STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225488	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tremont Health Care Center	605 Main Street Wareham, MA 02571

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50740 Based on observations, record reviews, and interviews, the facility failed to notify the physician of a need to alter treatment significantly for two Residents (#9 and #30), out of a total sample of 18 residents. Specifically, the facility failed: 1. For Resident #9, to ensure the Resident's physician and Resident Representative (RR) were notified of the recommendations made by the Psychiatric Mental Health Nurse Practitioner (PMHNP) to adjust psychotropic medication because of the Resident's continued fluctuations of mood with paranoid behavior; and 2. For Resident #30, to ensure the physician was notified that STAT (urgent) labs were not obtained timely. Findings include: 1. Resident #9 was admitted in February 2024 with diagnoses including major depressive disorder, anxiety disorder, paranoid personality disorder, PTSD, and vascular dementia. Review of the Minimum Data Set (MDS) assessment, dated 5/10/24, indicated that Resident #9 scored 6 out of 15 on the Brief Interview for Mental Status (BIMS) indicating that he/she was severely cognitively impaired. Review of the Psychiatric Evaluation and Consultation, dated 7/23/24, indicated that Resident #9 was last seen by Nurse Practitioner (NP) #2 on 7/2/24 for a follow-up disease and medication management and that at that time, she recommended increasing Resident #9's Lamictal (a medication used for mood stabilization). Resident #9 continued to exhibit fluctuations of mood with paranoid behavior. On 7/23/24, NP #2 recommended increasing Lamictal from 75 milligrams (mg) to 100 mg, discontinuing Seroquel (an antipsychotic medication), and starting Risperdal (an antipsychotic medication) 0.5 mg by mouth in the morning. Review of the Psychiatric Evaluation and Consultation, dated 7/30/24, indicated that none of the recommendations made by NP #2 on 7/23/24 had been implemented. Review of Resident #9's Physician's Orders indicated but were not limited to the following: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Lamictal Oral Tablet 25 mg (Lamotrigine); Give 75 mg by mouth in the morning (order date 7/2/24) -Seroquel Oral Tablet 100 mg (Quetiapine Fumarate); Give 200 mg by mouth in the evening (order date 2/2/24) -Seroquel Oral Tablet 25 mg; Give 25 mg by mouth in the morning (order date 2/2/24) Review of the medical record, including Nursing Progress Notes from 7/23/24 to 7/31/24, failed to indicate the physician was notified of the Psych NP's recommendations to adjust Resident #9's medications. Review of Resident #9's Nursing Progress Notes indicated but were not limited to the following: -7/27/24 accusatory of staff and roommate. -7/28/24 noted with adverse behaviors, arguing with his/her roommate, accusatory towards staff, redirected with little to no effect. During an interview on 8/5/24 at 11:35 A.M., Unit Manager (UM) #1 said that new recommendations were made by NP #2 on 7/23/24. UM #1 said that when NP #2 makes recommendations, the recommendations are written on a log sheet and communicated to the resident's attending provider (or their designee) for approval. UM #1 said that he was unable to locate the 7/23/24 log sheet in the binder where it would typically be kept and was unable to locate any progress notes indicating that the recommendation had been reviewed by the attending physician or their designee. During an interview on 8/5/24 at 2:33 A.M., the Director of Nursing (DON) said that the PMHNP (NP #2) writes her recommendations on a log and in her progress note. The DON said that the facility nurses should review NP #2's recommendations with the resident's attending provider (or their designee) for implementation. On 8/5/24 at 8:49 A.M., the surveyor left a voicemail message left for Resident #9's RR. The RR was away and returned the surveyor's call on 8/12/24. During a telephonic interview on 8/12/24 at 1:54 P.M., the RR said that she was not aware of any recent psychotropic medication recommendations or changes. Refer to F740 34145 2. Resident #30 was admitted to the facility in February 2024 with diagnoses including chronic renal failure. The Resident had bilateral nephrostomy tubes (tubes that let urine drain from the kidney through an opening in the skin on the back) implanted on 3/9/24 during a recent hospitalization . Review of the MDS assessment, dated 3/29/24, indicated Resident #30 had moderate cognitive impairment as evidenced by a BIMS score of 11 out of 15, and received anticoagulant and antibiotic medication. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record indicated a Nursing Progress Note, dated 3/29/24, which indicated Resident #30 had 200 milliliters (ml) of slight pink tinged yellow/gold color liquid in the left nephrostomy drain bag, and 100 ml dark gold colored liquid in the right nephrostomy drain bag. The Resident complained of pain at approximately 5:20 P.M. Review of Physician's Orders indicated a 3/29/24 STAT order for a Complete Blood Count (CBC) with differential (measure of the number of red blood cells, white blood cells, and platelets in the blood, including the different types of white blood cells (neutrophils, lymphocytes, monocytes, basophils, and eosinophils) and Comprehensive Metabolic Panel (CMP). Review of a Nursing Progress Note, dated 3/29/24, indicated the lab called to inform them that they have no staff available to come out this evening to draw labs for Resident #30, and would come to the facility on [DATE]. Further review of the medical record failed to indicate facility staff informed the Physician that STAT labs were not drawn on 3/29/24 as ordered. Review of a Nursing Progress Note, dated 3/30/24, indicated STAT labs (ordered 3/29/24) were drawn this morning, results pending, MD aware. During an interview on 8/5/24 at 11:31 A.M., the Director of Nursing (DON) and the surveyor reviewed Resident #30's medical record. She said Nursing staff should have notified the Physician the lab was unable to draw STAT labs as ordered on 3/29/24. The DON said the Physician may have wanted the Resident to be sent to the hospital to have the labs drawn.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 50740 Based on record review and staff interview, the facility failed to ensure that necessary information was communicated to the receiving health care institution to ensure a safe and effective transition of care for one Resident (#36), out of a total sample of 18 residents. Findings include: Resident #36 was admitted in June 2023 with diagnoses which included Alzheimer's Disease and repeated falls. Review of Resident #36's Minimum Data Set (MDS) assessment, dated 6/28/24, indicated that he/she was discharged to the hospital with return anticipated. Review of Resident #36's Nursing Progress Note, dated 6/28/24, indicated Resident #36 was found on the floor, 911 was called to transfer the Resident to the hospital, and the Resident's Health Care Proxy and physician were notified. Further record review indicated that there was no evidence showing that any communication was made to the receiving hospital from the facility. During an interview on 7/31/24 at 8:41 A.M., the Staff Development Coordinator said that for hospital transfers, the SBAR tool (Situation-Background-Assessment-Recommendation, a worksheet that can be used to organize information in preparation for communicating about an ill resident) is completed in the electronic medical record. During an interview on 7/31/24 at 11:17 A.M., the Assistant Director of Nursing (ADON) said a physician's order and SBAR should be documented in the medical record when a resident is transferred to the hospital. The ADON said that Resident #36 was transferred out to the hospital after a fall and no SBAR tool was completed because it was an emergency transfer. During an interview on 8/5/24 at 10:14 A.M., Nurse #6 said that she was the nurse on duty when Resident #36 was transferred to the hospital after a fall on 6/28/24. Nurse #6 said that when a resident is transferred to the hospital, the facility staff calls 911 and then notifies the resident's family and doctor. Nurse #6 said a copy of Resident #36's demographic information and advanced directive were copied from the chart and sent with the Resident to the hospital. Nurse #6 said that no additional documentation was completed and/or sent to the hospital.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46562 Based on observation, interview, and record review, the facility failed to ensure residents were provided care in accordance with professional standards of practice for six Residents (#15, #36, #39, #47, #42 and #30), out of a total sample of 18 residents. Specifically, the facility failed: 1. For Residents #15, #36, #39, and #47, to ensure a physician's order was in place to transfer them to the hospital; and 2. For Resident #42, to ensure a physician's order was followed to obtain a blood pressure prior to administering antihypertensive medication (used to lower blood pressure); and 3. For Resident #30, to ensure Physician's orders were in place to include PICC line catheter flushing before and after administration of intravenous antibiotic medication according to professional standards of practice and facility policy. Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated but was not limited to: Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. 1A. Resident #15 was admitted to the facility in February 2023 with the following diagnoses: cirrhosis of liver and diabetes mellitus. Review of Resident #15's Minimum Data Set (MDS) assessments, dated 4/29/24 and 6/11/24, indicated he/she was discharged to the hospital with return anticipated. Review of Resident #15's Nursing Progress Note, dated 4/29/24, indicated he/she was transferred to the emergency department. Review of Resident #15's Nursing Progress Note, dated 6/11/24, indicated he/she was transferred to the hospital. Review of Resident #15's Order Listing Report for 4/28/24 through 8/1/24 failed to indicate an order to transfer him/her to the hospital on 4/29/24 or 6/11/24. During an interview on 8/5/24 at 12:55 P.M., the Director of Nurses (DON) said there was no order to transfer Resident #15 to the hospital on 4/29/24 or 6/11/24. The DON said a physician's order should be obtained when a Resident is transferred to the hospital. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	50740 B. Resident #36 was admitted in June 2023 with diagnoses which included Alzheimer's disease and repeated falls. Review of Resident #36's MDS assessment, dated 6/28/24, indicated that he/she was discharged to the hospital with return anticipated. Review of Resident #36's Nursing Progress Note, dated 6/28/24, indicated Resident #36 was found on the floor, 911 was called to transfer the Resident to the hospital, and the Resident's Health Care Proxy and physician were notified. Review of Resident #36's Order Listing Report for 6/27/24-8/31/24 failed to indicate an order to transfer him/her to the hospital on 6/28/24. During an interview on 8/5/24 at 10:14 A.M., Nurse #6 said that she was the nurse on duty when Resident #36 was transferred to the hospital after a fall on 6/28/24. Nurse #6 said that when a resident is transferred to the hospital, the facility staff calls 911 and then notifies the resident's family and doctor. Nurse #6 said that she was not sure if a physician's order is needed when a resident is transferred to the hospital. During an interview on 7/31/24 at 11:17 A.M., the Assistant Director of Nurses (ADON) said a physician's order should be documented in the medical record when a resident is transferred to the hospital. C. Resident #39 was admitted in November 2022 with diagnoses which included dementia and rheumatoid arthritis. Review of Resident #39's MDS assessment, dated 6/16/24, indicated that he/she was discharged to the hospital with return anticipated. Review of Resident #39's Nursing Progress Note, dated 6/16/24, indicated Resident #39 fell on the floor in the hallway, 911 was called for transfer to the hospital, and the Resident's family and physician were notified. Review of Resident #39's Order Listing Report for 6/15/24-8/31/24 failed to indicate an order to transfer him/her to the hospital on 6/16/24. During an interview on 7/31/24 at 11:17 A.M., the Assistant Director of Nurses (ADON) said a physician's order should be documented in the medical record when a resident is transferred to the hospital. 48695 D. Resident #47 was admitted to the facility in June 2023 with diagnoses of atrial fibrillation and hypertension. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #47's MDS assessment, dated 3/27/24, indicated he/she was discharged to the hospital with return anticipated. Review of Resident #47 Nursing Progress Note, dated 3/27/24, indicated but was limited to: -Resident c/o (complaining of) left side hip pain after fall around 4:15 while this nurse was doing neuro (neurological) assessment. Resident sent out to ER (emergency room) for further evaluation. MD (Medical Doctor) and healthcare proxy notified. Review of Resident #47's Order Listing Report for 3/27/24 through 8/31/24 failed to indicate an order to transfer him/her to the hospital on 3/27/24. During an interview on 7/31/24 at 2:56 P.M., Nurse #1 said she thought she may have obtained an order from the Doctor to send Resident #47 to the hospital but could not remember. Nurse #1 said she should have documented the order under Physician's Orders. During an interview on 7/31/24 at 2:59 P.M., Unit Manager (UM) #1 said the expectation was that when a resident is sent to the hospital, the nurse will obtain a Physician's Order to send the resident out to the hospital and document it. UM #1 reviewed Resident #47's Order Listing Report for 3/27/24 through 8/31/24 and said he did not see an order to send Resident #47 to the hospital, but there should have been one. During an interview on 7/31/24 at 3:20 P.M., the DON said a physician's order should be obtained and documented when a resident was transferred to the hospital. 2. Review of the facility's policy titled Medication Administration- Oral, dated June 2015, indicated but was not limited to: - Procedure: - Verify Medication order on MAR. Check against physician order. - If necessary, obtain vital signs. Resident #42 was admitted to the facility in March 2022 with diagnoses of hypertension and heart failure. On 7/31/24 at 9:16 A.M., the surveyor observed Nurse #1 prepare and administer 8:00 A.M. morning medications to Resident #42 in his/her room. Nurse #1 administered the Resident's Metoprolol Tartrate (a medication that treats hypertension and heart failure) and Nurse #1 did not obtain Resident #42's vital signs including blood pressure and pulse prior to administering the medication. Review of Resident #42's current 2024 Physician's Orders indicated but was not limited to: -Metoprolol Tartrate 25 milligram (mg) tab. Give 25 mg by mouth two times daily. Hold for SBP (systolic blood pressure) < (under) 110, DBP (diastolic blood pressure) <60 and HR (Heart rate) <60 (dated 1/17/23) (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with record review on 7/31/24 at 9:58 A.M., Nurse #1 reviewed Resident #42's Metoprolol Tartrate order and said she did not check Resident #42's blood pressure and pulse prior to administering the medication. Nurse #1 said that Resident #42 last had his/her vital signs checked at 5:53 A. M. Nurse #1 said she had not reviewed the vital signs from 5:53 A.M. or taken Resident #42's vital signs prior to administering the medication. Nurse #1 said she should have checked Resident #42's vital signs prior to administering the medication. During an interview on 7/31/24 at 3:07 P.M., UM #1 said when administering a medication with an order to check a blood pressure and pulse the nurse should check those prior to administering the medication. UM #1 said Nurse #1 should have obtained Resident #42's blood pressure and pulse prior to administering the medication. 34145 3. Review of the facility's policy titled Central Venous Access Device Flushing, dated January 2022, indicated but was not limited to: Policy: -A prescriber order is required for vascular access device (VAD) flushing. The order will be specific with regards to flushing solution, volume, and frequency. -The VAD will be flushed before and after administration, in between multiple intravenous medication administration, and routinely at established intervals when the VAD is not in use. Procedure: -Verify prescriber's order. -Document procedure in resident's medical records, including but limited to: -Date and time -Site assessment -Flushing agent and volume flushed -Any difficulty flushing -Resident's response to procedure Review of Lippincott Nursing Procedures, eighth edition, dated 2008, indicated but was not limited to the following: Peripherally Inserted Central Catheter (PICC) Use: Flushing the PICC: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-All catheters require flushing with normal saline before medication administration to clear the lumen and assess catheter function, between each medication administered to prevent drug precipitate, and after medication administration to again clear the line. Resident #30 was admitted to the facility in February 2024 with diagnoses including chronic renal failure. Review of the Minimum Data Set (MDS) assessment, dated 3/29/24, indicated Resident #30 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15, received anticoagulant and antibiotic medication. Review of the medical record indicated Resident #30 was admitted to the hospital on 3/8/24 and diagnosed with severe sepsis. Review of the hospital's Inpatient Discharge Summary, dated 3/21/24, indicated a single lumen PICC line was inserted into the left basilic vein on 3/18/24 and intravenous (IV) antibiotic therapy was started in the hospital. The Resident was discharged back to the facility on [DATE] with orders to continue antibiotic therapy IV Vancomycin and IV Ertapenem 1 gram (gm) every 24 hours for two weeks. Review of March 2024 Physician's Orders indicated but was not limited to: -Flush PICC line with 10 milliliters (ml) of normal saline (NS) every shift (3/21/24) -Monitor PICC insertion site for signs/symptoms of infection every shift (3/21/24) -Ertapenem Sodium Injection Solution Reconstituted 1 gm IV one time a day (3/21/24) -Vancomycin HCl Intravenous Solution 1250 milligrams (mg)/250 ml, use 1250 mg IV one time a day (3/21/24) Further review of the medical record failed to indicate an order for PICC line flushes before and after administration of the IV antibiotic medication according to professional standards of practice and facility policy. Further review of the medical record failed to indicate a comprehensive care plan was developed and implemented for the care and treatment of the PICC device in place upon re-admission to the facility on [DATE]. Review of the March 2024 Medication Administration Record/Treatment Administration Record (MAR/TAR) indicated Ertapenem was administered at 2:00 P.M., Vancomycin was administered at 3:00 P.M. and the PICC line was flushed with 10 ml of NS as ordered by the Physician on the 7:00 A.M. to 3:00 P.M. shift by Nurse #5. