STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225622	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nemasket Rehabilitation and Healthcare Center	314 Marion Road Middleborough, MA 02346

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 48084 Based on record review and interview, the facility failed to maintain professional standard of practice for management of bowels for one Resident (#47), out of a total sample of 19 residents. Specifically, the facility failed to ensure hospital discharge orders were implemented, bowel regime was followed per physician's orders, the physician was notified of abnormal stools/bowel sounds/refusal of medications, and skilled notes were written per physician's order. Findings include: Review of the facility's policy titled Bowel Management Protocol, dated as last revised 9/2020, indicated but was not limited to the following: -Although aging increases the potential for incontinence and constipation, this facility has developed systems and procedures to assure: Interventions are defined, implemented, monitored, and revised, as appropriate, in accordance with current standards of practice; and Changes in condition are recognized, evaluated, reported to the practitioner, and addressed. -The following protocol has been adopted at this facility to manage. It may be overridden by any physician or authorized practitioner at any time, or as requested by the resident (with physician order) in the course of provision of care. a. If the resident has no bowel movement (BM) in two days, give Milk of Magnesia (MOM) 30 milliliters (ml) by mouth at bedtime. b. If the resident has not had a BM, give Bisacodyl suppository on the 11-7 shift. c. If still no BM, give Fleet's enema on the 7-3 shift. d. If still no BM or in the presence of abdominal pain or absent bowel sounds, consult the physician immediately. -The nurse should check nightly to review the resident's bowel status to ensure optimum care. Review of the facility's policy titled Charting and Documentation, dated as last revised July 2017, 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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical physical, functional, psychosocial condition, shall be documented in the resident's medical record. -The medical record should facilitate communication between the interdisciplinary team, regarding the resident's condition and response to care. -The following information is to be documented in the resident medical record: Observations, medications administered, treatments or services provided, changes in the resident's condition, events, incidents, or accidents involving the resident, progress toward or changes in the care plan goals and objectives. -Documentation of procedures and treatments will include care-specific details, including: the date and time the procedure/ treatment was provided, the assessment data and/or unusual findings, how the resident tolerated the procedure/ treatment, whether the resident refused the procedure/ treatment, and notification of family, physician or other staff. Resident #47 was admitted to the facility in February 2022 with diagnoses which included failure to thrive, dementia, and constipation. Review of the Minimum Data Set (MDS) assessment, dated 12/26/24, indicated Resident #47 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact and was frequently incontinent of his/her bowels. Review of the medical record indicated Resident #47 had been transferred to the hospital in June 2024 with a moderate colonic ileus (when the intestinal walls can't push the contents of the digestive tract forward, also known as a non-mechanical bowel obstruction). Review of the nursing progress notes indicated but were not limited to the following: -5/27/24: noted extended abdomen, resident reported last BM had been a while, per record last BM was 5/25. Given scheduled medications and a suppository, awaiting for effect. Physician was notified and ordered a kidney, ureter, and bladder (KUB) x-ray if no BM during the night. -5/28/24: KUB showed generalized ileus. -6/10/24: Repeat KUB ordered related to abdominal distention and prior ileus. -6/10/24: KUB showed moderate colonic ileus unchanged from 5/28/24. New order to send to the hospital for further evaluation. Review of the BM log indicated on 6/7/24 he/she had a large/1000 milliliters (ml) liquid stool. Review of the Hospital Discharge Summary indicated but was not limited to the following: -Diagnosis: Sigmoid Volvulus (sigmoid colon twists on itself, obstructing the colon and compromising blood supply). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Patient probably has slow transient gastrointestinal system complicated by increased immobility. -Encourage out of bed for meals. -Strict Monitoring of bowel pattern is imperative; Patient should not go any more than two days without a BM with intervention. -Glycerin Suppository at bedtime. -MiraLAX 34 grams (G) twice daily. -Full Liquid Diet, any advancement in diet should be done with extreme caution. Review of the comprehensive care plan indicated but was not limited to the following: PROBLEM: Constipation related to Sigmoid Volvulus (6/28/24) GOAL: Resident will have soft, formed bowel movements. APPROACH: -Administer medications per health care provider order. -Assess presence/absence of awareness of need to defecate. -Assess what was the normal pattern for the resident. -Document frequency and character of bowel movements. -Monitor/Document presence/absence of bowel sounds/abdominal pain/distention/decreased appetite/fever. Review of the Physician's Orders after returning from the hospital in June 2024 indicated