STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225667	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Bay of Brewster Rehab Center	383 South Orleans Road Brewster, MA 02631

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 48362 Based on observation and interview, the facility failed to ensure residents in one of two dining areas experienced a dignified and homelike dining experience. Findings include: On 3/12/24 at 12:05 P.M., the surveyor made the following observations on the North Two Unit dining room: - Fourteen residents were seated at various tables in the dining room. - Staff members were delivering meal trays to the residents off the first lunch truck that had arrived on the unit. - At 12:08 P.M., seven out of the 14 residents in the dining room area were served their lunch meal. One out of four residents seated at the table closest to the television was not served a meal. One out of two residents seated at the table by windows was not served a meal. Two residents seated at table diagonally positioned to the television were not served a meal. Three residents seated at a table closest to the entrance of the dining area were not served a meal. - At 12:14 P.M., the second lunch truck arrived on the unit. - The last resident in the dining room was served their meal at 12:23 P.M., 15 minutes after the first seven residents in the dining room were served their meals. - All lunch meals were served to residents on trays. On 3/13/24 at 11:46 A.M., the surveyor made the following observations on the North Two Unit dining room: - Twenty-one residents were seated at various tables in the dining room. - At 11:54 A.M., the first lunch truck arrived in the dining room and staff began serving residents. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- At 12:02 P.M., the first lunch truck is removed from the dining room and 10 residents were not served their meals. Two out of five residents at the table across from the television were not served meals. Two out of four residents at the table in the back of the dining area were not served meals. Three out of four residents at a table diagonally positioned to the television in the dining area were not served meals. Three out of six residents at the table closest to the entrance of the dining area were not served meals. - At 12:05 P.M., staff were speaking with multiple residents in the dining area and telling them that their lunch meal was coming. - At 12:10 P.M., Resident #107 (who was without a meal tray) grabbed a coffee cup off Resident #77's plate and began drinking the coffee. Nurse #4 intervened and replaced Resident #77's coffee. - At 12:13 P.M., the second lunch truck arrived on the unit. - The last resident in the dining room was served their meal at 12:21 P.M., 25 minutes after the first resident in the dining room was served. - All lunch meals were served to residents on trays at each table. On 3/14/24 at 11:34 A.M., the surveyor made the following observations on the North Two Unit dining room: - 16 residents were seated at various tables throughout the dining room. - All lunch meals were served to residents on trays at each table. On 3/19/24 at 8:45 A.M., the surveyor made the following observations on the North Two Unit dining room: - Seven residents were seated at various tables throughout the dining room. - All breakfast meals were served to residents on trays at each table. During an interview on 3/14/24 at 12:16 P.M., Certified Nursing Assistant (CNA) #1 said two trucks come up to the North Two Unit at each mealtime and at different times. CNA #1 said when the first truck arrives on the unit, residents with meals on the truck who eat in the dining room are served. CNA #1 said residents whose meals arrive on the second truck wait for their meals in the dining room until they can be served when the truck arrives. During an interview on 3/14/24 at 12:25 P.M., Nurse #4 said two trucks arrive on the North Two Unit for each mealtime. Nurse #4 said the first truck arriving on the unit is supposed to be for residents who eat in their rooms. Nurse #4 said the second truck arriving on the unit is for the dining room. Nurse #4 said there was a recent change to the trucks arriving on the unit, creating a mix of residents in the dining room being served at different times. Nurse #4 said residents eating in the dining room should all be served at the same time. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/14/24 at 12:44 P.M., the Food Service Director (FSD) said the North Two Unit receives two trucks for each mealtime. The FSD said the second truck arriving on the unit should be for residents in the dining room, so they eat at the same time. The FSD said the trucks should not have a mix of residents eating in their rooms and eating in the dining room. During an interview on 3/14/24 at 1:42 P.M., the Regional Clinical Director said meals in the dining room should all arrive on the unit at the same time. The Regional Clinical Director said residents seated at a table should all be served meals at the same time for a dignified experience. The Regional Clinical Director said meals should be served off trays for a homelike dining experience.

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48362 Based on observation, record review, and interview, the facility failed to ensure medications were not self-administered without a physician's order and an assessment for self-administration was completed for one Resident (#41), out of a total sample of 24 residents. Findings include: Review of the facility's policy titled Self-Administration of Medications, revised January 2023, indicated but was not limited to the following: - The resident may request to keep medications at bedside for self-administration in accordance with Resident Rights. - Criteria must be met to determine if a resident is both mentally and physically capable of self-administering medication and to keep accurate documentation of these actions. - In addition to general evaluation of decision-making capacity, the nurse will perform a more specific skill assessment, this can be accomplished on paper or through EHR system. - If residents are determined to be able to self-administer: (a) the nursing staff will determine who will be responsible (the resident or the nursing staff) for documenting that medications were taken; (b) if the resident is able and willing to take responsibility for documenting their self-administration of medications, the resident will be instructed on how to complete a record indicating the administration of the medication; (c) resident/representative will complete a consent for self-administration (C-MED-10a). - Self-administered medications must be stored in a safe and secure place, which is not accessible by other residents. - Storage should be in a locked box in resident's drawer. - Staff shall identify and give to the Charge Nurse any medications found at the bedside that are not authorized for self-administration, for return to the family or responsible party. - The Electronic Medical Record (EMAR) or Medical Record (MAR) must identify meds that are self-administered, and the medication nurse will need to follow-up with the resident as to documentation and storage of medication during each med pass. - The staff and practitioner will periodically (for example, during quarterly MDS reviews) reevaluate a resident's ability to continue to self-administer medications. Resident #41 was admitted to the facility in June 2020 with diagnoses including atrial fibrillation (abnormal heart rhythm) and emphysema (a lung condition causing shortness of breath). (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) assessment, dated 2/28/24, included a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating he/she was cognitively intact. The MDS further indicated the Resident required supervision to perform activities of daily living. During an observation with interview on 3/12/24 at 10:40 A.M., the surveyor observed Resident #41 in a bedside recliner with an overbed table in front of them. The surveyor observed an Incruse Inhaler (prescription medication used to treat breathing conditions such as emphysema), dated 3/1/24, on the bedside table. The Incruse Inhaler was observed to have 22 puffs left. The Resident said he/she takes the medication daily for shortness of breath and keeps the medication in the top drawer of his/her dresser. The surveyor then observed the Resident place the medication in the top right-hand corner of the dresser drawer which was not able to be locked. During an observation with interview on 3/14/24 at 12:05 P.M., the surveyor observed the Resident in a bedside recliner with an overbed table in front of them, eating lunch. The surveyor observed an Albuterol Inhaler on the windowsill next to the Resident. The Resident said he/she only uses the Albuterol Inhaler in emergency situations for shortness of breath. The Resident said he/she had another inhaler in the top drawer of their dresser that they used daily. The Resident opened the top dresser drawer and the surveyor observed an Incruse Inhaler, dated 3/1/24, in the top right-hand corner. The Resident did not unlock the dresser drawer to show the surveyor the inhaler. The Incruse Inhaler was observed to have 19 puffs left. On 3/19/24 at 9:40 A.M., the surveyor observed the Resident in a bedside recliner. The surveyor observed an Albuterol Inhaler on the windowsill. The Resident said he/she had an additional inhaler in the top right-hand corner of their dresser drawer. The Resident opened the drawer and the surveyor observed an Incruse Inhaler, dated 3/1/24, with 15 puffs left. Review of Resident #41's active Physician's Orders included but was not limited to: - 6/25/20: Incruse Ellip 62.5 MCG (30INH); one puff inhale orally one time a day for emphysema, administered by clinician at 9 A.M. - 1/6/22: Ventolin HFA Aerosol Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate HFA); two puffs inhale orally every four hours as needed for congestion/wheezing, administered by clinician. Further Review of Resident #41's active physician's orders failed to include orders for self-administration of the Incruse Inhaler or the Albuterol Inhaler. Review of Resident #41's March Medication Administration Record (MAR) indicated Resident #41 received the Incruse Inhaler daily. The MAR indicated Resident #41 did not receive the Albuterol Inhaler. Review of Resident #41's medical record indicated a Self-Administration of Medications Informed Consent and Assessment was signed by the Resident on admission to the facility on [DATE], indicating he/she wished to self-administer their medications. Further review of the form failed to indicate an assessment was completed to determine if the Resident was appropriate to self-administer medications. Further review of Resident #41's medical record failed to indicate the facility completed any additional Self-Administration of Medication Assessments. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/19/24 at 9:40 A.M., Resident #41 said no one ever checks to make sure he/she is taking the inhaler medications correctly. Resident #41 said he/she takes the Incruse Inhaler daily and marks it down on a paper when he/she takes it. Resident #41 said he/she only takes the Albuterol Inhaler in emergency situations. Resident #41 said when both inhalers need to be replaced, he/she brings the medication to the nurse for them to reorder. During an interview on 3/19/24 at 9:50 A.M., Nurse #5 said there were no residents on their assignment who were able to self-administer medications. Nurse #5 said they were unaware of any processes the facility had for assessment of Residents who wanted to self-administer medications. Nurse #5 and the surveyor reviewed the observations made in Resident #41's room. Nurse #5 said Resident #41 does self-administer their inhaler medications. Nurse #5 said Resident #41 brings the medications to the nurse when they need to be refilled. Nurse #5 said the medications were taken by the Resident and then marked on the MAR. During an interview on 3/19/24 at 10:52 A.M., Unit Manager (UM) #1 said if a resident in the facility wants to self-administer medications an assessment needs to be completed to ensure he/she can safely and appropriately administer medications. UM #1 said she believed the assessments would be completed quarterly thereafter, as well as with any change in status. UM #1 said orders would be put in place and they would indicate which specific medications the resident was able to self-administer. UM #1 said the care plan would be updated to indicate the residents were able to self-administer medications and would indicate specifically the medications they were able to administer. UM #1 said she was uncertain if medications needed to be stored in a locked container at a resident's bedside. UM #1 said the nurse was responsible for checking the expiration date of the medication daily and marking it in the MAR. UM #1 and the surveyor reviewed the observations. UM #1 said Resident #41 should have an assessment and orders to self-administer the inhaler medications. During an interview on 3/19/24 at 2:53 P.M., the Regional Clinical Director said an assessment for self-administration of medications needed to be completed for each resident who desired to self-administer. The Regional Clinical Director said the assessment ensures the resident is correctly administering the medication. The Regional Clinical Director said self-administering assessments were to be completed either quarterly or annually and with any significant changes. The Regional Clinical Director said self-administered medications needed to be locked safely at the resident's bedside. The Regional Clinical Director said a care plan and orders should be updated for each resident who is self-administering medications. The Regional Clinical Director and the surveyor reviewed the observations made. The Regional Clinical Director said a self-administration assessment should have been completed for the Resident. The Regional Clinical Director said the orders and care plan should reflect the Resident's ability to self-administer medications.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 36542 Based on a resident group meeting, staff interviews, and document review, the facility failed to ensure grievances and concerns from the Resident Council were documented to ensure they were acted upon timely and included the facility response and rationale for response. Findings include: Review of the facility's policy titled Resident Council, last revised January 2023, indicated the following: -Resident Council meetings should be held monthly -meeting minutes will be recorded by designated staff representative -minutes from the previous month will be reviewed at the start of every meeting before opening up the meeting for new concerns -concerns that are raised at the meeting must be recorded in minutes and followed with a concern/response form filled out by the designated staff representative and addressed to the corresponding Department Head to provide a resolution. Concern/response forms must be completed within 7 days of being issued. During the entrance conference on 3/12/24 at 9:40 A.M., the surveyor requested three months of Resident Council minutes, with approval from the Resident Council President. During an interview on 3/12/24 at 3:35 P.M., the Administrator said the facility staff responsible for taking meeting minutes during Resident Council was the Activity Director. He said the facility no longer had an Activity Director and he was only able to locate Resident Council meeting minutes for January 2024. He said the facility had not held a Resident Council meeting in February 2024 due to an infectious outbreak. He said he was unable to locate the Resident Council meeting minutes from November 2023 or December 2023. Review of the Resident Council Meeting Minutes, dated 1/30/24, failed to include any old business or follow up to concerns/grievances brought forward the prior month at Resident Council. On 3/13/24 at 2:00 P.M., the surveyor held a group meeting with 16 residents in attendance. The residents said they prefer to hold Resident Council on a monthly basis and that facility staff attend to document any of their concerns. They said Resident Council meetings were held in November and December 2023. The residents said that at the meeting in December 2023 they had to repeat their concerns from the previous Resident Council meeting and sometimes it takes two to three meetings before something changes. The residents said they did not feel the Resident Council was effective for listening to and responding to their concerns. Review of the Resident Council Meeting Minutes, dated 1/30/24, indicated but was not limited to the following concerns: (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-being shorthanded and waiting too long to get out of bed and long call light wait times -request for more art supplies, craft activities, in-house music and musicians Review of the Resident Council Resolution forms indicated spoke with staff to ensure that staffing is scheduled appropriately. There was no Resident Council Resolution form to address the request for additional activity supplies and music activities. During the group meeting on 3/13/24 at 2:00 P.M., the residents went on to say that they continued to have concerns regarding long call light wait times and not getting out of bed until 11:00 A.M. or 12:00 P.M. and had not heard back regarding resolutions. The residents said they had not heard back regarding additional craft supplies, including supplies for making bracelets and had not heard back regarding additional in-house music activities. During an interview on 3/15/24 at 9:00 A.M., the Administrator said the facility staff had been unable to locate Resident Council meeting minutes from November 2023 or December 2023 and was unable to locate any follow up to any concerns. He said he thought all concerns brought forward during the January 2024 Resident Council meeting had been addressed.

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F 0580 Level of Harm - Actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 48362 Based on observations, interviews, record reviews, and policy review, the facility failed to notify the physician about a change in condition in order to re-evaluate the potential need to alter the treatment plan for two Residents (#2, #61), out of a total sample of 24 residents. Specifically, the facility failed: 1. For Resident #2, to notify the physician regarding a 12.66% severe significant weight loss in three months (11/21/23 to 2/3/24) and 5.39% in one month (2/3/24 to 3/8/24); and 2. For Resident #61, to notify the physician regarding a 6.95% (10/21/23 to 11/21/23) severe significant weight loss in one month, as well as a 10.54% (10/21/23 to 1/25/24) severe significant weight loss in three months and an additional 10.74% severe significant weight loss in three months (11/30/23 to 3/18/24). Findings include: Review of the facility's policy titled Weight Assessment and Interventions, revised May 2019, included but was not limited to: - The multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight change for our residents. - Monthly weights will be obtained each month or as ordered by physician. - Weights will be recorded in the medical record (electronic health record where available) for each resident. - Any weight change of five pounds (lbs.) in a month or three pounds in a week since their last weight assessment should be retaken within 72 hours for confirmation and verified by Nursing. - Re-weigh should be reviewed by the Licensed Nurse. - Licensed Nurses should notify Dietician of identified weight change once reviewed. - Dietician notification should be documented within Resident's medical record. - Dietician or diet technician should respond within 72 hours of receipt of notification. - The threshold for significant unplanned and undesired weight change will be based on the following criteria: (a) one month: 5% weight change is significant, greater than 5% is severe; (b) three months: 7.5% weight change is significant; greater than 7.5% is severe; (c) six months: 10% weight change is significant; greater than 10% is severe. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Some	1. Resident #2 was admitted to the facility in February 2021 with diagnoses including schizoaffective disorder and type II diabetes. Review of the Minimum Data Set (MDS) assessment, dated 1/24/24, indicated Resident #2 had a severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 6 out of 15. Further review of Section K of the MDS assessment indicated Resident #2 had a weight loss of 5% or more in the last month or 10% or more in the last six months. Section K of the MDS assessment indicated Resident #2 was not on a prescribed weight loss regimen. Review of Resident #2's active Physician's Orders included but were not limited to: - 2/26/24: Weekly Weight - weekly weight secondary to weight loss every day shift every seven days Review of Resident #2's weights in the electronic medical record indicated the following weights: - 11/21/23: 191.2 lbs. - 12/2023: not obtained - 01/23/24: 172.2 lbs. - 02/03/24: 167.0 lbs. - 03/08/24: 160.0 lbs. Review of Resident #2's weights indicated he/she had a 12.66% severe significant weight loss in three months. Further review of Resident #2's weights indicated a 5.39% significant weight loss in one month (2/3/24 and 3/8/24). Review of Resident #2's nutritional care plan indicate interventions included but were not limited to: - Obtain weight per physician (MD) order on same scale. Notify MD/Nurse Practitioner (NP)/Registered Dietician (RD) of significant weight changes (revised 11/14/23). Review of a dietary progress note, dated 2/12/24, indicated Resident #2 had a 12.7% significant weight loss over the past three months. The RD recommended the facility obtain a reweight of Resident #2 prior to any further intervention changes. Further review indicated the RD recommended Resident #2 to have weekly weights, sugar free house supplement (four ounces twice daily) and change to regular size portions (versus the previously recommended large portions). Documentation failed to indicate MD/NP notification of continued significant weight loss was completed. Review of MD/NP notes failed to indicate MD/NP documentation related to Resident #2's significant weight loss. During an interview on 3/18/24 at 1:58 P.M., Nurse #4 said when weights are input into the electronic medical record they populate red for a significant change. Nurse #4 said the Dietitian would notify the MD directly of any new recommendations or changes. (continued on next page)

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F 0580

Level of Harm - Actual harm

Residents Affected - Some

During an interview on 3/18/24 at 3:13 P.M., Unit Manager (UM) #1 said she and the RD should be reviewing weights of all residents on the unit. UM #1 said she was uncertain if Resident #2's MD was aware of their significant weight loss. UM #1 said she would be responsible for notifying the MD of changes in weight. UM #1 said staff should be notifying the MD of changes in weight to ensure the interdisciplinary team are aware.

During an interview on 3/18/24 at 4:09 P.M., the RD said she reviews weights for significant weight loss when they are obtained by staff at the facility. The RD said she then determines an individualized plan for each resident to address the weight loss. The RD said the goal is to review each resident in the facility quarterly, or more often if a significant weight loss is identified. The RD said Resident #2 has had a continued significant weight loss. The RD said she notifies nursing staff of recommendations to notify the MD. The RD said she does not notify the MD of significant weight loss or recommendations herself.

During an interview on 3/18/24 at 4:27 P.M., the Director of Nurses (DON) said her expectation would be for the RD to identify a significant weight loss for any residents in the building. The DON said she would expect the nursing staff and/or the RD to notify the MD regarding the changes identified. The DON said the UM should be looking at changes to identify risk factors for residents on each unit.

2. Resident #61 was admitted to the facility in December 2021 with diagnoses including hypertension, atrial fibrillation (abnormal heart rhythm), and cerebral infarction (stroke).

Review of the MDS assessment, dated 2/21/24, specified a BIMS score of 14 out of 15, indicating he/she had intact cognition. Further review of Section K of the MDS assessment indicated Resident #61 had a weight loss of 5% or more in the last month or 10% or more in the last 6 months. Section K of the MDS assessment indicated Resident #61 was not on a prescribed weight loss regimen.

Review of Resident #61's weights in the electronic documentation system indicated the following weights:

- 9/2023: not obtained

- 10/21/23: 178.4 lbs.

- 11/21/23: 166.0 lbs.

- 11/30/23: 169.4 lbs.

- 12/2023: not obtained

- 1/25/24: 159.6 lbs.

- 2/2024: not obtained

- 3/18/24: 151.2 lbs.

(continued on next page)

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NAME OF PROVIDER OR SUPPLIER Pleasant Bay of Brewster Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 383 South Orleans Road Brewster, MA 02631	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #61's weight indicated that Resident #61 had a 6.95% severe significant weight loss between 10/21/23 and 11/21/23. Further review indicated Resident #61 had a 10.54% severe significant weight loss in three months (10/21/23 to 1/25/24). Additionally, a second severe significant weight loss of 10.74% was identified in three months (11/30/23 to 3/18/24). Review of Resident #61's nutritional care plan indicated interventions included but were not limited to: - Obtain weight per physician (MD) order on same scale. Notify MD/Nurse Practitioner (NP)/Registered Dietician (RD) of significant weight changes (revised 10/5/23). Review of MD/NP progress note documentation, dated 3/5/24, indicated the Resident was seen for family concerns related to weight loss and poor appetite. Further review of the documentation indicated Resident #61's weight was down but failed to address the significant weight loss. Documentation indicated Resident #61 may benefit from house supplement shakes three times per day. Further review of the medical record failed to indicate the MD was notified of the Resident's severe significant weight loss between 10/21/23 to 11/21/23 (6.95%), 10/21/23 to 1/25/24 (10.54%) and 11/30/23 to 3/18/24 (10.74%). During an interview on 3/18/24 at 1:58 P.M., Nurse #4 said when weights are input into the electronic medical record they populate red for a significant change. Nurse #4 said the Dietitian would notify the MD directly of any new recommendations or changes. During an interview on 3/18/24 at 3:25 P.M., UM #1 said she and the RD should be reviewing weights of all residents on the unit. UM #1 said she was uncertain if Resident #61's MD was aware of their significant weight loss. UM #1 said she would be responsible for notifying the MD of changes in weight. UM #1 said staff should be notifying the MD of changes in weight to ensure the interdisciplinary team are aware. During an interview on 3/18/24 at 4:09 P.M., the RD said she reviews weights for significant weight loss when they are obtained by staff at the facility. The RD said she then determines an individualized plan for each resident to address the weight loss. The RD said she pulls a weight report for each resident when reviewing their documentation. The RD said the goal is to review each resident in the facility quarterly, or more often if a significant weight loss is identified. The RD said Resident #61 has had a continued significant weight loss and it needed to be addressed. The RD said she notifies nursing staff of recommendations to notify the MD. The RD said she does not notify the MD of significant weight loss or recommendations herself. During an interview on 3/18/24 at 4:27 P.M., the DON said her expectation would be for the RD to identify a significant weight loss for any residents in the building. The DON said she would expect the nursing staff and/or the RD to notify the MD regarding the changes identified. Refer to F692

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225667	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Bay of Brewster Rehab Center	383 South Orleans Road Brewster, MA 02631

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 43935 Based on observation, interview, record review, and policy review, the facility failed to ensure one Resident (#94), out of a total sample of 24 residents, was assessed for a less restrictive device based on the Resident's medical symptoms. Findings include: Review of the facility's policy titled Restraint Use, dated as revised 1/2023, indicated but was not limited to the following: Physical restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot easily remove which restricts freedom. - the use of restraints may only be used to ensure the immediate physical safety of the resident and must be discontinued at the earliest possible time - restraints may only be used when less restrictive interventions have been determined to be ineffective to protect the resident or others from harm - the type of restraint must be the least restrictive intervention that will be effective to protect the resident or others from harm - the use of the restraint shall be based on a comprehensive assessment that includes a physical assessment to identify medical conditions that may be causing behavior changes in the resident; the assessment will also be performed to determine the safety and protective needs of the resident prior to restraint application - medical symptoms that warrant the use of the restraint must be documented in the resident's medical record, ongoing assessments, and care plans - while there must be a physician's order reflecting the presence of a medical symptom, the physician order alone is not sufficient to warrant the use of the restraint. - the facility shall engage in a systematic and gradual process towards reducing restraints for those resident's whose care plans indicate a need for restraints - interventions shall be developed and implemented to minimize or eliminate a resident's medical symptom, and also to identify and address any underlying problems causing the medical symptom The Restraint order: - the order should be implemented in the least restrictive manner and in accordance with safe and appropriate restraining techniques (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- the interdisciplinary team (IDT) shall request a new physician order if there are changes in the resident's condition that require removing or modifying restraints Documentation in the medical record shall include: - restraint orders with rationale for restraint, type of restraint and body part to be restrained - alternatives or less restrictive interventions attempted, as applicable - the medical condition or symptom that warranted the use of the restraint - resident's response to the restraint, with assessment and reassessment of the resident - revisions to the treatment plan and unanticipated changes in the resident's condition - condition/behavior required of the resident for the release of restraints - discussions with the resident/family regarding the need for restraints Resident #94 was admitted to the facility in May 2021 and had the following diagnoses: Unspecified dementia, moderate with other behavioral disturbances and major depressive disorder. Review of the most recent Brief Interview for Mental Status (BIMS), dated 1/19/24, for Resident #94 indicated he/she was severely cognitively impaired with a score of 3 out of 15 and he/she had a family guardian in place. Review of the last annual Minimum Data Set (MDS) assessment, dated 8/1/23, indicated but was not limited to the following: - Section GG indicated under question 0170 mobility indicated the Resident was dependent for bed to chair and chair to bed transfers with the helper putting in all the effort for the task to be performed. During an observation with interview on 3/12/24 at 12:28 P.M., the surveyor observed Resident #94 sitting in a high back wheelchair (w/c) in the hallway with a mechanical lift sling behind him/her and a velcro alarm seatbelt closed over his/her lap. The Resident was unable to demonstrate how to remove or undo the seatbelt when requested by the surveyor. When the Resident was asked if he/she knew how to remove the seat belt he/she replied, No. During a telephone interview on 3/12/24 at 1:52 P.M., the Guardian of Resident #94 said the Resident used to wear a pelvic restraint, but to the best of his knowledge Resident #94 has not ever been restrained at this facility and does not have a restraint in place at this time. Review of the current Physician's Orders for Resident #94, dated 3/13/24, indicated but were not limited to the following: (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Velcro belt alarm on w/c. Can Resident release velcro seat belt when asked, does it proper fit and functioning when up in w/c. every day and evening shift for prevention of injury from falls (5/12/22) - Remove velcro seat belt everyday during lunch and document any attempts to stand or self transfer one time a day for monitoring (8/25/22) - Remove w/c velcro seat belt three times a week during activity and document any attempts to stand or self transfer every day shift every Monday, Wednesday, Friday for monitoring (8/31/22) - Assess Resident's ability to release velcro seat belt when asked daily every day shift (7/14/21) - 15 minute checks while in w/c every day and evening shift related to unspecified dementia without behavioral disturbance (5/10/21) Review of the Medication Administration Records (MAR) and Treatment Administration Records (TAR) for February 2024 and March 1 through March 13, 2024 for Resident #94 indicated but were not limited to the following: - Assess Resident's ability to release velcro seat belt when asked daily every day shift: indicated the Resident was unable to self release the seat belt 15 of 42 days with two additional day documented as not applicable (n/a) - Remove w/c velcro seat belt three times a week during activity and document any attempts to stand or self transfer every day shift every Monday, Wednesday, Friday for monitoring: documentation was completed throughout the two month period with a check mark only; there was no documentation available indicating the Resident's attempts to stand or self transfer - Remove velcro seat belt everyday during lunch and document any attempts to stand or self transfer one time a day for monitoring: documentation was completed throughout the two month period with a check mark only; there was no documentation available indicating the Resident's attempts to stand or self transfer - Velcro belt alarm on w/c. Can Resident release velcro seat belt when asked, does it proper fit and functioning when up in w/c. every day and evening shift for prevention of injury from falls: documentation was completed on 48 of 83 opportunities throughout the month with those 5 missed opportunities being blank and one indicating 8 = other - The February and March MAR and TAR failed to indicate that 15 minute checks while in the w/c every day and evening shift were being completed. The surveyor made the following observations of Resident #94 in his/her w/c: (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 3/13/24 at 11:50 A.M., Sitting in high back w/c at the nurses' station with velcro alarm seat belt in place secured around the Resident and mechanical lift sling under the Resident - 3/13/24 at 12:27 P.M., Sitting in high back w/c in the hallway next to his/her bedroom with velcro alarm seat belt in place secured around the Resident while he/she was consuming their lunch, the Resident had a mechanical lift sling underneath them in the w/c - 3/14/24 at 8:42 A.M., Sitting up in bed, alert consuming his/her breakfast - 3/14/24 at 10:39 A.M., Sitting up in bed, alert - 3/14/24 at 12:32 P.M., Sitting up in bed, alert - 3/15/24 at 8:38 A.M., Sitting in high back w/c in the hallway next to his/her bedroom with velcro alarm seat belt secured around the Resident and a mechanical lift sling underneath them in the w/c - 3/15/24 at 11:21 A.M., Sitting in high back w/c in the hallway next to his/her bedroom with velcro alarm seat belt secured around the Resident and a mechanical lift sling underneath them in the w/c At no time did the surveyor observe Resident #94 attempt to stand, self-transfer or be malpositioned in his/her w/c. Review of the February 2024 and March 1 through 13, 2024 CNA Care task documentation for Resident #94 indicated but was not limited to the following: Behaviors: of 158 potential opportunities, 46 opportunities were documented and of those all 46 documented opportunities indicated the Resident did not exhibit any behaviors Sit to stand: 158 potential opportunities, 63 opportunities were documented and of those 41 indicated task did not occur, 13 indicated maximum assistance, 1 indicated independent and 8 indicated total dependence with the ability to stand from a seated position During an interview on 3/14/24 at 12:33 P.M., Certified nurse assistant (CNA) #5 said Resident #94 was a mechanical lift for transfers and is not capable of standing or transferring without the use of a mechanical lift. She said the seat belt is to prevent the Resident from falling and the CNAs place it on him/her when they get out of bed and the Nurses do the special monitoring. During an interview on 3/14/24 at 12:36 P.M., CNA #6 said Resident #94 wears a seat belt in the w/c to keep him/her safe and prevent them from falling. She said the Resident is not capable of standing or getting out of bed without the use of the mechanical lift. She said she could not recall the last time she heard the seat belt alarm go off or alert the staff of the Resident removing the belt or attempting to stand up. She said the Resident used to attempt to get up on his/her own but she is not sure how long ago that was and the Nurses would know more. (continued on next page)

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F 0604

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During an interview on 3/14/24 at 12:52 P.M., Nurse #1 said Resident #94 has a seat belt alarm in place when he/she is in the w/c. She said the seat belt is in place because the Resident is a fall risk. She said the staff attempt to have the Resident self-release the seatbelt once a day on command, but the Resident requires a lot of cueing to get through the process of self-releasing the belt. She said there is a quarterly assessment that is required to be completed but was unsure if any other documentation was necessary. She said the Resident sets the alarm off and removes the seat belt spontaneously maybe once a month and that is usually triggered by a large music event in the facility or when the Resident has a lot of visitors and is excited to try to leave with them. She said hearing the seat belt alarm is pretty uncommon and definitely occurs less than weekly. She said the Resident is a mechanical lift for transfers and is not capable of standing on his/her own.

During an interview on 3/14/24 at 12:56 P.M., Nurse #2 said the seat belt is in place for fall prevention and safety and it is monitored by the Nurses daily. She said the Resident is not capable of standing or self-transferring but can self-propel in the w/c and that may cause him/her to slide forward. She said once in a while the Resident will attempt to stand if there is a lot of commotion on the unit or a big event, but she cannot recall the last time she heard the Resident's seat belt alarm alert the staff to him/her standing or attempting to remove the seat belt independently. She said there is a quarterly assessment that needs to be completed but she is unaware of any other documentation required for the Resident to have the seat belt. She said the Resident is physically capable of removing the seat belt but requires the staff to prompt and cue him/her on how to do so related to the Resident's cognitive issues.

Review of Resident #94's behavior monitoring on the February 2024 and March 1 through March 13 2024 MARs indicated, but was not limited to the following:

Behavior monitoring: Document number of episodes per shift of target behaviors: 1. exit seeking, 2. agitation, 3. refusing care every shift for behavior monitoring.

Review of the February 2024 and March 1 through 13, 2024 MARs for Resident #94 failed to indicate the Resident exhibited or was monitored for any behaviors of attempting to stand impulsively.

