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	02/11/2026

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 - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, document review, and interview, the facility failed to ensure professional standards of practice were maintained when providing care for three Residents (#14, #75, and #10), out of a total sample of 19 residents. Specifically, the facility failed to ensure:1. For Residents #14 and #75, narcotic pain medications were administered in accordance with the prescribed parameters in the physician's order; and 2. For Resident #10, a splint/palm guard was not applied to the Resident's left hand after it was discontinued. Findings include: Review of [NAME], Manual of Nursing Practice 11th edition, dated 2019, indicated the following: -The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated: -Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescriber's 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. -In any situation where an order is unclear, or a nurse questions the appropriateness, accuracy, or completeness of an order, the nurse may not implement the order until it is verified for accuracy with a duly authorized prescriber. 1. 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 MAR -Verify that the medication is being administered at the proper time, in the prescribed dose and by the correct route. A. Resident #14 was admitted to the facility in May 2024 with diagnoses including chronic pain. Review of Resident #14's medical record indicated but was not limited to the following: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(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 - Some	-Care plan for Pain/Potential for pain with intervention to administer pain medication as ordered (5/21/24) -Last pain evaluation, completed on 1/18/26 indicating use of the verbal pain scale, frequent pain that is relieved with rest and/or medications -Order: Oxycodone HCL (a narcotic pain medication) 5 milligrams (mg), give one tablet by mouth every six hours (Q6hrs) as needed (PRN) for severe pain of 6-10 on the pain scale (11/3/25) Review of Resident #14's MARs for January 2026 and February 1-10, 2026, indicated but was not limited to the following: January 2026: Oxycodone HCL 5mg one tab by mouth Q6hrs PRN for severe pain of 6-10 on pain scale (11/3/25) Oxycodone was administered 14 times outside of the ordered parameters as followed: 9 times for a pain rating of 5 out of 10 (on the 0-10 verbal-numeric pain scale), twice for a pain rating of 4 out of 10, twice for a pain rating of 3 out of 10, and once for a pain rating of 0 out of 10. February 1-10, 2026: Oxycodone HCL 5mg one tab by mouth Q6hrs PRN for severe pain of 6-10 on pain scale (11/3/25) Oxycodone was administered twice outside of the ordered parameters as followed: one time for a pain rating of 5 out of 10 and one time for a pain rating of 4 out of 10. During an interview on 2/10/26 at 11:05 A.M., Nurse #3 said she knows the Resident very well. She said the Resident's pain is usually in his/her neck, back or legs and is typically rated at about a 5 on the 0-10 pain scale. On review of the MAR, Nurse #3 was identified as one of the Nurses who was administering the Oxycodone outside of the ordered parameters. She said the Oxycodone is ordered to be administered as needed if the Resident's pain is at least a 6 out of 10, and he/she has received it multiple times for pain levels below the ordered parameter. She said the Oxycodone had been administered without following the physician's order. During an interview on 2/10/26 at 12:19 P.M., the Unit Manager said the process for administering PRN pain medications is for the nurses to assess the residents and ascertain a pain rating prior to administering a PRN to ensure the orders are followed and then re-evaluate the resident's pain to ensure effectiveness. On review of the MARs for Resident #14, she said the Resident had been administered his/her PRN Oxycodone outside of the physician ordered parameters and the expectation is for physician's orders to be followed as written and in this circumstance that had not occurred. B. Resident #75 was admitted to the facility in June 2025 with diagnoses including: hypertension, peripheral vascular angioplasty (procedure to unblock narrowed or clogged arteries), and had recently undergone a right knee arthroplasty. Review of Resident #75's medical record indicated but was not limited to the following: (continued on next page)

