said she helps for a few hours when she can. UM #1 said there were more than 20 residents on the first and third floor units. During an interview on 4/1/24 at 8:30 A.M., Nurse #1 said the first-floor unit typically only has one nurse on the day and evening shifts. Nurse #1 said there has been a second nurse on the first-floor unit for the past week or so because they are orienting to the facility. Nurse #1 said most of the residents on the first-floor unit require extensive assistance from staff and some residents require two staff members for daily care. Nurse #1 said sometimes the unit manager will assist in medication and treatment passes when they are able. Nurse #1 said the unit is always close to full with around 35 to 40 residents. During an interview on 4/1/24 at 9:00 A.M., Nurse #4 said there is typically one nurse on the third-floor unit in the day and evening shifts. Nurse #4 said the unit currently does not have a unit manager. Nurse #4 said staff must be aware at all times of what is always going on throughout the unit. Nurse #4 said the residents on the unit are at high risk for falls and many require extensive assistance for care. Nurse #4 said the unit has 36 residents currently. During an interview on 4/1/24 at 9:37 A.M., the ADON said the facility schedules one nurse on the first and third floor units for the day and evening shifts. The ADON said if census increases they can increase nurse staffing on those units accordingly. The ADON said unit managers assist for part of shifts when only one nurse is on the medication cart. The ADON said when they are able, the facility attempts to cover half of the shift with additional nursing staff, but it can be challenging. The ADON said the management team (DON, ADON, unit managers) often must jump on carts to cover open shifts. The ADON and the surveyor reviewed the facility assessment. The ADON said the information in the facility assessment was inaccurate. The ADON said the current nurse staffing ratio was one nurse to 30 residents for day and evening shifts. During an interview on 4/1/24 at 10:01 A.M., the DON said approximately six months ago the facility was staffing two nurses per shift on each unit. The DON said staffing ratios had since changed. The DON and the surveyor reviewed the facility assessment as updated on 1/12/24. The DON said the facility assessment was incorrect and the ratios should be one nurse to 30 residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cape Regency Rehabilitation & Health Care Center	120 S Main Street Centerville, MA 02632

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 0838 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 4/1/24 at 10:30 A.M., the Administrator said the facility looks at the needs of the building for staffing. The Administrator said the facility utilizes an electronic scheduling system to determine the staffing needs based on census. The Administrator and the surveyor reviewed the facility assessment nurse staffing plan. The Administrator said the facility assessment was incorrect. The Administrator said the facility assessment was not updated properly when reviewed annually. The Administrator said the nurse staffing ratio for day and evening shifts should reflect a one nurse to 30 resident ratio.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cape Regency Rehabilitation & Health Care Center	120 S Main Street Centerville, MA 02632

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 49425 Based on observation, interview, and policy review, the facility failed to: 1. Maintain an infection prevention and control program which included a complete and accurate system of surveillance to identify any trends or potential infections; 2. Ensure staff performed hand hygiene in between each resident during a medication pass and did not touch the medications with their bare hands; 3. Ensure staff performed hand hygiene in between glove changes during a dressing change treatment for Resident #257; and 4. Ensure transmission based precautions (TBP) were implemented according to Centers for Disease Control and Prevention (CDC) guidance for Resident #21. Findings include: 1. Review of the facility's policy titled The Infection Prevention Program, dated as revised October 2022, included but was not limited to the following: -This facility follows the professional standards set forth as recommended by the CDC/OSHA. The goal of the Infection Prevention Program is to prevent, recognize, and control, to the extent possible, the onset and spread of infection within the facility. -The facility has a system in place for the prevention, identification, reporting, investigation and control of infections and communicable disease of residents, staff, and visitors. -Responsibility for ongoing collection and analysis of data and required follow up is assigned to the Infection Preventionist (IP). -Elements of the Infection Prevention Program includes monitoring and documenting infections, tracking and analyzing outbreaks of infections, managing resident health initiatives and provision of early, uniform identification and reporting of infections. -The IP will perform surveillance and investigation of infections to prevent, to the extent possible, the onset and spread of infection. -Analyze trends and clusters of infection, and any increase in the rate of infection or resistant organisms, in a timely manner. -Maintain the monthly infection reports by unit to record each resident infection Review of the facility's policy titled Surveillance for Healthcare, dated as revised October 2022, included but not limited to the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 S Main Street Centerville, MA 02632	