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a documentation flow sheet (a flowsheet template provided by the consultant pharmacy and not a physician's order) titled Infusion Medication Administration Record, dated March 2024, identified the PICC line and checked off two instructions: Flush before administration 10 ml NS and Flush after administration 10 ml NS. The times for flushes were handwritten 2:00 P.M. and 3:00 P.M. The boxes corresponding to March 22 had handwritten Xs in them. The bottom of the flow sheet indicated Nurse # 5's signature and initials. Review of the medical record indicated four Nursing Progress Notes dated 3/22/24. Only one note, written at 2:24 P.M., indicated the Resident continued on IV antibiotics for sepsis; no adverse reactions noted. PICC line intact to left upper arm; no signs/symptoms of infection; flushed without difficulty. The note failed to indicate the agent and volume flushed, failed to identify if the PICC line was flushed before and after administration of antibiotic medications administered at 2:00 P.M. and 3:00 P.M. or if the flush referenced in the note was the flush ordered by the physician during the shift. Further review of the medical record indicated Resident #30 had a change of condition and was transferred to the hospital on 3/23/24 and admitted . The PICC line was removed during this hospitalization . During an interview on 8/5/24 at 10:59 P.M., Unit Manager #1 reviewed the Resident's medical record and said there should have been an order to flush the PICC line before and after each administration of the IV antibiotics and there was not. He said the Infusion Medication Administration flow sheets are redundant to the MAR/TAR, but don't represent Physician's orders. He said if Nurse #5 did the flushes before and after the medications were administered, she should have ensured an order was in place and written her initials in the corresponding box to indicate the flushes were done and not written X's. He said he doesn't know for sure if the flushes were done because there was no order to do it. Unit Manager #1 said a care plan was not developed for the PICC but should have been. He said the care plan should have identified the Resident's severe sepsis, the PICC line, and IV antibiotic treatment. During an interview on 8/5/24 at 11:31 A.M., the Director of Nursing (DON) reviewed Resident #30's medical record and said there should be orders to flush the PICC line before and after the IV medications were administered, but there is not. She said if Nurse #5 did do the flushes, there should have been an order and she should have signed off on the MAR/TAR and flowsheet with her initials, and not an X because it is confusing. During an interview on 8/5/24 at 2:14 P.M., Nurse #5 said she wrote an X on the flowsheets to indicate the IV antibiotics were administered and the flushes before and after were done. The surveyor asked Nurse #5 if she verified that there were orders prior to flushing the PICC line before and after the antibiotic administration, and she said there should have been an order, but she doesn't remember. She said if there wasn't an order, it is protocol to flush between medications and would have done it anyway.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 46562 Based on record review and interview, the facility failed to ensure residents were free from accident hazards for one Resident (#34), out of a total sample of 18 residents. Specifically, the facility failed to complete his/her quarterly smoking evaluation and safety screen. Findings include: Review of the facility's policy titled Smoking, dated as revised 11/2020, indicated but was not limited to: -Residents who smoke will be evaluated for their ability to smoke safely upon admission, quarterly and as dictated by any significant change in condition, to ensure that they continue to be capable of smoking and use smoking materials without presenting a danger to themselves or others. The need for assistive and/or safety devices will be identified and noted in the residents individualized care plan. Resident #34 was admitted to the facility in June 2021 with the following diagnoses: dementia and hypertension. Review of Resident #34's Minimum Data Set (MDS) assessment, dated 6/28/24, indicated he/she was cognitively intact as evidenced by a Brief Interview Mental Status (BIMS) score of 14 out of 15 and utilized tobacco products. Review of Resident #34's medical record indicated his/her last smoking evaluation and safety screen was completed on 4/23/24. During an interview on 8/1/24 at 1:32 P.M., Unit Manager (UM) #2 said smoking assessments were completed electronically and should be conducted quarterly. UM #2 said Resident #34's smoking assessment should have been completed by 7/23/24. Further review of the medical record, on 8/5/24, indicated the smoking assessment had not been completed. During an interview with record review on 8/5/24 at 12:55 P.M., the Director of Nurses (DON) said smoking assessments/evaluations should be completed quarterly. The DON reviewed Resident #34's medical record and said his/her last smoking assessment was completed on 4/23/24 and should have been completed on 7/23/24.

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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. 46562 Based on record reviews and interviews, the facility failed to ensure that necessary behavioral health care and services were provided to create an environment to maintain the highest psychosocial well-being for two Residents (#34 and #9), out of a total sample of 18 residents. Specifically, the facility failed to review and revise the behavioral health care plan when the Residents had a change in condition. Findings include: 1. Resident #34 was admitted to the facility in June 2021 with the following diagnoses: depression, anxiety, schizoaffective disorder, post-traumatic stress disorder (PTSD), and insomnia. Review of the Minimum Data Set (MDS) assessment, dated 6/28/24, indicated Resident #34 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15 and received antipsychotic and antidepressant medication. Review of Resident #34's care plan indicated but was not limited to: -Focus: Resident has episodes of anxiety/history of anxiety (revised 7/12/21) Interventions: encourage participating in activities of interest as form of diversion to reduce anxiety (7/12/21), observe behaviors as/and if indicated [sic] (7/12/21), psych evaluation and follow up as needed for medication management and counseling (7/12/21) -Focus: Behavior Problem related to diagnosis: anxiety, schizoaffective disorder (revised 7/17/24) Interventions: Administer and monitor the effectiveness and side effects of medications as ordered (9/22/22), anticipate care needs and provide them before the resident becomes overly stressed (9/22/22), Investigate/monitor need for psychological/psychiatric support. Provide services as ordered by the physician (9/22/22), Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, person involved (9/22/22), Report to MD new or change in acute behavioral status (9/22/22) -Focus: Resident is having trouble sleeping (3/13/24) Interventions: Allow resident to ventilate feelings, concerns that may be keeping resident awake (3/13/24), Offer medications as ordered and determine effectiveness of medication used to promote sleep (3/13/24) Review of Resident #34's Physician's Orders indicated but was not limited to: -Invoke Health Care Proxy (12/8/23) (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Paroxetine (antidepressant medication) 30 milligrams (mg) by mouth in the morning related to anxiety, 11/17/23 -Risperdal (antipsychotic medication) 0.5 mg by mouth two times per day related to schizoaffective disorder, 6/13/24 Review of Resident #34's progress note, dated 7/22/24, indicated he/she had voiced concerns of suicidal ideation to the Certified Nursing Assistant (CNA) and had been assessed by Nurse Practitioner (NP) #1. The progress note indicated that a note was left in the psych book. Review of the Resident Log, dated 7/22/24, indicated Resident #34 had a change in condition as evidenced by increased depression, life stressor, and suicidal ideation. Further review of the log indicated NP#2 had initialed the report on 7/23/24. Review of Resident #34's progress note, dated 7/23/24, composed by Nurse #4, indicated the Resident was evaluated by NP #2 who recommended Remeron (antidepressant medication, also called Mirtazapine) 7.5 mg daily at bedtime for insomnia and depression. Further review of the progress note indicated the physician was made aware and agreed and that a message was left for the Resident Representative to obtain consent. Review of Resident #34's Psychiatric Evaluation and Consultation, dated 7/23/24, indicated but was not limited to: -The nursing staff reported that the patient was severely depressed. This