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	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tremont Rehabilitation & Skilled 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 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. 42742 Based on observation, interview, and record review, the facility failed to follow professional standards of practice for one Resident (#40), out of a total sample of 21 residents. Specifically, the facility failed to administer medications per physician's orders. Findings include: Review of Lippincott Nursing Procedures, Eighth Edition, [Wolters Kluwer], 2019, indicated but was not limited to the following: -To promote a culture of safety and to prevent medication errors, nurses must avoid distractions and interruptions when preparing and administering medications and adhere to the five rights of medication administration: identify the right patient by using at least two specific identifiers; select the right medication; administer the right dose; administer the medication at the right time; and administer the medication by the right route. Recent literature identifies nine rights of medication administration, which in addition to the five rights includes the right documentation, the right action (or appropriate reason for prescribing the medication), the right form, and the right response. Verifying the Medication Order: -Follow a written or typed order, or an order entered into a computer order-entry system. Review of the facility's policy titled Medication Administration - Oral, dated June 2015, indicated but was not limited to the following: -Verify medication order on Medication Administration Record (MAR). Check against physician order. -Compare the medication label to the resident's/patient's MAR. -Verify that the medication is being administered at the proper time, in the prescribed dose, and by the correct route. Resident #40 was admitted to the facility in November 2021 and had diagnoses including chronic venous insufficiency and chronic embolism and thrombosis of deep veins. Review of current Physician's Orders indicated the following: (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Aspirin Tablet Chewable 81 milligrams (mg), give 1 tablet by mouth in the morning for pain, 3/29/24 On 1/6/25 at 8:56 A.M., the surveyor observed Nurse #8 prepare Resident #40's medications and observed the following: 8:56 A.M. - Nurse #8 opened an over-the-counter bottle of generic chewable aspirin, 81 mg, from the top drawer of the medication cart and added one whole tablet into a medication cup along with five other various whole medication tablets. Nurse #8 did not separate the chewable aspirin from the other medications. 9:03 A.M. - Nurse #8 administered the medications all together in the same medication cup to Resident #40. Nurse #8 did not separate the chewable aspirin from the rest of the medications and did not prompt Resident #40 to chew the aspirin. During an interview on 1/6/25 at 9:05 A.M., the surveyor reviewed Resident #40's medical record with Nurse #8 who said the order was for the Resident to chew the aspirin, not swallow it whole. She said the reason for a chewable aspirin is that it is absorbed faster. Nurse #8 said medications should be administered per physician's orders and the physician notified if they can't be. During an interview on 1/6/25 at 11:35 A.M., the Director of Nursing (DON) said medications should be administered per physician's orders and the chewable aspirin was probably prescribed for the Resident because of gastrointestinal reasons and easier absorption but would have to look and get back to the surveyor. She said the chewable aspirin should have been separated from the other medications and the Resident prompted to chew it. The DON said if there was any issue with the Resident not being able to chew it versus swallow it whole, then the physician would be notified to obtain a new order for a different route.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34145 Based on observation and interview, the facility failed to provide an ongoing program of individual and group activities designed to meet the interests of and support the physical, mental, and psychosocial well-being of Residents on one (B Unit) of two nursing units and specifically for two out of 21 sampled Residents (#6 and #48). Specifically, the facility failed: 1. For Resident #6, to ensure that staff offered and encouraged engagement in activities according to their comprehensive assessment and identified preferences; 2. For Resident #48, to ensure that staff offered and encouraged engagement in activities according to their comprehensive assessment and identified preferences; and 3. To ensure staff provided a meaningful and engaging activity program, including materials for self-directed activity, for residents residing on the B Unit (secured). Findings include: Review of the facility's policy titled Activity Programs, last revised August 2017, indicated but was not limited to: -Recreational activities are designed to contribute to the achievement of the long and short-term goals established for each resident. -The goal of this department is to assist each resident in the resumption of normal activities and maintain the optimal level of psychosocial functioning. -These leisure services encompass a versatile scope of activities that promote the cultural, spiritual, social, intellectual, and physical growth and fulfillment of each resident. -In order to achieve this, a wide and diversified leisure service program has been developed based on the needs and personal interests of each resident. -Appropriate supplies and equipment are provided to ensure the safe implementation and continuation of meaningful recreational activities. -Provisions are made by the Recreation staff in accordance with the resident's level of participation. -Maintain accurate daily attendance records on each resident's progress and use these notes as a reference point for accurately assessing each resident's Recreation Plan as per care plan policy. During the entrance conference on 1/2/25 at 8:37 A.M., the Administrator said the B Unit was a secure unit with several residents with a diagnosis of dementia. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Matrix for Providers (Centers for Medicare and Medicaid Services document used to identify pertinent care categories) provided by the facility on 1/2/25 at 11:00 A.M., indicated 44 residents resided on the B Unit, 34 of which have a diagnosis of dementia. 1. Resident #6 was admitted to the facility in September 2022 and had diagnoses including Alzheimer's disease, major depression, and anxiety. Review of the Minimum Data Set (MDS) assessment, dated 10/25/24, indicated Resident #6 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 5 out of 15. Review of the comprehensive MDS assessment, dated 7/26/24, indicated that it was very important to the Resident to: -have books, newspapers, and magazines to read -listen to music you like -do things with groups of people -do your favorite activities -to go outside to get fresh air when the weather is good Review of a Therapeutic Recreation Quarterly Progress Note, dated 10/23/24, indicated but was not limited to: -Attends activities independently; requires reminders to attend activities; is an active participant; is a passive participant. -Wellness/healing: dance/Zumba(R); light movement; massage therapy. -Mental wellness: music therapy; pet therapy -Cognitive: oriented to person; forgetful/requires reminders and cues; short attention span; requires verbal cueing; cannot comprehend instruction (Spanish speaker. Cannot comprehend English instruction). -Activity preferences: social, religious, creative crafts, music, sing a long, baking, active games, outdoor. -Notes: Resident is independent in choosing leisure pursuits; needs invitations and reminders to attend groups of interest. Resident is Spanish speaker. Enjoys small crafts, music groups and sing a long, religious groups, going outside, dancing and several others. Enjoys self-directed tasks like sorting and folding, conversing in Spanish with other Spanish-speakers. Activities staff continue to support resident as needed. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Resident's Activity Care Plan, last revised 11/12/24, listed interventions including but not limited to: -Provide Resident with the Daily Activities flier and a Spanish Communication Board -Activity staff will inform, invite, and encourage him/her to participate in activities -Activity staff will introduce Resident to peers with similar interests -Offer Resident independent leisure activities per his/her request No evidence was found in the Activity Care Plan to include interventions for musical activities, religious activities, or to go outside when the weather was good. Review of the Resident's Activity Participation Log indicated the following: December 2024: -1 day of a observing a craft activity -1 day of listening to music -6 days of receiving something from the refreshment cart -1 day of engaging in 1:1 conversation -1 day of a pet visit -1 day reading materials offered -2 days of playing a balloon game -7 days of Bingo/group board game -8 days of coffee club -1 day of trivia -1 day of exercise -6 days of arts and crafts -4 days of holiday events -12 days with no activity recorded (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the December 2024 Activity Participation Logs showed no evidence that the Resident had been offered to go outside, attend religious groups, or more than one day of reading materials provided to the Resident for independent activity. Review of the Resident's Activity Participation Log for January 2025 failed to indicate the Resident was offered or participated in any activities. 2. Resident #48 was admitted to the facility in August 2022 and had diagnoses including Alzheimer's disease. Review of the MDS assessment, dated 12/30/24, indicated Resident #48 had severe cognitive impairment as evidenced by a BIMS score of 00 out of 15. Review of the comprehensive MDS assessment, dated 3/11/24, indicated that it was very important to the Resident to: -listen to music you like -be around animals such as pets -do things with groups of people -do your favorite activities -to go outside to get fresh air when the weather is good Review of a Therapeutic Recreation Quarterly Progress Note, dated 11/27/24, indicated but was not limited to: -Requires reminders to attend activities; is a passive participant. -Wellness/healing: light movement. -Mental wellness: music therapy; pet therapy -Cognitive: forgetful/requires reminders and cues; confused; short attention span, cannot comprehend instruction. -Activity preferences: music, sing a long, outdoor. Review of the Resident's Activity Care Plan, last revised 1/5/25, listed interventions including but not limited to: -Activity staff will visit Resident daily to inform, invite and encourage him/her to participate in activities -Offer Resident independent leisure activities as needed (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No evidence was found in the Activity Care Plan to include interventions for musical activities, sing along, pet therapy, or to go outside when the weather was good. Review of the Resident's Activity Participation Log indicated the following: August 2024: -2 days of listening to music -2 days of engaging conversation -1 day of refreshment cart -2 days of socializing with peers -29 days with no activity recorded Further review of the August 2024 Activity Participation Logs showed no evidence that the Resident had been offered to participate in a sing along, pet therapy, participate in light movement, or to go outside. Review of the Resident's Activity Participation Log indicated the following: September 2024: -1 day of engaging conversation -1 day of socializing with peers -29 days with no activity recorded Further review of the September 2024 Activity Participation Logs showed no evidence that the Resident had been offered to participate in music therapy, sing along, pet therapy, participate in light movement, or to go outside. Review of the Resident's Activity Participation Log indicated the following: October 2024: -1 day of listening to music -30 days with no activity recorded Further review of the October 2024 Activity Participation Logs showed no evidence that the Resident had been offered to participate in sing along, pet therapy, participate in light movement, or to go outside. Review of the Resident's Activity Participation Log indicated the following: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	November 2024: -1 day of basketball -2 days of Bingo/group games -1 day of Tea Club -2 days of exercise -3 days of arts & crafts -2 days of entertainment -18 days with no activity recorded Further review of the November 2024 Activity Participation Logs showed no evidence that the Resident had been offered to participate in sing along, music, pet therapy, or to go outside. Review of the Resident's Activity Participation Log indicated the following: December 2024: -1 day of reading materials offered -1 day of a holiday event -29 days with no activity recorded Further review of the December 2024 Activity Participation Logs showed no evidence that the Resident had been offered to participate in sing along, music, pet therapy, participate in light activity, or go outside. Review of the Resident's Activity Participation Log for January 2025 failed to indicate the Resident was offered or participated in any activities. During an interview on 1/3/25 at 1:00 P.M., the Activity Director (AD) said she documents all residents' participation in the activity program in the electronic medical record. She could not explain why Residents #6 and #48 did not participate in programming according to their comprehensive assessment and preferences. During an interview on 1/6/25 at 10:56 A.M., Activity Assistant #3 she said she is the program coordinator for the dementia activity program. She said the program is held off the unit and limited to 10 to 12 residents that could benefit from smaller group activities. She said Residents #6 and #48 have not participated in the dementia activity program. 3. On the following days of survey, the surveyor made the following observations of the B Unit activity/dayroom: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-1/2/25 at 9:18 A.M., 18 residents were seated in the dayroom with no staff members present. Hospice Aide #1 was seated next to one resident. The television was on, but only three residents were facing the television. Two residents were sleeping and 13 residents were awake with nothing to do. The residents were not provided with materials for self-directed activity and were not otherwise engaged in meaningful activity. During an interview on 1/2/25 at 9:23 A.M., Hospice Aide #1 said she comes to the facility four times a week from 8:00 A.M. to 12:00 P.M. to care for four residents. She said when she is here, she sees no staff engagement with the residents in the dayroom and wishes there were more activities for the residents to do. -1/2/25 at 9:58 A.M., 12 residents were seated in the dayroom with one staff member present who was sitting in a chair along the wall not engaging with the residents. The television was on a music station, but the sound was low and inaudible. One resident had a shape [NAME] toy, and one resident had a tube search puzzle in front of him/her. Ten residents were awake with nothing to do. The residents were not provided with materials for self-directed activity and were not otherwise engaged in meaningful activity. -1/2/25 at 10:10 A.M., 11 Residents were seated in the dayroom with Activity Assistant #1 in the room with a coffee cart. Activity Assistant #1 gave a cup of coffee to one resident, then left the room. Hospice Aide #1 was seated next to one resident. One resident was engaged in manipulating puzzle pieces, five residents were sleeping in their chairs, two residents were looking at the TV (which was showing an exercise program) and three residents were awake with nothing to do. There was no staff interaction, and the residents were not provided with materials for self-directed activity and were not otherwise engaged in meaningful activity. -1/2/25 at 10:34 A.M., 13 residents were seated in the dayroom with no staff member in the room. Hospice Aide #1 was seated next to one resident. Ten of 13 residents were awake with nothing to do and three residents were sleeping. The residents were not provided with materials for self-directed activity and were not otherwise engaged in meaningful activity. The activity calendar posted outside the dayroom indicated Noodle Balloon was supposed to be occurring but was not. At 10:36 A.M., Activity Assistant #1 came into the dayroom and returned to the coffee cart. -1/3/25 at 11:44 A.M., 11 residents were seated in the dayroom with no staff member in the room. One resident was looking at magazines. Ten residents were awake and had nothing to do. The residents were not provided with materials for self-directed activity and were not otherwise engaged in meaningful activity. During an interview on 1/3/25 at 11:45 A.M., Resident #144's family member said she said she comes in as often as she can to visit her loved one. She said she has seen the residents play Bingo before but otherwise has not seen any activities going on. She said there is rarely any activity staff on the unit. The family member said she is not sure if every time she is here, if staff are on a break, they call out sick, or they just don't have anyone to work. (continued on next page)