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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 - Some	-Care plan for Pain with intervention to administer pain medication as ordered (6/10/25) -Last comprehensive pain evaluation, completed on 2/8/26 indicating use of the verbal pain scale, frequent pain that is relieved with rest, polar ice and/or medications -Order: Oxycodone HCL 10 mg, give one tablet by mouth every four hours (Q4hrs) PRN for severe pain of 6-10 on the pain scale (2/7/26) Review of Resident #75's MARs for January 2026 and February 1-10, 2026, indicated but was not limited to the following: January 2026: Oxycodone HCL 5mg two tabs by mouth every 8 hours (Q8hrs) PRN for moderate-severe pain, 6-10 on pain scale (12/7/25) Oxycodone was administered 20 times outside of the ordered parameters as followed: 15 times for a pain rating of 5 out of 10, three times for a pain rating of 4 out of 10, and twice for a pain rating of 0 out of 10. February 1-10, 2026: Oxycodone HCL 5mg two tabs by mouth Q8hrs PRN for moderate-severe pain, 6-10 on pain scale (12/7/25) Oxycodone was administered once outside the ordered parameters for a pain score of 3 out of 10. During an interview on 2/10/26 at 11:19 A.M., Nurse #3 said she knows the Resident very well and cares for them often. She said the Resident recently had a knee surgery and is using both his/her PRN pain medications and a polar care system to manage their pain. On review of the MAR, Nurse #3 was identified as having administered the PRN Oxycodone numerous times outside of the ordered parameters. She said the Resident received the medications outside of the ordered parameters and the orders should be followed. During an interview on 2/10/26 at 12:21 P.M., the Unit Manager reviewed the Residents' MARs for January and February 2026. She said the Nurses are administering the Oxycodone outside of the prescribed order parameters and they should be following the physician's orders as written. She said the physician's order is not being consistently followed for this Resident's pain medication administration. During an interview on 2/10/26 at 1:28 P.M., the Director of Nurses (DON) reviewed the MARs and said the Nurses didn't follow the prescribed physician's parameters in the order as required. 2. Review of the facility's policy titled Splints/Orthotics/Prosthetics, dated April 2015, indicated but was not limited to the following: -Residents will receive splint/orthotic/prosthetic devices as deemed appropriate by the physician and rehabilitation services. Staff will monitor the circulation and skin integrity of residents using these devices at least every shift as part of routine care, or more often as ordered by the physician. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Nursing staff will apply/remove the designated splint/orthotic/prosthetic device during the scheduled wearing times. Resident #10 was admitted to the facility in February 2024 with diagnoses which included hemiplegia (paralysis affecting one side) and hemiparesis (weakness or partial paralysis affecting one side) following intracerebral hemorrhage (stroke resulting in bleeding into the brain) affecting left dominant side, weakness, protein calorie malnutrition, and dementia. Review of the Minimum Data Set (MDS) Assessment, dated 10/24/25, indicated he/she was rarely/never understood and was dependent on staff for care. The surveyor made the following observations: -2/5/26 at 12:16 P.M., he/she was lying in bed with left palm guard on. -2/10/26 at 11:30 A.M., he/she was sitting in Broda recliner chair with left palm guard on. -2/10/26 at 1:40 P.M., he/she was sitting in Broda recliner chair with left palm guard on. -2/10/26 at 2:27 P.M., he/she was sitting in Broda recliner chair with left palm guard on. Review of the active Physician's Orders failed to indicate an order for a left palm guard. Review of the Comprehensive Care Plan failed to indicate a left palm guard should be in place. Review of the Physiatry (physical medicine and rehabilitation) progress note, dated 1/27/26, indicated he/she had a left-hand contracture, and therapy had been applying a hand splint. Review of the Occupational Therapy Discharge summary, dated [DATE], indicated the left palm guard was discontinued from the plan of care as not indicated at this time. Review of the discontinued Physician's Orders indicated the order for the left palm guard was discontinued on 2/5/26 at 10:00 A.M. because it was no longer needed. Review of the Comprehensive Care Plan history indicated the intervention for a left palm guard had been resolved on 2/5/26. During an interview on 2/10/26 at 2:45 P.M., Certified Nursing Assistant (CNA) #3 said Resident #10 wears the left palm guard every day. She said she was not assigned to him/her today, but typically the CNAs will put it on when they wash him/her in the morning. She said it was written on the Resident Care Card (a reference sheet for the CNAs to know how to care for each individual resident). Review of the Resident Care Card for Resident #10, last revised on 1/12/26, indicated but was not limited to the following: SPLINTS/BRACES/IMMOBILIZERS: -TYPE: palm guard (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-WHERE: left hand -WHEN: at all times During an interview on 2/11/26 at 12:31 P.M., Nurse #4 said splints are ultimately