provider assessed the patient and reported a lack of sleep at bedtime. He/she denied suicidal ideation/homicidal ideation. -Current Assessment/Plan: This provider assessed the patient; the patient endorsed a lack of sleep at bedtime. This provider recommended Mirtazapine 7.5 mg by mouth at bedtime. The patient will continue to take the medications as prescribed. Review of Resident #34's Physician's Orders failed to indicate an order for Remeron had been initiated. During a telephonic interview on 8/1/24 at 11:00 A.M., Resident Representative #1 said the facility had not notified her of the suicidal ideation, change in condition or NP #2's recommendation to start Remeron. Resident Representative #1 said she did not have any messages from the facility regarding a need to alter Resident #34's plan of care. Resident Representative #1 said Resident #34 had expressed to her a desire to move to another unit because there is constant yelling on the one he/she is currently on. Resident Representative #1 said she was working with the facility to decrease the medication and did not know why they would start another medication without getting to the bottom of the issue first. Resident Representative #1 said a unit change would be beneficial. During an interview on 8/5/24 at 12:33 P.M., Resident #34 said he/she had not been getting much sleep at all since he/she moved her room to the current unit. Resident #34 said he/she is not aware of any sleeping medication and could not sleep because it was too loud at night. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/1/24 at 1:18 P.M., Nurse # 4 said she took care of Resident #34 on 7/23/24 but did not recall the plan of care changing and did not know anything about the recommendation to initiate Remeron. Nurse #4 said she would need to follow up with Unit Manager #2. Nurse #4 and the surveyor reviewed Resident #34's medical record and Nurse #4 said the Remeron was never initiated and his/her plan of care had not changed since 7/23/24. During an interview on 8/1/24 at 1:32 P.M., Unit Manager (UM) #2 said NP #2 saw Resident #34 on 7/23/24 and there was no concern for suicidal ideation. Unit Manager #2 said she did not recall Remeron being recommended. During an interview on 8/1/24 at 2:01 P.M., the Director of Nurses (DON) and UM #2 said there was no evidence that a recommendation was made but the NP had initialed the resident log on 7/23/24 indicating the Resident had been seen. During an interview on 8/1/24 at 2:20 P.M, Social Worker #1 said she saw Resident #34 on 7/23/24 and the Resident did not recall the event and was stable. Social Worker #1 said she had not documented the visit with the Resident because everyone else had met his/her needs. During an interview on 8/1/24 at 2:17 P.M., UM #2 said the facility spoke with NP #2 who said the Resident was clear and denies suicidal ideation but if he/she continued to make comments, he/she may need to start Remeron. UM #2 said the Nurse must have misunderstood NP #2. During a telephonic interview on 8/2/24 at 11:50 A.M., NP #2 said she saw Resident #34 on 7/23/24 who voiced concerns with a lack of sleep. NP #2 said she made a recommendation to initiate Remeron 7.5 mg at bedtime and had intended for the medication to start right away. NP #2 said she discussed her recommendations with the Nurse who was providing care to the Resident on that day, the Unit Manager and the Assistant Director of Nurses (ADON) because the DON was not in the facility on that date. During an interview on 8/5/24 at 7:25 A.M., the DON said she wanted to clarify the concerns brought to her attention regarding Resident #34. The DON said she spoke with NP#2 who stated she did intend for the Resident to start Remeron and had reviewed her recommendation with the facility staff on 7/23/24. The DON said the plan of care should have been adjusted at that time. The DON provided the surveyor with a copy of a Resident Log, dated 7/23/24, which indicated a new recommendation for Remeron 7.5 mg by mouth for insomnia/depression. The DON said since this discovery a call had been made to the Resident Representative to discuss the recommended changes in the Resident's plan of care. Subsequent review of Resident #34's medical record, on 8/5/24, indicated a nursing progress note dated 8/2/24 which indicated the Resident Representative had been called and a message had been left to obtain consent for the use of Remeron. 50740 2. Resident #9 was admitted in February 2024 with diagnoses including major depressive disorder, anxiety disorder, paranoid personality disorder, PTSD, and vascular dementia. Review of the Minimum Data Set (MDS) assessment, dated 5/10/24, indicated that Resident #9 scored 6 out of 15 on the Brief Interview for Mental Status (BIMS) indicating that he/she was severely cognitively impaired. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Psychiatric Evaluation and Consultation, dated 7/23/24, indicated that Resident #9 was last seen by Nurse Practitioner (NP) #2 on 7/2/24 for a follow-up disease and medication management and that at that time, she recommended increasing Resident #9's Lamictal (a medication used for mood stabilization). Resident #9 continued to exhibit fluctuations of mood with paranoid behavior. On 7/23/24, NP #2 recommended increasing Lamictal from 75 milligrams (mg) to 100 mg , discontinuing Seroquel (an antipsychotic medication), and starting Risperdal (an antipsychotic medication) 0.5 mg by mouth in the morning. Review of the Psychiatric Evaluation and Consultation, dated 7/30/24, indicated that none of the recommendations made by NP #2 on 7/23/24 had been implemented. Review of Resident #9's Physician's Orders indicated but were not limited to the following: -Lamictal Oral Tablet 25 mg (Lamotrigine); Give 75 mg by mouth in the morning (order date 7/2/24) -Seroquel Oral Tablet 100 mg (Quetiapine Fumarate); Give 200 mg by mouth in the evening (order date 2/2/24) -Seroquel Oral Tablet 25 mg; Give 25 mg by mouth in the morning (order date 2/2/24) Review of the medical record, including Nursing Progress Notes from 7/23/24 to 7/31/24, failed to indicate the physician was notified of the Psych NP's recommendations to adjust Resident #9's medications. Review of Resident #9's Nursing Progress Notes indicated but were not limited to the following: -7/27/24 accusatory of staff and roommate. -7/28/24 noted with adverse behaviors, arguing with his/her roommate, accusatory towards staff, redirected with little to no effect. On 7/30/24 at 9:09 A.M., the surveyor observed Resident #9 in the hallway crying and yelling at the Staff Development Coordinator. On 7/30/24 at 9:18 A.M., the surveyor observed Resident #9 in her room crying. On 7/31/24 at 9:40 A.M., the surveyor observed Resident #9 crying and yelling at a facility staff member on the unit. During an interview on 8/5/24 at 11:35 A.M., Unit Manager (UM) #1 said that new recommendations were made by NP #2 on 7/23/24. UM #1 said that he was unable to locate the 7/23/24 log sheet with NP#2's recommendations and was unable to locate any progress notes indicating that the recommendations had been implemented or declined by the attending physician or their designee. During an interview on 8/5/24 at 2:33 A.M., the Director of Nursing (DON) NP #2 writes her recommendations on a log and in her progress note. The DON said that the facility nurses should review NP #2's recommendations with the resident's attending provider (or their designee) for implementation. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/5/24 at 8:49 A.M., the surveyor left a voicemail message Resident #9's Resident Representative (RR). The RR was away and returned the surveyor's call on 8/12/24. During a telephonic interview on 8/12/24 at 1:54 P.M., the RR said that she was aware of Resident #9's behaviors, but was not aware of any recent psychotropic medication recommendations or changes.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 48695 Based on observations, interview, and policy review, the facility failed to ensure staff stored all drugs and biologicals used in the facility in accordance with currently accepted professional principles. Specifically, the facility failed to: 1. Ensure the medication and treatment carts were locked when not in direct supervision of the licensed nurse; and 2. Ensure safe storage of medications and biologicals according to current standards of practice. Findings include: Review of the facility's policy titled Medication Administration- Oral, dated June 2015, indicated but was not limited to: - Medication carts are always locked when unattended. Review of the facility's policy titled Medication Storage Room/Medication Cart Policy, dated February 2018, indicated but was not limited to: - Policy: 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. - Procedure: - Medications are stored primarily in a locked mobile medication cart which is accessible only to licensed nursing personnel. - The medication cart is to be kept locked at all times when not in use by the nurse. The medication cart is to be locked when stored in the medication room or some other location. 