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	225488	A. Building B. Wing	01/07/2025

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/3/25 at 1:00 P.M., the Activity Director (AD) said Activity Assistant #1 works on the B Unit, and Activity Assistant #3 runs a dementia activity program on the first floor for about 10 residents. The Activity Director was unable to explain why the specialized programming was not available to all residents on the B Unit. She said Unit Manager #1 is in charge of the program and would be able to provide more detailed information. -1/3/25 at 1:41 P.M., 13 residents were seated in the Unit B dayroom awake with one staff member present who was sitting in a chair along the wall not engaging with the residents. The television was on to a music video. Three residents were watching the TV, and 10 residents were not in the line of sight to the television and had nothing to do. The residents were not provided with materials for self-directed activity and were not otherwise engaged in meaningful activity. During an interview on 1/3/25 at 2:00 P.M., Unit Manager #1 said she is really not in charge of the dementia activity program. She said there is no specific eligibility criteria or assessment process for residents to participate in the program. She said they select residents that need smaller group activities, and someone that may be a fall risk or a wanderer. She said the program runs Monday through Friday after breakfast until 1:30 P.M. -1/6/25 at 9:56 A.M., 15 residents were seated in the dayroom with one staff member present who was sitting in a chair along the wall not engaging with the residents. The TV was on, but the volume was low and inaudible. All the residents were awake with nothing to do. The residents were not provided with materials for self-directed activity and were not otherwise engaged in meaningful activity. -1/6/25 at 10:09 A.M., 17 residents were seated in the dayroom with one staff member present who was sitting in a chair along the wall not engaging with the residents. The TV was on, but the volume was low and inaudible. All the residents were awake with nothing to do. The residents were not provided with materials for self-directed activity and were not otherwise engaged in meaningful activity. The activity calendar posted outside the activity room indicated Coffee Club was scheduled during this time, but this activity was not occurring. -1/6/25 at 10:22 A.M., 12 residents were seated in the dayroom with one staff member present and walking around the room. The residents were awake and were not provided with materials for self-directed activity and were not otherwise engaged in meaningful activity. Coffee Club was not occurring as noted on the activity calendar. -1/6/25 at 10:31 A.M., 11 residents were seated in the dayroom with no staff present in the room. One resident was sleeping, eight residents were awake with nothing to do, and two residents were wandering in the dayroom. The TV was on, but no residents were watching it. The residents were not provided with materials for self-directed activity and were not otherwise engaged in meaningful activity. The activity calendar posted outside the activity room indicated Seated Kickball was supposed to be occurring, but it was not. -1/6/25 at 10:43 A.M., eight residents were seated in the dayroom with no staff present in the room. All eight residents were awake with nothing to do. The residents were not provided with materials for self-directed activity and were not otherwise engaged in meaningful activity. The activity calendar posted outside the activity room indicated Seated Kickball was supposed to be occurring as noted on the activity calendar but was not. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-1/6/25 at 10:49 A.M., eight residents were seated in the dayroom with no staff present in the room. The TV was on with one resident watching it. Seven residents were sitting with nothing to do. The residents were not provided with materials for self-directed activity and were not otherwise engaged in meaningful activity. Seated Kickball was supposed to be occurring during this time as noted on the activity calendar but was not. -1/6/25 at 10:52 A.M., the surveyor observed Activity Assistant #1 in the hallway at the opposite end of the B Unit pushing a coffee cart in the hallway. During an interview on 1/6/25 at 10:56 A.M., Activity Assistant #3 said she is the program coordinator for the dementia activity program and tries to have 10 to 12 residents attend the program that otherwise would just sit with nothing to do. She said she can often get residents to participate when they come to the program; they come down daily or a few days a week for small group activities and to eat lunch. She said the program starts at 10:00 A.M. and ends around 1:30 P.M. every day during the week. She said after 1:30 P.M., she has her lunch, then goes upstairs to either the A or B Unit to do activities such as Bingo until 4:00 P.M. The Activity Assistant said no other activity staff do anything like this program upstairs on the B Unit for those that do not participate in the special program. She said they have regularly scheduled activities as noted on the calendar. She said she is aware that there are many periods of time that the residents on the B Unit are in the dayroom with nothing to do. She said there is a closet in the Unit B dayroom that is filled with supplies such as puzzles and sorting items for residents to use. She said the closet has a numerical lock on it, and all staff have the code and can access it at any time. She said the residents should never sit with nothing to do. -1/6/25 at 2:08 P.M., 10 residents were seated in the dayroom, four of which had Bingo cards. Activity Assistant #1 was seated at a table, positioned with her back to two of the four residents with cards as she called out Bingo numbers. There were no other staff in the room to assist in the activity. As she called out Bingo numbers, one resident fanned his/her face with the Bingo card, one resident was staring at the Bingo card, and two residents were not looking at their Bingo cards at all. Activity Assistant #1 did not assist the residents with playing the game or otherwise engage with the residents. During an interview on 1/7/25 at 9:20 A.M., Activity Assistant #1 said when she called Bingo on the B Unit on 1/6/25, she said she did not assist the residents with playing, but took turns playing their cards for them so they could win a prize. She said she did not consider playing a different game or activity that would be more appropriate for the residents' cognitive level so they could participate. She said they have low staff and she can't do it all on her own. During an interview on 1/7/25 at 11:56 A.M., the Director of Nursing (DON) said the Activity Director's last day at the facility was 1/3/25. She said she didn't get very involved with the activity program. She said they hope to hire a new Director soon and plan to work on the activity program.