the nurse's responsibility. She said they will populate on the Treatment Administration Record (TAR) when to apply, remove, and to check the skin. She said therapy and the CNAs apply them as well, but the nurse must double check they are on if they should be on and off if they should be off. She said when a resident has a splint it is written in the orders, the care plan, and on the Resident Care Card so the aides know to put it on. She said Resident #10's splint should not have been applied after the order was discontinued. She said when a splint is discontinued the nurse taking the order should also discontinue it from the Resident Care Card, so everyone knows it was discontinued. During an interview on 2/11/26 at 12:37 P.M., Nurse #5 said she was unable to locate the Resident Care Card binder, but if the splint was discontinued it should no longer be on the Resident Care Card. During an interview on 2/11/26 at 12:47 P.M., Resident Care Assistant (RCA)/CNA #2 said she was in charge of updating the Resident Care Cards. She said they are updated at the quarterly care plan meetings, but she also gets a weekly order report to look for changes, and sometimes at morning meeting she would be told things that should be on the Resident Care Card to update them. She said the nurses could update them in the interim, but she was unsure if they do. During the interview she provided the surveyor with the updated Resident Care Card for Resident #10. This Resident Care Card indicated the palm guard was discontinued. She said the Staff Development Coordinator (SDC) updated it yesterday (2/10/26) afternoon after surveyor inquiry. During an interview on 2/11/26 at 1:00 P.M., the SDC said she discontinued the palm guard from the Resident Care Card and did education with the staff yesterday (2/10/26) afternoon. She said it should have been discontinued from the Resident Care Card on 2/5/26 and the palm guard should not have been applied after that date. Additionally, she said RCA/CNA #2 updates the Resident Care Cards, but she was unsure how often they were updated or how she got the information to update them. She said the nurses on the unit should be updating them with any day-to-day changes. She said the Resident Care Card was never updated and the CNAs were not educated on the change, so the CNAs probably kept applying it every day because Resident #10 had it for so long. During an interview on 2/11/26 at 1:20 P.M., the DON said the Resident Care Card should reflect the care the individual resident needs. She said the Resident Care Card is usually updated by the RCA/CNA #2, though the nurses can update them. She said the team reviews new orders in the morning to see what changes to the Resident Care Cards need to be made. She said in this case the splint was discontinued on 2/5/26 and it was not discontinued from the Resident Care Card. She said the palm guard should not have been applied after it was discontinued on 2/5/26. She said the CNAs were following the Resident Care Card, but unfortunately it was not accurate, and was not updated.

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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. Based on observation, interview, and document review, the facility failed to maintain an infection prevention and 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. Specifically, the facility failed to:1. Maintain an infection prevention and control program which included a complete and accurate system of surveillance to identify any trends or potential infections; and2. Ensure nasal cannula oxygen tubing was stored in a sanitary manner to protect it from potential contamination by germs and environmental debris for one Resident (#14), out of a total sample of 19 residents. Findings include: 1. Review of the facility's policy titled Infection Control Program, undated, indicated but was not limited to the following: -The facility has a system in place for prevention, identification, reporting and control of infections and communicable diseases of residents-Responsibility for ongoing collection and analysis of data and required follow up is assigned to the Infection Preventionist (IP)-Elements include but are not limited to monitoring and documenting infections, tracking and analyzing outbreaks of infections, managing resident health initiatives and provisions of early uniform identification and reporting of infections-Perform surveillance and investigation of infections to prevent, to the extent possible, the onset and spread of infection-Ensure compliance with all State and Federal regulations related to infection control and preventionSurveillance for Healthcare associated infections (HAI)s-Surveillance is defined as the ongoing, systematic collection, analysis, interpretation and dissemination of data-The facility will closely monitor all residents who exhibit signs/symptoms (s/s) of infection-The IP will gather additional data for infection tracking and reporting-The IP or designee will monitor the residents with infections and/or potential infections by completing the monthly infection report During an interview on 2/10/26 at 8:15 A.M., the Director of Nurses (DON) said the facility uses McGeer criteria to determine if an illness rises to the level of an infection for their surveillance program. Review of the McGeer criteria checklist in use by the facility, indicated but was not limited to the following: Category: Urinary tract infection (UTI)Criteria: Must fulfill both 1 AND 2. 