1. The surveyor observed the following medication/treatment carts to be unlocked and unattended: - 7/30/24 at 10:04 A.M., Unit A Cart 2 medication cart was unlocked in the hallway and unattended with the keys in the lock. Nurse #1 was in a Resident's room with her back to the medication cart. - 7/31/24 at 9:01 A.M., Unit A Cart 2 medication cart was unlocked in the hallway and unattended. Nurse #1 was in a Resident's room with her back to the medication cart. - 7/31/24 at 11:22 A.M., Unit A Cart 2 medication cart was unlocked in the hallway and unattended. Nurse #1 was in a Resident's room behind a privacy curtain. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 7/31/24 at 11:29 A.M., Unit A Cart 2 medication cart was unlocked in the hallway and unattended. Nurse #1 was in a Resident's room diagonally across the hall. - 7/31/24 at 12:40 P.M., Unit A Cart 2 medication cart was unlocked in the hallway and unattended. - 8/1/24 at 8:02 A.M., Unit A Cart 2 medication cart was unlocked in the hallway and unattended. Nurse #1 went into the medication room with the door closed. - 8/1/24 at 2:35 P.M., Unit A Cart 2 medication cart was unlocked and unattended in the hallway diagonally across from the nurses' station out of view of the nurse. During an interview on 8/1/24 at 12:05 P.M., Nurse #1 said a medication cart should never be left unlocked and unattended, especially with keys hanging out of the lock. Nurse #1 said the medication cart should be always locked when a nurse is next to it. During an interview on 8/1/24 at 2:28 P.M., the Director of Nursing (DON) said if a medication cart is out of the view of the nurse it should be locked. The DON said the medication cart should never be unlocked and unattended, especially with keys left in the lock of the cart. 2. Resident #48 was admitted to the facility in June 2024 with diagnoses of gastrostomy (g-tube, tube inserted through the belly that brings nutrition and medication directly to the stomach) and malignant neoplasm (cancer) of pharynx (throat). Review of the Minimum Data Set (MDS) assessment, dated 7/3/24, indicated that Resident #48 scored 12 out of 15 on the Brief Interview for Mental Status (BIMS) indicating that he/she had moderate cognitive impairment. On the following dates and times, the surveyor observed a clear plastic medication cup with white cream in it on Resident #48's nightstand: -7/30/24 at 9:48 A.M. -7/30/24 at 2:35 P.M. -7/31/24 at 8:58 A.M. -7/31/24 at 11:23 A.M. During an interview on 7/31/24 at 8:58 A.M., Resident #48 said the cream on his/her nightstand is used by nurses to put on the area around his/her g-tube site. Review of Resident #48's current July 2024 Physician's Orders indicated but was not limited to: -Treatment: Miconazole (anti-fungal) Nitrate External Cream 2% Location g-tube site every shift for red area (dated 7/18/24) (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/1/24 at 2:37 P.M., Nurse #1 said she was unaware there was a medicated cream on Resident #48's nightstand. Nurse #1 said Resident #48 should not have medicated cream on his/her nightstand. During an interview on 8/1/24 at 2:28 P.M., the DON said medications should not be left at any residents' bedside unless it is in a locked drawer and they have an order to self-administer the medication.

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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. 49428 Based on observation, policy review, and interview, the facility failed to follow their policy and 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: 1. Ensure the main kitchen was maintained in a clean and sanitary condition; 2. Ensure two of two unit kitchenettes were maintained in a clean and sanitary condition; 3. Ensure food items were properly labeled, dated, and stored in the main kitchen; and 4. Ensure food items were properly labeled and dated in two of two unit kitchenettes. Findings include: 1. Review of the 2022 Food Code by the Food and Drug Administration (FDA), revised 1/2023, indicated but was not limited to the following: 3-305.11 (A) Except as specified in paragraphs (B) and (C) of this section, food shall be protected from contamination by storing the food (1) in a clean, dry location. 4-602.11 (D) Equipment is used for storage of packaged or unpackaged food such as a reach-in refrigerator and the equipment is cleaned at a frequency necessary to preclude accumulation of soil residues. 6-501.12 (A) Physical facilities shall be cleaned as often as necessary to keep them clean. Review of the facility's policy titled Dietary Department Guidelines, undated, indicated but was not limited to: -The facility must store, prepare, and distribute food under sanitary conditions. -The Dietary Department Supervisor will be a qualified food operator and have completed certification programs as required by state regulation. She or he will oversee the entire dietary program in collaboration with the dietitian, including the purchase, storage, preparation, and serving of food to residents, employees, and visitors as indicated. She or he also will supervise the cleaning and sanitizing of dishware and utensils, as well as the cleaning of the physical dietary plant. -The Dietary Department will be maintained in a clean and sanitary manner to prevent foodborne illness. -All food items should be labeled and dated to allow for rotation of supplies. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-All items stored in the refrigerator will be covered, labeled with the contents and the date. All potentially hazardous foods must be discarded within three calendar days after the date prepared. -All foods shall be prepared according to Food and Drug Administration (FDA) Food Code, with special attention paid to potentially hazardous foods . and will be handled with extreme caution throughout the preparation and storage processes. -Foods brought into the facility by family members will be kept in appropriate storage, refrigerated if indicated, must be labeled and dated and will be discarded as appropriate. For example, prepared foods that require refrigeration should be discarded after three calendar days, whereas crackers stored in an airtight container may be kept longer. Review of the facility's policy titled Personal Food Policy, dated November 2016, indicated but was not limited to: -Families and visitors of residents are permitted to bring food into the facility for the resident's use. However, nursing home residents are at risk for serious complications from foodborne illness which may occur from unsafe food handling practices. In order to ensure the safety of our residents, food may only be brought into the facility in accordance with this policy. -The staff person receiving the personal food shall label the container with the date it was brought into the facility (or the date of preparation, if known) and the name of the resident receiving it. -Dietary aides are responsible for checking nourishment refrigerator daily and discarding any unused refrigerated food after three days. Frozen foods should be discarded after three months. -Any perishable items that are found outside of the refrigerator or unlabeled shall be discarded unless it can be verified that the food has not been out for more than 2 hours. 1. On 7/30/24 at 8:15 A.M. and on 7/31/24 at 8:40 A.M., the surveyor observed the following: Main kitchen: -exposed ceiling piping covered with a noticeable layer of dust along its span, with some areas of the piping located above food prep areas; -one section of ceiling pipe with dark splotches and corrosion located above an area where meal trays are assembled; -several walls, areas of the ceiling, and bulkhead with a noticeable layer of dust; -one mini-split covered with a layer of dust, located over a food prep table; -soil and debris buildup along the perimeter of the kitchen floor and underneath kitchen equipment; -two chest refrigerators containing single-serve drinks, such as milk cartons and juices, both with condensation and black buildup along the rubber sealings. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Walk-in refrigerator: -drips of condensation along the refrigerator condenser located above lidless cardboard boxes containing unopened packages of cheese and above opened and re-wrapped packages of fresh spinach and fresh broccoli florets; -light fixture with condensation running along the inside of its plastic covering and smaller amount of condensation on its exterior which was located above a rolling cart that contained several different single-serve beverages; -buildup of tan-colored, powdery substance on several areas of all shelving, easily removed by the wipe of a finger; -walls with brown spots and splashes of substances; -buildup of soil and debris around the perimeter of the floor; -debris, such as coffee creamers, plastic lids, and packaging, underneath the shelving. Walk-in freezer: -Debris, such as frozen vegetable pieces and paper and plastic packaging, on the floor and underneath the shelving. During an interview on 8/1/24 at 8:21 A.M., the Food Service Director (FSD) said he expected kitchen areas and equipment to be maintained in a clean and sanitary condition. The FSD said kitchen staff followed the following two cleaning schedules: A. Review of the cleaning schedule titled Cleaning Checklist, undated, included but was not limited to the following: -A.M. Diet Aides to sweep floors after meals. -Cook to clean all freezers and refrigerators, interior and exterior, weekly. -Diet Aide to empty and clean milk refrigerators weekly. B. Review of the cleaning schedule titled Dietary Cleaning Schedule, undated, included but was not limited to the following: -Monday, Morning