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	225488	A. Building B. Wing	01/07/2025

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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. 43935 Based on observation, document review, and interview, the facility failed to ensure it provided an environment free of potential safety hazards for one Resident (#59), out of a total sample of 21 residents. Specifically, the facility failed to ensure medications were administered safely and not left at the Resident's bedside unsecured by the licensed staff. Findings include: Review of the facility's policy titled Medication Administration - Oral, dated June 2015, indicated but was not limited to the following: PROCEDURE: Identify resident; verify that medication is being administered at the proper time, stay with the resident until he/she has swallowed the medication Resident #59 was admitted to the facility in April 2024 and has diagnoses including: Visual disturbances, mild cognitive loss and dysphagia (difficulty swallowing). Review of the Brief Interview for Mental Status (BIMS) for Resident #59, dated 10/2/24, indicated the Resident suffered from moderate cognitive impairment with a score of 11 out of 15. During an observation with interview on 1/2/25 at 8:01 A.M., the surveyor observed Resident #59 sitting on his/her bed with two small cups on the overbed table. One cup contained two red larger oval gel caps and three small white round pills; the second cup was full to the top measurement line with a light orange liquid. The Resident said he/she does not self-administer and they do not store any medications in their room. The Resident said the cups were their morning medications but he/she was not sure what they were and that the nurses always leave them there for him/her to take while he/she is eating breakfast or prior to their smoking time. The Resident said he/she believed the medications were left so he/she could take them when he/she was ready and because the nurses are busy, they don't have to come back for him/her to take them. When asked to look in the cup and try to identify what the medications were the Resident said they take a pill for sadness and something for their eyes because they cannot see well and some type of liquid but couldn't identify them by name or say what time they were supposed to be taken except in the morning. Review of the medical record indicated but was not limited to the following: - One self-administration of medication evaluation, dated 4/1/24, and indicated the Resident did not have a desire to self-administer their medications - Current, active physician's orders, dated 1/3/25, failed to indicate an order for Resident #59 to self-administer medications (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	01/07/2025

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Progress notes from 11/1/24 through 1/3/25 failed to indicate the Resident expressed a desire to self-administer medications or any steps were taken in the process to identify if it were safe to leave medications at the Resident's bedside. Review of the current care plans for Resident #59 indicated but were not limited to the following: FOCUS: Resident has difficulty seeing because of decreased visual acuity - cataracts (4/1/24) GOAL: Resident will not have an accident related to impaired vision for 90 days (4/1/24) INTERVENTIONS: Announce your presence so resident will not be startled (4/1/24) FOCUS: Resident has a past medical history of dysphagia and malnutrition - placing them at increase risk for difficulty swallowing (4/2/24) INTERVENTIONS: Aspiration precautions; verbally inform resident of location of food/drink items, slow pace (4/2/24) The care plans failed to indicate medications could be left at the bedside safely or the Resident was capable of self-administering. During an interview on 1/3/25 at 8:34 A.M., Nurse #7 reviewed the medication administration record and pill cards and bottles for Resident #59's morning medications with the surveyor. She said the Resident receives two capsules of Preservision AREDS (a multivitamin formulated for eye health) [two red large oval gelcaps}, Lexapro (an antidepressant) three small white tablets of 5 milligrams (mg) each to equal the prescribed dose of 15 mg, and 30 milliliters of liquid protein (light orange colored liquid). Nurse #7 confirmed these were the Resident's prescribed morning medications, verifying the surveyor's observation the previous morning of the medications left at the bedside. She said Resident #59 is visually impaired and has some intermittent confusion and cannot self-administer medications, does not have an order to self-administer medications and that medications should not have been left at the bedside for safety reasons. She said the process is for the licensed nurses to ensure that when residents are administered medications that they observe the residents take all of their medications prior to leaving the room and that process was not followed on 1/2/25. During an interview on 1/3/25 at 12:57 P.M., Nurse #8 said medications cannot be left at the bedside unless a resident has an evaluation to determine they can safely self-administer and there is a doctor's order and care plan in place. She said Resident #59 is confused at times and is vision-impaired and would not be capable of safely self-administering their own medications or having their medications left at the bedside because he/she would be likely to forget to take them timely. She said licensed nurses should remain with the Resident while they are taking their medications to ensure the medications are swallowed. During an interview on 1/3/25 at 3:25 P.M., the Director of Nurses was made aware of the surveyor's observations and said the Resident does not want to self-administer medications and wouldn't likely be capable of doing so. The Resident's medications should not have been left at the bedside for the Resident. The process for safe medication administration was not followed.