Review of the most recent Side rail/Restraint assessment for Resident #94, dated as completed on 1/25/24, indicated but was not limited to the following:

- Reason for assessment: Other: self-releasing seat belt in w/c and siderails

- Does the level of consciousness fluctuate: this section was left blank

- Cognition: yes the Resident has cognitive impairment, a diagnosis of dementia, is alert confused and impulsive with poor safety awareness

- Other: provides security for the Resident

- Risks/benefits of alternative: discussed with Resident and family

- Potential/actual restraint assessment: physical considerations

- Ambulation: wheelchair mobility

(continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Sitting: leans to a side, forward or backward - Transfers: unstable when making transfers - Other: history of falls - Comments: lower extremity weakness, impaired balance, slides down in w/c The document failed to indicate if the seat belt was necessary and if any alternatives were attempted as a least restrictive device for the Resident. Review of the current care plans for Resident #94, as of 3/14/24, indicated but were not limited to the following: Focus: Risk for falls due to poor safety awareness, can be impulsive, confusion, dementia and history of falls (revised: 8/17/23) Goal: Resident will be free of injury related to falls (revised: 9/13/23) Interventions: Physical therapy (PT) evaluate and treat as ordered or as needed, follow facility fall protocol (5/9/21) Anticipate and meet the Resident's needs, be sure call light is in reach and encourage use, clutter free environment, psych consult, use call bell for assistance with all transfers, ensure Resident is wearing appropriate footwear/non-skid socks when ambulating or mobilizing in the w/c, Self-releasing seat belt in w/c - ask Resident daily to release seat belt (revised: 10/5/23) Focus: Use/application of an external device for prevention of injury to self or others characterized by high risk for injury/falls, impaired mobility, physical aggression related to cognitive impairment, decreased strength, injury, loss of balance, poor posture (7/31/21) Goal: Resident will stay seated and have no falls while velcro seat belt is removed during lunch and during one activity three times per week; Resident will not injure self or others; No falls (revised: 9/13/23) Interventions: (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing to continue to evaluate need for velcro seat belt, remove velcro seat belt when at lunch meal and also when at one activity three times a week and document any attempts to stand (revised: 10/5/23) Discuss application of restraining device with Resident/ family on application of device, quarterly and when removed, use safety device (velcro seat belt) when in w/c (revised: 11/21/23) Monitor number/seriousness of falls for Resident and place in fall prevention program (1/31/24) Review of the medical record progress notes for Resident #94 from 1/1/24 to 3/13/24 failed to indicate the Resident suffered from any falls in the last three months. During an interview on 3/14/24 at 3:40 P.M., the Director of Nurses said if the Resident cannot release the seat belt whenever he/she wants then the seat belt is considered a restraint. She said the physician's order should be specific to the reason for the restraint including the medical condition or reason for its use and the care plan should also identify the medical condition for the use of the restraint and all less restrictive alternatives attempted and failed. She said it appears those pieces are not available or documented in the Resident's medical record and the Resident likely needs to be reassessed for the use of the seat belt or a less restrictive device. During an observation with interview on 3/15/24 at 11:21 A.M., Resident #94 was observed sitting in a high back w/c in the hallway with a velcro seat belt secured around the Resident and a mechanical lift sling underneath the Resident. Unit manager (UM) #1 was observed to request the Resident self-remove the velcro seat belt. The Resident said they would remove the belt but required significant cues by the UM on where to put his/her hand to grab the release strap of the seat belt and in which direction to pull the belt in order to remove it and then finally the Resident was capable of physically releasing the belt. She reviewed the medical record and said the documentation does not reflect the necessity of the velcro seat belt and there is no indication that less restrictive alternatives were attempted or have been attempted since the initiation of the seat belt about two years ago. She said the physician order is not specific to meet the policy guidelines with a medical condition or symptoms for the necessity of the seatbelt restraint and the Resident would likely benefit from other interventions like activity involvement and should be seen by rehab to determine if there is another device that could benefit the Resident and be less restrictive. She said in general a seat belt should not be used for fall prevention and since the Resident is a mechanical lift and incapable of standing the entire device likely requires reassessment. She said the last completed assessment was vague and really did not address the need for the seat belt. She said the seat belt would be a restraint for this Resident since the Resident cannot easily remove the belt without significant cueing and prompting by the staff related to their cognitive impairment. She said the expectation for restraint use and facility policy were not being met at this time.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 48084 Based on record review and interview, the facility failed to complete a Minimum Data Set (MDS) assessment that accurately reflected the status of one Resident (#108), out of a total sample of 24 residents. Specifically, for Resident #108, Section C of the MDS, the Brief Interview for Mental Status (BIMS), was not assessed and Section H, indicated Resident #108 had an indwelling catheter and he/she did not. Findings include: Resident #108 was admitted to the facility in April 2023 with diagnoses which included urinary retention and chronic kidney disease. Review of the MDS assessment, dated 10/17/23, indicated Resident #108 had scored 15 out of 15 on the BIMS, indicating he/she was cognitively intact. Review of the MDS assessment, dated 1/10/2024, Section C, indicated the BIMS assessment was not completed and Section H, indicated Resident #108 had an indwelling catheter. Review of the physician's orders failed to indicate Resident #108 had an indwelling catheter. During an interview on 3/18/24 at 4:18 P.M., MDS Nurse #1 said Resident #108 is alert and oriented and the BIMS should have been completed; she said she would have to complete a new BIMS and correct that. Additionally, she said Resident #108 does not have an indwelling catheter; the MDS was incorrect, and would have to be modified.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 42742 Based on record review, policy review, and interview, the facility failed to ensure staff developed and implemented a baseline care plan within 48 hours of the resident's admission, which included the instructions needed to provide effective and person-centered care to the resident and provide the resident and/or their representative with a summary of the baseline care plan for two Residents (#38 and #108), out of a total sample of 24 residents. Specifically, the facility failed: 1. For Resident #38, to provide him/her a written summary of the baseline care plan by completion of the comprehensive care plan and document receipt of the information within the Resident's clinical record; and 2. For Resident #108, to develop and implement a baseline care plan for the Resident's urinary retention, indwelling Foley catheter, and need for straight catheterization (insertion of a catheter into the bladder to drain urine which is then removed once the bladder is empty). Findings include: Review of the facility's policy titled Care Plans - Baseline, revised October 2022, indicated but was not limited to the following: -A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within 48 hours of admission. -The interdisciplinary team (IDT) will review the healthcare practitioner's orders (e.g. medications, routine treatments, etc.) and implement a baseline care plan to meet the resident's immediate care needs including but not limited to: a. initial goals based on admission orders b. physician orders c. therapy services d. social services -The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan. -The facility will provide the resident and the representative if applicable with a written summary of the baseline care plan by completion of the comprehensive care plan. -Facility will document and record receipt of information by family, whether in the form of a copy of signed acknowledgment or note within the resident's clinical record. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Resident #38 was admitted to the facility in October 2023 and had diagnoses including hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following cerebral infarction, depression, and anxiety disorder. Review of the Minimum Data Set (MDS) assessment, dated 10/31/23, indicated Resident #38 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. During an interview on 3/18/24 at 1:50 P.M., Resident #38 said no one from the facility met with him/her to discuss his/her baseline care plan and had not had a care plan meeting since admission but would like to. The Resident said he/she wasn't provided a copy of the document either. Review of the medical record for Resident #38 failed to indicate documentation that a care plan meeting had taken place upon admission or that the Resident was provided a written summary of the baseline care plan by completion of the comprehensive care plan that included the initial goals of the resident, a summary of the resident's medications and dietary instructions, any services and treatments to be administered by the facility, and any updated information based on the details of the comprehensive care plan, as necessary. During an interview on 3/18/24 at 2:44 P.M., Social Worker (SW) #1 said she would ask Social Worker #2 about it as she was assigned to the Resident and was not there today. SW #1 said when residents are admitted they should have an interdisciplinary care plan meeting with the resident and/or representative upon admission within 14 days and quarterly thereafter or as needed in between. SW #1 said the Resident was his/her own person and should have had a meeting by now and provided a copy of his/her care plans. During an interview on 3/19/24 at 7:10 A.M., SW #2 said she wasn't sure if she had a previous care plan meeting with the Resident upon admission or if she gave him/her a copy but had just conducted one on 3/18/24 and wrote a late entry in the medical record on 3/12/24. SW #2 provided the surveyor with a copy of her 3/12/24 and 3/18/24 progress notes but did not provide any documented evidence prior to those dates upon request. During an interview on 3/19/24 at 12:18 P.M., Consulting Staff #1 said every discipline should initiate a care plan and meetings are set up by the social workers. She said this should be done usually within 48-72 hours and the social workers would then print out a copy of the care plans to provide to the resident and/or the representative. 48084 2. Resident #108 was admitted to the facility in April 2023 with diagnoses which included urinary retention. Review of the Admission Nursing Evaluation-V7, dated 4/24/23, indicated Resident #108 had urinary retention and straight catheterization twice daily. Further review of the evaluation failed to indicate a care plan was initiated for urinary retention or the catheterization. Review of the Physician's Progress Note, dated 4/25/23, indicated Resident #108 had urinary retention and had an indwelling catheter in place draining clear yellow urine. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225667	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2024
NAME OF PROVIDER OR SUPPLIER: Pleasant Bay of Brewster Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 383 South Orleans Road Brewster, MA 02631	

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record failed to indicate a care plan had been developed upon admission. Further review of the medical record indicated the care plan was not developed until 8/9/23. During an interview on 3/18/24 at 4:18 P.M., the Minimum Data Set (MDS) Nurse #1 said there should have been a urinary retention/catheterization care plan developed on admission and she did not know why it was not done until 8/9/23. Additionally, she said Resident #108 was admitted in April 2023 with the issue. During an interview on 3/19/24 at 9:18 A.M., Unit Manager #1 said there should have been a care plan developed on admission. During an interview on 3/19/24 at 9:35 A.M., Nurse #12 said the baseline care plan is in the computer under evaluation and it should have been care planned on admission. During an interview on 3/19/24 at 12:26 P.M., Nurse #6 said the baseline care plan is generated from the Admission Nursing Evaluation-V7. She said a urinary care plan was not developed and it should have been. During an interview on 3/19/24 at 12:49 P.M., Nurse #13 said a care plan should have been developed and it was not. The Director of Nurses (DON) was not available for interview on 3/18/24 or 3/19/24. During an interview on 3/19/24 at 3:13 P.M., Consulting Staff #1 said the baseline care plan for his/her urinary retention and catheterization was not developed and it should have been.

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 42742 Based on observations, interview, policy review, and record review, the facility failed for nine Residents (#24, #226, #49, #14, #26, #58, #94, #44, and #114), out of a total sample of 24 residents, to develop and implement individualized person-centered care plans to meet the resident's physical, psychosocial and functional needs. Specifically, the facility failed: 1a. For Resident #24, to develop and implement a care plan that identified risk factors as well as interventions designed to reduce or prevent the development of pressure related ulcers/injuries upon which the Resident developed a facility acquired full thickness unstageable (actual depth of ulcer is completely obscured by slough and/or eschar in the wound bed) left heel ulcer; and b. to develop and implement a care plan that identified risk factors as well as interventions designed to help prevent incidents/accidents upon which the Resident who had six total falls, one of which resulted in an acute left-sided 7th rib fracture, healing 5th and 6th rib fractures, and a closed head injury; 2a. For Resident #226, to develop and implement a care plan to help prevent incidents/accidents; and b. to develop and implement a care plan to address the Resident's physical, psychosocial, and functional needs while receiving dialysis services; 3. For Resident #49, to develop a care plan for activities; 4. For Resident #14, to implement a care plan intervention of continual supervision during meals for the Resident's high risk for aspiration (the drawing of food or fluid into the lungs while eating); 5. For Resident #26, to develop a person-centered care plan for the use and care of a splint device to help prevent the worsening of a left hand contracture; 6a. For Resident #58, to develop and implement a person-centered care plan to ensure the use of physician ordered Geri-sleeves to help protect the Resident from skin tears on his/her bilateral arms, and b. to ensure the Resident was engaged in leisurely activities to help enhance his/her quality of life and had an individualized care plan indicating what types of leisurely pursuits the Resident may enjoy within their cognitive abilities; 7. For Resident #94, to implement the activities person-centered care plan; 8. For Resident #44, to develop and implement an individualized care plan for this Resident who would take their bedroom furniture apart; and (continued on next page)

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F 0656

Level of Harm - Actual harm

Residents Affected - Few

9. For Resident #114, to develop a care plan for activities.

Findings include:

Review of the facility's policy titled Care Plans Comprehensive, dated as revised 10/2022, indicated but was not limited to the following:

-a comprehensive, person-centered care plan that includes measurable objectives, and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.

-care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment

-the comprehensive person centered care plan will: describe services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being; include resident preferences and goals; incorporate identified problem areas and risk factors; reflect the resident's expressed wishes regarding care and treatment; aid in preventing or reducing the decline in the resident's functional status; enhance the optimal function of the resident; reflect currently recognized standards of practice for problem areas and conditions

-identify problem areas and their causes and develop interventions that are targeted and meaningful

1. Resident #24 was admitted to the facility in December 2023 with diagnoses including encephalopathy (any brain disease that alters brain function or structure), diabetes mellitus type 2, seizures, unsteadiness on feet, and lack of coordination.

Review of the Minimum Data Set (MDS) assessment, dated 12/28/23, indicated Resident #24 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15, was at risk for developing pressure ulcers, and had no unhealed pressure ulcers. The MDS also indicated the Resident was frequently incontinent of urine, was a substantial/maximum assist for toileting. The MDS failed to indicate an admission fall history was determined.

a. Review of the medical record for Resident #24 failed to indicate a comprehensive care plan was developed on admission for the prevention of skin breakdown and pressure injuries despite the MDS indicating the Resident was at risk for developing pressure injuries.

Review of the Admission Physician's Progress Note, dated 12/23/23, indicated the Resident's skin was warm and dry and had chronic lower extremity edema versus lymphedema. There was no mention of an alteration in skin integrity.

Review of a nursing Skilled Evaluation note, dated 1/5/24, indicated the Resident's skin was warm and dry, skin color within normal limits and turgor was normal. There was no mention of an alteration in skin integrity to the Resident's left heel.

Review of a Physician's Progress Note, dated 1/8/24, indicated Resident #24 reported left heel pain. His/Her extremities were edematous and swollen and a left heel blister was noted with some darkened fluid as if there was mild bleeding within; no erythema or induration to suggest infection.

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of the medical record indicated a Norton Scale for Predicting Risk of Pressure Ulcer assessment was completed on 1/12/24, three days after the identification of a left heel blister and three weeks after admission, indicating Resident #24 was at high risk for developing pressure injuries. Review of the medical record indicated a care plan was developed on 1/12/24 for an alteration in skin integrity, three days after the left heel blister was identified. Interventions included but were not limited to weekly skin checks, follow MD orders for skin care and treatments, heels off-loaded when in bed, inspect feet daily with care and moisturizer, and pressure ulcer risk assessment weekly x 4 upon admission then quarterly and with change in condition. Review of the medical record indicated a Clinical Admission note was completed as a late entry on 1/24/24, 33 days after admission. The progress note indicated Resident #24 had a left heel diabetic foot ulcer with slough present in the wound bed, purulent wound exudate, fragile skin peri wound, minimal dressing saturation, boggy skin, pain, and was receiving daily wound treatments. Resident #24 was referred to the Wound Physician for evaluation. Review of the Initial Wound Evaluation and Management Summary for Resident #24, dated 1/25/24, indicated an unstageable (due to necrosis) full thickness wound was located on the left heel. The visit note indicated the wound was a new injury, >11 days in duration, measured 4.3 x 2.5 x 0.1 centimeters (cm) and was a pressure wound. Recommendations included: Primary Dressing - normal saline wash apply once daily for 30 days, Iodosorb gel, apply once daily for 30 days Secondary Dressing - abdominal pad apply once daily for 30 days, gauze roll (stretch) 4 apply once daily for 30 days, tape (waterproof adhesive) apply once daily for 30 days -Peri-wound Treatment - skin prep apply once daily for 30 days Plan of Care Recommendations - elevate legs, float heels in bed, off-load wound, reposition per facility protocol, pillows, booties Review of Resident #24's care plan indicated the recommended intervention for booties was not implemented until 2/6/24, 12 days after the wound doctor assessed the Resident. During an interview on 3/14/24 at 10:42 A.M., the surveyor observed Resident #24 lying in bed. The Resident did not have a foam bootie on his/her left foot as recommended by the wound doctor. He/she said the last time it was applied was maybe last week, but lately never. The Resident said he/she started with a blister on his/her left heel which had gotten worse since then, hurt more, and felt like it was infected. During an interview on 3/14/24 at 3:18 P.M., Nurse #9 said Resident #24 was at risk for developing pressures and had a stage 2 pressure ulcer on his/her left heel. On 3/18/24 at 11:20 A.M., the surveyor observed Resident #24 lying in bed. The Resident's heels were not elevated off the mattress and a foam bootie was not observed on the Resident's left heel in accordance with the Resident's plan of care. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/19/24 at 10:26 A.M., Nurse #13 said Resident #24 was at risk for developing pressures, had pressure sites on his/her feet, and had basic bootie and heel protection orders. She said the 1/25/24 wound note indicated an unstageable pressure wound of the left heel that was new and > 11 days old. She said a new treatment was recommended on that visit and subsequent visits for a normal saline wash and Iodosorb dressing daily along with to float the Resident's heels while in bed, elevate the legs, and use pillows and booties, but the order was not entered until 3/14/24. She said there was no admission skin evaluation, no Braden risk assessment (Norton Scale) completed until 1/12/24, and a care plan for skin integrity was not developed or implemented until 1/12/24. She said interventions and treatments should have been implemented consistently to improve skin and to prevent/avoid any pressure related injuries. During an interview on 3/19/24 at 1:35 P.M., the surveyor reviewed the medical record with the Director of Nurses (DON) and Consulting Staff #1. Consulting Staff #1 said the Resident was not admitted with a left heel wound. She said physician's notes dated 12/23/23 (admission note) did not mention anything about the Resident's heels until the 1/9/24 note. She said the first skin evaluation was not conducted until 1/24/24 but should have been done upon admission and weekly. Consulting Staff #1 said the initial wound note on 1/25/24 indicated the left heel was a new pressure wound. Consulting Staff #1 said there was no care plan in place for skin integrity until 1/12/24 and care planned interventions should be reviewed and revised quarterly and with any changes. b. During an interview on 3/14/24 at 10:42 A.M., Resident #24 said he/she had had three falls in the last month and a half and said, I get dizzy when I stand up. The Resident said his/her legs were weak and unsteady. The Resident said he/she gets up on his/her own to go to the bathroom and loses his/her balance and does hit the call bell, but they don't come in time. Resident #24 said he/she currently had a broken rib with a 3 out of 10 (10 being the worst) pain every time I breathe and was taking Oxycodone for pain. Review of the medical record failed to indicate a comprehensive fall care plan was developed on admission to the facility and implemented for the prevention of falls and injury. Review of the medical record indicated Resident #24 had an unwitnessed fall on 1/10/24 at 11:15 P.M. and was found sitting on the floor in the bathroom with his/her walker at his/her back. The Resident stated he/she went into the bathroom to urinate, was washing his/her hands and lost balance and stumbled to the floor. The Resident complained of left arm pain and right rib pain and requested to be transferred to the emergency department (ED) for evaluation (no acute findings). Review of the fall incident reported indicated predisposing factors included weakness, decreased safety awareness, impaired memory, and decreased strength/endurance. No injuries were observed by staff. Review of the medical record indicated an Admission Fall Risk Evaluation was not completed until 1/12/24, three weeks after the admitted and two days after the first fall was sustained, which indicated Resident #24 was at high risk for potential falls. The evaluation indicated prevention protocol should be initiated immediately and documented on the care plan. Further review of the medical record failed to indicate the interdisciplinary team (IDT) had identified and implemented appropriate interventions to help reduce the risk of falls or injuries upon admission until 1/12/24, two days after the first fall. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Resident #24's comprehensive care plan initiated on 1/12/24 indicated he/she was at moderate risk for falls related to deconditioning, incontinence and medication use. A goal was developed to not sustain serious injury and included (but not limited to) interventions to be sure the call light is within reach and prompt response to all requests, ensuring appropriate footwear is in place when ambulating, physical therapy as needed and ensuring a safe environment with floors free from spills and/or clutter; adequate light and a working call light within reach. Further review of the medical record indicated Resident #24 had an unwitnessed fall on 1/13/24 at 11:27 A.M. , and was found sitting on his/her bottom with his/her back to the bathroom wall. The Resident stated he/she was toileted by an aide and when finished, he/she got up to get back into bed and lost his/her balance and fell . No injuries were observed pre- or post-incident. Predisposing factors included confusion and gait imbalance. Review of the care plans failed to indicate new interventions were implemented to help keep the Resident safe and prevent a repeat fall. Review of the medical record indicated Resident #24 had a third unwitnessed fall on 1/21/24 at 1:00 P.M. and was found sitting on the floor next to the room door and bathroom door. The call light was placed by the roommate. The Resident had complaints of arm pain and said he/she had tendonitis. Weakness was noted to the bilateral lower extremities (HX of CVA). No injuries were observed. The Resident was noted to have some confusion stating he/she was going to the bathroom. The Resident is a total assist at baseline. Predisposing factors identified included confusion, weakness, decreased safety awareness, and decreased strength. A new Risk for Falls care plan was initiated on 1/21/24 and included interventions such as to assist the resident with ambulation and transfers utilizing therapy recommendations, educate the resident on maintaining a safe environment, ensure call light is available, and if a fall occurs alert the provider and initiate frequent neuros and bleeding eval per facility protocol. There were no goals listed. Further review of the medical record indicated Resident #24 had another unwitnessed fall on 2/19/24 at 5:00 A.M. and was found sitting on his/her bottom on the floor at the bedside. The Resident stated he/she had just finished using the urinal and his/her feet slid out from under him/her. The Resident complained of a sore left arm and bottom after landing on them. No injuries were observed. Predisposing factors included poor lighting, gait imbalance, and decreased strength. Review of the care plans failed to indicate new interventions were implemented to help keep the Resident safe and prevent a repeat fall. The medical record further indicated Resident #24 had a second unwitnessed fall on 2/19/24 at 10:23 P.M. and was found sitting on the floor in the bathroom. The Resident stated he/she was toileting self with walker and lost his/her foot grip with non-skid slipper socks on and fell to the floor. The Resident complained of left rib cage and left arm/elbow pain with limited range of motion to the left upper extremity. The Resident refused ED transport. A stat x-ray was ordered for the left rib cage and left upper extremity. No injuries were observed at the time of the incident. Predisposing factors included trip hazard, impulsiveness, and ambulating without assist. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of the care plans failed to indicate new interventions were implemented to help keep the Resident safe and prevent a repeat fall. Review of the medical record indicated Resident #24 had an unwitnessed fall on 2/25/24 at 11:51 P.M and was found on the floor in the room next to his/her bed. The Resident stated, I fell and hit my head really hard and it's hurting. No injuries were observed at the time of the incident. The Resident was transported to the ED for evaluation. Predisposing factors included gait imbalance and decreased strength and that the incident occurred during unassisted self-transfer from the bed and ambulating independently. Review of the ED report, dated 2/26/24 at 12:18 A.M., indicated but was not limited to the following: -The Resident has a history of prior strokes with left-sided weakness and was status post an unwitnessed fall at the rehab center going to the bathroom, lost his/her balance and fell back. Resident reported striking his/her head and brief loss of consciousness. He/she stated he/she was unable to get up off the ground and was found approximately 10 minutes later. Complaints of right shoulder pain, headache, and neck pain. ED diagnoses included healing fractures of the left 5th and 6th ribs, an acute fracture in the left 7th rib, and a closed head injury. The Resident was discharged back to the facility at 3:17 A.M. Review of the care plans failed to indicate new interventions were implemented to help keep the Resident safe and prevent a repeat fall. On 3/19/24 at 7:50 A.M., the surveyor observed Resident #24 awake and lying sideways in the bed, with both feet on the ground. The Resident was not wearing non-skid socks or footwear. During an interview on 3/19/24 at 11:25 A.M., Nurse #13 said Resident #24 was at risk for falls and had had multiple falls since admission. She said a fall risk care plan was not initiated until 1/12/24 and new interventions were not identified or implemented after each fall to help reduce the Resident's fall risk. Nurse #13 said if interventions are unsuccessful and a resident continues to fall, they should be assessed for changes and additional interventions put in place. During an interview on 3/19/24 at 1:09 P.M., with the DON and Consulting Staff #1, the DON said she was new to the facility with a start date of 3/4/24 and referred questions to Consulting Staff #1. Consulting Staff #1 said there was no falls care plan in place, or a fall risk assessment completed prior to the Resident's first fall on 1/10/24 but should have been as that would have potentially identified the Resident as being a fall risk with the appropriate interventions in place. Consulting Staff #1 said a care plan for falls and ADLs was not initiated until two days after the first fall and did not indicate an actual fall had occurred. She said new interventions were not added after each of the subsequent falls and, the interventions that were in place, were not effective to help prevent future falls and avoid injury. 2. Resident #226 was admitted to the facility in February 2024 with diagnoses including fracture of right neck of femur, reduced mobility, dependence on renal dialysis, symptoms and signs involving cognitive functions and awareness, difficulty in walking, muscle wasting and atrophy, and end stage renal disease. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of the MDS assessment, dated 2/24/24, indicated Resident #226 had moderate cognitive impairment as evidence by a BIMS score of 11 out of 15, required dialysis, used a walker, car transfer in/out of car or van was not attempted due to safety or medical concerns, walking 10 feet and 50 feet required supervision or touch assist, and walking 150 feet was not attempted. a. Review of the Patient Care Referral Form, dated 2/18/24, indicated Resident #226 presented to the ED on 1/26/24 after a mechanical fall at home. The Resident sustained a right femoral subcapital fracture (occurs in the neck of the thighbone) and underwent hemiarthroplasty (partial hip replacement) on 1/27/24. He/she was transferred to a short-term rehab facility on 2/2/24 through 2/18/24. The Resident's family was unable to provide the level of assistance needed for safe discharge home and ongoing rehab was recommended. The Resident was then transferred to the current nursing facility to continue to receive therapy services. Review of the medical record failed to indicate an Admission Fall Risk Evaluation had been completed to determine the Resident's history of falls and risk factors to help prevent subsequent falls. Further review of the medical record failed to indicate the interdisciplinary team (IDT) had identified and implemented appropriate care planned interventions to help reduce the risk of falls or injuries and the level of assistance required for activities of daily living (ADLs) per facility policy. During an interview on 3/14/24 at 8:17 A.M., Nurse #6 said Resident #226 was arranged to take a bus to and from dialysis, but the bus driver yesterday just dropped him/her off and did not wheel him/her in like they usually do. Nurse #6 and Nurse #10 said they both saw the resident just walking in to the facility's main lobby. During an interview on 3/19/24 at 9:10 A.M., the surveyor reviewed the medical record with Nurse #6 who said the Resident did not have a comprehensive, person-centered care plan that included risk factors for identified problem areas such as PT/rehab status post hip surgery, ADLs, and fall risk interventions to ensure the Resident's safety and maintain hip precautions. Nurse #6 said an admission Fall Risk Evaluation was not done. She said last week the Resident went to dialysis then she saw him/her in the lobby walking independently with a walker, I guess the driver just dropped him/her off, there was no one with him/her. During an interview on 3/19/24 at 12:44 P.M., with the DON and Consulting Staff #1, Consulting Staff #1 said the Resident should not have been ambulating independently and nursing staff should be aware of any precautions in place and the Resident's ambulatory status. She further said the Resident's care plan was not comprehensive for ADLs, PT/OT/rehab, and fall risk, and there was no fall risk evaluation completed upon admission but should have been. b. Review of current Physician's Orders indicated the following: -Resident to attend dialysis 3 times a week on Monday, Wednesday, and Friday. Pick up time at 10:30 A.M., by Cape Cod Regional Transit Authority (CCRTA) bus for a chair time of 12:00 P.M. - 5:00 P.M. for dialysis, 2/19/24 (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/12/24 at 10:53 A.M., Resident #226 said he/she goes to dialysis on Mondays, Wednesdays, and Fridays and had a left arteriovenous (AV) fistula (irregular connection between an artery and a vein used for dialysis). Review of the medical record failed to indicate a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs was developed and implemented with problem areas such as dialysis identified with targeted interventions added. During an interview on 3/19/24 at 9:16 A.M., the surveyor reviewed the medical record with Nurse #6 who said the Resident was receiving dialysis services but did not have a care plan in place for it or targeted interventions. During an interview on 3/19/24 at 12:44 P.M., Consulting Staff #1 said the Resident did not have a comprehensive care plan that included dialysis but should have. 3. Resident #49 was admitted to the facility in November 2023 with diagnoses including schizoaffective disorder, bipolar type, dementia, and anxiety disorder. Review of the MDS assessment, dated 1/1/24, indicated Resident #49 had moderate cognitive impairment as evidenced by a BIMS score of 12 out of 15. Review of current Physician's Orders indicated the following: -May participate in activities (as tolerated) not in conflict with medical care plan, 1/17/23 During an interview on 3/18/24 at 8:01 A.M., the surveyor observed Resident #49 sitting alone in the main lobby listening to music. The Resident said he/she liked to participate in activities but no one from the activities staff had met with him/her about it to discuss his/her preferences. The Resident said he/she wished there was more art as he/she liked to do that. Review of the Resident's medical record for Resident #49 failed to indicate an activities care plan had been developed for the Resident who liked to listen to music and participate in art activities. During an interview on 3/19/24 at 12:35 P.M., Consulting Staff #1 said Resident #49 had not had an activities assessment completed since admission and there was no care plan for it. 43935 4. Resident #14 was admitted to the facility in September 2018 and has the following diagnoses: Parkinson's disease, Diabetes mellitus type 2 and gastro-esophageal reflux disease (a condition in which stomach contents move up into the esophagus). Review of the most recent BIMS for Resident #14 indicated he/she was moderately cognitively impaired with a score of 11 out of 15 and his/her healthcare proxy (HCP) was invoked. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225667	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2024
NAME OF PROVIDER OR SUPPLIER Pleasant Bay of Brewster Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 383 South Orleans Road Brewster, MA 02631	