Aide #3 to empty and clean milk refrigerator. -Wednesday, Night Aide #2 to empty and clean milk refrigerator. -Friday, Night Aide #2 to sweep and mop walk-in refrigerator. Underneath shelves. -Friday, Night Aide #3 to empty and clean juice refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the same interview on 8/1/24 at 8:21 A.M., the FSD said he expected kitchen staff to clean every part of the milk and juice refrigerator chests with a multipurpose cleaner, including the rubber seals to remove any black buildup. The FSD provided cleaning schedules for the past two weeks indicating Dietary Staff had performed and signed off on their assigned cleaning tasks. During an interview on 8/1/24 at 8:40 A.M., the surveyor and FSD observed the walk-in refrigerator. The FSD said the condensation issues within the walk-in unit started within the last week and condensation should not be dripping on food or beverage items or packaging. The FSD said he expected the walk-in to be maintained clean and sanitary, including sweeping underneath the shelving. The FSD said the walk-in refrigerator could use a power wash of the walls, floors, and shelving to remove the existing soil and buildup in its interior and on the shelving. During an interview with the FSD, Maintenance Staff #1, and the Director of Housekeeping (DOH) on 8/1/24 at 10:01 A.M., the surveyor and FSD observed the walls and ceiling in the main kitchen. The FSD said he expected all kitchen walls to be clean of soil and dust collection, as well as the exposed ceiling pipes. The FSD and surveyor reviewed both cleaning checklists and observed that cleaning the walls and pipes in the main kitchen area were not on either of the cleaning checklists. The FSD said in the two years he had worked at the facility, he had never coordinated the cleaning of the walls and exposed pipe in the main kitchen with maintenance or housekeeping. Maintenance Staff #1 and the DOH confirmed there was no coordination among the departments regarding regularly scheduled cleaning of the main kitchen. On 8/5/24 at 11:00 A.M., the surveyor observed the rubber seal of the milk chest with a buildup of black substance, especially near the corners of the seals. 2. On 7/31/24 at 11:40 A.M. and on 8/1/24 at 2:57 P.M., the surveyor observed the following in the A Unit kitchenette: -soil buildup on the perimeter of the floor; -light colored grout in one corner of the kitchenette where the ice/water machine was located and the grout in the main kitchenette area black in color; -accumulation of soil, hair, food pieces, dust, a plastic bottle cap, and other debris in the gap between the refrigerator and the wall; -drips/splashes on the wall next to the refrigerator; -behind the sink, a discolored area of grout that was slimy and slick to the touch; -refrigerator interior shelving covered with sticky residue with food containers set on top; -ice and water machine with light colored residue or buildup on the interior of the ice chute where ice is dispensed. On 7/31/24 at 9:40 A.M. and on 8/1/24 at 8:13 A.M., the surveyor observed the following in the B Unit kitchenette: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-the interior door of refrigerator with sticky pink and brown substances on the shelving; -the bottom of the rubber gasket was ripped and hanging off and was discolored with black/brown substance; -the exterior left side of the refrigerator, which was located next to the countertop, was discolored with a brown substance. During an interview on 8/1/24 at 8:21 A.M., the FSD said maintenance was responsible for cleaning the interior of the ice/water machines in the facility. The FSD said Dietary Aides clean the interior and exterior of Unit refrigerators and cleaning the kitchenettes occurs daily as part of the stocking rounds. The FSD said Housekeeping cleans Unit kitchenettes daily. The FSD provided Housekeeping cleaning schedules titled A Wing and B Wing Housekeeper Responsibilities. The FSD referred to the cleaning schedules and said Housekeeping cleans Unit kitchenettes when they clean the day room from 1:00-2:00 P.M. The FSD said he expected the kitchenettes and kitchenette equipment to be maintained in a clean and sanitary condition. During an interview on 8/1/24 at 10:01 A.M., Maintenance Staff #1 said the maintenance department cleans the facility's ice/water machines monthly, usually the first of each month, and as needed. Maintenance Staff #1 said maintenance staff cleans the facility's ice bins and all internal parts. Maintenance Staff #1 said Unit staff typically only requested for maintenance to clean the exterior of the ice machine between scheduled monthly cleaning, and he could not recall any requests by Unit staff to clean any internal parts or the ice chute. Maintenance Staff #1 provided a completed quarterly schedule for all ice/water machines but could not locate the monthly schedules. Maintenance Staff #1 said the Director of Maintenance (DOM) likely had the monthly ice/water machine cleaning schedule records, and the DOM would be on vacation during the survey timeframe. On 8/1/24 at 2:57 P.M., the surveyor observed Dietary Aide #2 stocking the A Unit kitchenette with snacks. The surveyor observed Dietary Aide #2 drop a package of cookies onto the floor onto the black colored grout, pick up the package, and place the cookie package into the snack bin in the kitchenette cupboard. The surveyor did not observe Dietary Aide #2 clean any part of the ice/water machine. On 8/5/24 at 9:59 A.M., the surveyor observed the following in the B Unit kitchenette refrigerator: -one slice of pie with no label or date; -at least half of the bottom rack covered with red, sticky substance and eight bottles of cranberry and orange juice located on the same shelf; -exterior left side of the refrigerator widely covered with brown substance. On 8/5/24 at 11:11 A.M., the surveyor and Assistant FSD observed the A Unit kitchenette. The Assistant FSD said the ice/water machine and the floor and wall grout needed to be cleaned. The Assistant FSD said Dietary Staff were only responsible for cleaning the exterior of the ice/water machine. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/5/24 at 11:23 A.M., the surveyor and Assistant FSD observed the B Unit kitchenette. The surveyor observed that the refrigerator interior had been cleaned, however, the bottoms of some juice bottles still had pink sticky residue that was observed on the shelving previously. The Assistant FSD said she expected kitchenettes to be maintained in a clean and sanitary condition, including the interior and exterior refrigerator. During an interview on 8/5/24 at 11:32 A.M., the DOH said pulling out refrigerators and cleaning that area was not part of the cleaning tasks currently. During an interview on 8/5/24 at 12:10 P.M., the surveyor and Maintenance Staff #1 observed the A Unit kitchenette ice/water machine. Maintenance Staff #1 said the ice chute where the ice dispensed needed to be cleaned of the brown substance. 3. On 7/30/24 at 8:15 A.M., the surveyor observed the following in the main kitchen walk-in refrigerator and freezer: -one opened package of hotdogs wrapped with plastic, no label or date; -one opened carton of potato salad, wrapped with plastic, no date; -one unopened package of broccoli with contents turning brown, no label or date; -one pitcher of liquid, no label or date; -one opened package of frozen green beans, rewrapped with plastic, no label or date; and -one opened package of frozen peas, no label or date; -one bag of fresh spinach, opened, no label or date, with watery brownish yellow substance inside; -one container of thickened lemon-flavored water, opened and dated 5/13; the manufacturer label states may be kept up to 7 days under refrigeration. On 7/31/24 at 8:40 A.M., the surveyor observed the following in the dry storage room: -four containers of mayonnaise, out of box, no manufacturer expiration date, undated; -one bag of flake cereal, wrapped in plastic, no label or date; -one opened 25 pound bag of panko bread crumbs, no date; the bag was loosely twisted at the top and insecurely sealed; -one package of hard taco shells, out of box, no label or date; -six bags of brownie mix, out of box, no manufacturer expiration date, undated; -four bags of white cake mix, out of box, no manufacturer expiration date, undated; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-two bags of yellow cake mix, out of box, no manufacturer expiration date, undated; -four bags of corn bread and muffin mix, out of box, no manufacturer expiration date, undated. On 7/31/24 at 4:15 P.M., the surveyor observed the following in the walk-in refrigerator: -two pieces of cake, plated and wrapped in plastic, no label or date; -one tray containing plated desserts, no label or date; -one opened bag of whipped cream, wrapped in plastic, no date; -one unopened package of broccoli with contents turning brown, no label or date. On 8/1/24 at 8:21 A.M., the surveyor observed the following in the main kitchen walk-in refrigerator and freezer: -one unopened bag of broccoli with contents turning brown, no label or date. -frozen meat with no label or date; -frozen bacon, opened and wrapped with plastic, no label or date. On 8/1/24 at 8:25 A.M., the surveyor and FSD observed the walk-in refrigerator and freezer, and the dry storage room. The FSD said all food and drink items should be labeled and dated, including any opened items or items taken out of their original boxes or packaging. The FSD said the fresh bag of broccoli should have been dated and was spoiled; the frozen meat and bacon should be labeled and dated; the dry storage items that were out of their original packaging and contained no manufacturer expiration date should be labeled and dated; any opened packaging should be closed securely to prevent contamination and spoilage. On 8/5/24 at 11:00 A.M., the surveyor observed an opened carton of Lactaid milk with no date in the walk-in refrigerator. The manufacturer label stated to consume the product within 14 days of opening. During an interview on 8/5/24 at 11:10 A.M., the Assistant FSD said the Lactaid milk should be dated. 