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Surveillance is defined as the ongoing, systematic collection, analysis, interpretation and dissemination of data. -The facility will closely monitor all residents who exhibit signs/symptoms of infection. The IP will record the information on the Infection Control Log. -The IP will gather additional data for infection tracking and reporting and provide consultation and education as needed. -The IP or designee will monitor the residents with infections and/or potential infections by completing the Monthly Infection Report by Unit. Review of the facility's Monthly Resident Infection and Antibiotic Stewardship Report tool for the months of December 2023, January 2024, and February 2024, indicated but was not limited to the following: -The December 2023 report tool had missing documentation for 23 out of 25 residents. Specifically, 23 of the 25 residents had no documented signs and symptoms of an illness. -The January 2024 report tool had missing documentation for 16 out of 16 residents. Specifically, 2 of the 16 residents had no documented site of infection and 16 out of 16 residents had no signs or symptoms of an illness. -The February 2024 report tool had missing documentation for 11 out of 13 residents. Specifically, 11 of the 13 residents had no signs or symptoms of an illness; and 2 of the 13 residents had no documentation to determine if their illness/infection was a Healthcare acquired or Community acquired infection (HAI/CAI). During an interview on 3/28/24 at 10:05 A.M., with the Staff Development Coordinator (SDC) who is assisting the IP with surveillance, and the IP, the SDC said she only has surveillance for residents taking antibiotics, and not any other potential illnesses for other residents. She said the facility utilizes McGeer Criteria to analyze if an illness is an infection. She said she is new to this position and will attempt to find additional surveillance information and provide it to the surveyor. The SDC reviewed the report tools for December 2023, January 2024, and February 2024 with the surveyor and said the report tool was incomplete. The IP reviewed the report tools for December 2023, January 2024 and February 2024 with the surveyor and said the tools are not complete. During an interview on 3/28/24 at 11:25 A.M., the IP said when a resident has signs and symptoms of an infection it is documented in the medical record, and not placed on the infection report tool for tracking and trending infections. She said the report tool is only used for antibiotics, and should include other illness. She said the facility's primary IP, who is on a leave of absence, would produce a monthly infection report by unit, but she does not know where they would get the information to produce the report or how that is completed. During an interview on 3/28/24 at 12:12 P.M., the SDC and IP said they could not locate any additional surveillance information. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER: Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 120 S Main Street Centerville, MA 02632	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/28/24 at 1:39 P.M., the Director of Nursing (DON) said the expectation is for infection surveillance to be complete on residents whether they are on antibiotics or not. She said the IP is expected to document all information on the monthly infection report tools for tracking and trending of illnesses and symptoms to prevent the spread of infection, as much as possible. She reviewed the infection report tool for the months of December 2023, January 2024, and February 2024 with the surveyor and said the monthly surveillance tool was incomplete. On 4/1/24 at 11:41 A.M., the DON provided the surveyor with documentation from previous outbreaks which did not include any further monthly surveillance data of illnesses. 43935 2. Review of the facility's policy titled: Medication Administration - Oral, dated June 2015, indicated but was not limited to the following: Procedure: - Verify medication administration record for orders and identify the resident - perform hand hygiene (HH) - prepare medications for one resident at a time - do not touch the medication when opening the bottle or unit package - administer the medications - stay with the resident as they swallow the medications - perform HH On 3/27/24 at 7:46 A.M., the surveyor observed Nurse #1 passing medications and observed the following: - Nurse #1 was not observed to perform HH prior to preparing Klonopin 0.25 (milligrams) mg for Resident #3 by popping it from the unit package directly into her hand prior to placing it into a cup - Nurse #1 was not observed to perform HH after administering the Klonopin to Resident #3 or prior to preparing the medications for Resident #71; - Nurse #1 popped a Metoprolol ER 25 mg directly into her hand from the unit package for Resident #71 and administered the medication to the Resident then performed HH; - Nurse #1 popped a Metformin 500 mg tablet directly into her hand prior to placing it into a cup to administer to Resident #7, she then administered the medication to the Resident, but was not observed to perform HH after administering the medication to Resident #7; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER: Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 120 S Main Street Centerville, MA 02632	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Nurse #1 was not observed to perform HH prior to preparing medications for Resident #21; she popped an Aricept 5 mg tablet directly into her hand prior to placing it into a cup and administering it to Resident #21; - Nurse #1 then prepared medications for Resident #41, but was not observed