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F 0656 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 3/12/24 at 12:38 P.M., Family Member #3 said he doesn't get to come by much but there are issues with the Resident eating meals and another family member comes to the facility weekly to make sure the Resident gets the help he/she needs since the facility does not help him. During a telephone interview on 3/21/24 at 2:31 P.M., Family Member #4 said he specifically comes to visit Resident #14 at least weekly at meal time to help the Resident consume his/her meal. He said most of the time the Resident struggles to get the food from the spoon to his/her mouth and more than half the meal usually ends up on the Resident's lap or table and causes the Resident frustration. He said he doesn't know if the facility staff don't have the time or if the Resident is ineligible for assistance at meals, but the Resident grew up with his/her entire family running a restaurant business and food brings him/her lots of joy. He said he would be grateful if the facility would provide the Resident with more assistance during meals because he/she loves to eat and the entire experience of having a meal. He said he comes in to assist the Resident, who needs to be reminded not to rush because he/she is a choking risk and gets pneumonia. He said the Resident is not always capable of completing the task of eating independently and they leave the Resident alone to do so and that is his only concern. Review of the current care plans for Resident #14 indicated, but were not limited to the following: Focus: Resident has a self care deficit secondary to limited physical mobility related to Parkinson's disease and impaired vision (revised: 5/31/22) Goal: Resident will safely perform to maximum ability with self care activities through target date (revised: 3/12/4) Interventions: Eating: Continual supervision; aspiration risk (revised: 1/22/24) The surveyor made the following observations and had the following interactions with Resident #14: - 3/12/24 at 8:39 A.M., Resident in bed with breakfast in front of him/her. Resident was using a weighted spoon and attempting to eat his/her puree pancakes. The spoon was half empty or empty once the Resident got the food to his/her mouth landing on the Resident's shirt and overbed table. Resident #14 said, I'm doing poorly, I can't get this, and continued to attempt to scoop a spoon of scrambled egg into his/her mouth, but the food was dropping off the spoon and the Resident placed an empty spoon into their mouth. There was no staff in the room providing supervision or assistance to the Resident. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	- 3/12/24 at 8:49 A.M., Resident attempting to eat breakfast with the weighted spoon. Resident got approximately a half spoon full of egg into his/her mouth and said, Got some. Egg and pancake were observed on the Resident's clothing and table. There was no staff in the room providing continual supervision or assisting the Resident. - 3/12/24 at 8:53 A.M., Resident eating egg and pancake mixture with weighted spoon, but the Resident's hands were shaking hands as he/she attempted to scoop them into his/her mouth. There were no staff in the room providing supervision or assistance, Resident #14 said: I need help, I can't get it all. - 3/12/24 at 12:23 P.M., Sitting in high back wheelchair in his/her room leaning slightly forward to the right. Lunch was in front of the Resident and he/she appeared to be struggling while attempting to scoop ground meat with tomato sauce on it into his/her mouth with the weighted spoon. The Resident said, It's a bit hard. There were no staff members providing supervision or assistance to the Resident. The surveyor observed three Certified nurse assistants (CNA) standing at the opposite end of the hall socializing. - 3/12/24 at 12:36 P.M., CNA #8 entered Resident #14's room and asked the Resident if he/she was done eating lunch. The Resident replied, I'm hungry still and the CNA replied, Ok, well go ahead and eat then and left the room without providing the Resident any assistance or supervision. Only about 25% of the lunch meal was observed to be missing from the lunch tray at this time. - 3/12/24 at 12:47 P.M., CNA #8 re-entered Resident #14's room and asked if the Resident was still eating or if she could take the lunch tray. The Resident replied: ok can I just have a little something and the CNA offered the Resident a pudding dessert and milk. CNA #8 said the Resident ate about 50% of his/her meal. Food was observed on the Resident's lap. She did not remain with the Resident while he/she consumed their pudding and milk. - 3/13/24 at 8:03 A.M., CNA #7 repositioned Resident #14 in his/her bed and provided him/her their breakfast tray. The tray consisted of scrambled eggs and moist puree appearing pancakes and the Resident was left alone to consume it. CNA #7 did not stay in the room to provide the Resident with supervision or assistance if needed. - 3/13/24 at 8:20 A.M., Resident was struggling to use the weighted spoon to bring a scoop of eggs to his/her mouth. Food was falling off the spoon as it made its way to the Resident's mouth. There were no staff in the room providing supervision to the Resident. - 3/13/24 at 8:49 A.M., Resident observed to have eggs on their lap/clothing. There was no staff in the room to supervise or assist the Resident. Resident #14 said, I'm trying to get more and thank you for checking on me. - 3/13/24 at 12:23 P.M., Sitting up in the bed with lunch meal in front of him/her and the weighted spoon in his/her right hand. The Resident was attempting to scoop a spoonful of ground meat with tomato sauce into his/her mouth and some food was falling off the spoon as he/she reached their mouth landing on his/her lap. The Resident said, I'm having a problem and was observed to be having difficulty consuming their meal. There were no staff in the room providing supervision. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225667	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2024
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F 0656 Level of Harm - Actual harm Residents Affected - Few	-3/14/23 at 8:30 A.M., Sitting in bed, using the weighted spoon to bring scrambled egg to his/her mouth with shaking hands. The Resident was observed to cough following a full spoon of eggs making it into his/her mouth. A second attempt of bringing a scoop of egg to his/her mouth resulted in egg being spilled on the Resident's chest. There was no staff in the room to supervise the Resident. 3/14/24 at 12:24 P.M., Sitting in high back wheelchair in his/her room consuming his/her lunch. There were no staff in the room providing supervision to the Resident. 3/15/24 at 8:39 A.M., Sitting in bed attempting to eat scrambled eggs with a weighted spoon, there is egg observed on the Resident's chest, there are no staff in the room supervising the Resident. Review of the medical record for Resident #14 indicated a Speech Language Pathology (SLP) skilled therapy discharge summary dated: 9/6/23, that indicated, but was limited to the following information: - Resident is at elevated risk for aspiration with all by mouth (PO); Resident is receptive to cues for small bites, slow rate of intake. - Resident requires supervision or assistance at meal time due to safe swallowing 76 - 90% of the time During an interview on 3/13/24 at 1:52 P.M., the SLP said she knew Resident #14 and had treated him/her. She said Resident #14 is very high risk for aspiration and should be supervised for meals to ensure he/she is safe from aspiration. During an

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 48362 Based on record review and interviews, the facility failed to ensure care plans were reviewed with the interdisciplinary team (IDT) as required for one Resident (#2), out of a total sample of 24 residents. Specifically, the facility failed to review and revise the fall care plan with the IDT after each Minimum Data Set (MDS) assessment. Findings include: Review of the facility's policy titled Comprehensive Care Plan, revised October 2022, included but was not limited to: - A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychological and functional needs is developed and implemented for each resident. - The IDT, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. - The IDT reviews and updates the care plan when there has been a significant change in the resident's condition; when the desired outcome is not met; when the resident has been readmitted to the facility from a hospital stay; and at least quarterly, with scheduled quarterly MDSs. Review of the facility's policy titled Fall Prevention and Management, revised January 2023, included but was not limited to: - The IDT identifies and implements appropriate interventions to reduce the risk of falls or injuries while maximizing dignity and independence. - The staff will implement goals and interventions with resident/patient/family for inclusion in the IDT care plan based on the resident's individual needs. - The staff will review and review the IDT care plan when a change is identified, after an event. - The IDT should monitor and document on resident's response/success with fall reduction interventions. - Resident's who continue to fall with interventions in place will be assessed for changes in or additions to interventions. Resident #2 was admitted to the facility in February 2021 with diagnoses including schizoaffective disorder, type II diabetes, hypertension, and depression. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) assessment, dated 1/24/24, indicated Resident #2 had a severe cognitive impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 6 out of 15. Further review of the MDS assessment indicated Resident #2 had a history of two or more falls since previous assessment and required assistance from staff for bed mobility, transfers, toileting, dressing and hygiene. Review of the IDT fall care plan for Resident #2 indicated he/she was at risk for falls characterized by history of falls/injury, multiple risk factors related to impaired balance as well as use of psychotropics and opioids (revised 8/17/23). Review of Resident #2's Incident Report, dated 12/1/23, indicated Resident #2 had a witnessed fall in the dining room while attempting to rise from his/her wheelchair. Further review of Resident #2's IDT care plan failed to indicate it was reviewed or revised after the fall. Review of Resident #2's Incident Report, dated 12/9/23, indicated Resident #2 had an unwitnessed fall in the dining room while attempting to rise from his/her wheelchair. Further review of Resident #2's IDT care plan failed to indicate it was reviewed or revised after the fall. During an interview on 3/19/24 at 9:57 A.M., Nurse #5 said when a resident falls an evaluation is completed including an assessment of vitals and pain. Nurse #5 said they were unsure of who was responsible for updating care plans and developing interventions to the fall. Nurse #5 said they attempt to keep Resident #2 in line of sight once he/she is out of bed for the day related to their history of falls. Nurse #5 said Resident #2 is often found close to the nurses' station or in the dining room with supervision. During an interview on 3/19/24 at 11:00 A.M., Unit Manager (UM) #1 said fall packets are completed post assessment to indicate the circumstances surrounding the fall. UM #1 said fall packets should include information regarding immediate interventions put in place to prevent further falls. UM #1 and the surveyor reviewed the medical record findings for Resident #2. UM #1 said care plans should have been updated after each fall including interventions put into place to prevent further incidents. During an interview on 3/19/24 at 2:56 P.M., the Regional Clinical Director said an assessment is completed after each fall to identify the incident. The Regional Clinical Director said an immediate intervention should be documented and updated in the care plan after a resident fall. The Regional Clinical Director said each fall should have had an intervention put in place post incident and been reflected in an updated care plan.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 42742 Based on record review, interview, and policy review, the facility failed to follow professional standards of practice for six Residents (#38, #227, #226, #58, #108, and #70), out of a total sample of 24 residents. Specifically, the facility failed: 1. For Resident #38, to follow a physician's order to complete a physical therapy evaluation; 2. For Resident #227, to obtain weights per physician's orders; 3. For Resident #226, to obtain weights per physician's orders; 4. For Resident #58, to follow physician's orders for the use of Geri-sleeves; 5. For Resident #108, to schedule a urology follow up appointment; and 6. For Resident #70, to complete an incident report, fall evaluations, neurological assessments, and post fall notes per facility policy. Findings include: 1. Review of the facility's policy titled Therapy Referral, revised January 2023, indicated but was not limited to the following: -Once a resident is identified as needing an evaluation by speech, occupational or physical therapy services the following procedure will be followed: a. Physician notification with request for referral. b. Order written by physician or by nurse and sent to the therapy department for the evaluation and treatment as indicated. c. The therapist shall evaluate the resident and establish treatment plans and goals. Resident #38 was admitted to the facility with diagnoses including hemiplegia (paralysis on one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebral infarction affecting the left non-dominant side. Review of the Minimum Data Set (MDS) assessment, dated 10/31/23, indicated Resident #38 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 and was dependent on staff for toileting, bathing/showering, and chair to bed/bed to chair transfer. Walking was not assessed. During an interview on 3/13/24 at 12:04 P.M., Resident #38 said he/she transferred from another facility and was not screened by physical therapy upon admission. (continued on next page)

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F 0658

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Review of current Physician's Orders indicated the following:

-Physical Therapy (PT) eval and treat, 11/20/23

During an interview on 3/14/24 at 1:05 P.M., the Rehabilitation Director (RD) said the Resident was screened upon admission and screened out but could not locate the documentation that this was done. She said she was unaware the physician had written an order for a PT eval and screen in November and was not done.

During an interview on 3/18/24 at 1:50 P.M., Resident #38 said he/she spoke to a rehab staff member the first week he/she was here to request therapy services but was told they had to screen all the patients who came from the hospital first. The Resident said he/she never heard back. Resident #38 said he/she had a history of a stroke, and his/her left leg and arm didn't work well, and no one got back to him/her about it until last week after the surveyor said something.

During an interview on 3/18/24 at 3:12 P.M., Nurse #8 said the physician's order for PT to eval and treat was entered on 11/30/23 and should have been completed. She said if there's an order for it, then nursing staff will print it out and put a copy in the rehab box downstairs or use a therapy referral sheet to alert them She said rehab won't know there's an order unless they are alerted to it by nursing staff as their system is different.

During an interview on 3/19/24 at 12:18 P.M., Consulting Staff #1 said every resident upon admission should be screened by the rehab team to determine if they need an evaluation and treatment and it didn't matter if they were a short-term resident or a long-term resident. She said if a physician orders a PT eval and treatment, the nurse fills out a rehab screen tool and gives it to rehab as there is nothing to alert the rehab staff there is someone newly admitted . Consulting Staff #1 said the rehab staff can see the facility's electronic health record (EHR) system but do not get alerted if there's a PT eval ordered. She said rehab should be receiving a list of residents who are new to the facility.

2. Review of the facility's policy titled Weight Assessment and Interventions, revised May 2019, indicated but was not limited to the following:

-The nursing staff will measure resident weights within 24 hours of admission, weekly for four weeks, then monthly thereafter

-Weights from the hospital should not be used in lieu of weighing the resident

-Weights will be recorded in the medical record for each resident

Resident #227 was readmitted to the facility in March 2024 and had diagnoses including severe protein-calorie malnutrition, acute kidney failure, cerebral infarction, malignant neoplasm of the parotid gland, Hodgkin lymphoma, and intestinal bypass and anastomosis.

Review of the MDS assessment, dated 3/4/24, indicated Resident #227 was cognitively intact as evidenced by a BIMS score of 15 out of 15, was 68 inches tall and weighed 103 pounds, and had a feeding tube.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225667	A. Building B. Wing	03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #227's Weight Summary indicated the following: 2/28/24 (11:04 A.M.), 103.0 pounds (Lbs.) 2/28/24 (3:40 PM.), 103.0 Lbs. chair scale Review of current Physician's Orders indicated the following: -Weekly weight every day shift every Monday, 3/11/24 Review of Dietitian Notes, dated 3/12/24 and 3/16/24, indicated the Resident's current weight was pending. Further review of Resident #227's Weight Summary and review of the March 2024 Treatment Administration Record (TAR) failed to indicate the 3/11/24 weekly weight was obtained and recorded in the Resident's electronic medical record as ordered by the physician. During an interview on 3/18/24 at 11:02 A.M., Nurse #7 said the Resident had a feeding tube for severe dysphagia (difficulty swallowing), malnutrition, esophageal stricture, and parotid gland mass. She said the last weight she could see in the medical record was on 2/28/23. She said the ordered 3/11/24 weekly weight was not documented as being obtained and if it wasn't documented, then it wasn't done. During an interview on 3/19/24 at 12:39 P.M., Consulting Staff #1 said she did not see a weight recorded since 2/28/24 but should have been done and, if not, then a reason documented as to why not. 3. Review of the facility's policy titled Weight Assessment and Interventions, revised May 2019, indicated but was not limited to the following: -Residents receiving hemodialysis treatment should be weighed pre- and post-treatment at dialysis. Post weights should be recorded in the Resident's medical record (EHR where applicable) upon return from hemodialysis treatments by their licensed nurse. Resident #226 was admitted to the facility in February 2024 with diagnoses including dependence on renal dialysis and end stage renal disease (ESRD). Review of the MDS assessment, dated 2/24/24, indicated Resident #226 had moderate cognitive impairment as evidenced by a BIMS score of 11 out of 15 and was receiving dialysis services. Review of Physician's Orders indicated the following: -Resident to attend dialysis 3 times a week on Monday, Wednesday, and Friday. Pick up time at 10:30 A.M. for a chair time of 12:00 P.M.-5:00 P.M., 2/18/24 -Record post dialysis weight on Mondays in the evening every Monday, record post-dialysis weight from dialysis, call if not recorded by dialysis center, start 2/26/24, stop 3/7/24 (continued on next page)

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F 0658

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

-Weight every week for four weeks one time a day every 7 days until 3/11/24, start 2/19/23, stop 2/22/24

-Record post dialysis weight on Friday in the evening, every Friday, call if not recorded by dialysis center, 3/7/24

Review of a Dietitian's Note, dated 2/19/24, indicated the Resident's weight was 179.2 pounds per hospital record, weight is stable.

Review of the Nutrition care plan, initiated 2/22/24, indicated to obtain weight per MD order on the same scale and record post dialysis weight, 2/22/24

Review of Resident #226's Weight Summary indicated the following weights:

2/22/24 - 179.2 pounds, hospital weight

Review of a Dietitian Note, dated 2/22/24, indicated to record post dialysis weight, once weekly - order clarified, current weight is pending

Review of the February 2024 Treatment Administration Record (TAR) indicated the following:

2/19/24 - weekly weight not completed, reason code 1 (out of the facility)

2/26/24 - post dialysis weight not completed, reason code 1 (out of the facility)

Review of the March 2024 TAR indicated the following:

3/4/24 - post dialysis weight documented as being obtained, no actual weight recorded

3/8/24 - post dialysis weight documented as being obtained, no actual weight recorded

Review of the medical record failed to indicate documentation that an admission weight was obtained within 24 hours and failed to indicate documentation of post-dialysis weights in the Resident's medical record upon return from hemodialysis treatments by their licensed nurse per facility policy and care planned intervention.

Resident #226's Dialysis Communication Book was unable to be located by staff until the last day of survey on 3/19/24.

During an interview on 3/18/24 at 1:16 P.M., Dialysis Staff #1 said Resident #226 had had 13 visits to the dialysis facility thus far. She said the dialysis book includes the primary means of communication but can be verbal as well. She said the book contains communication forms that indicate the pre and post dialysis weights. She said if there is no book that accompanies the Resident then dialysis staff will write a note and send it back with the Resident. She further said she only saw some documentation of communications in their record system with the nursing facility's dietitian, not the nurses.

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F 0658

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

During an interview on 3/19/24 at 9:36 A.M., Nurse #13 said she found a folder in the Resident's bag on the back of the Resident's wheelchair that was for dialysis and was initiated by the dialysis facility, not the nursing facility. Upon review of the folder with Nurse #13, only three communication forms out of 13 visits were included and dated 3/6/24, 3/8/24, and 3/18/24. There was no post dialysis weight documented on the 3/8/24 form.

During an interview on 3/19/24 at 9:16 A.M., Nurse #6 said without all the dialysis visit communication forms, she was unable to locate the other post dialysis weights and said none were documented in the Resident's electronic record. She said upon the Resident's return from dialysis, if he/she did not come back with his/her dialysis book staff should call the dialysis center to obtain the information including post dialysis weights and any other relevant data. She said there was no documentation in the medical record that this was being done.

During an interview on 3/19/24 at 12:55 P.M. with the Director of Nursing and Consulting Staff #1, Consulting Staff #1 said the nursing facility should have started a dialysis binder for the Resident which would include communication forms with weights recorded. She said the book goes with the Resident to dialysis and facility staff are to ensure it's received back. If not, staff were expected to call the dialysis facility to obtain the information including weights. If the book is received back, then staff should be recording the post dialysis weights in the medical record. Consulting Staff #1 said communication forms should be completed for each visit and said there were no post dialysis weights documented as obtained in the electronic record. She said all orders/treatments should be done consistently.

43935

4. Review of the facility's policy titled Charting and Documentation, dated as revised 1/2023, indicated but was not limited to the following:

-all observations, medications administered, services performed, etc. must be documented in the medical record

-documentation of procedures and treatments shall include care specific details and shall include at a minimum: date and time, assessment data and any unusual findings, how the resident tolerated the procedure/treatment, whether or not the resident refused the treatment

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.

Resident #58 was admitted to the facility in October 2023 and has diagnoses including: Alzheimer's dementia and depression. Review of the most recent BIMS for Resident #58 indicated he/she was severely cognitively impaired with a score of 1 out of 15 and his/her healthcare proxy (HCP) was invoked.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225667	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2024
NAME OF PROVIDER OR SUPPLIER Pleasant Bay of Brewster Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 383 South Orleans Road Brewster, MA 02631	

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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	On 3/12/24 at 8:21 A.M., the surveyor observed a sign posted over Resident #58's bed that indicated the following: Resident's geri sleeves is to stay on at all times. Remove only for hygiene. Please and thank you. [sic] During a telephone interview on 3/12/24 at 4:48 P.M., Family Member #1 said the she believes the Resident wears geri-sleeves as a preventative for skin tears. She said she has not seen the geri-sleeves on her family member in quite some time and does not know why. The surveyor made the following observations of Resident #58 at the following times: - 3/12/24 at 8:21 A.M., Lying in bed, no geri-sleeves observed on the Resident's bilateral (both) arms - 3/12/24 at 10:29 A.M., Sitting in Broda chair (positioning chair) in the hallway, no geri-sleeves observed on the Resident's bilateral arms - 3/12/24 at 12:21 P.M., Sitting in Broda chair in the hallway, no geri-sleeves observed on the Resident's bilateral arms, staff assisting the Resident with his/her lunchtime meal - 3/12/24 at 3:23 P.M., Sitting in Broda chair in the hallway, no geri-sleeves observed on the Resident's bilateral arms - 3/13/24 at 8:09 A.M., Sitting in Broda chair in the hallway, no geri-sleeves observed on the Resident's bilateral arms - 3/13/24 at 8:54 A.M., Sitting in Broda chair in the hallway, no geri-sleeves observed on the Resident's bilateral arms Review of the current care plans for Resident #58 indicated but was not limited to the following: Focus: Potential skin: potential alteration in skin integrity (revised: 2/9/24) Goal: Skin will remain intact through next review (revised: 1/9/24) Interventions: Follow MD orders for skin care and treatments (11/24/23) The care plan failed to indicate the Resident wore geri-sleeves at all times. Review of the certified nursing assistant (CNA) visual/bedside Kardex, dated 3/14/24, failed to indicate the Resident required bilateral geri-sleeves be worn. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/13/24 at 12:34 P.M., CNA #3 said Resident #58 did have geri-sleeves at one time and said perhaps they got soiled and needed to be sent to laundry which is why the Resident has not been wearing them. She said there was not a pair of geri-sleeves available for use in the Resident's room. Review of the current Physician's Orders for Resident #58, dated 3/13/24, indicated but was not limited to the following: -Geri-sleeves at all times, every shift for skin protection (11/15/23) Review of the February and March 2024 treatment administration record (TAR) for Resident #58 indicated but was not limited to the following: - 2/2/24 Evening shift: documentation was blank - 2/9/24 Night shift: documentation was blank - 2/11/24 Day shift: documentation was blank - 3/8/24 Evening and night shift: documented code of 8 = other - 3/12/24 Evening shift: documented code of 8 = other During an interview on 3/13/24 at 12:37 P.M., Nurse #1 said the Resident is supposed to wear geri-sleeves at all times. She reviewed the TAR with the surveyor and said the code of 8 means other and there should be a note indicating why the geri-sleeves are not in place. She reviewed the progress notes for Resident #58 and said on 3/8 and 3/12 the documentation indicated the geri-sleeves were out of stock and not available but that should not be the case and there should always be some in the facility. Review of the progress notes from 1/1/24 to 3/13/24 indicated but were not limited to the following: - 1/18/24: Skin to bilateral upper extremities (BUE) very fragile, geri-sleeves at all times, remove only for hygiene - 3/8/24: geri-sleeves at all times: out of stock/not available - 3/12/24: geri-sleeves at all times: on order/not available The progress notes failed to indicate why the Resident did not have geri-sleeve documentation on February 2nd, 9th or 11th or how the Resident had geri-sleeves on each day when they were out of stock with the exception of 3/8/24 and 3/12/24. During an interview on 3/13/24 at 12:38 P.M., Nurse #3 said the Resident is supposed to wear geri-sleeves at all times and if there are none available on the unit the staff should have requested some from the central supply room. She then went to the central supply room and retrieved a pair of geri-sleeves for Resident #58 to use. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/13/24 at 12:41 P.M., Unit Manager #1 said the Resident has a current order for geri-sleeves to be in place at all times and the expectation would be that the physician order is followed. She said Resident #58 should have geri-sleeves on and a back up pair in his/her room in case a pair is soiled and needs to go to laundry. She reviewed the TAR for February 2024 and said the missing documentation indicated the geri-sleeves were not in place as they should have been. She said physicians' orders are to be implemented as written. 48084 5. Review of the facility's policy titled Physician - Consultations, dated as last revised 10/2022 indicated but was not limited to the following: -It is the policy of this organization that all residents receive medical care in a timely manner. -Follow up: to be done within the time frame requested by the consultant and approved by attending physician. Resident #108 was admitted to the facility in April 2023 with diagnoses which included urinary retention. Review of the MDS assessment, dated 1/10/24, failed to indicate a BIMS had been completed. Review of the MDS Assessment, dated 10/17/23, indicated Resident #108 had scored a 15 out of 15 on the BIMS, indicating he/she was cognitively intact. Review of the medical record indicated Resident #108 was hospitalized in June 2023. Review of the Discharge Summary, dated 7/3/23, indicated but was not limited to the following: -Resident was treated for a urinary tract infection (UTI) in the setting of self-straight catheterization. -Out-patient follow up with urology. Review of the Physician's Orders failed to indicate an order to see urology. Review of the care plan indicated: -Follow up with urology as needed (8/9/23) Review of the Physician's Visit Note, dated 5/22/23, indicated follow up urology appointment pending. Review of the medical record including progress notes and care plans failed to indicate an appointment was made with a urologist at any point since admission or that the physician and/or resident declined to see urology. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/18/24 at 12:00 P.M., Resident #108 said they had not gone out to see a urologist since admission to the facility. During an interview on 3/9/24 at 9:18 A.M., Unit Manager #1 said long term straight catheterization puts the Resident at risk for UTIs and he/she should have had a urology follow up by now or a note as to why they haven't been seen. During an interview on 3/19/24 at 12:26 P.M., Nurse #6 said it was noted on the Discharge Summary and in the physician's progress note to follow up with urology, but it wasn't done. She said there is nothing in the consults section of the chart and no note regarding urology. Additionally, she said when someone needs an appointment, we fill out the consult sheet and make the appointment. She said the unit secretary used to help with it, but she no longer works here and there has not been a Unit Manager on this unit for several years, which makes it difficult; things get missed because it all falls on the medication nurse and this floor is very busy. During an interview on 3/19/24 at 3:13 P.M., Consulting Staff #1 said she recalled the Resident was followed by urology and he/she was supposed to go out for a follow up but did not know why the appointment was never made. During an interview on 3/19/24 at 4:15 P.M., Nurse #6 said she had called the Urology office and Resident #108 had not been seen. Additionally, she said he/she was supposed to be seen and was at the hospital when the office tried to arrange the appointment and she was unsure why there was not any follow up after his/her return in July. 6. Review of the Fall Prevention and Management Policy, dated as last revised January 2023, indicated but was not limited to the following: ASSESSMENT AND PREVENTION -Fall risk assessments will be completed for all residents; initially on admission / readmission, quarterly, significant change and after an identified fall. -Review and revise IDT care plan when a change is identified, after an event. POST FALL -Obtain neurological checks per policy for any unwitnessed fall or any fall with evidence of injury to head. -The nurse will complete an incident report. -Resident fall will be evaluated for 72 hours post fall, including full vital signs every shift. -Resident will be referred to therapy for a screen. Review of the facility's policy titled Incident Reports, dated as last revised October 2022 indicated but was not limited to the following: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-It shall be the responsibility of the person in charge to ensure that all incidents involving resident injury are followed by the completion of an incident report. -Incident reports shall be completed and submitted within eight hours of the incident. -Incident reports shall be filled out for any unusual or dangerous occurrence. Example: Resident Fall. -All sections of the incident report must be completed -The incident report and statements shall be completed as soon as possible after the incident has occurred by the licensed person and/or certified nursing assistant (CNA) involved, and then forwarded to the Nurse Manager. Review of the Falls Packet, undated, indicated but was not limited to the following: -Incident Procedure: a. In electronic medical record under risk management create a new incident and save. b. Fill out all sections as appropriate. c. Complete fall evaluation. d. Care plan needs to be updated, under problem add dated of the fall, under interventions add the intervention put in place to keep the resident safe/prevent a repeat fall. e. Fall packet with witness statements and neurological check go to the Director of Nurses (DON), along with a copy of the rehab screen. f. Rehab screen goes to rehab department. -If it was a fall there must be an accompanying intervention. Resident #70 was admitted to the facility in April 2023 with diagnoses which included Alzheimer's disease, anemia, orthostatic hypotension, difficulty walking, syncope and collapse, and a history of falls. Review of the MDS assessment, dated 12/19/23, indicated Resident #70 had a score of 3 out of 15 on the BIMS, indicating severe cognitive impairment, needed supervision/assistance with ADLs, was occasionally incontinent of urine, and had a history of falls. Review of Resident #70's medical record indicated he/she had sustained four falls between October 2023 and March 2024 (10/26/23, 10/27/23, 12/10/23, and 3/1/24). FALL on 10/26/23: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the progress note, dated 10/26/23 at 6:41 P.M., indicated Resident #70 was alert and confused at baseline, Resident was noted on the floor with a small area to left side of temple. Review of Complete Incident Report provided, dated 10/26/23, indicated the Predisposing Environmental Factors section and the Predisposing Physiological Factors section were not completed. Further review of the Complete Incident Report provided failed to include witness statements, a neurological evaluation worksheet, or the rehab screen per policy. Review of the Fall Risk care plan for Resident #70 failed to indicate a new intervention had been implemented. Review of the medical record including evaluations/assessments failed to indicate a Fall Risk Evaluation had been done after the fall per policy. FALL on 10/27/23: Review of the progress note, dated 10/27/24 at 6:24 A.M., indicated at 4:15 A.M., staff heard a loud noise down the hall and found Resident #70 lying on the floor on his/her right side. Review of the Complete Incident Report provided, dated 10/27/23, failed to include witness statements, a neurological evaluation worksheet, or the rehab screen per policy. Review of the Reportable Incident Folder indicated but was not limited to the following: -Date of Incident: 10/27/23 at 4:15 A.M. -There were three witness statements related to the fall on 10/26/23. -There were not any witness statements related to the fall on 10/27/23. The facility failed to update the Fall Risk care plan or initiate a Fall care plan after the fall with a new intervention to keep the resident safe/prevent a repeat falls per facility policy and Fall Packet procedure guide. The facility failed to complete a Fall Risk Evaluation after the fall per policy. FALL on 12/10/23: Review of the progress note, dated 12/10/23 at 3:59 A.M., indicated a loud noise was heard coming from the room. The Resident was observed on the bathroom floor with a hematoma to the right side of his/her head and a skin tear to the right arm. There was no incident report completed for this fall, per policy. Review of the medical record failed to indicate a neurological evaluation worksheet had been initiated, per policy. The facility failed to request and complete a rehab screen, per policy. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to update the Fall Risk care plan or initiate a Fall care plan after the fall with a new intervention to keep the resident safe/prevent a repeat falls per facility policy and Fall Packet procedure guide. The facility failed to complete a Fall Risk Evaluation after the fall per policy. FALL on 3/1/24: Review of the progress note dated 3/1/24 at 2:52 P.M., indicated Resident #70 fell in the lobby, he/she was observed sitting on the floor and was assisted back into wheelchair by a visitor. Review of the Complete Incident Report provided failed to include witness statements. The facility failed to complete a Fall Risk Evaluation after the fall, per policy. Review of the progress notes failed to indicate any post fall notes on the following shifts: 3/2/24 (11p-7a), 3/3/24 (all three shifts), 3/4/24 (all three shifts). During an interview on 3/18/24 at 12:37 P.M., Nurse #1 said after a fall an incident report is done, the fall packet is completed, and the care plan should be updated. During an interview on 3/19/24 at 9:18 A.M., Unit Manager #1 said after a fall, an incident report should be completed. She said the process includes obtaining statements from everyone working, neurological assessment, a rehab screen and updating the care plan with a new intervention to prevent further fall. She said her expectation is that staff are following the care plan. Additionally, Unit Manager #1 said she could not speak to the falls on 10/26/23, 10/27/23, and 12/10/23 as she had not been employed at the facility at that time. During an interview on 3/19/24 at 11:55 A.M., the Rehab Director said rehab screens are done after every fall and there was no fall screen done after the 12/10/23 fall as she was not aware of that fall. The Director of Nurses was not available for interview on 3/18/24 or 3/19/24. The Staff Development Coordinator was not available for interview on 3/19/24. During an interview on 3/19/24 at 3:26 P.M., Consulting Staff #1 said the falls process includes completing an incident report, updating the care plan with the new intervention, therapy screen, notes for 72 hours after the fall, and completing a fall risk evaluation. She said she would expect to see a new intervention with every fall and the care plan updated and it was not done after the falls on 10/26/23, 10/27/23 and 12/10/23. Additionally, she did not know why an incident report was not done after the fall on 12/10/23 as it should have been or why the fall risk evaluations were not done. She said her expectation is for staff to follow the policies of the facility and they were not.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36542 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 three of three nursing units and specifically for nine out of 24 sampled Residents (#44, #69, #100, #114, #58, #94, #49, #227, and #24). Specifically, the facility failed: 1. To provide and offer scheduled activities that were structured by staff for all residents in the facility including: A. During an infectious outbreak; B. Residents on the secure unit and C. Residents admitted for short term rehabilitation; 2. For Resident #44, to structure an individualized activity program to assist with the Resident taking apart furniture and trying to fix items; 3. For Resident #69, to offer and invite to activities of interest, including religious services; 4. For Resident #100, to invite or provide the Resident with activities of interest; 5. For Resident #114, to assess and determine an individualized activity for the Resident who was admitted for short term rehabilitation; 6. For Resident #58, to ensure the Resident was engaged in leisurely activities to help enhance his/her quality of life and had an individualized care plan indicating what types of leisurely pursuits the Resident may enjoy within their cognitive abilities; 7. For Resident #94, to offer and provide activities to assist the Resident in independent or group leisurely pursuits as indicated in his/her care plan; 8. For Resident #49, to ensure the Resident was assessed and provided activities of interest; 9. For Resident #227, who was admitted to the short-term rehab unit, to assess and ensure the Resident had an individualized care plan indicating his/her activity preferences; and 10. For Resident #24, who was admitted to the short-term rehab unit, to assess and ensure the Resident had an individualized care plan indicating his/her activity preferences. Findings include: The facility failed to provide the surveyors with a policy for the provision of activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	As of 3/12/24 the facility had the following census: North 1 Unit had 41 residents, South [NAME] Unit had 40 residents and North 2 Unit had 42 residents. 1. On 3/12/24 at 8:00 A.M., the surveyors observed each unit to have their own bulletin board. The surveyors observed the North 1 unit, South [NAME] unit and North 2 unit bulletin boards to have a calendar with activities for the month of February 2024 (12 days prior) and information regarding Black History Month. During an interview on 3/12/24 at 3:45 P.M., Activity Assistant #2 said the facility had not been holding activities on this day because of a recent infectious outbreak at the facility and large group activities would resume the following day. She said the activity staff had decided to invite a small group of residents for an activity and pointed to the lobby where the surveyor observed Activity Assistant #1 sitting with seven residents and asking trivia questions. The surveyor observed one Resident to say to Activity Assistant #1 What time is it? Are we going to do anything today? Like entertainment? On 3/13/24 at 10:25 A.M., the surveyor observed the bulletin board on the North 1 unit to have a March activity calendar and the bulletin boards on the South [NAME] unit and North 2 unit continue to have the February activity calendar. On 3/13/24 at 10:30 A.M., the surveyor observed a religious service with 17 residents in attendance in the first floor main dining/activity room. There were 14 residents from the North 1 unit and 3 residents from the North 2 unit, two of which had been brought down by their hospice aide. During a group meeting on 3/13/24 at 2:00 P.M., Resident #103 said that when the activity staff do not show up for an activity, he/she will lead the Trivia or morning Sittercise (exercise program which allows residents to remain seated). During an interview on 3/13/24 at 3:55 P.M., Activity Assistant #2 said she had started at the facility in January 2024 and did not have any prior activity or long term care experience. On 3/14/24 at 10:15 A.M., the surveyor observed 12 residents gathered in the first floor main dining/activity room with Resident #103 leading the morning coffee and trivia, there were no staff in the room. During an interview with observation on 3/14/24 at 10:18 A.M., the surveyor observed Activity Assistant #2 to be hand writing on the North 1 unit bulletin board and hanging up painted bunnies. Activity Assistant #2 said Resident #103 was leading the activity because she was working on the activity board but that she would look in on the activity intermittently. The Activity Assistant said Resident #103 was providing the other residents with socialization and trivia and the Activity Assistant had poured coffee for the residents and left to work on the bulletin board. During an interview on 3/14/24 at 11:35 A.M., Activity Assistant #3 said she had started at the facility in January 2024, with no previous activity experience, and was currently transitioning out of the activity department to the laundry department. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/14/24 at 12:15 P.M., Activity Assistant #1 said she had started at the facility in 2019 and was a part time activity assistant. She said the March activity calendar had been created based off of the previous month's activity calendars. She said that this was the responsibility of the Activity Director, but since the facility did not have one, they had been repeating the activities for January, February and March 2024. She said the current activity staff were responsible for holding group activities and when residents wanted to go, they would come, or residents would ask staff to bring them. She said mostly the same residents attended from the North 2 unit. She said the three current activity staff did not do any activity assessments, care plans, or notes. A. During a group meeting held on 3/13/24 at 2:00 P.M. with 16 residents, the residents said there had not been any activities for two weeks because of the outbreak. They said Activity Assistant #3 had worked very hard to deliver morning coffee to residents and worked in the laundry department during that time. During an interview on 3/13/24 at 3:55 P.M., Activity Assistant #2 said she and Activity Assistant #1 had not worked the the week prior and returned on 3/12/24. She said the only activity staff in the facility between 3/6/24 and 3/12/24 was Activity Assistant #3 who also worked in the laundry department during that time. During an interview on 3/14/24 at 11:35 A.M., Activity Assistant #3 said during the outbreak she had been working in the activity department to help for short periods of time during the day while also working in the laundry department. She said during that time there were no group activities held and she had passed out coffee and snacks to residents and no other activities were provided, individually or in groups. During an interview on 3/15/24 at 8:55 A.M., the Administrator said he had requested the activity program stop group activities on 2/27/24 due to the infectious outbreak. During an interview on 3/15/24 at 10:33 A.M., the Social Worker said the group activities were stopped on 2/27/24 due to an infectious outbreak and residents were asked to stay in their rooms. She said she was not involved in helping with activities or interactions with residents during this time. During an interview on 3/15/24 at 11:04 A.M., the Administrator said the plan during the outbreak was to stop group activities until the spread had decreased. He said group activities were put on hold from 2/27/24 until 3/13/24. He said the staff should have been providing non-group activities to residents during this time and not just delivering coffee. He said he had previously instructed the activity staff to not leave Resident #103 alone while doing activities and that the staff should be in there during this time. B. During the entrance conference on 3/12/23 at 9:30 A.M., the Administrator said the North 2 Unit was a secure unit with residents with a diagnosis of dementia. On 3/12/24 from 1:27 P.M. through 2:15 P.M., the surveyor observed the following on the North 2 unit activity/dining room: - Seven residents in the room, two actively watching Pup Academy (a live action television show with children and talking dogs with a TV-Y rating (programs with this rating are specifically designed for a very young audience, including children from ages 2 to 6). There were no staff in the room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225667	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2024
NAME OF PROVIDER OR SUPPLIER Pleasant Bay of Brewster Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 383 South Orleans Road Brewster, MA 02631	