1. At least one of the following signs and symptoms:- Acute dysuria (painful urination)- Fever or leukocytosis, and more than one of the following: acute costovertebral angle pain; suprapubic pain; gross hematuria; new or increase incontinence; new or increase urgency; new or increase frequency- If no fever than more than two of the above symptoms 2. At least one of the following microbiologic criteria- greater than 100,000 organism count of no more than two organisms on a voiding sample (urination in a cup/bag)- greater than 100,000 organism count of any organisms in a specimen collected by an in and out catheter (straight cath) Category: Pneumonia (PNU) (all three criteria must be present)1. A chest x-ray (CXR) positive for pneumonia or new infiltrate2. At least 1 of the following respiratory sub-criteria: new or increase cough, new or increase sputum production, Oxygen (O2) saturation less than (<) 94% on room air (RA) or a reduction in O2 saturation of greater than (>) 3% from baseline, new or changed lung examination abnormalities, pleuritic chest pain, respiratory rate of equal to or > 25 breaths per minute3. At least 1 of the constitutional criteria: fever, leukocytosis, acute change in mental status from baseline, acute functional decline Review of the Surveillance/Line listing sheets in use by the facility included the following categories: Name, Room #, Category, Date of onset (DOO), s/s (signs and symptoms), culture date, site, results, treatment, infection cleared, comments, final status (HAI/CAI), Count as infection (Y/N) Review of the facility line listings for November 2025 through January 2026 indicated but were not limited to the following: NOVEMBER 2025Resident #86, Category: UTI; DOO: 11/11; s/s: increased confusion (cf); culture (cx) date: 11/6; site: urine; results: positive (+); treatment: Ertapenem; final status: HAI; count: Y Review of the medical record for Resident #86 indicated the Resident also had signs and symptoms including a decrease in functional ability and the culture came back with E-coli as the predominant germ. The surveillance line listings did not include the results of the culture, and the signs and symptoms indicated on the line listing did (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not meet McGeer criteria for the illness to be counted as a UTI infection. In addition, there were three other UTIs under surveillance that did not include culture date or germ results making the surveillance both incomplete and inaccurate. DECEMBER 2025:Resident #5, Category: PNU; DOO: 12/18; s/s: temperature (T), cf; culture date, site and results are all blank; treatment: Macrobid; final status: HAI; Count: Y Review of the medical record for Resident #5 indicated signs and symptoms began on 12/15 and included swollen glands, sore throat, lethargy, dysuria, T, O2 saturation (O2 sat) of 84-86% on room air. The Resident was then hospitalized on 12/16. The facility line listing failed to include signs and symptoms that would indicate the Resident had met the criteria for a pneumonia infection and in addition did not reflect the correct date of onset for signs and symptoms. In addition, four additional residents were indicated for pneumonia on the surveillance without chest x-ray results documented on the sheets as well as one UTI without culture results making the surveillance sheets incomplete and inaccurate.Further review of the facility documents for December 2025 failed to indicate on their monthly infection analysis that any residents had any respiratory infections in December. JANUARY 2026Resident #68, Category: PNU; DOO 1/1; s/s: lethargy, T; results: CXR +; treatment: Augmentin; final status: HAI; count: Y Review of Resident #68's medical record indicated the Resident also had signs and symptoms of wheezes in the lungs (an abnormal lung sound made when air is not well exchanged). Resident #9, Category: UTI; DOO: 1/8; s/s: dysuria; culture date and site were blank; results: +; treatment: Macrobid; final status: HAI; count: Y Review of Resident #9's medical record indicated the Resident began exhibiting signs and symptoms of illness on 1/5 which included: urgency and increase frequency. Resident #41, Category: ESBL Urine; DOO 1/6; s/s: cf, lethargy; culture date and site were blank; results +; treatment: Ertapenem; final status: HAI; count: Y Review of Resident #41's medical record indicated the Resident began exhibiting signs and symptoms of an illness on 1/2 becoming unresponsive with a change in vital signs and resulting in hospitalization for sepsis (the body's extreme reaction to an infection). The facility surveillance line listings were inaccurate and did not include signs and symptoms of the category infections for Resident #68, #9 and #41. In addition, the line listings had incorrect dates of symptom onset for both Resident #9 and #41 and both UTI infections did not include the germ identified in the results column indicating the surveillance sheets were also incomplete. During an interview on 2/11/26 at 10:19 A.M., the IP confirmed the facility uses McGeer criteria to determine if an illness rises to the level of an infection. She said the surveillance sheets are line listing sheets provided by the laboratory and all sections should be completed for accuracy. She said the purpose of completing the line listings is to track all signs and symptoms of illness or infection and monitor the residents in one area that is easy for anyone to follow to identify a possible increase in illness or outbreak. The IP reviewed the line listings for December 2025 through January 2026 and said she does not use date of onset (DOO) as the date signs and symptoms were first identified and sometimes places the date a culture was done or the antibiotic was started in that section. She said she should be using the date of illness onset to better track and monitor any potential links. She said she doesn't complete the culture results section with the identified germ because the lab has the information. She said the lab results section should be completed to be able to identify if a specific germ is emerging in the facility. She said on review of the sheets, the sheets also don't have all the required signs and symptoms documented for each resident to indicate that McGeer criteria was met and therefore the illness was counted as an infection in the facility. She said looking at the sheets it appears the process needs work since the documents are both inaccurate and incomplete making the evaluation information incomplete and affecting the ability of the facility to properly evaluate their program. During an interview on 2/11/26 at 11:29 A.M., the DON reviewed the November 2025 through January 2026 line listings and monthly evaluation report documents. She said the expectation is that all the necessary information for monitoring, tracking and trending signs and symptoms and germs is documented on the line listings, so they are complete and accurate, and it does not appear that that had occurred. 2. Review of the facility's policy titled Oxygen Administration Nasal Cannula, dated as revised November 2020, indicated but was not limited to the following: -The (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nasal cannula will be stored in a plastic bag and maintained off the floor (when not in use) Resident #14 was admitted to the facility in May 2024 with diagnoses including: chronic obstructive pulmonary disease (COPD), acute respiratory distress syndrome, and obstructive sleep apnea. Review of the Minimum Data Set assessment, dated 1/23/26, indicated a Brief Interview for Mental Status score of 14 out of 15 indicating the Resident was cognitively intact. During an interview on 2/5/26 at 8:11 A.M., Resident #14 said he/she has two sets of oxygen tubing, one for the walker and one for the room. The Resident said they are supposed to be using the oxygen at all times but takes it on and off as needed. The Resident said he/she does not have any type of plastic bag or anything to put the oxygen tubing in when it is not in use, so he/she typically wraps it around the handlebars of their walker or puts it on the oxygen concentrator. The surveyor made the following observations of Resident #14's oxygen tubing not being stored in a sanitary way to prevent the potential contamination of the tubing by germs and environmental debris: -2/5/26 at 8:11 A.M., 4:25 P.M., and 4:44 P.M., the nasal cannula oxygen tubing was observed wrapped around and hanging off the Resident's walker's handlebars, not stored in a plastic bag and no plastic bag was observed in the area. -2/6/26 at 8:53 A.M. and 2:25 P.M., the nasal cannula oxygen tubing was observed lying across the Resident's bed directly on the bedlinens, no plastic bag was observed to be available in the area. During an interview on 2/10/26 at 9:12 A.M., the surveyor reviewed her findings with the DON of Resident #14's oxygen tubing not being stored in a plastic storage bag when not in use. The DON said the process is for the nurses to change out the tubing and plastic storage bags weekly and label them. She said this Resident should have had plastic storage bags to store their oxygen tubing when not in use in a sanitary way to protect it from potential germs and it appears that did not occur.