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	225488	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 34145 Based on record review and interview, the facility failed to ensure residents receiving psychotropic medications receive gradual dose reductions (GDR) unless clinically contraindicated, in an effort to discontinue these drugs for one Resident (#6), out of a total sample of 21 residents. Specifically, the facility failed to ensure a GDR of the antipsychotic medication Seroquel was attempted, unless documented by the prescriber as clinically contraindicated in the medical record. Findings include: Review of the facility's policy titled Psychotropic Medication Management, dated April 2015, indicated but was not limited to: -Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review. Resident #6 was admitted to the facility in September 2022 and had diagnoses including Alzheimer's disease, major depression, and anxiety. Review of the Minimum Data Set assessment, dated 10/25/24, indicated Resident #6 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status score of 3 out of 15, received antipsychotic medication on a routine basis only, a GDR has not been attempted, and has been documented by a physician as contraindicated on 10/11/24. Review of the Physician's Orders included the following medications: -Quetiapine Fumarate (Seroquel) 25 milligrams (mg) at bedtime, to be taken with 50 mg for total dosing 75 mg (10/27/22) -Quetiapine Fumarate 50 mg at bedtime to be taken with 25 mg for total dosing of 75 mg (10/27/22) Review of September 2024 through January 2025 Medication Administration Records (MAR) indicated Seroquel was administered to Resident #6 as ordered by the physician. During an interview on 1/3/25 at 2:12 P.M., consultant psychiatric Nurse Practitioner (NP) #3 said he sees Resident #6 on a routine basis for evaluation of psychotropic medications. He reviewed the Resident's medical record and said he thought he/she had had a GDR of Seroquel at some point. He reviewed the medical record and said the Resident has been treated with Seroquel since October 2022 with no GDR. Review of physician/NP notes, dated 8/30/24, 9/6/24, 10/4/24, 10/18/24, 11/7/24, 12/9/24, and 12/13/24, failed to indicate the Resident's treatment with Seroquel was evaluated for a GDR and failed to indicate a documented clinical rationale that a GDR of Seroquel was contraindicated, contrary to the 10/25/24 MDS assessment. (continued on next page)

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	225488	A. Building B. Wing	01/07/2025

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/7/25 at 11:56 A.M., the Director of Nursing (DON) reviewed Resident #6's medical record and said she has spoken to the physician in the past about her failure to document a clinical rationale for not initiating a GDR of psychotropic medication and will address it with her again. During an interview on 1/7/25 at 12:43 P.M., Physician #2 said she spoke with the DON a few minutes ago regarding documentation regarding a periodic evaluation of Seroquel for a potential GDR following surveyor inquiry. She said she had not documented a clinical rationale that a GDR was contraindicated and contacted her scribe in the office and directed her to add an addendum to her 12/10/24 progress note and forward it to the facility. During an interview on 1/7/25 at 2:30 P.M., the DON provided the surveyor with Physician #3's progress note dated 12/10/24. Review of the progress note indicated it was written and signed by Physician #3 on 1/7/25 at 2:28 P.M., following surveyor inquiry, and included a clinical rationale that a GDR of Seroquel was contraindicated.

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	225488	A. Building B. Wing	01/07/2025

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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. 34145 Based on observation and interview, the facility failed to ensure all medications used in the facility were safely and securely stored in accordance with currently accepted professional principles. Specifically, the facility failed to ensure unauthorized personnel do not have unsupervised access to medications in one of two medication rooms as required. Findings include: Review of the facility's policy titled Medication Storage Room/Medication Cart Policy, dated February 2018, indicated but was not limited to: -Medications are stored primarily in a locked mobile medication cart which is accessible only to licensed nursing personnel. -Storage for other medications will be limited to a locked medication room. On 1/3/25 at 2:15 P.M., the surveyor observed consultant psychiatric Nurse Practitioner (NP) #3 ask Nurse #2 to unlock the medication room so he could go inside and make a telephone call. Nurse #2 unlocked the medication room, and opened the door. Multiple medications, including emergency kits which contain medications including but not limited to anticoagulants, insulin, antibiotics, and antipsychotic medications, were observed on shelves inside the medication room. NP #3 went inside the medication room alone and closed the door. During an interview on 1/3/25 at 2:16 P.M., Nurse #2 confirmed that she had unlocked the medication room and allowed NP#3 to enter the room alone and remain in the room unaccompanied to make a telephone call. She said it was fine for him to be in the medication room alone. Nurse #9 was seated at the nursing station and said it was acceptable for NP#3 to enter the medication room and remain in there unaccompanied to make a telephone call. During an interview on 1/3/25 at 2:35 P.M., the Administrator said NP #3 should not have been allowed to enter and remain in the medication room alone. He said only nurses have keys and should be the only ones with access to the medication room.

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	225488	A. Building B. Wing	01/07/2025

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 42742 Based on observation, interview, and record review, the facility failed to ensure staff provided food that accommodated the allergies, intolerances, and preferences of one Resident (#85), out of a total sample of 21 residents. Specifically, the facility failed to ensure the Resident was not served gluten (a protein found in some grains including wheat) and onions despite being listed as allergens in the Resident's medical record; and sausage despite preferences listed to not receive. Findings include: Review of the facility's policy titled Allergies, dated April 2015, indicated but was not limited to the following: Policy: -To identify and respond to all allergic reactions. Procedure: -Interview resident/family to determine if there are any allergies to food/drugs, or other substances. -Review all clinical documents to determine if there are any allergies. -Record allergies on Physician's Order Sheet and Medication and Treatment Administration Record (MAR and TAR). -Notify the Dietary Department if there are any food allergies. Review of a U.S. Foods Menu Solutions document titled Gluten Restricted Diet, dated November 2019, indicated but was not limited to the following: -Gluten-restricted diets are required for the medical management of celiac disease or gluten sensitivity. Removal of gluten from the meal plan is essential for gastrointestinal (GI) health for individuals with these conditions. -To assure a Gluten Free menu, all products purchased to be used for recipes on this diet must be reviewed for gluten content. Resident #85 was admitted to the facility in August 2024 with diagnoses including irritable bowel syndrome with diarrhea (IBS- digestive condition that causes abdominal symptoms including constipation, diarrhea, gas, and bloating). Review of the Minimum Data Set (MDS) assessment, dated 11/15/24, indicated that Resident #85 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. (continued on next page)