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-At 1:47 P.M., there was one resident watching the show. Resident #2 moaning out. Resident #107 was taking his/her shoes off and wandering around the room, looking out the window. -At 2:00 P.M., the streaming service stops the show and asks are you still watching Pup Academy? -At 2:03 P.M., Nurse #5 enters the room, asks the residents if they are still watching, one resident says yes, one resident says no, no other residents answer and Nurse #5 turns Pup Academy back on and leaves the room. -At 2:05 P.M., Resident #2 was singing out, then started yelling Help!; Resident #81 self-propelled themselves out of the room and into hallway. -From 2:05 P.M. through 2:15 P.M., the Certified Nursing Assistants (CNAs) brought residents to the hallway (across from the nurses' station) or to their room. At 2:15 P.M. there was one resident left in the room. On 3/13/24 from 10:34 A.M. through 11:30 A.M., the surveyor observed the North 2 unit activity/dining room doors to be closed with no residents in the room. At 10:40 A.M., Resident #107 ambulated up to the doors, looked through the glass doors, turned to the surveyor and said, Can you get us in there so we can say hi? At 11:16 A.M., there were four residents seated across from the nurses' station and Resident #81 said, I guess we'll just sit here until lunch. The unit had low music playing through the sound system, but there were no other activities for the residents. On 3/13/24 at 1:25 P.M., the surveyor observed the North 2 unit to have 10 residents sitting in the unit dining/activity room. At 1:37 P.M. a nursing staff member came in and turned on the movie [NAME]. On 3/14/24 at 10:28 A.M., the surveyor observed the North 2 unit activity room to have eight residents; the television was on playing Red Notice (an American action comedy movie). There were three residents in Broda chairs (reclining high back wheelchairs), one resident was holding a baby doll, four residents were watching the movie which was playing a high action fight scene. At 10:35 A.M., as the surveyor walked by Resident #2, he/she said, Excuse me. Can I talk? I want to play. There were no staff members in the room. At 10:49 A.M., the surveyor observed Activity Assistant #3 passing out drinks and snacks to residents. There were now 12 residents in the room and Red Notice continued to be on the television. By 10:58 A.M., Activity Assistant #3 had passed out all the drinks and snacks and walked around the room saying hello to residents. There was no interactive activity and the television continued to play Red Notice with action scenes which included a gun fight with machine guns. At 11:29 A.M., the surveyor observed 12 residents in the room with Activity Assistant #3. The movie Red Notice continued to be on television; there were five residents looking at the screen and seven residents not looking. During an interview on 3/14/24 at 11:35 A.M., Activity Assistant #3 said she had started at the facility in January 2024 and had not really been up on the North 2 secure unit before. She said she had come up to the unit to give out snacks and did not know about the calendar for activities because the other Activity Assistants created the calendars. (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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/14/24 at 12:13 P.M., Activity Assistant #1 said there had previously been another Activity Assistant who was responsible for providing activities on the North 2 unit, but that Activity Assistant had been out on leave and that was why there had not been activities on that unit. During an interview on 3/14/24 at 12:15 P.M., Activity Assistant #2 said the North 2 unit had a separate activity calendar from the rest of the facility and would provide it to the surveyor as it was not posted on the unit. On 3/14/24 at 1:20 P.M., the surveyor observed CNA #2 turn on the live action Cinderella movie. At 1:39 P.M. , there were nine residents in the activity room in front of the television, one resident with their head down, one resident not facing the television, one resident asks to leave, one resident is wandering around the room. None of the residents were observed to be watching the movie. On 3/14/24 at 2:45 P.M., the surveyor observed 20 residents in the first floor main activity/dining room having ice cream for the scheduled ice cream social. During an interview on 3/14/24 at 3:08 P.M., Nurse #4 said none of the residents from the North 2 unit had been asked to attend the ice cream social and the activity staff had not provided an ice cream social to residents on the North 2 unit. On 3/14/24 from 3:08 P.M. through 3:24 P.M., the surveyor observed five residents in the North 2 unit activity room, one resident was observed pulling on tables trying to move them and Resident #107 was observed to be wandering in and out of the room. There was no music or television on and no staff in the room. During an interview on 3/15/24 at 11:00 A.M., the Administrator said the North 2 unit previously had a separate activity calendar from the rest of the facility but this had stopped when the previous Activity Director left in November 2023 (four months prior.) He said the North 2 unit should have been provided with activities based on the activity calendar. He said the residents on the North 2 unit should not have been watching a movie with machine guns and fights and he had talked to the activity staff about this previously. He said the residents on the North 2 unit should have had their own ice cream social as well. He said the residents needed to be offered structured activities. C. During the entrance conference on 3/12/23 at 9:30 A.M., the Administrator said the South [NAME] unit was comprised of mostly residents who were admitted for short term rehabilitation. On 3/14/24 at 10:20 A.M., the surveyor observed resident rooms on the South [NAME] unit. None of the rooms were observed to have a March activity calendar. On 3/14/24 at 11:30 A.M., the surveyor requested the resident activity participation log for the South [NAME] unit. The South [NAME] unit had a census of 40 residents on 3/12/24. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/14/24 at 12:15 P.M., Activity Assistant #1 said there was not a participation log for residents on the South [NAME] unit. She said the residents on the unit change out too fast and none of them wanted to go to activities. She said if the residents on South [NAME] had wanted to go to activities then they would tell the activity staff. She said the activity staff had not been meeting with newly admitted residents to address their activity preferences because that was the job of the Activity Director and there was no longer an Activity Director. Resident #114 was admitted to the facility in January 2024 with diagnoses of a compression fracture of vertebra and Parkinson's disease. During an interview on 3/12/24 at 9:20 A.M., Resident #114 said he/she did not participate in any group activities and was not sure what to do when he/she was not working with rehabilitation. There was no March activity calendar posted in the resident's room. During an interview on 3/18/24 at 8:01 A.M., the surveyor observed Resident #49 sitting alone in the main lobby listening to music. The Resident said he/she liked to participate in activities but no one from the activities staff had met with him/her about it to discuss his/her preferences. The Resident said he/she wished that there was more art as he/she liked to do that. 2. Resident #44 was admitted to the facility in October 2023 with a diagnosis of dementia. Review of the Minimum Data Set (MDS) assessment, dated 1/10/24, indicated Resident #44 scored a 5 out of 15 on the Brief Interview for Mental Status (BIMS), indicating the Resident had severe cognitive impairment. Review of the activity care plan for Resident #44 indicated the following: Focus: -Resident is social with others, speech is not always clear -has moments of increased agitation, some fatigue, moments of restlessness -enjoys music, being around other people, likes to be helpful -enjoys football and loves to be with family -active involved resident, short attention span, requires verbal cuing Goal: -attend schedule church service and entertainment on the first floor as tolerated -attend scheduled events on the unit with active participation for 20 or 30 minutes Interventions: -provide a calendar of events (continued on next page)

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	225667	A. Building B. Wing	03/19/2024

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-invite to groups -assist off the unit for entertainment and clergy events -loves jazz music, Patriots games -assist with re-engaging, offer verbal cues as needed, repeat as needed On 3/13/24 at 10:33 A.M., the surveyor observed the following in the room of Resident #44: -two table-tops from overbed tables, disconnected from stands (stands not present) and standing upright against a wall and a bureau -a nightstand with the drawer removed -a cable connector hanging from the wall -broken pieces of furniture -a wall-mounted television stand with no television During an interview on 3/14/24 at 8:00 A.M., the representative of Resident #44 said the Resident had always worked with his/her hands and prior to the diagnosis of dementia had always been moving and fixing things. She said Resident #44 was now always taking items apart and thought it was his/her way of fixing things. She said the Resident would often take apart items in his/her bedroom such as furniture and the television and said the facility had not provided the Resident with any projects to work on. She said the television was taken out when the Resident attempted to fix it and a new one had not been provided. She said she would like it if the staff would remove the broken items from the Resident's room. Review of the medical record for Resident #44, including the care plans failed to include a plan for Resident #44 who liked to fix things and work on projects. On 3/13/24 at 10:33 A.M., the surveyor observed Resident #44 lying in bed; there was no television in the room and no radio. The Resident asked the surveyor what time it was and when told responded Oh, I better get out of bed. The scheduled activity at this time was a visit from the local Baptist church. The surveyor observed the Baptist church to be holding a service on the first floor. On 3/13/24 at 1:43 P.M., the surveyor observed Resident #44 in his/her room sitting in a straight back chair with the door closed, no television, no music. The scheduled activity at this time was for one to one (1:1) room visits. On 3/14/24 at 10:46 A.M., the surveyor observed Resident #44 in his/her bed with their eyes closed. The scheduled activity at this time was trivia. The surveyor observed snacks being passed out and an action comedy movie being shown on the unit at this time. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/14/24 at 1:24 P.M., the surveyor observed Resident #44 ambulate out of his/her room, tell the nurse he/she can not find their book and start flipping through pages on top of the nurses' station. Resident #44 was observed to walk back to his/her room at 1:29 P.M. The scheduled activity at this time was 1:1 room visits. On 3/14/24 at 3:15 P.M., the surveyor observed Resident #44 lying on his/her bed with their eyes open. The scheduled activity was Ice Cream Social and Karaoke. The surveyor observed the Ice Cream Social being held on the first floor. During an interview on 3/14/24 at 3:32 P.M., Activity Assistant #1 said she was not familiar with the goals for activities for Resident #44. She said the Resident can ambulate, will walk to the unit activity room for snack, and then will leave. She said the Resident was confused and could not participate in activities. During an interview on 3/15/24 at 8:27 A.M., Nurse #4 said Resident #44 pulled items apart in his/her room because he/she was just working and this was not done in anger or outburst. During an interview on 3/15/24 at 10:26 A.M., the Social Worker said Resident #44 enjoyed small group activities and being around people as well as 1:1 visits. She said the Resident enjoyed telling stories. The Social Worker said the Resident would pull apart furniture, was constantly moving, and could easily be redirected. She said Resident #44 had a history of working with his/her hands and would benefit from a plan with more constructive goals to decrease being destructive. She said she had not addressed this in a care plan and there were no goals or interventions for taking items apart. She said integrating the Resident in activities would be helpful. 3. Resident #69 was admitted to the facility in December 2022 with a diagnosis of dementia with behavioral disturbance. Review of the MDS assessment, dated 12/19/23, indicated Resident #69 scored a 4 out of 15 on the BIMS, indicating the Resident had severe cognitive impairment. The MDS indicated a staff assessment for Activity Preferences was completed and indicated the Resident preferred listening to music, doing things with groups, participating in favorite activities and participating in religious activities. Review of the activity care plan for Resident #69 indicated the following: Focus: -daily animal companion presence -daily contact with close friends and/or relatives -involved in group activities such as: music, art, movies -spends time alone or watching television Goal: -will participate in self-directed activities of choice daily (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-will attend group activities once weekly -will accept/participate in one to one visits at least twice per week Interventions: -introduce to other residents with similar interests, abilities and/or limitations -invite to scheduled activities -invite family to attend activities with Resident -offer to assist/escort Resident to activity functions -offer variety of activity types and locations -provide leisure supplies for self-directed pursuits per Resident preferences Review of the Recreation Admission Assessment, dated 1/16/23, indicated Resident #69 enjoyed attending church services and finds strength in faith. The assessment indicated Resident specific interests including music, walking outdoors, watching television, children and pets. Review of the medical record indicated the last Recreation Assessment and Note were completed on 4/5/23. The assessment indicated the Resident attended 3 to 4 activities but would often ask to leave if he/she did not have someone to sit next to them that he/she could talk to. On 3/12/24 at 10:44 A.M., the surveyor observed Resident #69 seated in a wheelchair in the hallway outside his/her room. The Resident was not observed to be engaged in any activity. The scheduled activity was Trivia. The surveyor observed six residents in the unit activity/dining room having cookies and juice. On 3/12/24 at 2:41 P.M., the surveyor observed Resident #69 seated in the hallway, no interaction, no other residents around. The scheduled activity was Bingo. On 3/13/24 at 10:37 A.M., the surveyor observed Resident #69 in his/her room seated in a wheelchair, the television was not on, there was no music on. The scheduled activity was a visit from the local Baptist church. The surveyor observed 17 residents in the first floor activity/dining room to be attending the Baptist visit. During an interview on 3/13/24 at 10:44 A.M., the representative for Resident #69 said there was a lack of activities on the unit. She said if she visits around 9:00 A.M. or 10:00 A.M. the residents are just staring at each other and the most she has seen was the television on in the unit activity/dining room. She said the Resident's faith was very important and the Resident should be brought to all religious services, including the Baptist visit this morning. On 3/14/24 at 10:36 A.M., the surveyor observed Resident #69 seated in the hallway outside his/her room with his/her arms crossed on their chest. The scheduled activity was Trivia. The unit activity/dining room had the television on showing an action/comedy movie. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/14/24 at 11:23 A.M., the surveyor observed Resident #69 being brought to the unit activity/dining room and seated near the door of the room, not near other residents and not facing the television. The surveyor observed the Resident to continuously try to self-propel the wheelchair with his/her hands and feet. At 11:32 A.M., a CNA brought Resident #69 to face the television and the Resident responded Oh. On 3/14/24 at 2:01 P.M., the surveyor observed Resident #69 seated in his/her wheelchair in the unit activity/dining room with four other residents. Resident #69 attempted to converse with other residents, without response. There were no staff members observed in the room. During an interview on 3/14/24 at 3:33 P.M., Activity Assistant #1 said Resident #69 was confused and did not ask to attend activities. She said if the Resident was in the activity room during an interactive activity, such as games, then he/she would want to play and there are other times that he/she may sit there with his/her eyes closed. She said she did not know who was offering games on the unit since one of the activity assistants was on leave since the beginning of February 2024. 4. Resident #100 was admitted to the facility in April 2022 with a diagnosis of dementia with behavioral disturbance. Review of the MDS assessment, dated 12/27/23, indicated Resident #100 scored 6 out of 15 on the BIMS, indicating the Resident had severe cognitive impairment. The MDS indicated Activity Preferences of doing things with groups was somewhat important. Review of the activity care plan for Resident #100 indicated the following: Focus: -Resident loves children, enjoys most animals -enjoys reading, enjoys fresh air, music, gardening, likes crafts but not painting -member of church Goal: -will attend scheduled church services, crafts and entertainment -will be independently active by conversing on the phone, watching television and reading. Interventions: -provide a calendar of events -invite to groups -encourage to sing along in music groups -encourage to invite family to attend activities with Resident (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-encourage independent activities such as reading and watching television Review of the medical record indicated the last Recreation Assessment and Note was completed on 4/20/23. The assessment indicated Resident #100 enjoyed attending musical performances, bingo, and movies and needed friendly reminders of when activities were starting and assistance getting to the activity. On the following dates and times the surveyor observed Resident #100 seated in a straight back chair in his/her room next to the television, where the screen was out of their line of sight: 3/12/24 at 10:39 A.M. 3/12/24 at 1:54 P.M. 3/12/24 at 2:37 P.M. 3/13/24 at 10:36 A.M. During an interview on 3/13/24 at 1:20 P.M., the representative for Resident #100 said the Resident enjoyed activities. She said when she visits the facility the Resident was usually in the unit activity/dining room and there was usually music playing or the television on. She said Resident #100 does not communicate well but enjoyed being around other residents and watching activities. On the following dates and times, the surveyor observed Resident #100 seated in a straight back chair in his/her room next to the television, where the screen was out of their line of sight: 3/13/24 1:31 P.M., the surveyor observed a CNA bringing Resident #100 from the bathroom and walked the Resident to the chair. 3/14/24 at 10:47 A.M. 3/14/24 at 1:25 P.M. During an interview on 3/14/24 at 11:35 A.M., Activity Assistant #3 said she was on the unit providing snacks to residents. She said she provided snacks to the residents who were already in the unit dining/activity room and did not know which residents should be brought to the room. During an interview on 3/14/24 at 3:31 P.M., Activity Assistant #1 said Resident #100 has had increased confusion and just stares during activities now. She said the activity assistant who went out on leave at the beginning of February 2024 was responsible for providing activities on the unit and no structured activities had taken place since then. 5. Resident #114 was admitted to the facility in January 2024 with diagnoses of a compression fracture of vertebra and Parkinson's disease. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the MDS assessment, dated 2/4/24, indicated Section C- Cognitive Patterns was not completed for Resident #114. Further review of the MDS indicated Resident #114 found the following activities to be somewhat important: have books, newspaper, magazine; listen to music they like; be around animals such as pets; keep up with the news; do things with groups of people; do favorite activities; go outside to get fresh air when the weather is good; and participate in religious services or practices. During an interview on 3/12/24 at 9:20 A.M., Resident #114 said he/she did not participate in any group activities and was not sure what to do when he/she was not working with rehabilitation. There was no March activity calendar posted in the resident's room. Review of the medical record failed to include an activity assessment (Recreation Admission Assessment) or a care plan for recreational activities. During an interview on 3/14/24 at 12:13 P.M., Activity Assistants #1, #2 and #3 said they were the only activity staff at the facility. All three Activity Assistants said none of them were responsible for meeting with residents on the short term rehabilitation unit and had not met with Resident #114 to assess their individual activity goals and had not created a care plan for Resident #114. During an interview on 3/14/24 at 3:53 P.M., the Regional Clinical Director said there was no policy regarding activity assessments of residents but the expectation was that assessments would be completed upon admission and quarterly. 43935 6. Resident #58 was admitted to the facility in October 2023 with diagnoses including: Alzheimer's dementia and depression. Review of the most recent BIMS for Resident #58 indicated he/she was severely cognitively impaired with a score of 1 out of 15 and his/her healthcare proxy (HCP) was invoked. Review of the medical record indicated the Resident's last Activity Assessment and documentation was completed on 10/31/23 and indicated but was not limited to the following information: - Religious/Spiritual information: Resident #58 is Catholic and would be interested in attending religious services and receiving religious visits. - Interests/Preferences: gardening, music, Boston sports, movies, newspapers, cats and being with people is number one thing he/she enjoys - Participation Expectations: Family would like the Resident to attend groups, although he/she cannot partake, they believe the stimulation of being near other people would be beneficial. Unable to be independent in any situation but the staff can put on a television (TV) for sports, news or music. - Summary/Comments: Resident #58's family assisted with the assessment and wants him/her to be at scheduled programs, they are aware of the inability to interact, but wish for attendance for the audio stimulation. Resident will be offered groups when out of bed and staff will assist with putting the TV on for him/her when in his/her room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225667	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Bay of Brewster Rehab Center	383 South Orleans Road Brewster, MA 02631

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a telephone interview on 3/12/24 at 4:48 P.M., Family Member #1 said Resident #58 was very social in his/her life and enjoys being around people. She said s [TRUNCATED]

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. 36542 Based on interview, the facility failed to ensure the activity program was directed by a qualified professional from November 17, 2023, through the survey exit date 3/19/24. Findings include: During the entrance conference on 3/12/23 at 9:30 A.M., the Administrator said the facility did not have an Activity Director. During an interview on 3/13/24 at 3:55 P.M., Activity Assistant #2 said she had started at the facility in January 2024 with no previous experience in activities or long-term care. During an interview on 3/14/24 at 11:35 A.M., Activity Assistant #3 said she had started at the facility in January 2024, with no previous activity experience, and was currently transitioning out of the activity department to the laundry department. During an interview on 3/14/24 at 12:13 P.M., Activity Assistant #1 said she had started at the facility in 2019 and was a part time activity assistant and that she was not responsible for any oversight of the activity department. During an interview on 3/14/24 at 12:15 P.M., Activity Assistant #1, #2 and #3 said they were the only activity staff at the facility. All three Activity Assistants said none of them were responsible for meeting with residents to determine activity preferences, completing assessments of activity needs or creating care plans for residents.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 42742 Based on observation, interview, record review, and policy review, the facility failed to ensure one Resident (#24), out of a total sample of 24 residents, received care and treatment per professional standards of practice to promote optimal wound healing and to prevent the development of a facility acquired unstageable (actual depth of ulcer is completely obscured by slough and/or eschar in the wound bed) left heel ulcer, full thickness. Specifically, the facility failed to conduct a timely Braden risk assessment upon admission to predict the Resident's level of risk for pressure ulcer development, complete an admission comprehensive skin assessment documented in the Resident's electronic health record (EHR), develop and implement a care plan that identified risk factors as well as interventions designed to reduce or prevent the development of pressure related ulcers/injuries, obtain orders and provide wound care treatments per wound consultant recommendations, and consistently off-load the Resident's heels and ensure weekly skin checks were completed per physician's orders. Findings include: Review of the facility's policy titled Pressure Wound Prevention, revised February 2022, indicated but was not limited to the following: -Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. -Assess the resident on admission for existing pressure ulcer/injury risk factors. Repeat the Braden risk assessment weekly for 4 weeks then quarterly, annually or any significant change in resident condition. -Conduct a comprehensive skin assessment upon admission including: a. skin integrity - any evidence of existing or developing pressure ulcers or injuries; b. tissue tolerance; and c. areas of impaired circulation due to pressure from positioning or medical devices. -Identify any signs of developing pressure injuries and inspect pressure points. -Evaluate, report, and document potential changes in the skin. -Review the interventions and strategies for effectiveness on an ongoing basis. Review of the facility's policy titled Protocol - Wound Care and Rounds, revised January 2023, indicated but was not limited to the following: New Wound Identified in House: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Licensed nurse should complete an assessment of the wound including shape, size, depth, staging (if applicable) and condition of wound. -Licensed nurse/manager/supervisor will notify the physician and obtain a treatment order and an order for pain medication 30 minutes prior to treatment. -An Incident Report and Facility Acquired Pressure Ulcer Investigative Tool will be initiated. -Interdisciplinary team should review and revise the care plan for new interventions, during morning meeting the following day as applicable. -A comprehensive nurse's note will be completed identifying the wound as unavoidable/ avoidable with documentation including co-morbidities, risk factors and interventions. -Weekly rounds should take place on the same day each week Review of the facility's policy titled Wound - Ulcer, dated January 2023, indicated but was not limited to the following: -Nurses may not diagnose, just describe -Staff will institute a plan for any resident who has potential for skin breakdown or whose condition is deteriorating. This may include: d. floating areas of concern such as heels when appropriate f. use of elbow or heel protectors when appropriate Resident #24 was admitted to the facility in December 2023 with diagnoses including encephalopathy (any brain disease that alters brain function or structure), diabetes mellitus type 2, cognitive communication deficit, unsteadiness on feet, and lack of coordination. Review of the Minimum Data Set (MDS) assessment, dated 12/28/23, indicated Resident #24 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15, was at risk for developing pressure ulcers, and had no unhealed pressure ulcers. The MDS also indicated skin and ulcer treatments of ointments/medications were being applied other than to the feet. During an interview on 3/12/24 at 9:17 A.M., Resident #24 said he/she had a hematoma (pool of clotted blood) on his/her left heel from three to four weeks ago, was not sure how he/she got it, but it was very painful. The Resident said he/she was being followed by the wound doctor. December 2023 Review of the Admission Physician's Progress Note, dated 12/23/23, indicated the Resident's skin was warm and dry and had chronic lower extremity edema versus lymphedema. There was no mention of an alteration in skin integrity. (continued on next page)

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	225667	A. Building B. Wing	03/19/2024

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the medical record for Resident #24 failed to indicate a comprehensive care plan was developed on admission for the prevention of skin breakdown and pressure injuries despite the MDS indicating the Resident was at risk for developing pressure injuries. Review of Physician's Orders indicated the following: -Weekly skin assessment by a licensed nurse (documented in Point Click Care (PCC), electronic health record) every evening shift every Monday, 12/25/23 January 2024 Review of a Physician's Progress Note, dated 1/1/24, indicated Resident #24's skin was warm and dry with an erythematous patch on very low back and upper buttock and had a shingles rash. There was no mention of an alteration in skin integrity to the Resident's left heel. Review of a nursing Skilled Evaluation, dated 1/5/24, indicated the Resident's skin was warm and dry, skin color within normal limits and turgor was normal. There was no mention of an alteration in skin integrity to the Resident's left heel. Review of a Physician's Progress Note, dated 1/8/24, indicated Resident #24 reported left heel pain. His/her extremities were edematous and swollen and a left heel blister was noted with some darkened fluid as if there was mild bleeding within; no erythema or induration to suggest infection. Review of Physician's Orders indicated the following: -Mupirocin External Ointment 2%, apply to left heel topically two times a day for blister, wash with normal saline, pat dry, apply Mupirocin two times daily, start 1/9/24, stop 1/11/24 -Mupirocin External Ointment 2%, apply to left heel topically every day and evening shift for wound care, wash with normal saline, pat dry, apply Mupirocin two times daily, start 1/12/24, stop 3/14/24 Review of the medical record indicated a Norton Scale for Predicting Risk of Pressure Ulcer assessment was completed on 1/12/24, three days after the identification of a left heel blister and three weeks after admission, indicating Resident #24 was at high risk for developing pressure injuries. Review of the medical record indicated a care plan was developed on 1/12/24 for an Alteration in Skin Integrity related to diabetes, edema, urinary incontinence, and a left heel unstageable wound and was as follows: -Goal: Resident's skin would show improved healing through the next review date -Interventions: complete skin condition check weekly, dietary intervention/evaluation, follow MD orders for skin care and treatment, seen by wound MD, heels off-loaded when in bed, inspect feet daily and report changes to nurse, pressure ulcer risk assessment weekly x 4 weeks upon admission then quarterly and with change in condition, and to protect the skin with incontinent care, 1/12/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Further review of the medical record indicated a care plan was developed on 1/12/24 for Diabetes Mellitus and was as follows: -Goal: Resident will have no complications related to diabetes through the review date -Interventions: Check all of the body for breaks in skin and treat promptly as ordered by doctor, inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness, and monitor/document/report to MD as needed for signs and symptoms of infection to any open areas: redness, pain, heat, swelling or pus formation, 1/12/24 Review of the January 2024 Treatment Administration Record (TAR) failed to indicate a weekly skin assessment was conducted on 1/24/24 and failed to indicate the Mupirocin external ointment 2% was documented as being applied topically to the Resident's left heel every day and evening shift for wound care for 8 out of 26 shifts from 1/12/24-1/24/24. Review of a nurse's Clinical Admission Note, dated as a late entry on 1/24/24, 33 days after admission, indicated Resident #24 had a left heel diabetic foot ulcer with slough present in the wound bed, purulent wound exudate, fragile skin peri wound, minimal dressing saturation, boggy skin, pain, and was receiving daily wound treatments. Review of the Initial Wound Evaluation and Management Summary for Resident #24, dated 1/25/24, indicated an unstageable (due to necrosis) full thickness wound was located on the left heel. The visit note indicted the wound was a new injury, greater than 11 days in duration, measured 4.3 x 2.5 x 0.1 centimeters (cm) and was a pressure wound. Recommendations included: Primary Dressing - normal saline wash apply once daily for 30 days, Iodosorb gel, apply once daily for 30 days Secondary Dressing - abdominal pad apply once daily for 30 days, gauze roll (stretch) 4 apply once daily for 30 days, tape (waterproof adhesive) apply once daily for 30 days -Peri-wound Treatment - skin prep apply once daily for 30 days Plan of Care Recommendations - elevate legs, float heels in bed, off-load wound, reposition per facility protocol, pillows, booties Review of Resident #24's care plan indicated the recommended intervention for booties was not implemented until 2/6/24, 12 days after the wound doctor assessed the Resident. Review of a Nurse's Progress Note, dated 1/25/24, indicated the Resident presented with a wound on the left lower extremity (heel) at the time of bilateral leg wrapping treatment. The patient complained of having lots of pain coming from the heel. The wound was 4 x 6, red color around it with a small amount of slug (Sic). The patient was seen that day by the wound doctor. New orders in place and started today on the 3-11 shift. Review of the January 2024 TAR and Medication Administration Record (MAR) failed to indicate a treatment order was obtained for the Iodosorb gel, abdominal dressing, gauze roll stretch, and skin prep dressing to the left heel per the Wound Physician's recommendations. (continued on next page)

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F 0686

Level of Harm - Actual harm

Residents Affected - Few

Further review of the January 2024 TAR indicated the Mupirocin external ointment 2% continued to be applied topically to the Resident's left heel every day and evening shift for wound care for 8 out of 12 shifts from 1/26/24-1/31/24.