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. Based on observation, document review, and interview, the facility failed to develop and implement a smoking policy, that included a process for their independent smokers ensuring designated smoking areas, proper receptacles for safe cigarette disposal, and the storage of the lighting and smoking materials for 8 out of 16 current smokers in the facility. Findings include: Review of the Department of Health and Human Services Centers for Medicare and Medicaid Services Memorandum titled Smoking Safety in Long Term Care Facilities, dated 11/10/11, included but was not limited to:-Facilities must include assessment of smoking areas and provision of emergency equipment in the designated smoking areas. -The facility is obligated to ensure the safety of designated smoking areas which includes protection of residents from weather conditions. -The facility is also required to provide portable fire extinguishers and requires each smoking area be provided with ashtrays made of noncombustible material and safe design. Metal containers with self-closing covers into which ashtrays can be emptied must be readily available. Review of the facility's policy titled Smoking, dated as last revised November 2020, indicated but was not limited to the following: -It is the policy of the facility to provide a healthy and safe environment for residents, staff and visitors by limiting the use of tobacco smoking materials on campus.-Resident who express a desire to smoke will be asked to review and sign the Smoking policy, attesting that they will adhere to the guidelines set forth by the facility.-Residents who state they are occasional smokers will have an Occasional/Former smoker evaluation completed and signed.-Residents who smoke will be evaluated for their ability to smoke safely upon admission, quarterly and as dictated by a 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 devices and/or safety devices will be identified and noted in the residents individualized care plan.-All cigarettes, igniting and smoking materials will be kept in a secure location designated at the facility. Residents will not be permitted to retain such items in their possession. Any new cigarettes, igniting or smoking materials must be turned over to staff immediately upon arrival to the facility. -Smoking will be permitted at scheduled times, which will be posted in the facility. The facility reserves the right to make changes to the designated times if or when necessary, residents will be notified of such. -A designated smoking area will be determined with fire blanket and fire extinguisher readily accessible. -Smoking or use of smoking materials by residents will not be permitted on the grounds of the facility with the exception of the designated smoking area.-Smoking will take place under the supervision of a staff member. The staff member will have the responsibility of lighting all cigarettes. During an interview on 2/5/26 at 8:11 A.M., Resident #14 said he/she is an independent smoker and goes out to smoke whenever he/she wishes to do so. The Resident said when going out to smoke they are required to sign out and leave the property. During an interview on 2/5/26 at 4:09 P.M., the facility Smoking Attendant said she is only responsible for the supervised smokers and their smoking materials and lighter. She said the residents who are independent smokers do not smoke at the facility designated smoking area and the process for them is to sign out of the facility and leave the property to smoke. On 2/5/26 at 4:44 P.M., the surveyor observed Resident #14 outside the front door of the facility. The surveyor observed the Resident pull their cigarette lighter out of their jacket pocket and use it to light their cigarette and then place the lighter back into their pocket. On 2/6/26 at 2:15 P.M., the surveyor observed Resident #11 outside in the facility visitor parking lot on the lower-level smoking independently. During an interview on 2/6/26 at 2:18 P.M., Resident #75 said he/she is an independent smoker and keeps his/her own lighter and smoking materials in their jacket. The Resident said independent smokers are supposed to leave the property to smoke. During an interview on 2/6/26 at 2:20 P.M., the surveyor observed Resident #98 to have a cigarette lighter on his/her overbed table in their room. The Resident said he/she is an independent smoker and had permission to keep their lighter and smoking materials. The Resident said he/she goes out the front door to smoke on the front walkway once a day after (continued on next page)

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	225488	A. Building B. Wing	02/11/2026

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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4:00 P.M. On 2/6/26 at 3:08 P.M., the surveyor observed Resident #14 outside in the front visitor parking lot in between two vehicles smoking. During an interview with observation on 2/9/26 at 8:59 A.M., Resident #14 said only residents who require help or supervision smoke in the designated smoking areas. The Resident said he/she typically sits behind the trees on a bench, but the piles of snow have prevented that and therefore he/she has been standing in the facility parking lot with his/her walker. The surveyor observed that the Resident had his/her smoking materials on him/her and was ashing his/her cigarette and throwing the cigarette butts on the ground. During an interview on 2/10/26 at 11:03 A.M., Resident #11 said he/she is an independent smoker and was permitted to keep his/her own lighter and smoking materials in their jacket, which was observed by the surveyor. The Resident said he/she goes out to smoke whenever he/she wants to and usually sits in the parking lot because of all the snow, but he/she was told he/she should be leaving the property to smoke. During an interview on 2/6/26 at 9:01 A.M., Nurse #2 said the residents who are independent smokers go out the A-wing door (front door of the facility) after 4:00 P.M. until the morning and stand in the front walkway. She said the door is locked with a keypad safety code, so the staff have to let them in and out of the facility. She said prior to 4:00 P.M. those residents sign out and exit the facility out of the main entrance and are supposed to leave the property to smoke. She said independent smokers are allowed to smoke whenever they want and maintain their own lighters and smoking materials. During an interview on 2/6/26 at 10:53 A.M., the Unit Manager said she has independent smokers on her unit. She said the independent smokers are permitted to keep their own lighters and smoking materials and sign out of the facility to go smoke outside whenever they want to. She reviewed the facility provided list of smokers and identified 8 out of 16 of the smokers in the facility were independent. During an interview on 2/6/26 at 12:25 P.M., the Director of Nurses (DON) reviewed the Smoking policy with the surveyor. She said the smoking policy is really designed more for the supervised smokers at the facility and doesn't include a process for independent smokers. She said the facility's independent smokers are evaluated for safety and are allowed to keep their own smoking materials and lighters on them. She said they are supposed to leave the property to smoke. During an interview on 2/6/26 at 12:47 P.M., the Administrator and surveyor reviewed the facility smoking policy together. The Administrator said the independent smokers do not follow the smoking times or use the facility smoking location. He said the policy dictates that residents can only smoke at designated times and in the facility designated area and the policy is more for supervised smokers and doesn't include a process or information on independent smokers. He said since the policy indicated residents are not allowed to smoke anywhere on the grounds, the independent smokers are told to sign out and leave the property when they want to smoke, and they maintain all their own smoking materials. He said at the time the policy was revised the facility did not have any independent smokers and now that they do, they will need to revise the policy to include a process for the independent smokers.