but were not limited to the following: -Full liquid Diet (6/20/24) -Glycerin suppository rectally at bedtime (6/20/24) -MiraLAX 34G twice a day mix with 6 ounces of water (6/20/24) -Senna 8.6 milligrams (mg) two tablets twice daily (6/20/24) -Magnesium Citrate 150ml at bedtime as needed (PRN) for constipation. (6/20/24) -MOM 30ml once a day PRN if no BM by the 3rd day, give MOM on 3-11 shift (6/20/24) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Fleet's enema rectally once a day PRN if no BM after suppository give enema. If no result call physician (6/20/24) -DOCUMENTATION: Complete a skilled nursing note every shift to reflect resident health and functional status (6/20/24) The physician's orders failed to include the following: -Strict Monitoring of bowel pattern is imperative; Patient should not go any more than two days without a BM. Review of the nursing and physician progress notes failed to indicate the physician declined the hospital order/recommendation that he/she needed strict monitoring and should not go more than two days without a BM without intervention. Review of the nursing progress notes for June 2024 indicated but were not limited to the following: -6/20/24: Returned from hospital with diagnosis of Sigmoid volvulus. Strict bowel regimen to help with bowel issues. Full Liquid Diet. Diet Advancement to be done with extreme caution. -6/21/24: Refused suppository. -6/25/24: Refused suppository; education provided with little effect. -6/28/24: Patient complained of too many BMs; Suppository order changed from daily to every other day. The facility failed to notify the physician of the refusal of medication on 6/21/24 and 6/25/24. Additionally, progress notes were ordered and signed off every shift on the Treatment Administration Record (TAR) and notes were not written in the medical record 20 of 32 opportunities to reflect the health and functional status of the resident for the month of June. Review of the BM log indicated but was not limited to the following: -From 6/30/24 at 3:03 A.M. until 7/3/24 at 6:37 A.M., he/she did not move bowels.(3 days) -From 7/13/24 at 1:50 P.M. until 7/16/24 2:45 P.M., he/she did not move bowels. (3 days) -From 7/16/24 2:45 P.M. until 7/21/24 at 2:51 P.M., he/she did not move bowels. (5 days) -On 7/21/24 at 9:50 P.M., he/she had a 900ml liquid stool. -From 7/25/24 at 2:41 P.M. until 7/28/24 at 2:20 P.M., he/she did not move bowels. (3 days) -From 7/28/24 at 2:20 P.M. until 8/2/24 at 1:59 P.M., he/she did not move bowels. (5 days) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Administration Record (MAR) indicated none of the PRN bowel medications available were administered in the month of July. Review of the physician orders indicated but were not limited to the following: -Monitor/Document presence/absence of bowel sounds, abdominal pain/distention, decreased appetite. Notify MD of abnormal findings. (7/3/24) Review of the nursing progress notes, and MAR indicated but was not limited to the following: -7/3/24 at 10:45 P.M., abdomen still distended. -7/12/24: refused scheduled suppository. -7/14/24: refused scheduled suppository. -7/31/24: bowel sounds sluggish. The progress notes failed to indicate the physician was notified he/she had not moved bowels, that the bowel protocol was not followed, his/her abdomen was still distended, the refusal of the scheduled suppository, or that his/her bowel sounds were sluggish. Review of the follow up KUB, dated 7/12/24, indicated unremarkable abdomen examination. The findings are improved from 6/10/24 and there was modest amount of stool throughout the colon and rectum. Additionally, progress notes were ordered and signed off every shift on the TAR and notes were not written in the medical record 70 of 93 opportunities to reflect the health and functional status of the Resident for the month of July. Review of the Nursing Progress notes for August 2024 indicated but were not limited to the following: -8/19/24: KUB results-Moderate Colonic Ileus. NP made aware. New order for clear liquid diet until seen by physician. -8/22/24: Results improved since 8/19/24; Repeat KUB 8/28 and may advance diet. -8/28/24: Repeat KUB reads diffuse large and small bowel ileus. The findings are unchanged from 8/21/24 (sic). Review of the BM Log indicated but was not limited to the following: -8/5/24 at 12:06 P.M. until 8/8/24 at 2:49 P.M., he/she did not move bowels. (3 days) -8/11/24 at 1:31 P.M. until 8/14/24 at 2:13 P.M., he/she did not move bowels. (3 days) -8/15/24 at 2:33 P.M. until 8/18/24 at 2:47 P.M., he/she did not move bowels. (3 days) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MAR indicated none of the PRN bowel medications available were administered in the month of August. Additionally, progress notes were ordered and signed off every shift on the TAR and notes were not written in the medical record 68 of 93 opportunities to reflect the health and functional status of the Resident for the month of August. Review of the Gastroenterology (GI) Consult report, dated 8/30/24, indicated glycerin suppository nightly, tap water enema daily until ileus resolves, MiraLAX 2 packs daily, KUB with persistent ileus-needs to move bowels, clear liquids until moves bowels. Review of the BM log indicated but was not limited to the following: -8/31/24 at 2:47 P.M. until 9/3/24 at 5:40 A.M., he/she did not move bowels. (3 days) Review of the MAR indicated none of the PRN bowel medications available were administered. Review of the nursing progress notes for September 2024 indicated but were not limited to the following: -9/5/24: KUB results remain unchanged, and the abdomen remains distended with