4. On 7/31/24 at 9:40 A.M., the surveyor observed the following in the B Unit kitchenette: -one open carton of Thickened Lemon-Flavored Water, undated, with a manufacturer label which indicated after opening may be kept up to seven days under refrigeration; -one open box of Cranberry Cocktail, undated, with a manufacturer label which indicated after opening may be kept up to seven days under refrigeration; -one cup of an orange substance, dated 7/27; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-one cup of yellow substance, dated 7/25. On 7/31/24 at 11:40 A.M., the surveyor observed the following in the A Unit kitchenette: -four opened containers of thickened liquids, undated, with the manufacturer label stating the product can be stored up to seven days in the refrigerator after opening. On 8/1/24 at 8:13 A.M., the surveyor observed the following on the B Unit kitchenette: -one plastic food storage container containing pasta with no label or date; -one open carton of Thickened Lemon-Flavored Water, undated, with a manufacturer label which indicated after opening may be kept up to seven days under refrigeration; -one open box of Cranberry Cocktail, undated, with a manufacturer label which indicated after opening may be kept up to seven days under refrigeration; -one cup of an orange substance, dated 7/27. During an interview on 8/1/24 at 8:21 A.M., the FSD said the Dietary Staff was responsible for checking for labels and dates. The FSD said all food and drink in the Unit kitchenettes should be labeled and dated. The FSD said any food or drink item with no label and/or dated should be thrown away. The FSD said whoever opens a carton of thickened liquid should have labeled the carton with an opened date. On 8/1/24 at 1:14 P.M., the surveyor observed the following in the B Unit kitchenette: -two opened cartons of thickened liquids, undated; the manufacturer label stated to use the product within seven days of opening. On 8/1/24 at 2:57 P.M., the surveyor and Dietary Staff #2 observed the A Unit kitchenette together. Dietary Staff #2 said he made sure the items he stocked were labeled and he moved forward any opened containers and moved sealed/unopened containers toward the back of the refrigerator. The surveyor observed Dietary Staff #2 rearrange the opened containers of thickened liquid, some undated, to the front of the refrigerator and placing the sealed cartons of thickened liquid to the back of the refrigerator. Dietary Staff #2 said he was unsure if that was the right process. On 8/5/24 at 8:45 A.M., the surveyor observed the following in the A Unit kitchenette: -eight opened cartons of thickened liquid with no dates; the manufacturer label stated the product can be stored up to seven days in the refrigerator after opening; -one bowl of fresh honey dew, wrapped in plastic, no label or date; -four bowls with some type of dessert, no label or date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation with interview on 8/5/24 at 10:11 A.M., the surveyor and Dietary Staff #2 observed the A Unit kitchenette together. Dietary Staff #2 said two of the eight opened thickened liquids were opened on 8/2. He selected the two cartons, labeled them 8/2 as he said that was the date he brought those cartons to the Unit and the date they were opened. The surveyor asked Dietary Staff #2 if any other cartons of thickened liquid were open and he said no. The surveyor requested Dietary Staff #2 check the remaining cartons at which point Dietary Staff #2 observed the other six cartons had broken seals. Dietary Staff #2 said he thought he should put the opened ones in the front but was not sure. Dietary Staff #2 said he did not know cartons of thickened liquids state they should only be stored in the refrigerator up to seven days after opening. The surveyor asked Dietary Staff #2 about the unlabeled and undated honeydew in the refrigerator. Dietary Staff #2 opened the refrigerator and said the honeydew should be removed since it had no label or date. During an observation with interview on 8/5/24 at 11:11 A.M., the surveyor and Assistant FSD observed the A Unit kitchenette. The Assistant FSD said cartons of thickened liquids should be labeled and dated with an opened date by the person who opens the carton. The Assistant FSD said any opened cartons with no date should be thrown away. The Assistant FSD said any food items with no label and/or date should be thrown away, and any open or prepared food or drink item that is labeled and dated has a shelf life of three days in the refrigerator. During an observation with interview on 8/5/24 at 11:32 A.M., the surveyor and Assistant FSD observed the B Unit kitchenette. The surveyor observed one slice of pie with no label or date. The Assistant FSD said the pie was from yesterday's lunch and should be thrown away as it had no date or label. The surveyor observed one Tupperware container labeled with a resident's name and dated 8/1. The Assistant FSD said the contents should be thrown away because it has been stored for greater than three days.

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	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. 48695 Based on document review and interview, the facility failed to conduct and implement a comprehensive facility wide assessment that was inclusive of resources necessary to provide both emergency and day to day care of the population the facility currently serves. Specifically, the facility failed to: 1. Ensure the identification for residents with special treatments and conditions the facility consistently provides services for was accurately completed; 2. Failed to identify facility Resources needed to provide competent support and care for resident population every day and during emergencies; and 3. Failed to accurately identify Managing Health Care System. Findings include: Review of the Facility Assessment Tool last updated 6/15/24 and last review with QAA (quality assessment and assurance)/QAPI (quality assurance performance improvement) committee 6/27/24. 1. Review of the Facility Assessment Tool Part 1 section 3 titled Acuity failed to identify Number/Average or Range of Residents with Special Treatments and Conditions including but not limited to: - Respiratory - Oxygen therapy- left blank - Bitmap (bilevel positive airway pressure)/CPAP (continuous positive airway pressure) - left blank - Other- left blank - G-Tube (gastrostomy) feeding- left blank - Falls- left blank - Falls with major injury- left blank - Indwelling Catheter- left blank - Pain- left blank - Urinary Tract Infection- left blank - Declines in ADL (activities of daily living) - left blank (continued on next page)

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	- Limited Range of Motion- left blank - Physical Therapy- left blank - Occupation Therapy- left blank - Speech Therapy- left blank - Excessive Weight Loss- left blank - Facility Acquired Pressure Ulcer- left blank - Worsening Pressure Ulcer- left blank - Medications- left blank - Insulin- left blank - Anticoagulation therapy- left blank - Diuretic- left blank - Opioid- left blank - Hypnotic- left blank - Anti-anxiety- left blank - Anti-psychotic- left blank 2. Review of the Facility Assessment Tool Part 3 section 3.2 Staffing Plan failed to identify the Assistant Director of Nursing (ADON) as part of the staffing plan. 3. Review of the Facility Assessment Tool Part 3 section 3.5 identified an inaccurate Managing Health Care System as the quality team which evaluates the policies and procedures. During an interview on 8/5/24 at 1:24 P.M., the Administrator said this was the most recent Facility Assessment, and he updated it quarterly and as needed. The Administrator said the facility should have included the accurate Managing Health Care system, listed the ADON, and included accurate acuity of the residents. The Administrator said the Facility Assessment was inaccurate.