February 2024

Review of the Wound Evaluation and Management Summary for Resident #24, dated 2/1/24, indicated an unstageable (due to necrosis) full thickness wound was located on the left heel. The visit note indicated the wound size was 4.3 x 2.6 x 0.1 cm and was not at goal. Surgical excisional debridement (dead or unhealthy tissue removed) was performed. The Wound Physician recommended the same treatment as indicated in the previous 1/25/24 visit.

The Resident's Alteration in Skin Integrity care plan was revised to include a left heel bootie on while in bed as tolerated, initiated 2/6/24.

Review of the Wound Evaluation and Management Summary for Resident #24, dated 2/8/24, indicated an unstageable (due to necrosis) full thickness wound was located on the left heel. The visit note indicated the wound size was 4.7 x 2.8 x 0.1 cm and was not at goal. Surgical excisional debridement was performed. The Wound Physician recommended the same treatment as indicated in the previous 1/25/24 and 2/1/24 visits.

Review of the Wound Evaluation and Management Summary for Resident #24, dated 2/15/24, indicated an unstageable (due to necrosis) full thickness wound was located on the left heel. The visit note indicated the wound size was 4.7 x 3.2 x 0.1 cm and was not at goal. Surgical excisional debridement was performed. The Wound Physician recommended the same treatment as indicated in the previous 1/25/24, 2/1/24, and 2/8/24 visits.

Review of the Wound Evaluation and Management Summary for Resident #24, dated 2/22/24, indicated an unstageable (due to necrosis) full thickness wound was located on the left heel. The visit note indicated the wound size was 4.7 x 3.3 x 0.1 cm and was not at goal. Sharp selective debridement was performed. The Wound Physician recommended the same treatment as indicated in the previous 1/25/24, 2/1/24, 2/8/24, and 2/15/24 visits.

Review of the Wound Evaluation and Management Summary for Resident #24, dated 2/29/24, indicated an unstageable (due to necrosis) full thickness wound was located on the left heel. The visit note indicated the wound size was 4.4 x 3.5 x 0.1 cm and was not at goal. Surgical excisional debridement was performed. The Wound Physician recommended the same treatment as indicated in the previous 1/25/24, 2/1/24, 2/8/24, 2/15/24, and 2/22/24 visits.

Review of the February 2024 TAR and MAR failed to indicate a treatment order was obtained for the Iodosorb gel, abdominal dressing, gauze roll stretch, and skin prep dressing to the left heel per the Wound Physician's recommendations and no documentation was found in nurse progress notes to suggest the specific wound treatment recommendations were being followed.

Further review of the February 2024 TAR indicated the following:

-weekly skin assessments not conducted on 2/12/24 and 2/19/24

(continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-left foot bootie/heel protector not documented as being applied for 21 out of 87 shifts -Mupirocin external ointment 2% continued to be applied topically to the Resident's left heel every day and evening shift for wound care for 29 out of 58 shifts March 2024 Review of the Wound Evaluation and Management Summary for Resident #24, dated 3/7/24, indicated an unstageable (due to necrosis) full thickness wound was located on the left heel. The visit note indicated the wound size was 3.7 x 2.8 x 0.1 cm and improved. Surgical excisional debridement was performed. The Wound Physician recommended the same treatment as indicated in the previous 1/25/24, 2/1/24, 2/8/24, 2/15/24, 2/22/24, and 2/29/24 visits. Review of Physical Therapy Treatment Encounter Notes, dated 1/24/24, 1/30/24, 2/1/24, 2/6/24, and 2/7/24, indicated the patient denied gait training and/or transferring due to pain in the left heel, increased sensitivity, and/or due to wound. Review of the Resident's Alteration in Skin Integrity care plan indicated it was revised to include a consultation with the vascular surgeon, initiated 3/14/24. Review of the March 2024 TAR and MAR failed to indicate a treatment order was obtained for the Iodosorb gel, abdominal dressing, gauze roll stretch, and skin prep dressing to the left heel per the Wound Physician's recommendations until 3/14/24. Further review of the March 2024 TAR indicated the following: -weekly skin assessments not conducted on 3/11/24 -Mupirocin external ointment 2% continued to be applied topically to the Resident's left heel every day and evening shift for wound care for 24 out of 26 shifts During an interview on 3/14/24 at 10:42 A.M., the surveyor observed Resident #24 lying in bed. The Resident did not have a foam bootie on his/her left foot as recommended by the wound doctor. He/she said the last time it was applied was maybe last week, but lately never. The Resident said he/she started with a blister on his/her left heel which had gotten worse since then, hurt more, and felt like it was infected. During an interview on 3/14/24 at 11:00 A.M., Certified Nursing Assistant (CNA) #11 said she was assigned to the Resident that day and was familiar with him/her. She said the Resident had no pressure areas she was aware of or skin issues but should have a pillow under his/her heels. She said she didn't know if he/she was supposed to have a foam bootie on. During an interview on 3/14/24 at 3:18 P.M., Nurse #9 said Resident #24 was at risk for developing pressures and had a stage 2 pressure ulcer on his/her left heel. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an observation with interview on 3/14/24 at 4:05 P.M., the surveyor observed the Resident's left heel wound with the Wound Physician and Nurse #9. The Wound Physician said the left heel was an unstageable necrosis pressure injury and the Resident came in with it. He said it was much better this day and getting a lot smaller. The wound, per surveyor observation, was approximately 2 cm x 2 cm x unstageable. The wound had a dark center and small area of detached necrotic tissue from the wound bed which was removed by the physician. Once removed, the wound bed was red in color with scant sero-sanguinous drainage. The surrounding skin was pink. The Wound Physician said they were originally using betadine (used to treat or prevent skin infection) products but the Resident was still in pain, so the new treatment was to use Iodosorb gel (gel that's applied to the skin to treat wet ulcers and wounds). The surveyor informed the Wound Physician that there was no order for the Iodosorb gel dressing treatment since the initial visit recommendation on 1/25/24 and that staff had been documenting on the TARs the mupirocin ointment application to the left heel since early January. The Wound Physician said the mupirocin treatment shouldn't have been continued as it was an antibiotic and would have needed to be monitored. He said there had been a lot of turnover with the Director of Nurses (DON) position and there was no designated wound nurse, but wound recommendations should be followed. The Wound Physician further said because the Resident crossed his/her left leg over his/her right, staff needed to off-load both. He said the Resident had bilateral lower extremity circulation issues so that may be a factor in his/her wound healing. During an interview on 3/18/24 at 11:17 A.M., Unit Manager (UM) #1 said she was not the designated wound nurse. She said sometimes the Infection Preventionist would round but whoever was available to help would help. On 3/18/24 at 11:20 A.M., the surveyor observed Resident #24 lying in bed. The Resident's heels were not elevated off the mattress and a foam bootie was not observed on the Resident's left heel in accordance with the Resident's plan of care. On 3/19/24 at 7:50 A.M., the surveyor observed Resident #24 lying sideways in bed awake with his/her feet on the ground. No foam bootie was observed in the Resident's room. During an interview on 3/19/24 at 10:26 A.M., Nurse #13 said Resident #24 was at risk for developing pressures, had pressure sites on his/her feet, and had basic bootie and heel protection orders. She said the 1/25/24 wound note indicated an unstageable pressure wound of the left heel that was new and greater than 11 days old. She said a new treatment was recommended on that visit and subsequent visits for a normal saline wash and Iodosorb dressing daily along with to float the Resident's heels while in bed, elevate the legs, and use pillows and booties, but the order was not entered until 3/14/24. She said there was no designated wound nurse but if recommendations are made by the wound physician, she wasn't sure who would take and implement them. She said there was no admission skin evaluation, no Braden risk assessment (Norton Scale) completed until 1/12/24, and a care plan for skin integrity was not developed or implemented until 1/12/24. She said interventions and treatments should have been implemented consistently to improve skin and to prevent/avoid any pressure related injuries. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/19/24 at 1:35 P.M., the surveyor reviewed the medical record with the DON and Consulting Staff #1. Consulting Staff #1 said the Resident was not admitted with a left heel wound. She said physician's notes, dated 12/23/23 (admission note) and 1/1/24, did not mention anything about the Resident's heels until the 1/9/24 note. She said the first skin evaluation was not conducted until 1/24/24 but should have been done upon admission and weekly. Consulting Staff #1 said the initial wound note on 1/25/24 indicated the left heel was a new pressure wound. She said if there's a wound physician recommendation, it gets printed and placed in the physician's book. If there's a change, then the nurse should call the physician to get orders and any interventions completed consistently without blank holes to prevent a pressure ulcer from forming or worsening. Consulting Staff #1 said there was no care plan in place for skin integrity until 1/12/24 and care planned interventions should be reviewed and revised quarterly and with any changes.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 43935 Based on observation, interview, policy review, and record review, the facility failed to provide services, equipment and assistance for one Resident (#26), out of a total sample of 24 residents, to prevent the decline and discomfort of his/her left-hand contracture. Findings include: Review of the facility's policy titled Appliances - Braces/Slings/Splints, dated as revised 10/2022, indicated but was not limited to the following: - in order to protect the safety and well-being of residents, and to promote quality care, this facility uses appropriate techniques and devices for appliances, splints, braces and slings - the facility policy is to assure all splints, braces, slings, etc. are used appropriately and cared for properly and upper and lower extremities are maintained in a functional position - Therapy evaluates splints/device/appliance at a minimum of quarterly for effectiveness and documents continued need Nursing: - ensures proper donning (putting on) and doffing (taking off) appliances is known by certified nurse assistant (CNA) staff and provides appropriate sign off of task options - releases devices and appliances per physician order - notify rehab department of any changes, modifications or repairs needed Resident #26 was admitted in December 2020 with diagnoses including: hemiplegia and hemiparesis (one-sided muscle weakness or paralysis) affecting the left non-dominant hand and polyneuropathy (the damage of multiple peripheral nerves resulting in problems with sensation, coordination, and/or function). Review of the most recent Brief Interview for Mental Status (BIMS), dated 12/6/23, indicated Resident #26 was cognitively intact with a score of 15 out of 15 and made his/her own decisions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225667	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2024
NAME OF PROVIDER OR SUPPLIER: Pleasant Bay of Brewster Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 383 South Orleans Road Brewster, MA 02631	

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation with interview on 3/12/24 at 8:59 A.M., the surveyor observed that Resident #26 had a contracted left hand with no splint or device in place. The Resident said his/her left hand was contracted and he/she used to have a splint he/she wore but the device doesn't work and was broken and now it just sits in his/her bottom drawer. The Resident showed the surveyor a printout (hanging on their bedroom wall) about the splint and how long it was supposed to be worn. The Resident said it hasn't been worn in probably one or two months and they are afraid the hand will freeze closed and they will never be able to use it again. The Resident said that no one notices or seems to care. The Resident said he/she had told the nursing staff about the issues with his/her splint but nothing had been done about it. Review of the posted paper on Resident #26's wall titled Wearing your splint, undated, indicated but was not limited to the following: - Wearing your splint was highlighted on as needed for your comfort / between A.M. and P.M. care about four to six hours. - May remove for hand washing, bath and shower, wound care or exercises - Contact your therapist if you have any questions or any of the following happen: your splint is not comfortable, or you feel your splint needs to be fixed Review of the current Physician's Orders for Resident #26 as of 3/14/24 indicated, but were not limited to the following: - Nursing staff to assist to don hand/wrist orthosis (splint) daily between A.M. and P.M. care, as tolerated for four to six hours a day. Care also includes hourly skin checks to assess for areas of redness, blanched skin, pain, pressure, tingling or soreness and to ensure proper fit of orthosis. If patient experiences any of the above symptoms remove orthosis and contact occupational therapy department. (9/7/23) Review of the CNA Visual bedside Kardex (summary of resident's care and preferences) for Resident #26 as of 3/14/24 failed to indicate the Resident wore a splint on his/her left hand or required staff assistance with putting the splint on daily. Review of the current care plans in place for Resident #26 as of 3/14/24 indicated but were not limited to the following: Focus: - Hemiplegia/hemiparesis related to stroke (10/13/22) Goal: - Will remain free of complications or discomfort related to Hemiplegia/hemiparesis through review date (revised: 1/9/24) Interventions: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Discuss with Resident and family any concerns, fears, issues regarding diagnosis and treatments; give medications as ordered (revised: 12/20/23) - Obtain and monitor diagnostics and labs work as ordered; pain management as needed (revised: 12/20/23) - Provide referrals to community resources as needed (PRN) (revised: 12/20/23) - Physical therapy (PT), Occupational therapy (OT), Speech therapy (ST) evaluate and treat as ordered (12/20/23) The care plan failed to indicate Resident #26 should wear an orthosis/splint on his/her left hand or that nursing staff should assist the Resident with putting the device on daily. During an interview on 3/13/24 at 8:35 A.M., Resident #26 said therapy is no longer working with him/her for his/her left-hand contracture and said: they have given up on stopping his/her left hand contracture from worsening. The Resident said, I'm so scared it will keep getting worse and they aren't trying to help me stop it. He/she said they had informed the nursing staff that the splint doesn't work and is not comfortable. He/she said they will not wear the splint until rehab looks at it and sees them again to reevaluate it and in the meantime, it is stored in the bottom drawer of their bureau. The Resident said they would like a different brace or some other strategies to prevent the left hand from contracting further but no one is helping them figure that out. During an interview on 3/13/24 at 8:56 A.M., Certified nurse assistant (CNA) #4 said the Resident chooses not to wear his/her left-hand splint and she hasn't seen the splint in a while. During an interview on 3/13/24 at 10:16 A.M., CNA #7 said he has not seen the Resident wear his/her hand splint in a while. He said he has seen her exercise and open her hand, but not wear the splint. During an interview on 3/14/24 at 10:05 A.M., CNA #6 said Resident #26 is his/her own person and chooses not to wear the left-hand splint because they don't like it and thinks it is not the right one for them. She said she has not seen the splint on the Resident for quite a while. During an interview on 3/13/24 at 10:11 A.M., Nurse #2 said Resident #26 does not wear the splint. She said she does not know why the Resident chooses not to wear it and she has not asked the Resident or notified the rehab department or therapist of the issue. She said nursing does not document whether the Resident wears the splint anywhere and she was not aware of the process for notifying rehab if any issues were to arise with the splint. During an interview on 3/13/24 at 1:49 P.M., Rehab staff #2 said the Resident informed him today (3/13/24) that he/she wanted their left-hand splint looked at. He said he worked in the PT department and had notified the Rehab Director of the Resident's request since the Resident would need to be seen by OT for any splinting. He reviewed the medical record and said the last time the Resident was seen by OT was in September 2023 when they were discharged from skilled OT services. Review of the OT Discharge Summary, dated 9/8/2023, indicated but was not limited to the following: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Objective progress goals: -Short term goal (STG) #1 Met on 8/25/23: Resident will wear resting hand splint on left wrist/hand for up to six hours with minimal signs of redness, swelling, discomfort or pain -STG #2 Discontinued on 9/8/23: Resident will increase ability to don/doff splint Comments: Resident requires maximum/substantial assistance to don/doff splint. Patient tolerates eight plus hours of wear time. - Long term goal (LTG) #1 Met on 9/8/23: Resident will safely wear a resting hand splint on left hand/wrist for up to or greater than eight hours. - LTG # Discontinued on 9/8/23: Resident will increase ability to don/doff splint to independence. Discharge: Requires maximum assist to don/doff however Resident is independent with adjustments throughout wearing time. - Patient progress: Patient has made consistent progress with skilled interventions. Splinting facilitates improved skin integrity, decreased tone, and improved comfort for patient. - Discharge Recommendations: Patient should continue to wear hand/wrist splint to left upper extremity (LUE) between A.M. and P.M. care to improve skin integrity, decrease tone, reduce risk of contracture, and to improve comfort. Patient is trained in warning signs and is able to obtain assistance as needed. - Splint and brace program established. Nursing staff trained in assisting Resident with donning/doffing orthosis. During an interview on 3/14/24 at 12:35 P.M., Unit Manager #1 said that although the physician's order is in the medical record for the nursing staff to assist the Resident with donning/doffing his/her splint it was put in in a manner that does not require a sign off by staff. She said the Resident needed to be seen by OT quarterly and certainly requires it at this time since the Resident has a contracture and is not wearing his/her splint related to comfort. She said the nursing staff should have notified OT and did not do so. She said the policy and expectation was not met and the issue will be addressed now that it has been brought to the staff's attention by the surveyor. During an interview on 3/14/23 at 3:12 P.M., the Director of Nurses (DON) said the Resident should have been seen by OT and the staff should have taken action to ensure he/she could wear their splint to prevent further potential contracture of his/her left hand and the policy was not followed as it should have been. Review of the OT evaluation and treatment plan for Resident #26 with a start of care date of 3/15/24 indicated but was not limited to the following: - Initial encounter for orthotic (splint) management and training - Resident demonstrates good rehab potential (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Current referral: Patient was referred to OT for decline in the use of his/her orthotic. The current orthotic is no longer appropriate and not meeting the needs of the patient. Concerns/Complaints: Patient wants to be able to prevent further flexion of his/her digits (fingers) Referral and history: contracture formation on the left hand; prior dates of service for OT 6/29/23 - 9/10/23 for contracture management and orthotic fitting Musculoskeletal system assessment: - LUE range of motion (ROM) impaired at the shoulder, forearm, wrist, hand, thumb, index finger, middle finger, ring finger and little finger - LUE strength - impaired - Contracture: functional limitations present due to contracture; OT will treat to address contracture impairment Reason for therapy summary: Resident presents with impairments in fine motor coordination, strength, follow through and problem solving resulting in limitations with general task and demands of self-care which requires skilled OT services. Without skilled therapeutic intervention the Resident is at risk for contractures and further decline in function. Recommendations: Resident requires a resting hand orthotic with increased support at the wrist and hand to prevent further contracture formation and accommodate patient tone. During an interview on 3/15/24 at 12:57 P.M. OT #1 said she evaluated the Resident and the left-hand contracture had worsened since the Resident was no longer using his/her splint and the Resident would require OT services at this time and a new orthotic device (splint).

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 42742 Based on observation, record review, policy review, and interview, the facility failed to ensure that four Residents (#24, #70, #226, and #2), out of a total sample of 24 residents, were provided an environment free from accident hazards. Specifically, the facility failed to ensure staff: Provided adequate supervision and/or followed their Falls Prevention and Management policy of investigating falls and initiating fall prevention interventions for: 1. Resident #24, who had six total falls, all related to toileting, one of which consisted of an acute left-sided 7th rib fracture, healing 5th and 6th rib fractures, and a closed head injury; 2. Resident #70, who had two falls, less than 12 hours apart, one resulting in a fracture of the left femoral neck (left hip fracture) requiring inpatient hospital stay and surgical repair; and the other resulting in a hematoma to the right side of the head and a skin tear to the right arm; 3. Resident #226, to ensure adequate supervision and the appropriate level of staff assistance after the Resident was observed by staff to be ambulating independently with his/her walker into the facility's main lobby from a transit bus upon his/her return from dialysis; and 4. Resident #2, to ensure that falls were thoroughly investigated, and interventions were implemented to prevent further falls. Findings include: Review of the facility Fall Prevention and Management Policy, dated as last revised January 2023, indicated but was not limited to the following: -Fall Risk Evaluation will determine fall risk factors. The interdisciplinary team (IDT) identifies and implements appropriate interventions to reduce the risk of falls or injury while maximizing dignity and independence. ASSESSMENT AND PREVENTION -Fall risk assessments will be completed for all residents; initially on admission / readmission, quarterly, significant change and after an identified fall. -As part of the assessment, the nurse will help identify individuals with a history of falls and risk factors for subsequent falling. a. History of falling. b. History of one or more recent falls. c. Root cause for fall history will be identified. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	-The staff will implement goals and interventions based on the resident's individual needs. -Communicate interventions to care givers. -Review and revise IDT care plan when a change is identified, after an event. -If the resident continues to fall, the staff and physician will re-evaluate the situation and consider other possible reasons for the resident's falling and will re-evaluate the continued relevance of current interventions. POST FALL -The nurse will complete an incident report. -Resident fall will be evaluated for 72 hours post fall, including full vital signs every shift. -Resident will be referred to therapy for a screen. CAUSE IDENTIFICATION -For an individual who has fallen, staff will attempt to define possible causes within 24 hours of the fall -IDT should review resident's gait, balance, dizziness, and current medications to assess possible contributors to fall -The IDT and physician should continue to collect and evaluate information until causes for falls can be identified. MONITORING AND FOLLOW UP -IDT should monitor and document on residents' response / success with fall reduction interventions -Residents who continue to fall with interventions in place will be assessed for changes in or additions to interventions. Review of the facility's policy titled Incident Reports, dated as last revised October 2022, indicated but was not limited to the following: -It shall be the responsibility of the person in charge to ensure that all incidents involving resident injury are followed by the completion of an incident report. -Incident reports shall be completed and submitted within eight hours of the incident. -Incident reports shall be filled out for any unusual or dangerous occurrence. Example: Resident Fall. -All sections of the incident report must be completed (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	-The incident report and statements shall be completed as soon as possible after the incident has occurred by the licensed person and/or certified nursing assistant (CNA) involved, and then forwarded to the Nurse Manager. Review of the Falls Packet, undated, indicated but was not limited to the following: -Incident Procedure: a. In electronic medical record under risk management create a new incident and save. b. Fill out all sections as appropriate. c. Complete fall evaluation. d. Care plan needs to be updated, under problem add date of the fall, under interventions add the intervention put in place to keep the resident safe/prevent a repeat fall. e. Fall packet with witness statements and neurological check go to the Director of Nurses (DON), along with a copy of the rehab screen. f. Rehab screen goes to rehab department. -All incident reports must have a note written by the risk manager/DON stating the incident was investigated and the results of said investigation. -If it was a fall there must be an accompanying intervention The Falls packet included the following documents: -Blank Witness Statements with the following questions: a. When was the last time you saw the resident? b. What was the resident doing? c. When was the last time you toileted/changed the resident? d. Was the resident incontinent at the time of the incident? e. Did the resident have any behaviors not normal to the resident? f. What did the resident say he/she was doing at the time of the fall? g. Any other information that would help get to the cause of the incident? -Blank Neurological Assessment -Blank Referral/Screen to Rehab Services (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	1. Resident #24 was admitted to the facility in December 2023 with diagnoses including encephalopathy (any brain disease that alters brain function or structure), diabetes mellitus type 2, bipolar disorder, anxiety, seizures, cognitive communication deficit, unsteadiness on feet, and lack of coordination. Medications included antipsychotic, antidepressant, narcotic, diuretic, and anti-seizure medications. Review of the Minimum Data Set (MDS) assessment, dated 12/28/23, indicated Resident #24 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15, was a substantial/maximum assist for toileting, showering, and bathing, dependent on staff for putting on and taking off footwear, and a partial/moderate assist for walking 10 feet. The MDS also indicated Resident #24 was frequently incontinent of urine, always incontinent of stool, and was not on a urinary or bowel toileting program. The MDS failed to indicate an admission fall history was able to be determined. Review of the clinical record indicated Resident #24 sustained six falls between 1/10/24 and 2/25/24, one of which (2/25/24) resulted in an acute left-sided 7th rib fracture, healing 5th and 6th rib fractures, and a closed head injury. Six out of six falls were unwitnessed, and all were related to toileting. During an interview on 3/12/24 at 9:17 A.M., Resident #24 said he/she had a history of strokes with a left-sided deficit and decreased range of motion. During an interview on 3/14/24 at 10:42 A.M., Resident #24 said he/she had had three falls in the last month and a half and said, I get dizzy when I stand up. The Resident said his/her legs were weak and unsteady. The Resident said he/she gets up on his/her own to go to the bathroom and loses his/her balance and does hit the call bell, but they don't come in time. Resident #24 said he/she currently had a broken rib with a 3 out of 10 (10 being the worst) pain every time I breathe and was taking Oxycodone for pain. Review of the Falls Incident Reports (IR) for Resident #24 indicated but was not limited to the following: Fall #1 (1/10/24 at 11:15 P.M.): -Review of the medical record indicated Resident #24 had an unwitnessed fall and was found sitting on the floor in the bathroom with his/her walker at his/her back. The Resident stated he/she went into the bathroom to urinate, was washing his/her hands and lost balance and stumbled to the floor. The Resident complained of left arm pain and right rib pain and requested to be transferred to the emergency department (ED) for evaluation. Predisposing factors included weakness, decreased safety awareness, impaired memory, and decreased strength/endurance. No injuries were observed by staff. Review of the ED report, dated 1/11/24 at 12:00 A.M., indicated Resident #24 presented from the rehab facility after a fall in the bathroom which was unwitnessed. The Resident stated he/she hit the right side of his/her head, back, and right arm and reported right-sided neck pain and chest wall pain. There were no acute findings, and the Resident was discharged back to the facility. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Review of the medical record indicated an Admission Fall Risk Evaluation was not completed until 1/12/24, 19 days after the admitted and two days after the first fall was sustained, which indicated Resident #24 was at high risk for potential falls. The evaluation indicated prevention protocol should be initiated immediately and documented on the care plan. Review of the medical record indicated a Moderate Risk for Falls care plan was initiated 1/12/24, 19 days after admission and two days after the first fall was sustained, indicated Resident #24 was at risk due to deconditioning, incontinence, and psychoactive drug use. The goal was that the Resident will not sustain serious injury through the review date. Interventions included the call light within reach and encourage to use it for assistance as needed, appropriate footwear when ambulating, safe environment, and physical therapy (PT) eval and treat as ordered and as needed (prn). Further review of the medical record indicated an Activities of Daily Living (ADLs) Functional/Rehabilitation Potential care plan was initiated 1/12/24, 19 days after admission and two days after the first fall was sustained, indicated Resident #24 had a self-care deficit due to pain and decreased range of motion to the left shoulder. The goal was that the Resident will maintain the highest level of functioning through the target date. Interventions included answering the call light promptly and have within reach at all times, transfer assist x 1, toilet transfer assist x 1, bed mobility assist x 1, mobility ambulate with assist x 1, toileting hygiene max assist x 1. Review of the medical record failed to include a falls packet and one was not provided to the surveyor upon request. Fall #2 (1/13/24 at 11:27 A.M.): -Review of the medical record indicated Resident #24 had a second unwitnessed fall and was found sitting on his/her bottom with his/her back to the bathroom wall. The Resident stated he/she was toileted by an aide and when finished, he/she got up to get back into bed and lost his/her balance and fell . No injuries were observed pre- or post-incident. Predisposing factors included confusion and gait imbalance. Review of the medical record failed to include a falls packet, post fall risk evaluation, or new interventions implemented to help keep the Resident safe and prevent a repeat fall. Fall #3 (1/21/24 at 1:00 P.M.): -Review of the medical record indicated Resident #24 had a third unwitnessed fall and was found sitting on the floor next to the room door and bathroom door. The call light was placed by the roommate. The Resident had complaints of arm pain and said he/she had tendonitis. Weakness was noted to the bilateral lower extremities (HX of CVA). No injuries were observed. The Resident was noted to have some confusion stating he/she was going to the bathroom. The Resident is a total assist at baseline. Predisposing factors included confusion, weakness, decreased safety awareness, and decreased strength. Review of the medical record failed to include a falls packet and one was not provided to the surveyor upon request. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	A new Risk for Falls care plan was initiated on 1/21/24 and included interventions such as to assist the resident with ambulation and transfers utilizing therapy recommendations, educate the resident on maintaining a safe environment, ensure call light is available, and if a fall occurs alert the provider and initiate frequent neuros and bleeding eval per facility protocol. There were no goals listed. Fall #4 (2/19/24 at 5:00 A.M.): -Review of the medical record indicated Resident #24 had a fourth unwitnessed fall and was found sitting on his/her bottom on the floor at the bedside. The Resident stated he/she had just finished using the urinal and his/her feet slid out from under him/her. The Resident complained of a sore left arm and bottom after landing on them. No injuries were observed. Predisposing factors included poor lighting, gait imbalance, and decreased strength. Review of the medical record failed to include a falls packet, referral to therapy for a screen to determine the need for therapy interventions, post fall risk evaluation, or new interventions implemented to help keep the Resident safe and prevent a repeat fall. Fall #5 (2/19/24 at 10:23 P.M.): -Review of the medical record indicated Resident #24 had another unwitnessed fall, same day, and was found sitting on the floor in the bathroom. The resident stated he/she was toileting self with walker and lost his/her foot grip with non-skid slipper socks on and fell to the floor. The Resident complained of left rib cage and left arm/elbow pain with limited range of motion to the left upper extremity. The Resident refused ED transport. A stat x-ray was ordered for the left rib cage and left upper extremity. No injuries were observed at the time of the incident. Predisposing factors included trip hazard, impulsiveness, and ambulating without assist. Review of a Nurse Practitioner's Note, dated 2/20/24 at 4:14 P.M., indicated positive pain with pressure to the Resident's left ribs. Left arm with no obvious abnormalities. X-rays reviewed, no fractures. Review of the medical record failed to include a referral to therapy for a screen to determine the need for therapy interventions, post fall risk evaluation, or new interventions implemented to help keep the Resident safe and prevent a repeat fall. Fall #6 (2/25/24 at 11:51 P.M.): -Review of the medical record indicated Resident #24 had a sixth unwitnessed fall and was found on the floor in the room next to his/her bed. The Resident stated, I fell and hit my head really hard and it's hurting. No injuries were observed at the time of the incident. The Resident was transported to the ED for evaluation. Predisposing factors included gait imbalance and decreased strength and that the incident occurred during unassisted self-transfer from the bed and ambulating independently. Review of the ED report, dated 2/26/24 at 12:18 A.M., indicated but was not limited to the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225667	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2024
NAME OF PROVIDER OR SUPPLIER Pleasant Bay of Brewster Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 383 South Orleans Road Brewster, MA 02631	