to perform HH prior to preparing the medication of Humalog insulin and liquid protein. During an interview on 3/27/24 at 8:00 A.M., Nurse #1 said she should not be popping pills directly into her hand, especially since she did not perform HH before and after preparation and administration of each individual resident's medications. She said not performing HH before and after each resident was a potential infection control issue and her hands would be considered dirty. During an interview on 3/28/24 at 12:51 P.M., the Regional Nurse said Nurse #1 should not be popping medications into her hand and medications should not come in contact with the nurse's hands for infection control reasons. She said the policy and standard of practice dictates that nurses perform HH before and after preparing medications for each resident they are administering medications to and that expectation was not met as it should have been. 3. Review of the facility's policy titled Clean Dressing Technique, dated July 2017, indicated but was not limited to the following: - licensed staff nurses will use clean dressing technique for all dressing changes unless otherwise specified by the physician Procedure: - sanitize hands and apply clean gloves; remove old dressing and dispose of in plastic trash bag - remove gloves, sanitize hands and apply clean gloves; cleanse wound - remove gloves, sanitize hands and apply clean gloves; apply medications and/or dressing to wound - remove gloves and sanitize hands Resident #257 was admitted to the facility in March 2024 with a pressure ulcer to his/her sacrum (lower back just above the buttocks). On 3/28/24 at 11:20 A.M., the surveyor observed Nurse #2 perform a dressing change of Resident #257's sacral wound as follows: Nurse #2 performed HH by sanitizing her hands with ABHR (alcohol based hand rub) and put on clean gloves; she then removed the old dressing from the Resident's sacrum and removed her gloves throwing them in the trash with the dirty dressing. She was not observed to perform HH after removing her gloves. She then applied a new pair of clean gloves and cleansed the wound as prescribed. She removed her dirty gloves and put on a new pair of gloves without performing HH. She applied the prescribed treatment and cover dressing to the Resident's wound. She was observed to remove her dirty gloves and reposition the Resident for comfort. Prior to leaving the room she was observed to perform HH with ABHR. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 S Main Street Centerville, MA 02632	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/28/24 at 11:20 A.M., Nurse #2 said she should have performed ABHR HH in between each change of her gloves and did not and she made an error by not completing that step. During an interview on 3/28/24 at 12:50 P.M., the Regional Nurse said the nurse should have performed HH each time she removed a pair of dirty gloves and prior to putting on a clean pair of gloves per the facility policy and infection control standard. 49424 4. Review of the facility's policy titled Contact Precautions, dated July 2017, indicated but was not limited to: -Gowns and gloves should be put on before entering the resident's room and removed when leaving the room followed by hand hygiene. -Use contact precautions for residents known or suspected to be infected with microorganisms that can be easily transmitted by direct or indirect contact, such as environmental surfaces or direct resident care. -The use of appropriate transmission-based precautions when a resident develops symptoms of a transmissible infection or arrives in the facility with symptoms of infection (pending laboratory confirmation) reduces transmission opportunities. An example of this would be a strong suspicion of Clostridium Difficile (C. Diff) [a bacterium that causes an infection of the colon] or sudden onset nausea or vomiting. Resident #21 was admitted to the facility in December 2023 with the following diagnoses: encounter for orthopedic aftercare following surgical amputation, osteomyelitis, and cellulitis of lower limb. On 3/26/24 at 1:09 P.M., the surveyor observed a sign posted outside of Resident #21's room that indicated Enhanced Barrier Precautions: Everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also wear gloves and a gown for the following High-Contact Resident Care Activities: -dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs or assisting with the toileting device care or use, and wound care. On 3/26/24 at 1:10 P.M., the surveyor observed Activity Assistant #1 enter Resident #21's room and hand Resident #21 information for the daily activities. The surveyor did not observe Activity Assistant #1 perform hand hygiene prior to entering or exiting the room. During an interview on 3/26/24 at 1:12 P.M., the Activity Assistant said that she wasn't sure what the precautions were for the room and that she would just wear a mask in the resident room. Review of Resident #21's record indicated that he/she had a physician's order for contact precautions that was initiated on 3/22/24. Review of a nursing progress note, dated 3/22/24, indicated that the Resident was having loose bowel movements and the physician ordered a stool sample be obtained for C. Diff toxin and culture and sensitivity two times. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225338	A. Building B. Wing	04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cape Regency Rehabilitation & Health Care Center	120 S Main Street Centerville, MA 02632