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	225488	A. Building B. Wing	01/07/2025

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of current Physician's Orders indicated the following: -Allergies: Celery, chicken, fish and seafood, gluten, hard cheese, onions, shellfish -Gluten free diet, regular consistency texture, thin (regular) liquids consistency, multiple food allergies and intolerances for diet order, 8/29/24 Review of Resident #85's physician's Progress Note, dated 8/23/24, January 2025 MAR and TAR, and the Certified Nursing Assistant (CNA) Resident Care Card indicated the following: -Allergies: Celery, chicken, fish and seafood, gluten, hard cheese, onions, shellfish Review of the Nutritional Evaluation, dated 11/15/24, indicated the following: -Food Allergies: Shellfish allergy, gluten, onion, celery, lactose, chicken, fish, see list Review of a physician's Progress Note, dated 11/12/24, indicated the following: Diet and Allergy Management: -Maintain gluten free diet with regular consistency and thin liquids. Educate nursing and dietary staff to avoid known allergens and prevent cross-contamination in meal preparation. During an interview on 1/2/25 at 9:07 A.M., Resident #85 said he/she had multiple food allergies, and the facility is careless with food choices. The Resident said he/she has spoken to the Dietitian and Ombudsman with limited resolution. During an interview on 1/6/25 at 12:00 P.M., Resident #85 said the lunch tray had just been delivered which consisted of beef stew with gravy, but he/she refused it because there were onions in it, and he/she can't have gluten. The Resident said these foods will wreck his/her GI track and gets very nervous about the food at the facility and is afraid to eat it. The Resident said last night sausage was on the tray which has chicken in it and isn't supposed to have that either. The Resident said if he/she eats food that he/she is allergic to or intolerant of he/she will end up puking and [expletive] my brains out. The Resident said the facility offered gluten free bread, but he/she was not able to distinguish it from other breads so was too nervous to eat it. Resident #85 said the Director of Nursing (DON) and nursing staff are aware of the concern, but nothing has changed so he/she just relies on Cheerios, apple juice, and protein powder that's stored in their room. On 1/6/25 at 12:10 P.M., the surveyor, with CNA #4 and Resident #85 present, observed Resident #85's lunch meal tray and meal ticket stored on the food truck. The lunch tray consisted of beef stew including gravy, potatoes, green beans, and carrots. The Resident said there were onions in it as well showing the surveyor. It was unclear at the time of the observation if the gravy contained gluten. Review of Resident #85's meal ticket indicated the following: -Diet Order: Regular texture, gluten free, thin fluids -Allergies: Celery, chicken, fish and seafood, gluten, hard cheese, onions, shellfish (continued on next page)

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	225488	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Notes: No sausage During an interview on 1/6/25 at 12:22 P.M., with Nurse #1, CNA #5 and CNA #6, Nurse #1 said Resident #85 is allergic to hard cheeses, fish, onions, and is gluten free. She said the Resident gets irritated a lot of times because the kitchen doesn't have anything he/she can eat, just hamburgers and mashed potatoes. CNA #5 and CNA #6 said there aren't many snacks the Resident can have on the unit either. CNA #5 said the kitchen will just put a hamburger on a plate or egg salad with nothing else on the plate and did not feel that was right or presentable to the Resident. Nurse #1 said she did check the Resident's lunch tray this day and didn't see onions on it. During an interview on 1/6/25 at 3:31 P.M., the Food Service Director (FSD) said he used to have gluten free bread for Resident #85, cookies, and snacks but he/she didn't want them, so he stopped ordering them. He said he used the same toaster for the Resident's gluten free bread as other breads but toasted it first and would do a deep clean on the toaster. The FSD reviewed the gravy mix label used for the beef stew with the surveyor and said it contained gluten. The FSD said Resident #85 should not have gotten the beef stew because it had gluten and onions in the mix. On 1/7/25 at 8:15 A.M., the surveyor reviewed the Resident's breakfast meal tray with the Resident and CNA #7. The breakfast tray consisted of scrambled eggs, one hard-boiled egg, and two pieces of sausage. Resident #85 said, I can't have sausage and refused the tray. During an interview on 1/7/25 at 8:20 A.M., the surveyor reviewed the Resident's breakfast tray with Nurse #1. Nurse #1 said she checked the Resident's tray but didn't see the sausages on it. She said it was her responsibility to check the trays to ensure there were no foods on it that shouldn't be. She and CNA #7 said the Resident receives food items on his/her tray he/she shouldn't have every day. During an interview on 1/7/25 at 8:38 A.M., Resident #85 said he/she was intolerant of sausage and if ingested he/she will end up on the commode with diarrhea and would need a puke bucket at the same time. On 1/7/25 at 12:00 P.M., the surveyor reviewed the A-Unit Nourishment Kitchen with the Assistant Director of Nursing (ADON) who said the unit had no snacks to offer the Resident that he/she could have other than one frozen Lactaid ice cream in the freezer. During an interview on 1/7/25 at 12:25 P.M., the FSD said when a resident is admitted they inform staff of allergies. He said he speaks with the resident about their allergies as well as their likes and dislikes and does a menu with them. He said he used to do a menu with Resident #85, but he/she didn't want to do it anymore so dietary staff now just focuses on what he/she can have but it's very limited. The FSD said the Resident frequently sends the tray back. The FSD said the Resident should not have received the beef stew or sausages on his/her meal tray. During an interview on 1/7/25 at 12:38 P.M., the DON said nursing reviews allergies with all new admissions, and they get added to the electronic medical record. She said the pharmacy is made aware as well as the kitchen where a meal ticket gets printed out listing the allergies and intolerances. She said Resident #85 should have received the diet as prescribed by the physician.