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46562 Based on record review, document review, observations, and interviews, the facility failed to maintain an infection prevention and control program to help prevent the development and potential transmission of communicable diseases and infections. Specifically, the facility failed to: 1. Ensure COVID-19 testing was conducted in accordance with manufacturers guidelines during a COVID-19 outbreak; 2. Ensure Personal Protective Equipment was donned/doffed (put on/ taken off) according to current professional standards; and 3. Ensure Resident #48 performed hand hygiene prior to flushing his/her gastrostomy tube (G-tube inserted through the belly that brings nutrition and medication directly to the stomach). Findings include: 1. Review of the OSang Healthcare (OHC) COVID-19 antigen self-test manufacturer's instructions for use, dated as revised 2/2023, indicated but was not limited to: - Set the timer and read the test result at 15 minutes. Do not read the result after 20 minutes. -Warning: Inaccurate test interpretations may occur if results are read before 15 minutes or after 20 minutes. Review of the [NAME] BinaxNOW COVID-19 antigen self-test manufacturer's instructions for use, dated as revised 1/2023, indicated but was not limited to: -Wait 15 minutes. Read the results at 15 minutes. Do not read the result before 15 minutes or after 30 minutes. Review of the iHealth COVID-19 antigen self-test manufacturer's instructions for use, dated as revised 12/2021, indicated but was not limited to: -Wait 15 minutes. Do not interpret your test results until after your 15-minute timer has completed, as the test result may take as long as 15 minutes to appear. -A false negative or false positive result may occur if the test result is read before 15 minutes or after 30 minutes. On 7/31/24 between 3:02 P.M. and 3:18 P.M., the surveyor observed staff conducting self-testing during a COVID-19 outbreak, as follows: -Multiple boxes of COVID-19 self-tests kits available on a table including OHC antigen self-test, BinaxNOW antigen self-test, and iHealth antigen self-test kits (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Upon arrival to testing area there was one test card with the control line present, indicating the card had been utilized, sitting on a table that was unattended and completely blank, the test card remained unattended for the entire observation period. -Certified Nursing Assistant (CNA) #3 completed her swab/application of solution at 3:06 P.M. CNA #3 read her results at 3:11 P.M., disposed of the test and left the testing area. - CNA #4 completed her swab/application of solution at 3:09 P.M. CNA #4 read her results at 3:13 P.M., disposed of the test and left the testing area. - Nurse #4 completed her swab/application of solution at 3:11 P.M. Nurse #4 read her results at 3:15 P.M., disposed of the test and left the testing area. On 8/1/24, the surveyor observed staff conducting self-testing during a COVID-19 outbreak as follows: Multiple boxes of COVID-19 self-tests kits available on a table including OHC antigen self-test, BinaxNOW antigen self-test, and iHealth antigen self-test kits -CNA #5 completed her swab/application of solution at 7:08 A.M. CNA #5 read her results at 7:11 A.M., disposed of the test and left the testing area. During an interview on 8/5/24 at 11:30 A.M., the Infection Control Nurse said the facility was currently in a COVID-19 outbreak and was testing all staff members at the start of their shift. The Infection Control nurse said testing should be conducted per guidance and manufacturer's recommendations. The Infection Control Nurse said all staff should be waiting 15 minutes before leaving the testing area and reporting to their area of work. During an interview on 8/5/24 at 12:55 P.M., the Director of Nurses said staff should not be reporting to their area of work before the test has been completed as indicated in the manufacturer's instructions. 2. Review of the Centers for Disease Control (CDC) guidance titled: Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 3/18/24, indicated but was not limited to the following: -Personal Protective Equipment: Healthcare providers who enter the room of a patient with suspected or confirmed SARS-CoV-2 (COVID-19) infection should adhere to Standard Precautions and use an approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). Review of the Centers for Disease Control and Prevention (CDC) guidance titled Infection Control Guidance: SARS-CoV-2, dated 6/24/24, indicated but was not limited to: -Recommended routine infection prevention and control (IPC) practices included but was not limited to: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Source control is recommended for individuals in healthcare settings who: have suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze); or Had close contact (patients and visitors) or a higher-risk exposure (HCP) with someone with SARS-CoV-2 infection, for 10 days after their exposure -When used solely for source control, any of the options listed above could be used for an entire shift unless they become soiled, damaged, or hard to breathe through. If they are used during the care of patient for which a NIOSH Approved respirator or facemask is indicated for personal protective equipment (PPE) they should be removed and discarded after the patient care encounter and a new one should be donned. Review of the sign in use by the facility and posted outside of resident rooms to indicate positive COVID status indicated but was not limited to the following: -Isolation: Droplet/Contact Precautions -In addition to standard precautions staff and providers must: Clean hands when entering and exiting and, wear gown and change in between residents, N-95 respirator, eye protection (face shield or goggles), gloves and change in between residents On 7/31/24 at 9:54 A.M., the surveyor observed Housekeeper #1 exit Resident #17's room with an Isolation: Droplet/Contact Precautions sign posted at the entrance of the room. Housekeeper #1 entered the hallway with all of his PPE in place. Housekeeper #1 removed his gloves and gown while in the hallway and disposed of them in his cart. Housekeeper #1 did not sanitize his eye protection, change his N95 or perform hand hygiene. On 7/31/24 at 10:55 A.M., the surveyor observed Certified Nursing Assistant (CNA) #1 exit Resident #36's room with an Isolation: Droplet/Contact Precautions sign posted at the entrance of the room wearing eye protection and an N95 mask. CNA #1 did not change her N95 or sanitize her eye protection after exiting the room. On 8/1/24 at 8:36 A.M., the surveyor observed Activities Assistant #1 exit Resident #17's room with an Isolation: Droplet/Contact Precautions sign posted at the entrance of the room wearing an N95 and eye protection. Activities assistant #1 was carrying a tape dispenser and papers in her hands and did not sanitize her eye protection, change her N95, or perform hand hygiene. Activities assistant #1 went directly into another resident's room. On 8/1/24 at 9:06 A.M., the surveyor observed Nurse #5 exit Resident #17's room in which an Isolation: Droplet/Contact Precautions sign was posted at the entrance of the room. Nurse #5 did not change her N95 or sanitize her eye protection after exiting the room. On 8/1/24 at 9:11 A.M., the surveyor observed Nurse #5 exit Resident #36's room in which an Isolation: Droplet/Contact Precautions sign was posted at the entrance of the room. Nurse #5 did not change her N95 or sanitize her eye protection after exiting the room. Nurse #5 went directly into Resident #9's room for whom Isolation Precautions were not indicated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225488	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tremont Health Care Center	605 Main Street Wareham, MA 02571

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 - Some	During an interview on 8/1/24 at 10:03 A.M., Nurse #5 said the facility uses the CDC signs to indicate the precautions needed and notify staff and visitors of PPE required. Nurse #5 said the Isolation: Droplet/Contact Precautions sign indicated the resident was positive for COVID. Nurse #5 said when exiting a COVID room eye protection should be sanitized and a new N95 should be obtained. During an interview on 8/5/24 at 12:55 P.M., the Director of Nurses (DON) said staff should be following the CDC guidance for donning/doffing PPE. The DON said gowns and gloves should not be worn in the hallways. The DON said eye protection should be sanitized and a new N95 should be obtained after exiting a COVID room because those would be considered contaminated. 48695 Review of the Lippincott Manual of Nursing Practice, Eleventh Edition, Enteral gastrostomy and jejunostomy tube feeding and care, indicated but was not limited to: -Implementation -Perform Hand Hygiene Resident #48 was admitted to the facility in June 2024 with diagnoses of gastrostomy tube (G-tube) and malignant neoplasm (cancer) of pharynx (throat). Review of the Minimum Data Set (MDS) assessment, dated 7/3/24, indicated that Resident #48 scored 12 out of 15 on the Brief Interview for Mental Status (BIMS) indicating that he/she had moderate cognitive impairment. During an interview on 7/30/24 at 9:48 A.M., Resident #48 said he/she had a G-tube that was not being utilized for feedings or medication. Resident #48 said he/she flushed his/her own G-tube. On the following days and times, the surveyor observed Resident #48 flush his/her G-tube without performing hand hygiene prior: -7/31/24 at 8:58 A.M. -8/1/24 at 11:58 A.M. During an interview on 7/31/24 at 9:02 A.M., Nurse #1 said Resident #48 usually flushed his/her G-tube. During an interview on 8/1/24 at 11:58 A.M., Resident #48 said he/she flushed their G-tube just like he/she did when he/she was at home. During an interview on 8/1/24 at 12:05 P.M., Unit Manager #1 said an observation and competency should have been done prior to Resident #48 flushing his/her own G-tube. During an interview on 8/1/24 at 2:28 P.M., the Director of Nursing (DON) said the Resident should have had a competency completed with observation.