hypoactive bowel sounds. Send patient to emergency room for further evaluation. (returned in less than 24 hours) -9/6/24: Per Health Care Proxy (HCP), GI Physician, indicated surgical intervention, in the form of a colostomy (procedure to create an opening (stoma) in the abdominal wall to divert stool from the colon to an external bag, will likely be necessitated if normal motility does not return. Resident and HCP voiced opposition to this course of action. Review of the Gastroenterology (GI) Consult report, dated 9/13/24, indicated but was not limited to the following: -KUB today: no signs of obstruction; KUB is negative. -Medication changes were recommended with a follow up in 8 weeks. During an interview on 3/13/25 at 2:38 P.M., Resident #47 declined to discuss the hospitalization and the treatments in place indicating it was too embarrassing to talk about it. During an interview on 3/19/25 at 1:46 P.M., Nurse #2 said the typical bowel protocol is an order set that starts on day three of no BM and it is MOM on 3-11 shift, then a suppository on 11-7 shift, and then a Fleet's enema on the 7-3 shift if they still haven't moved their bowels. She said a progress note is ideal, but the PRN medications should at least be documented on the MAR/TAR. She said the electronic medical record system populates a report of anyone on day three, so the nurse can initiate the process. Additionally, she said anything out of the ordinary or specific situations like Resident #47's would require more frequent notifications, notes, and monitoring. She was unable to speak to the specifics of why the order for strict monitoring and that he/she should not go more than two days without a BM was not implemented as she was not in her role at that time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/19/25 at 1:53 P.M., Unit Manager #1 said the nurses are expected to follow the protocol or patient specific orders and they should be administering PRN meds, writing notes and notifying the physician of abnormal bowel sounds and refusal of meds, and he/she should have had skilled notes written every shift to closely monitor and they did not. For Resident #47 and his/her specific situation the daily skilled progress notes should have included the number/type of BMs, the form and consistency, any PRN meds given or pending, refusal of meds, etc. She was unable to speak to the specifics of why the order for strict monitoring and that he/she should not go more than two days without a BM was not implemented as she was not in her role at that time. During an interview on 3/19/25 at 2:08 P.M., the Director of Nurses (DON) said the standard protocol is to start utilizing PRN medication on day three. She said in this case; the orders should have indicated a stricter protocol, and they did not. Additionally, she said the report the electronic medical record system pulls is flawed because it counts anything as BM even if it's small or in liquid form, which especially in a pattern or someone prone to bowel issues that pattern would be concerning. She said she didn't think the report indicated what the last BM was, only that it is going on day three. The DON said the daily skilled notes should have been written per the physician's orders and they were not. She said in this case, the hospital indicated a two-day bowel protocol, which is not standard, but given the recent ileus, we should have been watching and tracking his/her bowel regime closer to try and prevent the ileus from recurring. She said in this case special circumstances required individualized care to be provided. She said they were not following the process.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 28450 Based on interviews and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice, for one Resident (#67), of one resident receiving dialysis, out of a total sample of 19 residents. Specifically, the facility failed to ensure ongoing communication and collaboration between the facility and the dialysis center. Findings include: Review of the facility's policy titled Hemodialysis, revised 12/2/24, included but was not limited to the following: -Facility will maintain ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. -The facility will coordinate and collaborate with the dialysis facility communication written format form, pre-dialysis vital signs (blood pressure, pulse, temperature, respirations) and weight. -On return from the Dialysis Center the form in the communication book should include documentation on pre- and post-vital signs, treatment tolerance, any medication given, and any new orders for resident care. Resident #67 was admitted to the facility in April 2023 with diagnoses including end stage renal disease and dependence on renal dialysis. Review of the Minimum Data Set (MDS) assessment, dated 12/16/24, indicated Resident #67 has no cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. The MDS indicated Resident #67 received hemodialysis. Review of Physician's Orders indicated an order for Resident #67 to attend dialysis three times a week on Tuesday, Thursday, and Saturday; Obtain vital signs prior to transfer to dialysis; Document in nurse's note prior to transfer to dialysis (picked up in timely manner and disposition of resident upon transfer); Send dialysis book with each dialysis session with updated information (8/6/24). Review of Resident #67's January, February and March 2025 Dialysis Communication Book indicated the following dialysis communication forms: 1/23/25 - Nursing Facility communication section with the Dialysis Center not completed Upper portion Last weight 1/25/25 (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing Facility communication section with the Dialysis Center not completed Upper portion: Last weight and last vital signs (blood pressure (BP), Heart rate (HR), Oxygen (O2), body temperature. 