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/26/24 at 1:15 P.M., Unit Manager #1 said that Resident #21 should be on contact precautions until C. Diff is ruled out through laboratory results. She said she wasn't sure why the signage did not reflect contact precautions because she was not working yesterday and came in late today. On 3/26/24 at 1:33 P.M., Unit Manager #1 said the sign that was up was correct and that the enhanced barrier precautions indicated use of gloves, hand hygiene, and gowns. She said that the precautions in place were the correct ones and appropriate for the Resident. On 3/26/24 at 2:16 P.M., the surveyor observed a contact precaution sign posted outside of Resident 21's room. The bright yellow sign indicated: - Everyone must clean their hands, including before entering and when leaving the room. - Providers and staff must also put on gloves before room entry. Discard gloves before room exit. - Put on Gown before room entry. Discard gown before room exit. - Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. During an interview on 3/28/24 at 10:17 A.M., the Staff Development Coordinator said the contact precautions sign was the correct sign for Resident #21 and the enhanced barrier precautions sign was placed accidentally and the staff should have been practicing contact precautions to reduce the risk of transmission of C. Diff. During an interview on 4/1/24 at 10:47 A.M., the Regional Nurse said that Resident #21 should be on contact precautions if the staff are awaiting results for suspicion of C. Diff. She said that enhanced barrier precautions and contact precautions are not the same and that contact precautions are used to prevent the transmission of C. Diff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cape Regency Rehabilitation & Health Care Center	120 S Main Street Centerville, MA 02632

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 49425 Based on record review, policy review, and interview, the facility failed to implement an Antibiotic Stewardship Program to measure and improve how antibiotics are prescribed by clinicians. Specifically, the facility failed to: 1. Complete antibiotic usage audit tools, which are used to track, report, and evaluate antibiotic prescribing patterns in accordance with the Antibiotic Stewardship Program; and 2. Ensure antibiotics prescribed are necessary for one Resident #40. Findings include: Review of the facility's policy titled Antibiotic Stewardship, dated as revised October 2022, indicated but was not limited to the following: -It is the policy of this facility to treat only symptomatic infections meeting criteria, and to promote antibiotic stewardship to reduce inappropriate antimicrobial use, improve patient care outcomes and reduce possible consequences of antimicrobial use. -The facility will establish an antimicrobial stewardship team dedicated to improving antimicrobial use. -When symptoms of an infection are documented, the following measures will be implemented: Symptoms will be reviewed, with the MD, and further testing will be obtained per MD order. -If a urine culture is ordered, a clean catch or catheterized urine will be obtained. If the resident has a catheter, the catheter and bag will be changed prior to obtaining the specimen. (Antibiotic therapy will not be initiated until after the culture results have been obtained unless otherwise ordered by the MD.) -Dosage, route and frequency of prescribed antimicrobials will be appropriate for the individual resident, as well as the site and type of infection. -All infections will be tracked by the Infection Preventionist (IP) or designee and reviewed for trends. -The antimicrobial Stewardship team will review antibiotic usage audit tool results and provide feedback. 1. Review of the facility's Monthly Resident Infection and Antibiotic Stewardship Report tools for the months of December 2023, January 2024, and February 2024 failed to include documentation to indicate what criteria was utilized for each resident to be placed on an antibiotic. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER: Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 120 S Main Street Centerville, MA 02632	

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The December 2023 report tool had missing documentation for 23 out of 25 residents. Specifically, 23 of the 25 residents had no documented signs and symptoms of an illness. All 25 residents were prescribed antibiotics. -The January 2024 report tool had missing documentation for 16 out of 16 residents. Specifically, 2 of the 16 residents had no documented site of infection and 16 out of 16 residents had no signs or symptoms of an illness. All 16 residents were prescribed antibiotics. -The February 2024 report tool had missing documentation for 11 out of 13 residents. Specifically, 11 of the 13 residents had no signs or symptoms of an illness; and 2 of the 13 residents had no documentation to determine if their illness/infection was Healthcare acquired or Community acquired infection (HAI/CAI). All 13 residents were prescribed antibiotics. During an interview on 3/28/24 at 10:05 A.M., with the Staff Development Coordinator (SDC), who is assisting the IP with surveillance, said she only has surveillance for residents taking antibiotics, and not any other potential illnesses for other residents. She said the facility utilizes McGeer Criteria to analyze if an illness is an infection. She said she is new to this position and will attempt to find additional information and provide it to the surveyor. The SDC reviewed the report tools for December 2023, January 2024, and February 2024 with the surveyor and said the report tool was incomplete. The SDC and the IP failed to provide the surveyor with any further documents to demonstrate the effective use of antibiotics in accordance with their antibiotic stewardship program by the time of exit. 