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F 0689 Level of Harm - Actual harm Residents Affected - Some	-The Resident has a history of prior strokes with left-sided weakness and was status post an unwitnessed fall at the rehab center going to the bathroom, lost his/her balance and fell back. Resident reported striking his/her head and brief loss of consciousness. He/she stated he/she was unable to get up off the ground and was found approximately 10 minutes later. Complaints of right shoulder pain, headache, and neck pain. ED diagnoses included healing fractures of the left 5th and 6th ribs, an acute fracture in the left 7th rib, and a closed head injury. The Resident was discharged back to the facility at 3:17 A.M. Review of the medical record failed to include a referral to therapy for a screen to determine the need for therapy interventions, post fall risk evaluation, or new interventions implemented to help keep the Resident safe and prevent a repeat fall. Review of a Physician's Progress Note, dated 2/26/24 at 9:06 P.M., indicated the Resident had a recent fall with healing rib fractures and an acute rib fracture and continued to be unsteady. Continue PT, use walker, fall precautions. Review of a Physical Therapy Treatment Encounter Note, dated 3/8/24, indicated the patient and nurse were educated to discharge from PT services at this time. Patient does remain a fall risk due to impaired cognition. Perhaps considering a toileting schedule may decrease patient's attempts at self-toileting. During an interview on 3/14/24 at 11:00 A.M., Certified Nursing Assistant (CNA) #11 said Resident #24 was at risk of falls and was incontinent at times. She said they had to watch him/her because he/she sits at the side of the bed and puts his/her feet on the ground including when sleeping. CNA #11 said the Resident was steady with a walker and could get up on his/her own but was encouraged to use the call light. She said the Resident did not always do that though so needed to be supervised. CNA #11 said the Resident had not had any falls in a while. During an interview on 3/14/24 at 3:18 P.M., Nurse #9 said Resident #24 gets out of the bed to the chair but was not safe to do it on his/her own. She said he/she was very unsteady and had fallen a bunch of times. Nurse #9 said the Resident had a history of a stroke and lost part of his/her eyesight so was unsteady on his/her feet and had no safety awareness. Nurse #9 said she was not aware of any falls that resulted in major injury, but said the Resident required supervision and shouldn't be getting up on his/her own. On 3/18/24 at 7:00 A.M., the surveyor observed Resident #24 sleeping in bed. Both feet were hanging off the side of the bed. During an interview on 3/18/24 at 7:05 A.M., Nurse #11 said the Resident was at risk for falls and had one a month ago but was not injured. He said the Resident could take him/herself to the bathroom but overestimates him/herself a lot. Nurse #11 said the Resident could stand by his/herself to use the urinal but required supervision to the bathroom saying, he/she'll let us know. He said interventions were to have the call light within reach, non-skid socks, and the bed in a low position. On 3/18/24 at 8:00 A.M., the surveyor observed Resident #24 awake and lying sideways in the bed with both feet on the ground. The Resident's feet were partially wrapped with Ace bandages. The Resident was not wearing non-skid socks or footwear. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Pleasant Bay of Brewster Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 383 South Orleans Road Brewster, MA 02631	

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F 0689

Level of Harm - Actual harm

Residents Affected - Some

During an interview on 3/18/24 at 2:11 P.M., the Rehab Director (RD) said Resident #24 was under therapy services from 12/22/23 through 2/7/24, then from 2/27/24 through 3/8/24. She said the Resident was always an assist while working with therapy and was non-compliant with calling for assistance. The RD said Resident #24 was not under therapy services at the time of the 2/19/24 and 2/25/24 falls and was not aware of them. She said nursing did not alert the Rehab Department of the falls or send referral requests for post-fall evaluations but should have. The RD said if a resident falls, nursing is supposed to send a referral for a falls screen, typically physical therapy (PT), and they would see the resident within 48 hours to determine the circumstances, what did they do, did they get hurt, and do they need services at that time. The RD further said the therapy department was not integrated with the facility's electronic record system so could not be alerted to orders or falls in that manner.

On 3/19/24 at 7:50 A.M., the surveyor observed Resident #24 awake and lying sideways in the bed, with both feet on the ground. The Resident was not wearing non-skid socks or footwear.

During an interview on 3/19/24 at 11:25 A.M., Nurse #13 said Resident #24 was at risk for falls and had had multiple falls since admission. She said there was no significant pattern of falls that she knew of, but the Resident did a lot of self-transferring, had poor safety awareness, and had a rib fracture. She said the Resident had some confusion and was taking high risk medications that could increase the risk of falls. She said a fall risk care plan was not initiated until 1/12/24 and new interventions were not identified or implemented after each fall to help reduce the Resident's fall risk. Post fall, Nurse #13 said the physician, patient's family/health care proxy, and DON should be notified and a rehab screen and falls packet completed after each fall. Nurse #13 said if interventions are unsuccessful and a resident continues to fall, they should be assessed for changes and additional interventions put in place. Nurse #13 said she had not received training or education for use of the fall risk tool, techniques to prevent falls, or transfer protocols regarding Resident #24 to help prevent further falls. She said it was just based off her own knowledge.

During an interview on 3/19/24 at 1:09 P.M., with the DON and Consulting Staff #1, Consulting Staff #1 said there was no falls care plan in place, or a fall risk assessment completed prior to the Resident's first fall on 1/10/24 but should have been as that would have potentially identified the Resident as being a fall risk with the appropriate interventions in place. She said she could not locate any of the other fall's packets, but after each fall there should have been a fall risk evaluation completed that shift, the physician notified, rehab referral, and an investigation completed to determine what happened with the appropriate new interventions put into place immediately. Consulting Staff #1 said a care plan for falls and ADLs was not initiated until two days after the first fall and did not indicate an actual fall had occurred. She said new interventions were not added after each of the subsequent falls and, the interventions that were in place, were not effective to help prevent future falls and avoid injury. She said she wasn't aware there was a pattern to the falls in that all the falls were related to toileting.

48084

2. Resident #70 was admitted to the facility in April 2023 with diagnoses which included Alzheimer's disease, anemia, orthostatic hypotension (low blood pressure that happens when standing up from sitting or lying down), difficulty walking, syncope (fainting or sudden temporary loss of consciousness) and collapse, and a history of falls.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225667	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2024
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F 0689 Level of Harm - Actual harm Residents Affected - Some	Review of the MDS assessment, dated 12/19/23, indicated Resident #70 had a score of 3 out of 15 on the BIMS, indicating severe cognitive impairment, needed supervision/assistance with ADLs, was occasionally incontinent of urine, and had a history of falls. Review of Resident #70's medical record indicated he/she had sustained four falls between October 2023 and March 2024 (10/26/23, 10/27/23, 12/10/23, and 3/1/24). FALL #1 on 10/26/23: Review of the progress note, dated 10/26/23 at 6:41 P.M., indicated Resident #70 was alert and confused at baseline, Resident was noted on the floor with a small area to left side of temple. Additionally, the note indicated the Resident had received new glasses yesterday after not having them for a while. Nurse will monitor to ensure he/she is adjusting to having the glasses on again. Review of Incident Report, dated 10/26/23, indicated the nurse heard Resident #70 call out and upon entering the room, Resident was noted to be on the floor on his/her left side with a 1x1x0.1 centimeter (cm) cut to the left temple from his/her glasses. Additionally, a 3x3 cm bruise was noted to the left elbow. The Resident did not know how he/she fell , however stated he/she hit his/her back on the footboard of the roommate's bed. The Mental Status section indicated he/she had memory impairment. The notes section indicated Resident complained of discomfort related to the fall, no visible injuries, ice applied, MD notified, leg equal in length will continue to monitor. The Predisposing Environmental Factors section and the Predisposing Physiological Factors section were not completed. The Predisposing Situation Factors section had other checked off and the comment noted the Resident had new glasses. Review of the care plans for Resident #70 indicated but were not limited to the following: Review of the Fall Risk Care Plan for Resident #70 indicated: FOCUS: Resident #70 is at risk for falls related to deconditioning, history of fall secondary to syncope and collapse (4/11/23). GOAL: He/she will be free of falls through review date (4/11/23). INTERVENTIONS: -Be sure Resident #70's call light is within reach and encourage him/her to use it for assistance as needed. He/she needs prompt response to all requests for assistance (4/11/23) -Ensure Resident #70 is wearing appropriate footwear when ambulating or mobilizing in wheelchair (4/11/23). -Follow facility fall protocol. (4/11/23) -Physical Therapy evaluate and treat as ordered or as needed (4/11/23) The facility failed to update the Fall Risk care plan or initiate a new intervention to keep the Resident safe/prevent a repeat fall per facility policy and Fall Packet procedure guide. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Review of the Activities of Daily Living (ADL) Care Plan prior to the fall on 10/26/23, indicated Resident #70 needed supervision with transfers, ambulation, and toileting. Review of the Vision Care plan for Resident #70, indicated the following: FOCUS: Resident #70 has impaired visual function related to age (8/12/23) GOAL: Resident #70 will show no decline in visual function through the review date (8/23/23) INTERVENTIONS: -Ensure appropriate visual aids (eyeglasses) are available to support his/her participation in activities (8/12/23) -Remind him/her to wear glasses when up. Ensure resident is wearing glasses which are clean, free from scratches, and in good repair. Report any damage to nurse/family. (8/12/23) There were no additional interventions on the vision care plan, current or historical. The facility failed to note the Resident had been without glasses for a while, had new glasses, or needed additional monitoring for adjustment to the new glasses status post fall. Review of the most recent Fall Risk Evaluation indicated an evaluation was done on 10/17/23 as part of the quarterly MDS schedule, and the total score was 9. The Fall Risk Evaluation determines the level of fall risk based on questions pertaining to current health status, recent fall history, ambulation status, blood pressure, vision, diagnosis/predisposing conditions, recent change in condition, and recent hospitalization . A score of 10 of greater would indicate HIGH risk for potential falls and prevention protocol should be initiated immediately and documented on the care plan. The facility failed to complete a Fall Risk Evaluation after the fall on 10/26/23 per policy. Further review of Resident #70's medical record, including progress notes, medication administration records (MAR), treatment administration records (TAR), and physician's orders failed to indicate any new intervention had been implemented to prevent additional falls/injury. FALL #2 on 10/27/23: Review of the progress note, dated 10/27/24 at 6:24 A.M., indicated at 4:15 A.M., staff heard a loud noise down the hall and found Resident #70 lying on the floor on his/her right side. Resident said he/she was coming out of the bathroom. The Resident was assisted back to bed and complained left hip was sore. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Pleasant Bay of Brewster Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 383 South Orleans Road Brewster, MA 02631	

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Review of the Incident Report, dated 10/27/23, indicated staff heard a loud noise down the hall, and found Resident #70 lying on the floor in his/her room. The Resident said he/she was coming back from the bathroom. Resident #70 was wearing regular socks, not slipper socks and complained left hip was sore. The Mental Status section indicated he/she was memory impaired and decision making impaired. The notes section indicated the Resident had his/her walker with them. Predisposing Environmental Factor included poor lighting and adaptive equipment. Predisposing Physiological Factors included confusion, decreased safety awareness, impaired memory, and decreased strength and endurance. Predisposing Situation Factors included using a walker, side rails up, and improper footwear. Further review of the Complete Incident Report, dated 10/27/23, failed to include witness statements. Review of the Reportable Incident Folder indicated but was not limited to the following: -Date of Incident: 10/27/23 at 4:15 A.M. -There were three witness statements dated 10/26/23, all three staff members indicated they saw the resident ambulating prior to the fall the evening of 10/26/23. None of the statements indicated the staff had intervened or provided assistance/supervision. None of the statements indicated when the resident was last toileted. (One response was not sure and the other two were N/A (not applicable) to the question regarding when the resident was last toileted. The resident required supervision/assistance with toileting. -There were not any witness statements related to the fall on 10/27/23. The facility failed to provide supervision with transfers and ambulation on 10/26/23, resulting in the Resident falling in his/her room striking head, elbow, and back and failed ensure a new intervention had been implemented to prevent additional falls/injury, resulting in Resident #70 falling again, less than 12 hours later while ambulating in room and toileting self. The facility failed to update the Fall Risk care plan or initiate a new intervention to keep the resident safe/prevent a repeat fall per facility policy and Fall Packet procedure guide. Further review of Resident #70's medical record, including progress notes, and physician's orders failed to indicate any new intervention had been implemented to prevent additional falls. Review of the progress note, dated 10/27/23 at 11:51 A.M., indicated Resident #70 complained of increased pain to the left hip, had compromised circulation, sensation, and motion (CSM) to left lower extremity, had a bruise to left hip, and was grimacing in pain. An order was obtained to transfer Resident #70 to the emergency room for evaluation. Review of the Discharge Summary from the hospital, dated 10/30/23, indicated but was not limited to the following: -Resident #70 had a left displaced (the bones are not in alignment) femoral neck (hip) fracture. -Resident #70 underwent a left hip hemiarthroplasty (surgery to replace half of the hip joint with an artificial one). (continued on next page)

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	225667	A. Building B. Wing	03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Bay of Brewster Rehab Center	383 South Orleans Road Brewster, MA 02631

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F 0689 Level of Harm - Actual harm Residents Affected - Some	The facility failed to provide supervision with transfers, ambulation, and toileting, and failed to ensure Resident #70 had proper footwear on while ambulating, resulting in the Resident falling in his/her room and fracturing his/her hip. The facility failed to complete a Fall Risk Evaluation after the fall on 10/27/23 per policy. FALL #3 on 12/10/23: Review of the progress note, dated 12/10/23 at 3:59 A.M., indicated a loud noise was heard coming from the room. The Resident was observed on the bathroom floor with a hematoma to the right side of his/her head and a skin tear to the right arm. The resident was assisted from the floor and into the wheelchair and then transferred to the emergency room for further evaluation. There was no incident report completed for this fall on 12/10/23 per policy. Review of the most recent Fall Risk Evaluation indicated an evaluation was done on 10/30/23 as part of the Admission/Re-Admission MDS schedule, the total score was 12, indicating the Resident was a HIGH RISK for potential falls and prevention protocol should be initiated immediately and documented on the care plan. The facility failed to complete a Fall Risk Evaluation after the fall on 12/10/23 per policy. Review of the ADL Care Plan prior to the fall 12/10/23, indicated Resident #70 needed assistance with transfers, ambulation, toileting, and dressing. Review of the Fall Risk care plan failed to indicate it had been updated with a new intervention to prevent further falls/injury and an actual Fall care plan had not been initiated, per policy. Further review of Resident #70's medical record, including progress notes, and physician's orders failed to indicate any intervention had been implemented to prevent additional falls. The Resident was sent to the hospital on 12/10/23 for further evaluation after the fall with head strike, he/she was treated at the hospital and subseque[TRUNCATED]

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 48084 Based on observations, interviews, and record review, the facility failed to ensure one Resident (#108), was not catheterized unless required by his/her clinical condition to manage urinary continence/incontinence and prevent urinary tract infections (UTI), out of a total sample of 24 residents. Specifically, the facility failed for Resident #108 to ensure staff provided training and education on self-catheterization technique, provided education on symptoms and complications, evaluated, and re-evaluated the Resident's ability to self-catheterize, developed, and implemented a care plan timely, and to make a follow up appointment with a urologist as recommended. Findings include: Review of the facility's policy titled Incontinence-Urine-Assessment and Management, dated as last revised 1/2023, indicated but was not limited to the following: -The staff and practitioner will appropriately screen for and manage individuals with urinary incontinence. -Identification and management of UTI will follow relevant clinical guidelines. -Functional and/or cognitive capabilities or limitations that could affect continence. -Additional information such as the type and frequency of physical assistance -The staff and physician will summarize an individual's continence status. -The staff and physician will identify individuals at risk for complications. -For individuals with persistent or recurrent urinary retention despite interventions, the staff and physician will seek treatable causes and consider intermittent catheterization. -The staff and physician will evaluate the effectiveness of interventions and implement additional pertinent interventions as indicated. The facility did not provide the surveyor with a policy for intermittent catheterization when requested. Instead, the surveyor was provided with a policy for Catheter Care. Review of the facility's policy titled Catheter Care, dated as last revised 1/2023, indicated but was not limited to the following: -The purpose of this procedure is to prevent catheter-associated UTIs and provide required care of Resident's who have an indwelling catheter. The facility did not provide the surveyor with a policy for Self- Administration of Treatments when requested. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Physician-Consultations, dated as last revised 10/2022, indicated but was not limited to the following: -It is the policy of this organization to ensure all residents receive medical care in a timely manner. -Follow-up: to be done within the time frame requested by the consultant and approved by the attending physician Resident #108 was admitted to the facility in April 2023 with diagnoses which included urinary retention. Review of the Minimum Data Set (MDS) assessment, dated 1/10/24, failed to indicate a Brief Interview for Mental Status (BIMS) had been completed. Further review of the MDS indicated the Resident had an indwelling catheter. During an interview on 3/18/24 at 4:18 P.M., MDS Nurse #1 said it was an error on the MDS and Resident #108 did not have an indwelling catheter; he/she should have had intermittent catheterization coded on the MDS. Additionally, she said Resident #108 is alert and oriented and should have had a BIMS done. Review of the Physician's Orders indicated the following: -Straight Cath (catheterize) once a shift for urinary retention. (4/30/23) Further review of the physician's order failed to indicate the Resident self-administered this procedure. Additionally, the order was entered into the EMAR as a standard order and does not populate onto the medication/treatment administration records for the nurse to see and/or sign off on the procedure. Review of the Admission Nursing Evaluation-V7, dated 4/24/23, indicated Resident #108 straight caths twice daily. Further review of the Evaluation failed to indicate education or competency training was provided or that a care plan was developed. Review of the comprehensive care plans indicated a Urinary Catheter care plan was not developed until 8/9/23. (107 days after admission) Further review of the care plan failed to indicate education or competency training had been completed. Review of the medical record indicated Resident #108 was hospitalized in June 2023 for chest pain, abdominal pain, chronic urinary retention, resistant E-Coli in the urine (suspect colonization) in the setting of self-straight catheterization, and hypokalemia (low potassium). Additionally, it was noted for the Resident to follow up outpatient with Urology. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the medical record including progress notes, care plans, consultations, and orders failed to indicate a Urology appointment had been arranged or a reason for not arranging the appointment. Review of the progress notes failed to indicate any education or competency training had been completed to ensure Resident #108 was mentally and physically capable of straight catheterizing him/herself or knew symptoms and complications to report to the nurse, prior to or after the hospitalization when he/she was treated for a UTI in the setting of self-catheterization. During an interview on 3/18/24 at 12:00 P.M., Resident #108 said they straight catheterize every day, a few times a day. He/she said the supplies are in the top drawer of the nightstand and he/she just must ask when more are needed. Additionally, Resident #108 said he/she was not provided any education related to the procedure, hygiene, symptoms, or complications that might arise on admission or any time since that he/she can recall. Resident #108 said he/she just does the procedure and it is not that hard. He/she said there has not been a urology appointment made that he/she is aware of. During an interview on 3/18/24 at 4:18 P.M., MDS Nurse #1 said Resident #108 should have had a urinary retention/straight catheterization care plan in place since admission in April 2023 and did not know why it was not implemented until August 2023. During an interview on 3/19/24 at 9:18 A.M., Unit Manager #1 said she was new to the facility, but she would expect to see a self-administration assessment like the one done for medications, indicating the Resident is able to do the procedure appropriately, including appropriate hygiene techniques. She said there should be a care plan in place with the self-catheterization process on it and the nurses should be checking on him/her and documenting on the treatment administration record (TAR). Additionally, she said self-catheterizing for that length of time leaves the Resident open to infection and he/she should be followed by a urologist. During an interview on 3/19/24 at 9:35 A.M., Nurse #12 said if someone self-catheterizes the order should read that way, so when it comes up on the TAR, it says they do it themselves. During an interview on 3/19/24 at 12:26 P.M., Nurse #6 said she did not know if any training, teaching, or education was done with Resident #108. She said she would expect to see education and competency training documented in the medical record and a quarterly re-evaluation when the MDSs are done. Additionally, Nurse #6 said she did not see any monitoring, education, or training in the record, nor did she see any documentation a urology appointment had been made since admission. She said the care plan should have been initiated on the admission evaluation and was not and she did not know why a care plan was not developed until August as it should have been there all along. During an interview on 3/19/24 at 12:49 P.M., Nurse #13 said when she started Resident #108 was already here. She said she would expect the medical record to have a self-administration assessment and quarterly re-evaluations. She said there is no nurse oversight, he/she does it independently, the nurse does not sign of the TAR, the order is in as a standard order so it goes no where that the nurses would see on the MAR or TAR. Additionally, she said the first time she worked on the unit she observed the procedure because it made her nervous and she did not know if he/she could do it independently but did not think she documented it anywhere. The Director of Nurse was not available for interview on 3/18/24 or 3/19/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225667	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Bay of Brewster Rehab Center	383 South Orleans Road Brewster, MA 02631

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Staff Development Coordinator was not available for interview on 3/19/24. During an interview on 3/19/24 at 3:13 P.M., Consulting Staff #1 said Resident #108 was straight catheterizing at home prior to admission to the facility, but a competency should have been done and documented in the medical record. Additionally, she said self-administration is reviewed quarterly and this should be as well. She said he/she refuses assistance and education but there is no documentation of that and there should be. She said Resident #108 does the procedure and the nurses are not monitoring it or signing off the TAR because he/she does it themselves. She said a care plan should have been implemented on admission and she could not recall what happened with urology because he/she was supposed to go.

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	225667	A. Building B. Wing	03/19/2024

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F 0692 Level of Harm - Actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. 48362 Based on observations, interviews, record review, and policy review, the facility failed to monitor the nutritional status for two Residents (#2, #61) with an unplanned significant weight loss, out of a total sample of 24 residents. Specifically, the facility failed: 1. For Resident #2, to continue to monitor the Resident's nutritional status after they experienced a severe significant weight loss of 12.66% in three months (11/21/23 to 2/3/24), resulting in a continued significant weight loss of 5.39% in one month (2/3/24 to 3/8/24) which the facility did not identify or address; and 2. For Resident #61, to continue to monitor the Resident's nutritional status after they experienced a severe significant weight loss of 6.95% in one month (10/21/23 to 11/21/23), resulting in a 10.54% severe significant weight loss in three months (10/21/23 to 1/25/24) and a 10.74% severe significant weight loss in three months (11/30/23 to 3/18/23) which the facility did not identify or address. Findings include: Review of the facility's policy titled Weight Assessment and Interventions, revised May 2019, included but was not limited to: - The multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight change for our residents. - Monthly weights will be obtained each month or as ordered by physician. - Weights will be recorded in the medical record (electronic health record where available) for each resident. - Any weight change of five pounds (lbs) in a month or three pounds in a week since their last weight assessment should be retaken within 72 hours for confirmation and verified by Nursing. - Re-weigh should be reviewed by the Licensed Nurse. - Licensed Nurses should notify Dietician of identified weight change once reviewed. - Dietician notification should be documented within Resident's medical record. - Dietician or diet technician should respond within 72 hours of receipt of notification. - The threshold for significant unplanned and undesired weight change will be based on the following criteria: (a) one month: 5% weight change is significant, greater than 5% is severe; (b) three months: 7.5% weight change is significant; greater than 7.5% is severe; (c) six months: 10% weight change is significant; greater than 10% is severe. (continued on next page)

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F 0692

Level of Harm - Actual harm

Residents Affected - Some

1. Resident #2 was admitted to the facility in February 2021 with diagnoses including schizoaffective disorder and type II diabetes.

Review of the Minimum Data Set (MDS) assessment, dated 1/24/24, indicated Resident #2 had a severe cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 6 out of 15. Further review of Section K of the MDS assessment indicated Resident #2 had a weight loss of 5% or more in the last month or 10% or more in the last 6 months. Section K of the MDS assessment indicated Resident #2 was not on a prescribed weight loss regimen. Further review of the MDS assessment indicated Resident #2 required set-up assistance for meals.

On 3/12/24 at 12:05 P.M., the surveyor observed Resident #2 eating his/her lunch meal in the dining room on the North Two Unit. Resident #2 was seated at a table with other residents and his/her meal was set-up by staff. Staff were observed to assist by cutting Resident #2's meal and opening drinks. Staff were not observed to provide any additional assistance with feeding to the Resident. The surveyor observed Resident #2 leaning to the right side in their wheelchair and gripping onto the table with both hands throughout the meal. The surveyor observed Resident #2 consume a few bites of his/her meal before fluctuating between sleeping and calling out to staff.

On 3/13/24 at 12:12 P.M., the surveyor observed Resident #2 brought into the North Two Unit dining room for lunch. Resident #2 was positioned at a table with other residents and set up by staff members for the meal. Staff were observed to assist by cutting Resident #2's meal and opening drinks. Staff were not observed to provide any additional assistance with feeding to the Resident. The surveyor observed Resident #2 asleep throughout the meal. Staff members were observed to encourage the Resident to initiate eating by tapping him/her on the shoulder and saying, it is time to eat. Resident #2 was observed to be asleep without initiating feeding throughout the mealtime. The surveyor did not observe Resident #2 consume any food during the lunch meal.

Review of Resident #2's active Physician's Orders included but were not limited to:

- 11/20/23: DIET - Regular Texture, Thin Liquid Consistency, Consistent/Controlled Carbohydrate (CCHO) Diet

- 2/21/24: House Diabetic Supplement - two four-ounce supplements per day

- 2/26/24: Weekly Weight - weekly weight secondary to weight loss every day shift every seven days

Review of Resident #2's Medication Administration Record (MAR) indicated a House Diabetic Supplement was provided to him/her twice daily from 2/21/24 through 3/17/24. Further review of the MAR indicated failed to indicate a percentage value of amount consumed on 15 out of 51 opportunities. Furthermore, the MAR indicated the Resident drank less than or equal to 50% of the house supplement provided on 23 of 51 opportunities.

Review of Resident #2's weights in the electronic medical record indicated the following weights:

- 09/2023: not obtained

- 10/2023: not obtained

(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 0692 Level of Harm - Actual harm Residents Affected - Some	- 11/21/23: 191.2 lbs. - 12/2023: not obtained - 01/23/24: 172.2 lbs. - 02/03/24: 167.0 lbs. - 02/26/24: not obtained - 03/04/24: not obtained - 03/08/24: 160.0 lbs. Review of Resident #2's weights indicated he/she had a 12.66% severe weight loss in three months. Further review of Resident #2's weights indicated a 5.39% significant weight loss in one month (2/3/24 and 3/8/24). A significant and/or severe weight loss value for six months was unable to be calculated due to failure of the facility to obtain a monthly weight value in 9/2023. Review of Resident #2's nutritional care plan failed to indicate he/she was at risk for nutritional decline. Interventions for Resident #2's nutritional care plan included but were not limited to: - Obtain weight per physician (MD) order on same scale. Notify MD/Nurse Practitioner (NP)/Registered Dietician (RD) of significant weight changes (revised 11/14/23). Review of Resident #2's Comprehensive Nutrition Assessment, dated 11/9/23, indicated his/her weight history was not stable. The RD recommended continued monthly weights and diet as ordered. No new interventions were recommended. Review of RD documentation failed to indicate any further assessment of Resident #2's weights until 2/12/24, three months after the Comprehensive Nutrition Assessment. Dietary progress note documentation, dated 2/12/24, indicated Resident #2 had a 12.7% significant weight loss over the past three months. The RD recommended the facility obtain a reweigh of Resident #2 prior to any further intervention changes. Further review of RD documentation on 2/21/24 indicated Resident #2 had triggered for significant weight loss of 12.7% over the past three months. The RD recommended Resident #2 to have weekly weights, sugar free house supplement (four ounces twice daily) and change to regular size portions (versus the previously recommended large portions). Further review of the RD documentation failed to indicate the RD identified the significant weight loss of 5. 39% in one month (2/3/24 to 3/8/24). Review of nursing notes failed to indicate documentation related to Resident #2's weight loss. Nursing documentation failed to indicate refusal or inability to obtain weekly weights on 3/4/24 and 2/26/24, as well for monthly weights in 12/2023, 10/2023, and 9/2023. Nursing documentation failed to indicate the RD or MD were notified of weight loss. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	Review of MD/NP notes failed to indicate documentation related to Resident #2's significant weight loss. During an interview on 3/18/24 at 9:42 A.M., Nurse #4 said staff try to obtain weights for all residents on the unit on the first Monday of each new month. Nurse #4 said staff go down the list until each resident's weight is obtained. Nurse #4 said sometimes it takes a while for weights to be obtained. Nurse #4 said some residents have orders to be weighed weekly and those orders come over on a specific day. Nurse #4 said residents with monthly weights do not necessarily have orders to be weighed on a specific day. Nurse #4 said monthly weights do not come up on the Medication Administration Record (MAR) for a specific date to obtain. During an interview on 3/18/24 at 10:20 A.M., Unit Manager (UM) #1 said weights are obtained monthly for most residents on the unit. UM #1 said weights should have a standard order to be obtained and the order would generate a date and shift to be inputted. UM #1 said refusal of weights should be documented in the medical record. During an interview on 3/18/24 at 1:58 P.M., Nurse #4 said when weights are input into the electronic medical record they populate red for a significant change. Nurse #4 said Resident #2 did populate on her MAR to obtain a weekly weight. Nurse #4 said she was unsure of weekly weights being obtained by other nursing staff. Nurse #4 said the Dietitian would notify the MD directly of any new recommendations or changes. During an interview on 3/18/24 at 3:13 P.M., UM #1 said she and the RD should be reviewing weights of all residents on the unit. UM #1 said she was uncertain if Resident #2's MD was aware of their significant weight loss. UM #1 said she would be responsible for notifying the MD of changes in weight. UM #1 said staff should be notifying the MD of changes in weight to ensure the interdisciplinary team are aware. UM #1 said Resident #2 should not have any missing weekly or monthly weights. During an interview on 3/18/24 at 4:09 P.M., the RD said she reviews weights for significant weight loss when they are obtained by staff at the facility. The RD said she then determines an individualized plan for each resident to address the weight loss. The RD said she pulls a weight report for each resident when reviewing their documentation. The RD said she typically pulls a weight report to review resident trends in weight loss. The RD said if weights are not obtained in greater than or equal to 30 days, the resident would not populate on the weight report. The RD said she does her best to compare weight reports monthly to not miss any resident weights. The RD said because weights are missing, she is patching together assessments. The RD said the goal is to review each resident in the facility quarterly, or more often if a significant weight loss is identified. The RD said she was behind on quarterly assessments. The RD said Resident #2 has had a continued significant weight loss. The RD said she notifies nursing staff of recommendations to notify the MD. The RD said she does not notify the MD of significant weight loss or recommendations herself. During an interview on 3/18/24 at 4:27 P.M., the Director of Nurses (DON) said her expectation would be for the RD to identify a significant weight loss for any residents in the building. The DON said she would then expect the RD to make any recommendations to address the significant weight loss. The DON said she would expect the nursing staff and/or the RD to notify the MD regarding the changes identified. The DON said the UM should be looking at changes to identify risk factors for residents on each unit. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Pleasant Bay of Brewster Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 383 South Orleans Road Brewster, MA 02631	

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F 0692 Level of Harm - Actual harm Residents Affected - Some	2. Resident #61 was admitted to the facility in December 2021 with diagnoses including hypertension, atrial fibrillation (abnormal heart rhythm), and cerebral infarction (stroke). Review of the MDS assessment, dated 2/21/24, specified a BIMS score of 14 out of 15, indicating he/she had intact cognition. Further review of Section K of the MDS assessment indicated Resident #61 had a weight loss of 5% or more in the last month or 10% or more in the last 6 months. Section K of the MDS assessment indicated Resident #61 was not on a prescribed weight loss regimen. The MDS assessment indicated Resident #61 had a mechanically altered diet and he/she required set-up feeding assistance. On 3/13/24 at 12:15 P.M., the surveyor observed Resident #61 in their room. Resident #61 said he/she did not want their lunch meal today. The surveyor did not observe as meal tray in Resident #61's room. Review of Resident #61's active Physician's Orders included but were not limited to: - 11/20/23: DIET - Regular Diet; Mechanical Soft Chopped Meat Texture; Thin Liquid Consistency - 6/6/23: REC - Aspiration Precautions; seated upright with head of bed (HOB) Raised for meals and for at least 45-60 minutes after meals; slow rate of intake; small bolus size; alternate solids and liquids - 3/5/24: House Supplement - three times per day for nutritional supplementation; eight ounces; prefers chocolate Ensure or clear supplement Further review of Resident #61's active Physician's Orders failed to include an order for monthly weights to be obtained. Review of Resident #61's Medication Administration Record (MAR) indicated a House Supplement was provided to him/her three times per day from 3/6/24 through 3/17/24. Further review of the MAR indicated the facility failed to document the percentage value consumed by Resident #61 as follows: - 3/6/24: 8:00 A.M. - 10:00 A.M. - 3/6/24: 12:00 P.M. - 2:00 P.M. - 3/6/24: 4:00 P.M. - 8:00 P.M. - 3/7/24: 8:00 A.M. - 10:00 A.M. - 3/7/24: 12:00 P.M. - 2:00 P.M. - 3/14/24: 12:00 P.M. - 2:00 P.M. Further review of the MAR indicated the Resident drank less than or equal to 50% of the house supplement provided on 10 of 36 opportunities. (continued on next page)

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F 0692

Level of Harm - Actual harm

Residents Affected - Some

Review of Resident #61's weights in the electronic documentation system indicated the following weights:

- 9/2023: not obtained

- 10/21/23: 178.4 lbs.