1/30/25 Nursing Facility communication section with the Dialysis Center not completed Upper portion: Last weight 2/4/25 Nursing Facility communication section with the Dialysis Center not completed Upper portion: Last weight 2/6/25 Nursing Facility communication section with the Dialysis Center not completed Upper portion: Last weight 2/8/25 Nursing Facility communication section with the Dialysis Center not completed Upper portion: Last weight 2/25/25 Nursing Facility communication section with the Dialysis Center not completed Upper portion: Last weight 3/4/25 Nursing Facility communication section with the Dialysis Center not completed Upper portion: Last weight 3/11/25 Nursing Facility communication section with the Dialysis Center not completed Upper portion: Last weight 3/15/25 (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing Facility communication section with the Dialysis Center not completed Upper portion: Last weight and last vital signs (blood pressure (BP), Heart rate (HR), Oxygen (O2), body temperature. The upper portion was not completed, the dialysis center nurse used a blank sheet of paper to record the pre- and post-dialysis vital signs and medication administered to the Resident at dialysis. During an interview on 3/18/25 at 02:13 P.M., Nurse #1 reviewed Resident #67's Dialysis Communication Book and said the forms were not completed as they should have been. She said the nursing staff sending the Resident to dialysis should complete the top part of the Dialysis Communication sheet. During an interview on 03/18/25 at 02:22 P.M., Unit Manager #2 reviewed Resident #67's Dialysis Communication Book and said the Dialysis Communication sheets were not completed as they should have been. Resident #67 goes to dialysis Tuesdays, Thursdays and Saturdays. The nurse sending the Resident to dialysis is to complete the top part of the form. During an interview on 03/19/25 at 02:43 P.M., the Director of Nurses (DON) said the expectation is that the staff at the nursing facility complete the top part of the communication form prior to the Resident leaving for dialysis on Tuesdays, Thursdays, and Saturdays, to present a baseline on pre-dialysis vital signs and weights.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48084 Based on observation and interview, the facility failed to follow professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to ensure the Three Bay Sink was operated in a safe and sanitary manner to ensure sanitation of the dishes. Findings include: Review of the facility's policy titled Pot and Pan Washing and Sanitization, undated, indicated but was not limited to the following: Procedure: follow the steps below when washing pots and pans. -Step 1: Wash -Step 2: Rinse -Step 3: Sanitize: Sanitize in dish machine OR In a third sink, immerse for one minute in a chemical sanitizer. Review of the Three Sink Washing and Sanitizing poster in the kitchen at the Three Bay Sink, undated, indicated but was not limited to the following: -After rinsing ware, submerge into sanitizer sink for at least one minute. Review of the Array Ultimate Sanitizer product label indicated but was not limited to the following: -Contact time one minute. On 3/14/25, the surveyor observed the following: -12:00 P.M., Dietary Aide #1 was washing dishes in the Three Bay Sink, after washing the pans, each one was quickly dipped in the rinse bay and then quickly dipped (less than 5 seconds) in the sanitation bay and put on the shelf to air dry. He then washed serving utensils repeating the same process. -12:20 P.M., Dietary Aide #2 was running large grey serving bins through the dishwasher to rinse and then walking them over to the Three Bay Sink to sanitize. He proceeded to quickly dip each bin into the sanitation bay and put them on the shelf to dry. -12:25 P.M., Dietary Aide #2 drained and refilled the Three Bay Sink. He proceeded to quickly dip the internal component of the coffee pot and the large coffee pot in each bay and put them on the rack to dry. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Both Dietary Aides #1 and #2 failed to submerge the items in the sanitizing solution for at least one minute prior to placing the items on the shelf to dry. During an interview on 3/14/25 at 12:20 P.M., the Food Service Director (FSD) said everything should be soaking in the sanitization bay for greater than 30 seconds and then put on the shelf to dry. During an interview on 3/14/25 at 12:30 P.M., Dietary Aide #2 said nothing must be soaked in the Three Bay Sink unless the food is really stuck. He said there is no soak time for the sanitizer, they only have to dip the items before drying. During an interview on 3/14/25 at 2:00 P.M., Dietary Aide #3 said after rinsing the dishes they must be dipped in the sanitizer bay for a few seconds and then air dried on the rack. During an interview on 3/19/25 at 9:30 A.M., the FSD said he did education with the staff on 3/14/25 after staff were observed not soaking the dishes in the sanitizer solution as they should have been. The in-service was provided to the surveyor. Review of the in-service with the FSD indicated to submerge items in the sanitizer bay for at least 30 seconds. Review of the poster at the Three Bay Sink with the FSD indicated items should be soaked for at least one minute. The FSM said he would have to look into the exact time items should be submerged to soak and sanitize before they are put on the rack to dry.