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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. Based on observation, interview, and record review, the facility failed to ensure that medications were labeled and stored in accordance with accepted professional principles in one out of two medication carts observed. Specifically, the facility failed to ensure medications were stored in the container with the pharmacy label; and ensure topical use medications were stored separate from oral medications.Findings include:Review of the facility's policy titled Medication Storage in the Facility, dated as revised December 2019, indicated but was not limited to, the following:-All medications dispensed by the pharmacy are stored in the container with the pharmacy label.-Orally administered medications are kept separate from externally used medications and treatments such as ointments and creams.-Outdated, contaminated, or deteriorated medications and those in containers that are without secure closures are immediately removed from inventory, disposed of. During an observation with interview on 2/10/26 at 9:21 A.M., the surveyor inspected a medication cart on Unit B with Nurse #1 and made the following observations:-In the top drawer, a clear plastic drinking cup, laying on its side, uncovered, with numerous brown, oval-shaped tablets inside. Handwritten in marker on the outside of the cup said Preservision. Nurse #1 said those pills are eye vitamins used for house stock. She said they should not be in use without the pharmacy container with the medication information. -In the second drawer, on the right-hand side, a clear plastic uncovered, unlabeled medication cup with 13 pills inside. The pills were different in color, shape and size.Nurse #1 said she did not prepare the medication and did not know what the pills were. She said she did not see it when she took over the cart this morning. Nurse #1 said that medications should never be left unlabeled and stored in the medication cart.-In the second drawer, adjacent to handheld respiratory inhalers, one tube of muscle rub cream, one tube of wound dressing ointment and a bottle of mineral oil. Handwritten in marker on the cap of the mineral oil bottle read mineral oil for scalps.Nurse #1 said those items are to be applied to skin or wounds and should not be stored in the medication cart. She said all skin and wound care medications should be stored in the treatment cart. During an interview on 2/11/26 at 11:47 A.M., the Director of Nursing (DON) said all medications should be stored in the packaging it was received in with the pharmacy label. She said no medications should ever be in the medication cart unlabeled and uncovered. The DON said all external use medications must be stored in the treatment cart, away from any oral medications.