- 11/21/23: 166.0 lbs.

- 11/30/23: 169.4 lbs.

- 12/2023: not obtained

- 1/25/24: 159.6 lbs.

- 2/2024: not obtained

- 3/18/24: 151.2 lbs.

Review showed Resident #61 had a 6.95% severe significant weight loss in one month (10/21/23 to 11/21/23). Further review showed two additional severe significant weight losses in a three-month period between 10/21/23 through 1/25/24 (10.54%) and 11/30/23 through 3/18/24 (10.74%).

Review of Resident #61's nutritional care plan indicated he/she was presenting with an undesired weight loss and further weight loss is not desired. Interventions for Resident #61's nutritional care plan included but were not limited to:

- Obtain weight per physician (MD) order on same scale. Notify MD/Nurse Practitioner (NP)/Registered Dietician (RD) of significant weight changes (revised 10/5/23).

Review of Resident #61's Comprehensive Nutrition Assessment, dated 11/30/23, indicated his/her weight history was not stable, and a significant weight loss was identified. The assessment indicated to continue with current diet as ordered, use of house supplements, and monitoring of intakes and weights.

Review of a Dietary progress note, dated 1/26/24, indicated review of the Speech Therapy diet texture to meet house formulary diets. No indication of continued weight loss was addressed in the documentation.

Further review of the Dietary progress notes failed to indicate the RD identified the Resident's 10.54% (10/21/23 to 1/25/24) and 10.74% (11/30/23 to 3/18/24) severe significant weight loss over three months and considered interventions to curb further weight loss.

Review of nursing progress notes failed to indicate documentation related to Resident #61's weight loss. Nursing progress note documentation failed to indicate refusal or inability to obtain monthly weights in 2/2024, 12/2023, and 9/2023. Furthermore, nursing progress note documentation failed to indicate the RD or MD were notified of the severe significant weight loss.

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F 0692 Level of Harm - Actual harm Residents Affected - Some	Review of MD/NP progress note documentation, dated 3/5/24, indicated the Resident was seen for family concerns related to weight loss and poor appetite. Further review of the documentation indicated Resident #61's weight was down. Documentation indicated Resident #61 may benefit from house supplement shakes three times per day. Further review of MD/NP progress note documentation indicated no weight changes addressed in reports dated 2/8/24, 2/6/24, 1/18/24, 1/2/24, and 11/30/23. During an interview on 3/12/24 at 11:11 A.M., Resident #61 said they prefer to eat their meals in their room. Resident #61 said they do not require assistance with meals. Resident #61 said they did not want breakfast this morning and did not eat. During an interview on 3/18/24 at 9:42 A.M., Nurse #4 said staff try to obtain weights for all residents on the unit on the first Monday of each new month. Nurse #4 said staff go down the list until each resident's weight is obtained. Nurse #4 said sometimes it takes a while for weights to be obtained. Nurse #4 said some residents have orders to be weighed weekly and those orders come over on a specific day. Nurse #4 said residents with monthly weights do not necessarily have orders to be weighed on a specific day. Nurse #4 said monthly weights do not come up on the Medication Administration Record (MAR) for a specific date to obtain. Nurse #4 said Resident #61 was on the list to obtain a weight today. Nurse #4 and the surveyor reviewed the most recent weights for Resident #61. Nurse #4 said she thought Resident #61 had been weighed in February but could not find the documentation. During an interview on 3/18/24 at 10:20 A.M., Unit Manager (UM) #1 said weights are obtained monthly for most residents on the unit. UM #1 said weights should have a standard order to be obtained and the order would generate a date and shift to be inputted. UM #1 said refusal of weights should be documented in the medical record. During an interview on 3/18/24 at 1:58 P.M., Nurse #4 said when weights are input into the electronic medical record they populate red for a significant change. Nurse #4 said the Dietitian would notify the MD directly of any new recommendations or changes. During an interview on 3/18/24 at 3:25 P.M., UM #1 said she and the RD should be reviewing weights of all residents on the unit. UM #1 said she was uncertain if Resident #61's MD was aware of their significant weight loss. UM #1 said she would be responsible for notifying the MD of changes in weight. UM #1 said staff should be notifying the MD of changes in weight to ensure the interdisciplinary team are on the same page. UM #1 and the surveyor reviewed the active physician orders for Resident #61. UM #1 said she could not see any weight orders for the Resident. UM #1 said Resident #61 should not have had any missing monthly weights. (continued on next page)

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	225667	A. Building B. Wing	03/19/2024

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F 0692 Level of Harm - Actual harm Residents Affected - Some	During an interview on 3/18/24 at 4:09 P.M., the RD said she reviews weights for significant weight loss when they are obtained by staff at the facility. The RD said she then determines an individualized plan for each resident to address the weight loss. The RD said she pulls a weight report for each resident when reviewing their documentation. The RD said she typically pulls a weight report to review resident trends in weight loss. The RD said if weights are not obtained in greater than or equal to 30 days, the resident would not populate on the weight report. The RD said she does her best to compare weight reports monthly to not miss any resident weights. The RD said because weights are missing, she is patching together assessments. The RD said the goal is to review each resident in the facility quarterly, or more often if a significant weight loss is identified. The RD said she was behind on quarterly assessments. The RD said Resident #61 has had a continued significant weight loss and it needed to be addressed. The RD said she notifies nursing staff of recommendations to notify the MD. The RD said she does not notify the MD of significant weight loss or recommendations herself. During an interview on 3/18/24 at 4:27 P.M., the Director of Nurses (DON) said her expectation would be for the RD to identify a significant weight loss for any residents in the building. The DON said she would then expect the RD to make any recommendations to address the significant weight loss. The DON said she would expect the nursing staff and/or the RD to notify the MD regarding the changes identified. The DON said the UM should be looking at changes to identify risk factors for residents on each unit.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 42742 Based on observation, interview, and record review, the facility failed for one Resident (#49), out of a total sample of 24 residents, to ensure staff provided the necessary care and services in accordance with professional standards of practice. Specifically, the facility failed to maintain sanitary conditions of oxygen (O2) tubing and equipment to help decrease the risk of potential contamination and infection and administer the O2 flow rate per physician's orders. Findings include: Review of the facility's policy titled Oxygen Therapy, revised October 2022, indicated but was not limited to the following: -Failure to administer Oxygen appropriately can result in serious harm to the patient. -Oxygen is administered according to physician's order. -Review the resident's care plan to evaluate for any special needs the residents may have. -Flow rate must be adjusted by a Licensed Nurse. -Tubing Change - Oxygen cannula tubing, without humidification, is changed weekly and as needed. -Concentrator filters should be washed at least weekly or as needed. Resident #49 was admitted to the facility in November 2023 with diagnoses including chronic respiratory failure with hypoxia (absence of oxygen), chronic obstructive pulmonary disease (COPD) (lung disease that blocks airflow and makes it difficult to breathe), dementia, and anxiety disorder. Review of the Minimum Data Set (MDS) assessment, dated 1/1/24, indicated Resident #49 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of 15 and was receiving Oxygen. Review of current Physician's Orders indicated the following: -Administer Oxygen at 2 Liters (L)/minute continuously every shift related to COPD with acute exacerbation, 11/30/23 -Change O2 tubing weekly and as needed, 11/30/23 -Portable Oxygen while out of room every shift, 11/30/23 -Wipe down the concentrator and clean filter weekly every night shift every Friday, 12/1/23 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225667	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2024
NAME OF PROVIDER OR SUPPLIER: Pleasant Bay of Brewster Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 383 South Orleans Road Brewster, MA 02631	

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation with interview on 3/12/24 at 10:31 A.M., the surveyor observed Resident #49 sitting in a wheelchair in his/her room. An oxygen concentrator (takes air from your surroundings, extracts, and filters it into purified oxygen for you to breathe) was observed on the floor next to the bed delivering 6 L of Oxygen through the attached nasal cannula (NC) (device that delivers extra oxygen through a tube and into your nostrils) tubing which was resting on the floor. The O2 tubing was not dated/labeled and was not contained in a storage bag to help prevent potential exposure to environmental contaminants. The filter on the back of the O2 concentrator was laden with dust. Resident #49 said he/she used the Oxygen all the time for his/her COPD. Resident #49 picked the oxygen tubing up from the floor and placed the NC prongs inside his/her nostrils. During an observation with interview on 3/13/24 at 8:25 A.M., Nurse #9 entered Resident #49's room with the surveyor and observed the oxygen concentrator off with the attached NC tubing resting on top of it. The tubing was not dated/labeled and was not contained in a storage bag to help prevent potential exposure to environmental contaminants. The filter on the back of the O2 concentrator was laden with dust. Resident #49 entered the room in his/her wheelchair and was not observed to be receiving Oxygen. A portable O2 tank was observed attached to the back of his/her wheelchair in the off position. Nurse #9 said the tubing should have been stored in a plastic bag but wasn't and the filter should have been cleaned as needed. Nurse #9 said the tubing was just changed earlier that morning but should have been labeled. Resident #49 said the Oxygen was usually set at 3L but had an anxiety attack the day prior and turned the Liter flow up his/herself to 6L because he/she felt like he/she couldn't breathe. During an interview on 3/13/24 at 8:32 A.M., the surveyor reviewed the medical record with Nurse #9 who said the Oxygen order was for the Resident to receive 2L continuous O2, but the Resident sometimes refused or adjusted on his/her own. She said the respiratory care plan did not address behavioral issues related to Oxygen use and was unable to locate documentation of education provided to the Resident regarding non-compliance. During an interview on 3/13/24 at 11:33 A.M., the Director of Nursing (DON) said the concentrator filters are supposed to be cleaned per physician's orders but didn't know if nurses were checking them or not. She said the expectation is that they be clean. The DON said the O2 tubing should be changed weekly, dated, and stored in a plastic bag when not in use. She said the flow rate should be set per physician's orders and checked each shift. The DON said if the Resident's self-adjusting the liter flow was an issue, then then he/she should be care planned for that, and that the Resident should not be doing that. During an interview on 3/18/24 at 8:01 A.M., the surveyor observed Resident #49 sitting in a chair with a wheelchair at his/her side in the main lobby listening to music. A portable O2 tank was observed on the back of the wheelchair with oxygen tubing resting on top of it. The Oxygen was turned off. The tubing was not stored in a plastic bag when not in use and potentially exposed to environmental contaminants. Resident #49 said he/she had not been set up to use the Oxygen yet that morning by staff and had just woken up, so his/her day was just starting. The Resident said he/she did not adjust his/her own flow rate; staff did that for him/her.

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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.

42742

Based on interview, record review, and policy review, the facility failed to ensure staff implemented dialysis care and services consistent with professional standards of practice for one Resident (#226), out of one total Resident receiving dialysis, by

a. providing ongoing communication between the nursing facility and dialysis facility, and

b. consistently documenting assessments of the Resident's condition and left Arteriovenous (AV) fistula (surgically created for hemodialysis treatment) site.

Findings include:

Review of the facility's policy titled Dialysis Management, revised October 2022, indicated but was not limited to the following:

-Residents receiving hemodialysis treatments will be assessed and monitored to ensure quality of life and well-being.

-On admission the resident will be assessed to determine access type. The site will be observed for function and signs and symptoms of infection.

-The nurse will obtain orders for monitoring of site, and interventions as appropriate. Orders to include are to observe shunt for thrills and bruits every shift; report any abnormal findings to the physician and/or dialysis.

-Facility will establish open communication with the resident's dialysis center utilizing a Dialysis Communication Book completing the Dialysis Communication Form:

a. the nurse will establish pre-dialysis vital signs (blood pressure (BP), pulse, temp, respirations)

b. Advanced Directive status

c. any pertinent resident information

d. information regarding medication administration by the nursing home and/or dialysis facility

e. nutritional/fluid management

f. dialysis adverse reactions/complications and/or recommendations for follow up observations and monitoring, and/or concerns related to the vascular access site.

-On return from the dialysis center the nurse will review the communication. The nurse should review specifically, pre- and post-vital signs, treatment tolerance, any meds given and any new orders for resident care.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The nurse will evaluate the resident post-dialysis for mental status, pain, access site condition and response to treatment. -Nurse will document findings in nurse's note. Review of the Long-Term Care (LTC) Facility Outpatient Dialysis Services Coordination Agreement, dated 4/4/20, indicated but was not limited to the following: Obligations of the Long-Term Care Facility and/or Owner: -The LTC Facility shall ensure that all appropriate medical and administrative information accompanies all ESRD residents. -The LTC Facility shall provide for the interchange of information useful or necessary for the care of the ESRD residents. Obligations of the ESRD Dialysis Unit and/or Company: -To provide to the LTC Facility information on all aspects of the management of the ESRD resident's care related to the provision of renal dialysis services including, but not limited to, bleeding, infection, and care of dialysis access site. Mutual Obligations: -Collaboration of Care. Both parties shall ensure that there is documented evidence of collaboration of care and communication between the LTC Facility and ESRD Dialysis Unit. Resident #226 was admitted to the facility in February 2024 with diagnoses including dependence on renal dialysis and end stage renal disease (ESRD). Review of the Minimum Data Set (MDS) assessment, dated 2/24/24, indicated Resident #226 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of 15 and was receiving dialysis services. Review of current Physician's Orders indicated the following: -Resident to attend dialysis 3 times a week on Monday, Wednesday, and Friday. Pick up time at 10:30 A.M. for a chair time of 12:00 P.M.-5:00 P.M., 2/18/24 -Monitor dialysis access site dressing, notify MD of any redness or bleeding. Left AV fistula every shift, 2/18/24 a. During an interview on 3/12/24 at 10:53 A.M., Resident #226 said he/she went to dialysis on Mondays, Wednesdays, and Fridays and staff did not send a book with him/her when he/she goes. The Resident said he/she had a left AV fistula for an access site. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The medical record failed to indicate a Dialysis Communication Book had been initiated to help establish open communication with the Resident's dialysis center and include documents such as the Resident's Advanced Directive and the Dialysis Communication Forms for each dialysis visit which would, per facility policy, include pre-dialysis vital signs (blood pressure (BP), pulse, temp, respirations), any pertinent resident information, information regarding medication administration by the nursing home and/or dialysis facility, nutritional/fluid management, if any dialysis adverse reactions/complications and/or recommendations for follow up observations and monitoring, and/or concerns related to the vascular access site. During an interview on 3/14/24 at 8:17 A.M., Nurse #10 and Nurse #6 said they could not locate the Resident's Dialysis Communication Book and said that maybe it was at the dialysis facility. They said the Resident was not scheduled for dialysis that day. During an interview on 3/14/24 at 8:21 A.M., Nurse #10 said she called the dialysis facility and they said they didn't have it there. During an interview on 3/14/34 at 2:25 P.M., the Resident and the Resident's spouse said he/she did not recall ever seeing a dialysis book and checked the bag hanging behind the Resident's wheelchair. The Resident's spouse said there wasn't anything in there. During an interview on 3/14/24 at 3:30 P.M., Nurse #9 said she had never seen a dialysis book for the Resident. During an interview on 3/18/24 at 1:16 P.M., Dialysis Staff #1 said Resident #226 was currently at the facility receiving dialysis but wasn't on the floor so could not be sure if he/she had a Dialysis Communication Book with him/her. Dialysis Staff #1 said Resident #226 had had 13 visits to the dialysis facility thus far. She said the dialysis book includes the primary means of communication but can be verbal as well. She said the book contains communication forms that have the pre- and post-weights, temperature, blood pressure, any events that occurred, if applicable, medications administered, and anything that occurred that was out of the ordinary. She said if there is no book that accompanies the Resident, then dialysis staff will write a note and send it back with the Resident. She further said she only saw some documentation of communications in their record system with the nursing facility's dietitian, not nurses. During an interview on 3/19/24 at 9:36 A.M., Nurse #13 said she found a folder in the Resident's bag on the back of his/her wheelchair that was for dialysis and was initiated by the dialysis facility, not the nursing facility. Upon review of the folder with Nurse #13, only three communication forms out of 13 visits were included and dated 3/6/24, 3/8/24, and 3/18/24. There was no post-weight documented on the 3/8/24 form. No other documents were observed inside the folder. Nurse #13 said all dialysis visit communication forms should have been in there along with the Resident's code status, current medications, and a face sheet, but weren't. b. Review of Physician's Orders did not indicate an order to monitor the Resident's AV fistula for thrill (vibration caused by blood flowing through the fistula) and bruit (to listen near the fistula site) to ensure patency or to report any abnormal findings to the physician and/or dialysis per facility policy. Review of the February 2024 Treatment Administration Record (TAR) indicated the following: (continued on next page)

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F 0698

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

-10 of 36 shifts, dialysis access site dressing for redness or bleeding not documented as being monitored (blank)

-no documentation that access site was being monitored for thrill and bruit

Review of the March 2024 TAR indicated the following:

-4 of 36 shifts, dialysis access site dressing for redness or bleeding not documented as being monitored (blank)

-no documentation that access site was being monitored for thrill and bruit

Further review of the medical record failed to indicate consistent documentation in the nurses' notes that the Resident's access site was being monitored for thrill and bruit to ensure patency, documentation of post-dialysis weights, and evaluations post-dialysis for mental status, pain, access site condition and response to treatment per facility policy including post-dialysis weights.

During an interview on 3/19/24 at 9:16 A.M., Nurse #6 said Resident #226 had a left AV fistula for dialysis. She said without all the dialysis visit communication forms, she was unable to locate the other post-dialysis weights and said they were not documented in the Resident's electronic record. She said upon the Resident's return from dialysis, if he/she did not come back with his/her dialysis book staff should call the dialysis center to obtain the information including post-dialysis weights and any other relevant data. She said there was no documentation in the medical record that this was being done. Nurse #6 said there was no order to monitor the site for bruit and thrill to ensure the fistula was working but staff should be doing this. Nurse #6 said there should be consistent monitoring and documentation by nursing staff in progress notes and on the TAR with no shift entries left blank.

During an interview on 3/19/24 at 12:55 P.M. with the Director of Nursing and Consulting Staff #1, Consulting Staff #1 said the nursing facility should have started a dialysis binder for the Resident which included a face sheet, medication list, code status, MOLST (Massachusetts Medical Orders for Life Sustaining Treatment), communication forms, vitals, and anything else that was new or pertinent. She said the book goes with the Resident to dialysis and facility staff are to ensure it's received back. If not, staff were expected to call the dialysis facility to obtain the information. Consulting Staff #1 said communication forms should be completed for each visit. She said nurses were expected to check the access dressing site and monitor for bruit/thrill and there should have been an order to do that to ensure there was no clot and it was functioning properly. She said all orders/treatments should be done consistently with no shift entries left blank. Consulting Staff #1 said there should be nursing post-dialysis notes any time the Resident comes back from dialysis.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 36542 Based on interviews, record review, and policy review, the facility failed to ensure monthly medication regimen reviews were maintained as part of the permanent medical record and failed to ensure recommendations made by the pharmacy consultant were addressed timely for 1 Resident (#69), out of 5 residents selected for an unnecessary medication review. Findings include: Review of the facility's policy titled Pharmacy Consultant Med (medication) Review, last revised January 2023, indicated the following: -The Pharmacy Consultant should report irregularities to the attending physician, medical director, and DON (Director of Nurses) with the resident's medication regimen -The Pharmacy Consultant will document his/her findings and recommendation on the monthly drug regimen review report -The unit manager/designee will make sure all recommendations are acted upon Review of the facility's policy titled Abnormal Involuntary Movement (AIMS), last revised October 2022 indicated an AIMS test would be completed by a licensed nurse every six months for residents on antipsychotic therapy. Resident #69 was admitted to the facility in December 2022 with a diagnosis of dementia with behavioral disturbance. Review of the medical record indicated Resident #69 was taking: - Seroquel (an antipsychotic) 100 milligrams (mg) once per day from 12/19/23 through 1/15/24 and - Seroquel 100 mg twice per day from 1/15/24 through record review on 3/15/24. Review of the medical record indicated the Pharmacy Consultant made recommendations on 1/5/24 and to see the Consultant Pharmacist Report for recommendations. Review of the electronic and paper medical records failed to include the Consultant Pharmacist Recommendation from January 2024. The surveyor requested the recommendation on 3/14/24 at 4:05 P.M., 3/15/24 at 7:54 A.M., and 3/15/24 at 10:45 A.M. On 3/15/24 at 12:30 P.M., the Consultant Pharmacist Recommendation to Nursing for Resident #69 was provided to the surveyor. Review of the Consultant Pharmacist Recommendation to Nursing, dated 1/6/24 indicated Resident #69 was taking an antipsychotic and an AIMS assessment was required every six months. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the electronic and paper medical record indicated the last AIMS assessment was completed on 1/18/23, 14 months prior. During an interview on 3/15/24 at 12:32 P.M., the Director of Nurses said the recommendation from the Consultant Pharmacist had not been reviewed or addressed by the facility. She said an AIMS had not been completed since January 2023 and should be completed every six months.

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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. 42742 Based on observation, interview, and policy review, the facility failed to ensure staff stored and properly labeled all drugs and biologicals used in the facility in accordance with currently accepted professional principles. Specifically, the facility failed to: 1. Ensure staff properly labeled, once opened, all drugs and biologicals stored in one of three medication carts reviewed; and 2. Ensure one (North 1 Unit) of three medication storage rooms reviewed was locked and secured. Findings include: 1. Review of the facility's policy titled Storage of Medications, dated 2017, indicated but was not limited to the following: -Certain medications or package types such as ophthalmics, once opened, require an expiration date shorter than the manufacturer's expiration date to ensure medication purity and potency. -When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. -The nurse shall place a date opened sticker on the medication and enter the date opened and the new date of expiration. The expiration date of the vial or container will be 30 days unless the manufacturer recommends another date, or the regulations/guidelines require different dating. On 3/13/24 at 12:24 P.M., the surveyor reviewed the Southwest Unit Medication 2 Cart with Nurse #9 and observed the following: -one opened bottle of Atropine sulfate (dilates the pupil, treats eye conditions such as lazy eyes) ophthalmic solution 1%, seal broken, stored inside a plastic pharmacy bag, packaging bag and bottle not labeled with the date when opened or the new expiration date, packaging insert indicated after opening, the preservative can only ensure the drops are safe for the eye for a period of 28 days. Beyond 28 days, using the drops may cause serious damage to the eye. -one opened bottle of Fluticasone propionate (relieves seasonal and year-round allergies) nasal spray, 50 micrograms, seal broken, stored inside the packaging container, packaging container and bottle not labeled with the date when opened or the new expiration date During an interview on 3/13/24 at 12:42 P.M., Nurse #9 said the medications should have been labeled with the date when opened and the expiration date as they both had shortened expiration dates. She said she thought the eyes drops were only good for 28 days and wasn't sure about the nasal spray. She said if used past their shortened expirations, it could decrease the effectiveness of the medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/19/24 at 12:08 P.M. with the Director of Nursing (DON) and Consulting Staff #1, Consulting Staff #1 said when medications are opened staff are supposed to use stickers that would say the date opened and the date that it expires on at least the medication itself. She said the eye drops and nasal spray have shortened expiration dates and would not be as stable after that. She said she believed they were both only good for 30 days. 43935 2. Review of the facility's policy titled Medication Storage, dated as revised 10/2022, indicated but was not limited to the following: - this center will have medications stored in a manner that maintains the integrity of the product, ensures the safety of the residents, and is in accordance with the Department of Health guidelines - with the exception of emergency drug kits, all medications will be stored in a locked cabinet, cart or medication room that is accessible only to authorized personnel, as defined by the facility policy On 3/12/24 at 9:43 A.M., the surveyor observed the North 1 medication storage room door wide open without any staff in the room or immediate area of the room. The surveyor could freely enter the room and observed an emergency medication kit on the counter, a box of nellimed nasal spray, and a box of Rizatriptan benzoate tablets (a prescription drug used to treat migraine headaches). On 3/12/24 at 12:21 P.M., the surveyor observed the North 1 medication storage room door wide open without any staff in the room or in the immediate area of the nurses' station or medication room. During an interview on 3/13/24 at 10:57 A.M., Unit Manager #1 said the medication storage rooms should be locked and secured at all times when staff are not in the room or sitting at the nurses' station. She said the medication room being left open is against the facility's policy and medications are to be left secured by lock and key at all times.