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	225488	A. Building B. Wing	01/07/2025

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

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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. 43935 Based on observation, interview and record review, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment, and to help prevent the development and potential transmission of communicable diseases and infections for four Residents (#294, #295, #40 and #144), out of a total sample of 21 residents. Specifically the facility failed: 1. For Resident #294, to maintain sanitary conditions of a nebulizer tubing set up and mask (parts of the nebulizer to administer aerosolized medications); 2. For Residents #295 and #40, to ensure appropriate personal protective equipment (PPE) was worn by staff while providing close contact care for a Resident on Enhanced Barrier Precautions (EBP); and 3. For Resident #144, to ensure appropriate personal protective equipment (PPE) was worn by staff while providing close contact care for a Resident on EBP and contact precautions. Findings include: 1. Review of the National Health, Blood and Lung institute document on How to use a Nebulizer, dated October 2021, indicated but was not limited to the following: How to store between uses: Store nebulizer parts in a dry clean plastic bag Resident #294 was admitted to the facility in December 2024 with diagnoses including: Chronic obstructive pulmonary disease (COPD) (a lung illness resulting in difficulty breathing). Review of the Nursing Admission Evaluation indicated the Resident was alert and oriented to person, place, and time. Review of the Self-Administration evaluations, dated 12/26/24, indicated but were not limited to the following: - Nebulizer: the Resident was capable of independently inhaling nebulizer medications by handheld device - the Resident did not express a desire to self-administer medications Review of the Resident's current interim care plans failed to indicate any information on the use of the nebulizer. (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	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/2/25 at 8:01 A.M., the surveyor observed the Resident in bed with his/her eyes closed and a nebulizer machine on the floor on the right side of the bed (not on) with the tubing and mask attached, not in use by the Resident, tucked slightly behind the pillow on the right side of the bed. The face mask and tubing were not stored in a plastic bag to protect them from environmental debris or germs while not in use. No plastic storage bag was observed in the room for the storage of the nebulizer tubing. Review of the current Physician's Orders for Resident #294, dated 1/2/25, indicated but were not limited to the following: - Formoterol Fumarate (a medication used to treat COPD) nebulizer solution 20 micrograms (mcg) per 2 milliliters (ml) orally via nebulizer two times a day related to COPD - Ipratropium albuterol (a medication used to open up the airways) inhalation solution 0.5 - 2.5 (3) milligrams (mg) per 3 ml every 4 hours as needed for shortness of breath, nebulizer - Change nebulizer tubing every Sunday night shift The surveyor made the following observations throughout the survey: 1/2/25: 3:21 P.M., Resident in bed, nebulizer mask not in use, nebulizer machine in the off position, tubing and mask lying on the bed, not stored in a plastic storage bag 1/3/25: at 7:41 A.M., 12:41 P.M., and 1:05 P.M., Nebulizer mask not in use, nebulizer machine in the off position, tubing and mask lying on the bed, not stored in a plastic storage bag - no storage bag observed in the room. During an interview on 1/3/25 at 7:41 A.M., Resident #294 said he/she keeps the mask close by in case they need a nebulizer treatment. He/She said they do not self-administer and the medications are provided by the nurses. The Resident said he/she was not provided with a bag to store the mask in between uses and the staff are aware he/she is leaving it on his/her bed with the machine on the floor because there is nowhere else to put anything. During an interview on 1/3/25 at 1:05 P.M., Nurse #8 said she had not recently provided a nebulizer treatment to the Resident. She said the process is usually to set up the treatment for the residents by placing the medications in the cup securing the mask or mouthpiece to the cup, turning on the machine and handing the device to the residents or helping them put the mask on. She said once the treatments are complete the tubing and medication cup are rinsed out and dried and then the pieces are stored in a plastic bag to keep them free of germs until the next use. She observed Resident #294's nebulizer mask and tubing on the linens of the Resident's bed not stored in a plastic bag and open to potential germs and environmental debris and said the mask and tubing should not be left on the bed for infection control reasons and the machine shouldn't be on the floor. During an interview on 1/3/25 at 1:23 P.M., the Infection Preventionist said the nebulizer machine should not be left on the floor for any resident as it could become an infection control concern. She additionally said that nebulizer tubing including the mask or mouthpiece should be stored in a plastic bag to keep it clean and free of potential germs when not in use and in this circumstance that did not occur as it should have. (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	01/07/2025

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/3/25 at 1:28 P.M., the Assistant Director of Nurses said she observed Resident #294's nebulizer machine on the floor and nebulizer tubing and mask resting on the bed. She said the equipment was not being managed and stored in an appropriate manner as it should have been. 2. Review of the facility's policy titled Enhanced Barrier Precautions, undated, indicated but was not limited to the following: It is the policy to implement EBP for preventing transmission of novel or targeted multi-drug resistant organisms (organisms that are resistant to all or most antibiotics) - EBP require the use of gown and gloves for certain residents during specific high contact resident care activities in which there is an increase risk for transmission of multi-drug resistant organisms. - Orders for EBP will be obtained, signage will be posted on the door or wall outside the room, carts with appropriate PPE will be outside the room, alcohol-based hand rub (ABHR) will be available for performing hand hygiene (HH) - EBP will be continued while the qualifying condition or indwelling device is still active or in use Review of the EBP sign in use by the facility, undated, indicated but was not limited to the following: Enhanced Barrier precautions, Everyone must: Clean their hands before entering and when leaving the room Providers and staff must also: Wear gloves and gown for the following High-Contact Resident Care Activities: Dressing, bathing, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, Device care or use of: central line, urinary catheters, feeding tubes, tracheotomies; wound care any skin opening requiring a dressing A. Resident #295 was admitted to the facility in December 2024 with diagnoses including: Open wound to right great toe. Review of the most recent Brief Interview for Mental Status (BIMS) for the Resident indicated he/she was cognitively intact with a score of 14 out of 15. On 1/2/25 at 8:36 A.M., the surveyor observed an EBP sign posted outside of Resident #295's bedroom door. During an observation with interview on 1/2/25 at 8:37 A.M., the surveyor observed Resident #295 in bed with a single lumen peripherally inserted central catheter (PICC) line in his/her right arm. The Resident said they were on antibiotics for an infection in their toe and received the medication through the PICC line three times a day. (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	01/07/2025