2. Resident #40 was admitted to the facility in January 2024 with diagnoses including acute kidney failure and urinary tract infection (UTI). Review of the Medication Administration Record (MAR) indicated Resident #40 had an order dated 2/12/24 for Ciprofloxacin (antibiotic) 500 milligrams (mg) one tablet by mouth two times a day for questionable UTI for 7 days. The MAR indicated Resident #40 received all doses of medication prescribed. Review of the laboratory results indicated the urine culture (urine test to detect infections) results were received on 2/14/24 at 1:30 P.M., indicating Resident #40 had an indwelling catheter and the sample was contaminated or colonized (bacteria present that does not cause any issues), and recommended further evaluation. Review of the February 2024 Monthly Resident Infection and Antibiotic Stewardship Report tool failed to include any information regarding Resident #40's UTI including antibiotic usage, signs or symptoms or infection. During an interview on 3/28/24 at 11:25 A.M., the IP said residents on antibiotics are placed on the report tool. She said the facility's primary IP, who is on a leave of absence, would produce a monthly infection report by unit, but she does not know where they would get the information to produce the report or how that is completed. The IP said while reviewing the incomplete report tool she has no way of knowing why the residents were placed on antibiotics or if they met McGeer Criteria for antibiotic usage. The IP reviewed the February 2024 report tool with the surveyor and said Resident #40 should have been included on the report tool and was not. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER: Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 120 S Main Street Centerville, MA 02632	

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/28/24 at 12:12 P.M., the IP said she reviewed Resident #40's medical record and he/she did not meet McGeer Criteria for antibiotic use and the IP should have notified the provider and documented the notification in the medical record. The IP said the expectation for the facility's antibiotic stewardship program is to follow up with a physician within three days of antibiotic use. During an interview on 3/28/24 at 1:39 P.M., the Director of Nursing (DON) said the expectation is for the IP to record antibiotic information and track the illness per McGeer Criteria. She said antibiotic tracking books are kept on the units and are monitored by the IP. The DON said Resident #40 should have been included on the February 2024 antibiotic report tool. She said the physician should have been notified of the continued antibiotic use and was not. She reviewed the report tool for the months of December 2023, January 2024, and February 2024 with the surveyor and said the monthly surveillance tools were incomplete.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER Cape Regency Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 S Main Street Centerville, MA 02632	

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 36542 Based on observation and interview, the facility failed to ensure the kitchen walk-in freezer was maintained in safe operating condition. Findings include: On 3/26/24 at 8:35 A.M., the surveyor observed the walk-in freezer, located in the main kitchen, to have frost accumulation on the bottom of the window on the outside of the door. The surveyor was able to pull open the freezer door without unlatching it. The surveyor observed the inside of the walk-in freezer to have shaved ice on the floor immediately inside the door. In addition, the surveyor observed ice accumulation on the floor below the back wall, on English muffins located below the cooling fan, and on two roasting pans covered with aluminum foil. The surveyor observed a block of ice with a direct dripping from the cooling fan. The door handle for the freezer did not latch and the door did not close all the way. On 3/28/24 at 10:55 A.M., the surveyor inspected the walk-in freezer with the Food Service Director and observed the outside window of the freezer to have an increased accumulation of ice; the inside of the freezer to have frost (looked like shaved ice) on the bags of vegetables that were immediately inside the door, and an accumulation of frost on the floor immediately inside the door. In addition, the block of ice with direct dripping from the cooling fan continued to be there and the roasting pan with aluminum foil continued to have ice on top of it. During an interview on 3/28/24 at 10:55 A.M., the Food Service Director said the handle of the walk-in freezer was broken and a repair company had come out to evaluate it months prior. She said the staff were chipping away the accumulated ice daily and they were unable to remove the ice block that had accumulated under the fan. She said the kitchen staff were often throwing out freezer burned food. She said the ice on the outside of the freezer door had been an issue for three or four months and the repair man had not been sure why it was happening. She said the Administrator was aware of the issue with the walk-in freezer door not closing completely. During an interview on 3/28/24 at 2:55 P.M., the Administrator said he was aware the walk-in freezer was not working properly and the Director of Maintenance would know the plan. During an interview on 3/28/24 at 2:56 P.M., the Director of Maintenance said the gasket (creates a seal that keeps cold air from escaping) had previously been replaced on the walk-in freezer door. He said he was aware the handle was broken and had not gotten an estimate from a repair company to get it fixed and there were no current plans to fix the walk-in freezer.