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on document review and interview, the facility failed to provide written documentation related to transfer discharge notices and bed hold upon hospitalizations and ensure this information was part of the medical record for two Residents (#1 and #8), out of a total sample of 19 residents. Findings include: Review of the facility's policy titled Reservation of beds (Massachusetts), dated as revised 11/8/2016, indicated but was not limited to the following: -This facility will reserve the bed of a hospitalized resident in accordance with facility policy, State and Federal regulations. Review of the facility's policy titled Discharge Planning Policy and Procedure, undated, indicated but was not limited to the following: -Social services will ensure systems are implemented to provide written notification to the resident/responsible party prior to transfer/discharge in accordance with Massachusetts DPH/Division of Health Care Facility Licensure-In the event of an unplanned transfer to an acute care setting, notice will be provided in writing to the resident/responsible party as soon as practicable. A. Resident #1 was admitted to the facility in September 2024 with diagnoses including: Vascular dementia, adult failure to thrive, and hypertension. Review of the Minimum Data Set (MDS) assessment, dated 12/29/25, indicated a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated the Resident was severely cognitively impaired. Review of the medical record for Resident #1 indicated he/she was transferred to the hospital for evaluation in June 2025 and November 2025. The record failed to indicate bed hold and transfer documents were provided to the Resident and/or his/her representative prior to transfer as required. During an interview on 2/10/26 at 1:52 P.M., Nurse #1 said the process for transferring a resident to the hospital includes sending a medication list, SBAR assessment form, advanced directives, and a face sheet. She said she believes they are supposed to send a transfer notice and bed hold sheet. She searched the B unit file cabinets and couldn't locate these forms on the nursing unit for resident transfers. She reviewed the medical record for Resident #1 and said there were no transfer notices or bed hold documents in the record or any evidence to indicate they were sent with the Resident at the time of the transfer to the hospital in either June or November 2025. B. Resident #8 was admitted to the facility in March 2025 with diagnoses including: Alzheimer's disease, dementia, and delusional disorder. Review of the MDS assessment, dated 12/12/25, indicated a BIMS score of 6 out of 15 indicating the Resident was severely cognitively impaired. Review of the medical record for Resident #8 indicated he/she was transferred to the hospital for evaluation in October 2025 and December 2025. The record failed to indicate bed hold and transfer documents were provided to the Resident and/or his/her representative prior to transfer as required. During a telephone interview on 2/10/26 at 12:33 P.M., the Guardian for Resident #8 said the nurses at the facility make him aware of any changes in the Resident's condition and when they are sending the Resident to the hospital. He said no one has ever discussed a bed hold with him or provided him any documents on the Resident's transfer or a bed hold at the times the Resident had been sent out to the hospital. During an interview on 2/10/26 at 12:54 P.M., Nurse #2 said when the nurses are transferring a resident to the hospital, they send an SBAR assessment, medication list and any advanced directives. She said prior to preparing the paperwork they notify the physician of the change in condition and receive an order for the transfer and notify the residents and their responsible party of the transfer occurring. She said they do not complete bed hold or transfer forms at the facility at the time a resident is transferred to the hospital for evaluation and to the best of her knowledge those documents are not used by the facility. During an interview on 2/10/26 at 2:18 P.M., the Unit Manager said she has worked at the facility for about a year and a half and has never seen any transfer or bed hold forms and as far as she knows the facility does not use them. During an interview on 2/10/26 at 2:35 P.M., the Regional Social Worker said the facility social worker is the one who completes and sends all bed hold and transfer forms to the residents' responsible parties and the ombudsman's office. She said the forms are kept in the social service (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	office in a binder and not in the medical record as required. During an interview on 2/10/26 at 3:27 P.M., the Regional Social Worker said the process for transfer and bed hold forms to be completed in the facility is driven by the facility social worker. She said if a resident goes out to the hospital the social worker completes the forms the next day. She said she is unsure of the process for the residents/resident's responsible parties to receive copies of the forms. She said the forms should be part of the medical record and she would expect a note to be written to indicate the information was provided. She said the transfer and bed hold information is supposed to be part of the individual residents' medical records and she isn't sure why it is not. Review of the Social service progress notes for Resident #1 and Resident #8 failed to indicate any transfer or bed hold documents were reviewed with the Resident or the responsible party or provided in written format. During an interview on 2/10/26 at 3:32 P.M., the Director of Nurses said the nursing units are supposed to have a packet that they complete when a resident is transferred out to the hospital which should include the transfer and bed hold forms. She said she does not know why that process isn't in place now as it should be. During an interview on 2/11/26 at 12:02 P.M., the Social Worker said social services is exclusively responsible for completing both the transfer and bed hold documents for all residents including those that are acutely transferred to the hospital. She said nursing is not involved in the process and does not complete either form, provide them to the resident or send an accompanying copy of the bed hold to the hospital with the resident. She said when she comes in, she reviews the 24-hour report or dashboard for any transfers and completes the documents required at that time, after the residents have been sent out. She said she does communicate with the resident's responsible parties, but she does not put any documentation in the medical record to indicate those conversations have occurred, or that she has sent the notices by mail. She said the documents are not part of the medical record and are kept in a binder in the social services office. She said she is aware that the bed hold form and transfer information is supposed to be provided to the residents and the bed hold form should accompany the resident to the hospital, but that is not the process they use at the facility. She said she also knows the documents are supposed to be part of each resident's individual medical record, but that is also not a process the facility currently has in place. She said the current process does not align with the federal requirements as it should.