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Resident record indicated but was not limited to the following: - Resident had a single lumen PICC line inserted into their right arm (in the basilic vein) on 12/17/24 - a baseline care plan was in place for use of the IV PICC line Review of the current Physician's Orders as of 1/2/25 indicated but were not limited to the following: Enhanced barrier precautions - every shift (12/20/24) During an observation with interview on 1/2/25 at 4:33 P.M., Nurse #5 said the Resident had just completed his/her dose of intravenous (IV) antibiotics and she was going to disconnect the PICC from the infusion pump. The surveyor observed Nurse #5 perform HH, don (put on) gloves, and then disconnect the IV tubing from the PICC line. Then, she flushed the PICC line with the prepared syringe of solution, doffed (took off) her gloves performed HH and left the room. At no time did the surveyor observe Nurse #5 to don a gown. Upon leaving the room, Nurse #5 confirmed that the Resident was on EBP for his/her wound and IV line. Nurse #5 said she was not aware that a gown needed to be worn when caring for the PICC line even though it is indicated on the sign posted outside of the Resident's room. During an observation with interview on 1/3/25 at 9:08 A.M., the surveyor observed Nurse #7 administer the Resident's IV antibiotic medication. Nurse #7 performed HH, donned gloves, attached the IV medication to the IV tubing, primed the line, flushed the PICC line, and then hooked the IV tubing up to the PICC line in the Resident's right arm. At no time was Nurse #7 observed to don a gown. She said the Resident is on EBP for having a wound and a central line and she should have worn a gown for that reason during the IV administration and forgot. She reviewed the EBP sign with the surveyor and said a gown should be worn during use or management of the IV line as it is a high-contact care activity and she did not wear one. During an interview on 1/3/25 at 11:18 A.M., the Director of Nurses (DON) said residents who are on EBP require staff to wear both gloves and a gown when providing high contact care. She was made aware of the surveyor's observations and said the Nurses should have put a gown on before providing any care or using the IV PICC line for Resident #295 in accordance with the guidelines and that expectation was not met. 34145 B. Resident #40 was admitted to the facility in November 2021 and has a history of Extended-Spectrum Beta-Lactamase (ESBL-a type of enzyme produced by certain bacteria that makes them resistant to a wide range of antibiotics). Review of Physician's Orders indicated but was not limited to: -Enhanced barrier precautions related to history of ESBL, every shift (12/25/24) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/3/25 at 8:03 A.M., the surveyor observed an EBP sign posted at Resident #40's doorway to indicate the Resident was on EBP and what PPE was to be worn for close contact care. The surveyor observed Certified Nurse Aide (CNA) #4 at Resident #40's bedside adjusting the bed linens wearing gloves and no gown. She told the Resident she was going to go get someone to assist her and left the room. On 1/3/25 at 8:09 A.M., CNA #4 returned to the Resident's room with CNA #2. Both CNAs wore gloves and no gown. CNA #4 placed shoes on the Resident's feet, then CNA #2 and CNA #4 physically assisted the Resident from a lying position to a seated position at the edge of the bed. At this time, CNA #3 entered the room, donned gloves, stood behind a wheelchair at the bedside, and assisted the other two CNAs to pivot the Resident and physically assist the Resident to sit in the wheelchair. During an interview on 1/3/25 at 8:13 A.M., CNA #3 said she didn't know Resident #40 was on EBP and only wore gloves when assisting the Resident into the wheelchair. She said if she knew the Resident was on EBP, she would have worn a gown and gloves. During an interview on 1/3/25 at 8:20 A.M., CNA #4 said when she repositioned the Resident and assisted him/her into the wheelchair, she did not wear a gown, just gloves. She said she didn't know she had to wear a gown when she repositioned the Resident. During an interview on 1/3/25 at 9:55 A.M., CNA #2 said she didn't know Resident #40 was on EBP and only wore gloves when assisting him/her into the wheelchair. During an interview on 1/6/25 at 11:30 A.M., the DON said CNAs #2, #3 and #4 should have worn gown and gloves when providing high contact care to Resident #40. 3. Review of Lippincott Nursing Procedures- 9th edition, dated 2023, section titled Contact Precautions, indicated but was not limited to: -Equipment: gowns, gloves, plastic bags, contact precaution signs; -Perform hand hygiene; -Put on a gown and gloves before entering the patient's room to comply with contact precautions; -Handle all items that have come in contact with the patient as you would for a patient on standard precautions; -Remove and discard your gown and gloves before leaving the room; -Perform hand hygiene before leaving the patient's room. Resident #144 was admitted to the facility in December 2024 and had diagnoses including ESBL in the urine and had a gastrostomy tube. Review of Physician's Orders indicated but was not limited to: -Enhanced barrier precautions related to history of ESBL, every shift (1/2/25) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Contact Precautions at all times due to ESBL Urine every shift until 1/6/25 (1/2/25) On 1/6/25 at 10:34 A.M., the surveyor observed an EBP sign and a contact precaution sign posted outside the doorway of Resident #144's room. The surveyor observed CNA #1 wearing gloves and no gown in the room physically assisting Resident #144 to get up from his/her bed. The CNA physically assisted the Resident to ambulate across the room and into the bathroom and closed the door. On 1/6/25 at 10:45 A.M., the surveyor observed CNA #1 and Resident #144, emerge from the bathroom and the CNA physically assisted the Resident to walk across the room and sit back onto the bed. The CNA adjusted the Resident's bed linen and clothing. During an interview on 1/6/25 at 10:46 A.M., CNA #1 said this was her first time working with Resident #144 and she didn't know he/she was on any type of precaution. The surveyor pointed out the contact precaution sign and EBP sign posted at the Resident's door. The CNA read the signs and said she should have worn a gown in addition to the gloves when she physically assisted the Resident with walking and when she toileted and changed the Resident. During an interview on 1/6/25 at 11:30 A.M., the DON said CNA #1 is new and she should have worn a gown and gloves when providing high contact care.