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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. 43935 Based on observation and interview, the facility failed to provide one Resident (#26), out of a total sample of 24 residents with a meal consistent with his/her allergies. Findings include: Resident #26 was admitted in December 2020 with diagnoses including: Hemiplegia and hemiparesis (one-sided muscle weakness or paralysis) affecting the left non-dominant hand and polyneuropathy (the damage of multiple peripheral nerves resulting in problems with sensation, coordination and or function). Review of the most recent Brief Interview for Mental Status (BIMS), dated 12/6/2023, indicated Resident #26 was cognitively intact with a score of 15 out of 15 and made his/her own decisions. During an interview on 3/12/24 at 8:59 A.M., Resident #26 said he/she has a consistent issue of being delivered strawberry jam on his/her breakfast tray and that he/she has an allergy to strawberries. Review of the medical record for Resident #26 indicated Allergies: strawberries was documented on: - the current physician's orders, dated 3/14/24; - the certified nurse assistant (CNA) visual/bedside kardex (summary of resident's care and preferences); - the medication and treatment administration records for March 2024; and - the December 2023 Comprehensive Nutritional Assessment Review of the current care plans for Resident #26 indicated but was not limited to the following: Focus: Nutrition: Resident presents as adequately nourished with a food allergy of strawberries (revised: 12/21/23) Goal: Resident will be free of signs and symptoms of allergic reactions (revised: 1/9/24) Interventions: May have regular desserts, allergies strawberries - maintain a diet free of strawberries (revised: 12/21/23) (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility provided food service meal tickets for Resident #26 indicated the Resident had an allergy to strawberries. During an interview on 3/13/24 at 8:37 A.M., Resident #26 said he/she has met with the food service director (FSD) to discuss her ongoing issues with receiving strawberry jam on his/her tray. He/she said they think the FSD listens to them and is trying to resolve the issue but believes the people who are on the line are putting the jam on their tray and not paying attention. On 3/13/24 at 8:49 A.M., Resident #26 received his/her breakfast tray late and the surveyor observed that there was a single serve packet of Smuckers sugar free strawberry jam on the tray. The ticket on the tray contained the Resident's name and a notation that the Resident had an allergy to strawberries. During an interview on 3/13/24 at 9:04 A.M., CNA #3 said the Resident had strawberry jam on his/her tray this A.M. and sometimes it is sent to the Resident in the mornings. She said the Resident did not want the CNA to remove the jam so he/she would have proof that the error occurred. She said the tray ticket indicates the Resident has an allergy to strawberry jam. During an interview on 3/31/24 at 11:21 A.M., the FSD said she does not know what happened with Resident #26's breakfast tray this morning and has no idea how or why the Resident is getting strawberry jam on his/her tray. She said having the jam there does not even make sense since the Resident receives a danish in the morning, not toast. She said the Resident has told her in the past that he/she was receiving strawberry jam on their breakfast tray and she thought she had resolved the problem but will look into it again.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225667	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2024
NAME OF PROVIDER OR SUPPLIER: Pleasant Bay of Brewster Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 383 South Orleans Road Brewster, MA 02631	

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48362 Based on observation, policy review, and interview, the facility failed to follow their policy and professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to: 1. Properly label and date food products, and maintain safe and clean equipment in two of two nourishment kitchenettes; 2. Handle ready-to-eat food (food which does not require cooking or further preparation prior to consumption) utilizing proper hand hygiene to prevent cross contamination (transfer of pathogens from one surface to another). In addition, to ensure the use of gloves was limited to a single use task; and 3. Properly label and store resident food items in the Southwest Unit medication refrigerator which was unintended for resident food storage use. Findings include: 1. Review of the facility's policy titled Food From Outside, last revised ,d+[DATE], indicated but was not limited to: - Food brought by family/visitors that is left with the resident to consume later will be labeled and stored in a manner that is clearly distinguishable from facility-prepared food. (Label will identify resident name, room number, item, date received and discard date). - All refrigerated foods should be discarded within 48 hours. On [DATE] at 11:22 A.M., the surveyor observed the following on the North Two Unit nourishment kitchenette: - Spilled liquid substance on the glass plate inside the microwave. - The top inside of the microwave had food particle spatter and dark brown stains. - The coffee pot located next to the microwave had white residue on the inside of the pot. The heating element of the coffee pot had rust stains. - The cabinet underneath the sink had several old and stained insect traps. The entire bottom portion of the cabinet had dark brown/black stains. There was an old water stain underneath the drain on the bottom portion of the cabinet. - The space between the cabinets and the refrigerator had buildup, including black/blue residue substance on the floor, food residue, an old thermometer, and an insect trap. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 12:57 P.M., the surveyor observed the following on the North One Unit nourishment kitchen: - The top inside and sides of the microwave contained residue and food splatter. - The coffee pot located next to the microwave contained white residue on the inside/outside of the pot. The coffee pot had old coffee residue on the bottom portion of the pot. - The cabinet underneath the sink had two soiled insect traps, appearing wet and covered in a dark brown substance. The bottom of the cabinet had dark black stains covering the entirety. - The refrigerator contained a bag of pre-sliced cheddar cheese that was unlabeled and undated. - The refrigerator contained a bag of bread, spreadable cheese, two containers of food leftovers and a block of cheese. The bags were labeled with a resident name and room number but were not labeled with a date received or discard date. On [DATE] at 12:12 P.M., the surveyor observed the following on the North Two Unit nourishment kitchenette: - The top inside of the microwave had food particle spatter and dark brown stains. - The coffee pot located next to the microwave had white residue on the inside of the pot. The heating element of the coffee pot had rust stains. - The cabinet underneath the sink had several old and stained insect traps. The entire bottom portion of the cabinet had dark brown/black stains. There was an old water stain underneath the drain on the bottom portion of the cabinet. - The space between the cabinets and the refrigerator had built up including black/blue residue substance on the floor, food residue, an old thermometer, and an insect trap. On [DATE] at 12:30 P.M., the surveyor observed the following on the North One Unit nourishment kitchenette: - The top inside and sides of the microwave contained residue and food splatter. - The coffee pot located next to the microwave contained white residue on the inside/outside of the pot. The coffee pot had old coffee residue on the bottom portion of the pot. - The cabinet underneath the sink had two soiled insect traps, appearing wet and covered in a dark brown substance. The bottom of the cabinet had dark black stains covering the entirety. - The refrigerator contained a bag of pre-sliced cheddar cheese that was unlabeled and undated. - The refrigerator contained a bag of bread, spreadable cheese, two containers of food leftovers and a block of cheese. The bags were labeled with a resident name and room number but were not labeled with a date received or discard date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 12:44 P.M., the Food Service Director (FSD) said nourishment kitchenettes were stocked by the dietary aide staff. The FSD said the equipment such as microwaves and inside of refrigerators were cleaned by dietary aide staff daily. The FSD said the housekeeping department helps clean floors and cabinets in the nourishment kitchenettes. The FSD and the surveyor reviewed observations made in the North One and North Two Unit nourishment kitchenettes. The FSD said the expectation was for microwaves to be cleaned daily by dietary aide staff. The FSD said microwaves should not have food residue or buildup on the inside. The FSD said housekeeping and maintenance would clean underneath the sink in the nourishment kitchenettes. The FSD said there should be no built-up residue or substances underneath the cabinets or on the floor. The FSD said items stored in the refrigerators should be labeled and dated per facility policy. During an interview on [DATE] at 12:52 P.M., the Director of Maintenance and the surveyor reviewed the observations from the nourishment kitchenettes. The Director of Maintenance said the cabinets should be clean and dry with no residue or buildup. During an interview on [DATE] at 1:39 P.M., the Administrator said the expectation was for kitchenette areas to be cleaned daily. The Administrator and the surveyor reviewed the observations made on the North One and North Two Unit nourishment kitchenettes. The Administrator said microwaves should remain clean and there should be no grime or residue underneath the cabinets. 2. Review of the 2022 Food Code by the U.S. Food and Drug Administration (FDA), revised ,d+[DATE], indicated but was not limited to the following: - ,d+[DATE].11 Preventing Contamination from Hands. (A) FOOD EMPLOYEES shall wash their hands as specified under S ,d+[DATE].12. (B) Except when washing fruits and vegetables as specified under S, d+[DATE].15 or as specified in (D) and (E) of this section, FOOD EMPLOYEES may not contact exposed, READY-TO-EAT FOOD with their bare hands and shall use suitable UTENSILS such as deli tissue, spatulas, tongs, single-use gloves, or dispensing EQUIPMENT. - ,d+[DATE].15 Gloves, Use Limitation. (A) If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. On [DATE] at 8:15 A.M., the surveyor made the following observations during the breakfast service line: - The cook grabbed pancakes during the breakfast service with gloved hands. The cook then touched condiment baskets with the same gloved hands and returned to the food service line to serve pancakes without changing their gloved hands. The cook opened drawers underneath the steam table with the same gloved hands and returned to the service line touching food products without utensils with the same unchanged gloves. - After completion of the breakfast service line, the cook touched carts and dirty pans with the same gloved hands. The cook then returned to the service line to place the remaining leftover food from the breakfast service into new containers to store the food without changing their gloved hands. On [DATE] at 7:24 A.M., the surveyor made the following observations during the breakfast service line: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225667	A. Building B. Wing	03/19/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The FSD was working the breakfast service line as the cook on this date. - The FSD moved off the service line, opened a package of pancakes that were put onto a plate and placed in the microwave which she set for two minutes. The FSD then returned to the breakfast service line without changing gloves and grabbed a hashbrown which she placed onto a plate with the unchanged gloved hands. During an interview on [DATE] at 9:30 A.M., the FSD said gloves should be changed when a cook moves between the service line and other equipment in the kitchen. The FSD said utensils should be used when handing food off the service line during all meals. During an interview on [DATE] at 1:39 P.M., the Administrator said dietary staff working on the food service line should switch their pair of gloves when moving between machinery or equipment and the service line. 42742 3. On [DATE] at 12:42 P.M., the surveyor, with Nurse #6 present, observed a free-standing refrigerator inside the medication room on the Southwest Unit with resident and/or staff personal food items stored inside. No medications were stored inside. The following items were observed: -one plastic Tupperware container of cooked French fries, not labeled -one half of a sandwich wrap in a clear plastic container, contents partially covered in green mold, not labeled -one unopened Chobani yogurt, 4.5 ounces (oz.), expired on [DATE] -one whole blackened banana -one unopened half pint of fat free milk, expired on [DATE] -one unopened bottle of therapeutic liquid nutrition, 8 fluid oz., expired on ,d+[DATE] -one container of Chinese food, dated [DATE], labeled with a resident's first name and last initial -one small plastic container of Chinese sauce, not labeled -two small plastic containers with green, moldy unidentified substances inside, not labeled -one unopened Chobani yogurt, 5.3 oz., expired [DATE], labeled with a resident's name only -one plastic container with a half of a seafood salad sandwich inside from a grocery store, dated as packed on [DATE], labeled with a resident's name only -one plastic container with a half of a roast beef sandwich inside from a local market, dated as packed on [DATE], not labeled (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-one plastic container of pasta, not labeled -one plastic container of questionable pasta and meatballs, dated [DATE], labeled with a resident's name and room number During an interview on [DATE] at 1:02 P.M., Nurse #6 said anyone could be responsible for cleaning out the refrigerator but didn't know if any specific person was designated. She said resident food should have been labeled with the resident's name, date they got it, and was only good for 72 hours. She said all the reviewed food items should have been disposed of. She said she didn't know who checked expiration dates because the refrigerator was in the medication room and kitchen staff could not go in there. During an interview on [DATE] at 9:09 A.M., the Food Service Director said her staff did not monitor that refrigerator because it was in a medication storage room but said food should be labeled for safe storage and to help prevent the potential for foodborne illness. During an interview on [DATE] at 9:18 A.M., the Administrator said the refrigerator used to be in the conference room across the hall from the nurses' station on the unit, but certified nursing assistants were congregating in there so the refrigerator was moved inside the medication storage room. He said the intent was for it to be used for medications only and the small medication refrigerator moved out. The Administrator said the communication got crossed and there was no oversight to ensure food was not being stored in there. He said because it was, the food should have been labeled and stored properly to help prevent the potential for foodborne illness.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 43935

Based on document review and interview, the facility failed to conduct and implement a comprehensive facility wide assessment that was inclusive of resources necessary to provide both emergency and day to day care of the population the facility currently serves. Specifically, the facility failed to:

1. Consistently and accurately identify and implement their nursing staffing pattern for optimal resident care; and

2a. Ensure the identification for residents with special treatments and conditions the facility consistently provides services for such as IV medications, isolation and quarantined individuals with infectious disease, those requiring dialysis, and the level of assistance with activities of daily living, and

b. Provide a full-time Activities Director to meet the needs of the residents.

Findings include:

Review of the Facility Assessment, dated as last revised: 3/8/24, indicated but was not limited to the following:

Persons involved in completing/updating assessment: Administrator, Director of Nurses (DON), Medical Director, Food Service Director (FSD), Building Services Manager, Business Office Manager, and Minimum Data Set (MDS) Nurse.

Staffing plan:

Description of general staffing plan to ensure sufficient staff to meet the needs of the Pleasant Bay residents at any given time:

- Licensed Staff:

1 full time Registered Nurse (RN) DON

1 full time RN Nursing supervisor

1 full time Infection Preventionist

Days: 9 Nurses, RN or Licensed practical nurse (LPN)

Evenings: 4.5 Nurses, RN or LPN

Nights: 3 Nurses, RN or LPN

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Direct care staff: Days: 12 Certified Nurse Assistants (CNA) or Resident Care Assistants (RCA) Evenings: 10 CNAs or RCAs Nights: 6 CNAs or RCAs Resident Profile: 135 bed facility Average daily census of 108 residents Typical average includes 20 short stay residents, with the remaining census being long term care Average number of Residents with Special treatments and conditions: - Intravenous (IV) medications = 0 - Dialysis = 0 - Isolation or quarantine for active infectious disease = 0 1. Review of the Daily Nurse Staffing sheets and time card reports from 12/1/23 through 3/18/24 indicated the following: - 12/10/23: Licensed Nurses: 1 nurse worked on each of the three resident units on the day and evening shift (only 3 nurses in the facility each shift) CNAs: 9.5 CNAs in the facility on the day shift and 9 on the evening shift - 12/24/23: Licensed Nurses: 1 nurse worked alone on the 2nd floor unit on the day shift (as scheduled) CNAs: 10 CNAs worked on day shift - 12/25/23: Licensed Nurses: 1 nurse on day shift for the North One unit and 1 nurse on day shift for the 2nd floor unit (as scheduled) - 1/4/24: (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Licensed Nurses: 2 nurses in the facility on the night shift (there were 2 nurses to cover 3 units) - 2/6/24: Licensed Nurses: 1 nurse on day shift on the North One unit and 1 nurse on day shift on the 2nd floor unit (as scheduled) - 2/11/24: Licensed Nurses: there were 5 total nurses in the facility on day shift (unit cannot be identified, as supervisor worked a unit resulting in one unit having 1 nurse on the day shift) - 3/14/24: Licensed Nurses: 1 nurse on day shift on the 2nd floor (as scheduled) - 3/15/24: Licensed Nurses: 1 nurse on day shift on 2nd floor (as scheduled) - 3/17/24: Licensed Nurses: 1 nurse on day shift on the North One unit - 3/18/24: Licensed Nurses: 1 nurse on the day shift on both the North One unit and the 2nd floor During an interview on 3/14/24 at 3:38 P.M., the DON was made aware of the surveyor's concerns with the inconsistent staffing pattern not meeting the facility determined necessary minimal. She said one nurse on a unit with 40 or more residents on a day or evening shift does not meet the staffing requirements and the nurse would not be capable of completing all tasks timely. She said the facility is actively advertising to recruit for staff. During an interview on 3/15/24 at 9:08 A.M., Nurse #1 said there are times that she works alone on a day shift on the North One or 2nd floor units. She said there are staffing issues in the facility and being the only nurse on a unit with 40 plus residents is very difficult and that medication compliance times suffer. She said, All you can do is the best you can in that situation and hope no emergencies or falls occur. She said, There are times that the staff are able to call a friend to come in and help them even if only for a few hours, but there are times you are alone and it is nerve wracking and feels unsafe, but you do the best you can to meet all the residents' needs as timely as possible. (continued on next page)

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F 0838

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

During an interview on 3/15/24 at 9:16 A.M., Nurse #4 said she is working alone today (3/15/24) and is scheduled alone often because there are staffing issues. She said, Sometimes she can convince the night nurse to stay a few hours or call a friend to help for a short time, but there are times when she works as the only nurse on the unit with more than 40 residents on a day shift. She said, It makes her anxious as a nurse and it is very difficult and potentially unsafe but you put on your roller [NAME] and do the best you can to complete everything as quickly as possible to meet all the resident needs.

During an interview on 3/15/24 at 9:22 A.M., the Nursing scheduler said the facility has recently stopped using the on-shift program (a computerized automated program that will send messages to staff) to assist with staffing needs and the new system has not been implemented yet. She said daily her staffing goals only change if the census on the Southwest (short term unit) drop below 15 and the census does not effect the staffing on North One or the 2nd floor (long term care units). She said she is supposed to staff 6 nurses during the day shift (2 on each nursing unit), 5.5 nurses on the evening shift (2 on both the Southwest and North One units and 1.5 on the 2nd floor), and 3 nurses at night (one on each unit). She said for CNAs she tries to schedule 5 on each unit for days, 4 on each unit for evenings and 2 for each unit on nights. She said she knows the staffing pattern on the facility assessment and reviewed the required numbers at this time. She said she cannot always staff to the facility assessment because they have a lot of openings and not enough staff available. She said the requirement of 9 nurses on the day shift she believes is an error, and likely contains the 3 management positions that are pulled out and account for 3 nurses. She said it is hard to fill openings because the facility recently lost two of their contracted travelers and only have one left and she is not allowed to contact any staffing agencies for nursing staff needs because the facility does not use them. She said she has about 8-10 day shift nurse positions open, 2-3 evening shift nurse positions and 2 night shift nurse positions. She said she needs about 2-3 CNAs for the day shift and 3-4 for the night shift but the evening shift is fully staffed. She said her per diem pool is minimal and without the use of a staffing agency she can only do the best she can with the staff she has. She was not aware of any recruitment efforts the facility currently had in process.

During an interview on 3/15/24 at 10:47 A.M., the Administrator said the facility advertises for staff on Indeed.com (a job recruitment website) and he requests that the staff speak to their healthcare worker friends and tell them about current opportunities at the facility. He said there are no other current recruiting modalities in place. He said the facility used to have one nursing staffing agency, but they were unreliable and their contract was eliminated. He said the facility has used traveler nurses in the past and currently still has one in place. He reviewed the facility assessment and said the need for 9 nurses on the day shift was an error and he must have inadvertently added the 3 management nurses into that number and the facility should be staffed with 6 nurses on the day shift each day for safe staffing. He could not explain why the facility staffed only 5 nurses on the day shift on numerous days. He said he has attempted to procure an additional nurse staffing agency to help manage the open positions, but it was a company decision to not use nursing staffing agencies at this time and that option is not available to the facility. He said the expectation for staffing is that staffing aligns with the facility assessment with 6 nurses a day 4.5 on evenings and 3 on nights, as well as 12 day CNAs, 10 evening CNAs and 6 night shift CNAs and he recognizes that there are times that has not occurred and the staffing has not been sufficient in accordance to the facility assessment.

42742

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Review of the Facility Assessment Tool failed to indicate information on the following: a. Section 1.5, titled Acuity, is identified as being used to determine the level of acuity of the resident population at the facility. The acuity level, according to the Facility Assessment, is recorded daily on the daily census and on CNA staff assignment sheets. Staffing as well as the resources needed to care for the residents are determined based on resident acuity. Section 1.5 failed to indicate the number/average or range of residents requiring specialized treatments to include: intravenous (IV) medications, dialysis, and isolation or quarantine for active infectious diseases. Additionally, Section 1.5 failed to identify the required assistance with activities of daily living (ADLs) including residents who were independent with dressing and bathing and those who were dependent on staff for eating. During an interview on 3/19/24 at 3:58 P.M., the Administrator said Section 1.5 was not accurate based on the resident population and needed revision. He said residents requiring specialized treatments such as IV medications, dialysis, and isolation or quarantine for active diseases should not have been zeros and would review that with the clinical team as well as for an accurate account of the level of assistance for resident ADL needs. b. Section 3.2, titled Staffing Plan, is identified as being used to ensure the facility had enough staff to meet the needs of the residents at any given time. Staff identified as Other consisted of a plan for a full-time Activities Director, 2 full-time assistants, and 1 part-time assistant. The facility failed to staff a full-time Activities Director since November 2023. During an interview on 3/19/24 at 3:06 P.M., the Administrator said the facility has been without an Activities Director since last November. He said there was no designated person as being responsible for the oversight of the activities program, but it would have to be him. During an interview on 3/19/24 at 3:55 P.M., the Administrator said there had been insufficient staffing for activities.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 48362 Based on interview and record review, the facility failed to ensure services were coordinated with the hospice provider to implement the resident's plan of care as required in the provider contract agreement for two Residents (#12 and #70), out of a total sample of 24 residents. Specifically, the facility failed: 1. For Resident #12, to provide ongoing documentation, and maintain a complete medical record of services to ensure prompt and effective communication and continuity of care for the Resident. 2. For Resident #70, to provide ongoing documentation, and maintain a complete medical record of services to ensure prompt and effective communication and continuity of care for the Resident. Findings include: Review of the facility's policy titled Hospice Services, last revised January 2023, indicated but was not limited to the following: - Our facility contracts for hospice services for residents who wish to participate in such programs. - When a resident participates in the hospice program, a coordinated plan of care between the facility, hospice agency, and resident/family will be developed and shall include directives for managing pain and other uncomfortable symptoms. - The facility and hospice will identify specific services that will be provided by each entity and this information will be communicated in the plan of care. - The hospice and facility will communicate with each other when any changes are indicated or made to the plan of care. - All hospice services are provided under contractual agreement. Complete details outlining the responsibilities of the facility and the hospice agency are contained in this agreement. A copy of this agreement is on file in the business office and hospice agency. Review of the facility's Hospice Agreement, dated September 2019, indicated but was not limited to the following: - Records: Facility shall prepare and maintain complete and detailed records concerning each Hospice Patient receiving Inpatient Services under this Agreement in accordance with prudent record-keeping procedures and as required by applicable federal and state laws and regulations and Medicare and Medicaid program guidelines. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225667	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2024
NAME OF PROVIDER OR SUPPLIER Pleasant Bay of Brewster Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 383 South Orleans Road Brewster, MA 02631	

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Records: Each clinical record shall completely, promptly, and accurately document all services provided to, and events concerning, each Hospice Patient, including evaluations, treatments, progress notes, authorizations to admission to Hospice and/or Facility, physician orders entered pursuant to this Agreement and discharge summaries. - Records: Each record shall document that the specified services are furnished in accordance with this Agreement and shall be readily accessible and systematically organized to facilitate retrieval by with party. 1. Resident #12 was admitted to the facility in October 2023 with diagnoses including Alzheimer's dementia, depression, and encounter for palliative care. Review of the Minimum Data Set (MDS) assessment, dated 1/10/24, indicated Resident #12 was receiving hospice services. Review of the hospice binder for Resident #12 on the unit included the following: - Home Health Aide (HHA) visit notes dating from 11/30/23 through 2/23/24. - Nursing visit notes dating from 11/30/23 through 2/23/24. - Nursing visit note indicating recertification assessment took place on 2/14/24, with recommendation for resident to continue with hospice services as reviewed by the Medical Director. - Chaplain and Social Service visit notes dating from 11/30/23 through 2/23/24. - Hospice Certification and Plan of Care with certification dates from 6/12/23 through 9/9/23. Further review of the hospice binder failed to include any additional documentation including: - Election Form of Services; - Consent to Treat; - Current/active Hospice Certification and Plan of Care; and - Documentation of any visits occurring after 2/23/24 by nursing, HHA, social services or the chaplain. Review of Resident #12's active physician's orders failed to indicate an order for election of hospice services. During an interview on 3/14/24 at 10:54 A.M., Nurse #4 said residents on hospice have a schedule of nursing and HHA visits weekly. Nurse #4 said the nurses and HHAs check in before and after seeing residents. Nurse #4 said hospice services communicate freely with the facility staff. Nurse #4 said documentation is faxed to the facility after the visits. Nurse #4 was unaware of how the documentation reaches the unit hospice binder for each resident. Nurse #4 said she thought documentation was filed by the unit manager or overnight staff. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/14/24 at 2:37 P.M., the Director of Nurses (DON) said the facility had agreements with several hospice agencies to care for residents. The DON said each resident typically has their own hospice binder on the unit. The DON said documentation, including nursing notes, should be complete in each binder on the unit. The DON said once a resident is assessed by hospice services and approved, orders would be written in the chart for admission to their services. The DON and the surveyor reviewed the documentation for Resident #12. The DON said she was unaware if updated certifications and plan of care from the hospice agency were to be kept in the hospice binder. The DON said there should be orders in the chart for residents to admit to hospice. During an interview on 3/14/24 at 2:41 P.M., the Regional Clinical Director said each resident admitted to hospice services in the building would have their own binder. The Regional Clinical Director said those binders would have information including notes, schedules, and other hospice documentation. The Regional Clinical Director said a resident admitted to hospice services should have orders in place. The Regional Clinical Director said she was uncertain if election of services, consent to treatment, certification of plan of care would be present in the resident chart. 48084 2. Resident #70 was admitted to the facility in April 2023 with diagnoses which included Alzheimer's disease, anemia, orthostatic hypotension, difficulty walking, syncope and collapse, and a history of falls. Review of the MDS assessment, dated 12/19/23, indicated Resident #70 was receiving hospice services. Review of the Physician's Orders indicated the following: - May have Hospice consult and admit if appropriate. (12/12/23) Review of the hospice binder for Resident #70 on the unit included the following: - Home Health Aide (HHA) visit notes dating from 12/2023 through 2/14/24. - Nursing visit notes dating from 12/2023 through 2/13/24. - Interdisciplinary Team (IDT) notes dating from 12/2023 through 2/14/24. - Social Service visit notes dating from 12/2023 through 2/8/24. - Hospice Initial Certification and Plan of Care with certification dates from 12/2023 through 3/10/24. Further review of the hospice binder failed to include any additional documentation including: - Current/active Hospice Certification and Plan of Care; and - Documentation of any visits occurring after 2/14/24 by nursing, HHA, social services or the chaplain. (continued on next page)

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	225667	A. Building B. Wing	03/19/2024

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/18/24 at 12:28 P.M., Unit Manager #1 said she did not have a current schedule of visits for Resident #70. She said the one posted was only through last week. Additionally, she said the Resident is still on services and the recertification and visit notes should be in the binder and they are not. During an interview on 3/18/24 at 12:37 P.M., Nurse #1 said they usually give report to the Hospice Nurse, but they do not always get report when they leave. She said the Hospice Nurse was here on Friday 3/15/24 and the recertification and visit notes should be in the binder but they are not. During an interview on 3/19/24 at 3:25 P.M., Consulting Staff #1 said each resident has their own Hospice binder and Resident #70 should have the current recertification and all the visit notes from all their providers in the binder. No additional hospice documentation was provided to the surveyor prior to survey exit.

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	225667	A. Building B. Wing	03/19/2024

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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.

48084

Based on observation, interview, and policy 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 within the facility. Specifically, the facility failed to:

1a. Implement COVID-19 testing every 48 hours for all staff during a COVID-19 outbreak for 11 out of 11 sampled staff members in accordance with their policy, state, and national standards, when the facility was experiencing an outbreak of COVID-19 infections, and

b. Implement COVID-19 testing every 48 hours for all residents during a COVID-19 outbreak in accordance with their policy, state, and national standards, when the facility was experiencing an outbreak of COVID-19 infections;

2. Ensure staff adhered to infection control protocols for personal protective equipment (PPE) use when providing care and services to residents requiring precautions to prevent the possible spread of germs and illnesses; and

3. Maintain an accurate line list for infection surveillance and tracking.

Findings include:

Review of the facility's policy titled Infection Control, dated as last revised 2/2023, indicated but was not limited to the following:

-The facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections.

-This facility's infection control policies and practices apply equally to all personnel, consultants, contractors, residents, visitors, volunteer workers, and the general public alike.

-The objectives of our infection control policies and practices are to:

a. prevent, detect, investigate, and control infections at the facility;

b. maintain a safe, sanitary, comfortable environment;

c. establish guidelines for implementing isolation precautions;

d. maintain records of incidents and corrective actions related to infections.

Review of the facility's policy titled Infection Control Program, dated as last revised 2/2023, indicated but was not limited to the following:

(continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The Infection prevention and control program (IPCP) is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement (QAPI) program. PROCEDURE: -The IPCP is coordinated and overseen by the infection prevention specialist (IP). -Surveillance data and reporting information is used to inform the committee of potential issues and trends. SURVEILLANCE: -Surveillance tools are used for recognizing the occurrence of infections. -Standard criteria are used to distinguish community acquired from facility acquired infections. DATA ANYALYSIS: -Data gathered during surveillance is used to oversee infections and spot trends. -Monthly rates can be compared side by side to allow for trend comparison. OUTBREAK MANAGEMENT: -Outbreak management is a process that consists of determining presence of an outbreak, managing affected residents, preventing the spread to other residents, documenting information about the outbreak, reporting the information to appropriate public health authorities, educating staff and public, monitoring for recurrences, reviewing the care after the outbreak subsided, and recommending new or revised policies to handle similar events in the future. PREVENTION OF INFECTION: -Educating staff and ensuring that they adhere to proper techniques and procedures. -Enhancing screening for possible significant pathogens. -Implementing appropriate isolation precautions when necessary. -Following established general and disease-specific guidelines such as those of the CDC [Centers for Disease Control and Prevention]. 1. Review of the facility's policy titled Outbreak Testing, dated as last revised 3/14/23, indicated but was not limited to the following: -It is the policy of this facility to follow all updated regulatory guidance from CDC, CMS, and Local Department of Public Health regarding resident care during the COVID-19 pandemic. (continued on next page)

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	225667	A. Building B. Wing	03/19/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Outbreak definition: Identification of ONE new positive staff or resident case. TESTING: -Once a new case is identified, the facility should initiate outbreak testing. Outbreak testing should include testing of all staff and residents on the affected unit(s), must take place as soon as possible, after the initial round of testing, facility should test residents and staff at least every 48 hours on the affected unit until the facility goes seven days without a new case or instructed by an epidemiologist. Review of the current COVID-19 Resident Outbreak Log indicated the outbreak started on 2/5/24. a. During an interview on 3/14/24, the IP said all staff test in the testing room down the hall every other day. She said she collects the sheets from the binder but does not track the staff testing. She said each department head is responsible for making sure everyone tests, she did not have time for that, and she did not know how they tracked it. Additionally, she said she did not track the nursing department tests, the Director of Nurses must do that, but she was unsure. Review of the Staff Testing Log in the staff testing room indicated that 35 tests had been documented between 3/9/24 and 3/18/24. The surveyor randomly selected 11 staff members to review for compliance with testing, per guidelines and facility policy, during the current outbreak: two staff members from the Kitchen, Activities, Therapy, and Housekeeping departments and three staff members from the nursing department. The IP reviewed the testing logs and an additional testing log that was in the therapy department for compliance and reported the following to the surveyor: The testing logs between 2/5/24 and 3/19/24 indicated the following: 1. Housekeeper #1 had zero tests logged. 2. Housekeeper #2 had one test logged (2/5/24). 3. Certified Nursing Assistant (CNA) #3 had one test logged (3/17/24). 4. CNA #5 had zero tests logged. 5. Nurse #8 had zero tests logged. 6. Dietary Staff #1 had zero tests logged. 7. Food Service Director (FSD) had zero tests logged. 8. Activities Assistant #2 had one test logged (2/29/24). 9. Activities Assistant #4 had zero tests logged. 10. Rehab Staff #5 had two tests logged (3/14/24 and 3/18/24). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11. Rehab Staff #4 had three tests logged (2/29/24, 3/14/24, and 3/18/24). Review of the timecards/calendar provided of days worked between 2/5/24 and 3/19/24 indicated the following: 1. Housekeeper #1 worked 22 days. 2. Housekeeper #2 worked 35 days. 3. CNA #3 worked 31 days. 4. CNA #5 worked 25 days. 5. Nurse #8 worked 20 days. 6. Dietary Staff #1 worked 33 days. 7. FSD worked 31 days. 8. Activities Assistant #2 worked 26 days. 9. Activities Assistant #4 worked 10 days. 10. Rehab Staff #5 worked 29 days. 11. Rehab Staff #4 worked 28 days. Review and Comparison of testing log and days worked for 11 out 11 staff members failed to indicate compliance with testing requirements. During an interview on 3/18/24 at 12:37 P.M., Nurse #1 said staff COVID testing is done downstairs, and it should all be documented on the logs in the binder. She said she was not testing because she was within the 30-day window of being positive. During an interview on 3/18/24 at 12:44 P.M., Unit Manager #1 said the IP tracks the testing. During an interview on 3/18/24 at 1:19 P.M., CNA #3 said she did not know the last time she had tested and that she should have tested today but has not done it yet. She said she usually does it in the morning and it should be done every other day. During an interview on 3/18/24 at 12:45 P.M., Nurse #7 said she did not have to test because she was recently positive, and she was not sure of the current staff testing process. During an interview on 3/18/24 at 12:50 P.M., CNA #5 said she tests at home every day and only sometimes does it at the facility. She said if she tests at home, she doesn't write it down anywhere, but if she tests at the facility, it would be on the log. Additionally, she said if they ask, she tells them she tested at home and she did not know who tracked the testing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/18/24 at 1:00 P.M., Housekeeping Staff #1 and #2 said testing should be done every other day. They said they tested today but did not document it on the log. Housekeeper #1 said we are supposed to write it down, but we did not. Additionally, she said she thinks her supervisor tracks it but was not sure. The IP was not available for interview on 3/19/24. The Director of Nurses was not available for interview on 3/19/24. During an interview on 3/19/24 at 3:39 P.M., Consulting Staff #1 said during an outbreak all staff should be testing at least every 48 hours when working. She said we do not make staff come in to test if not working and we do not accept tests done at home, all testing should be done in the testing room and documented on the log. Additionally, she said the department heads should be monitoring their staff, the IP should be checking the logs and following up with all department heads to ensure compliance. She said her expectation is for the IP to review the testing log and if there are not a lot of tests or a blank day she would intervene and correct the problem. She said these testing logs are not in compliance with every 48-hour testing guideline and facilty policy. 1b. During an interview on 3/14/24 at 9:10 A.M., Unit Manager #1 said resident testing is done every other day on the units. She said she has a binder at the desk on Unit #2 and Unit #3 and all tests should be logged there and then a progress note written. She said she was not sure how Unit #1 managed their testing, but she thought they just wrote it on the calendar. During an interview on 3/14/24 at 3:40 P.M., the IP said the resident testing is managed on the units. She said it should be done every other day and written on the log and a note written in the medical record. She said she collects the sheets and files them but does not track them. Review of the testing process and binders on the units indicated but was not limited to the following: Unit 1: -The unit did not have a binder on 3/13/24 and 3/14/24, and staff were unaware of the testing process. -3/18/24 Nurse #7 was unable to locate the new testing binder. (The surveyor was unable confirm testing had been completed as required on Unit 1 due to inability to review testing logs.) Unit 2: -March Testing logs in the binder were complete. Unit 3: -3/6/24 no worksheet was in the binder for rooms 301-311. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-3/12/24-3/13/24 worksheet had no tests logged for rooms 312-323. -3/15/24 worksheets were incomplete, with no test logged for 10 residents. -3/17/24 no worksheet was in the binder. During an interview on 3/14/24 at 9:05 A.M., Nurse #1 said the Unit Manager does most of the testing, but we help when we can, and all the tests should be documented in the binder and in the progress notes. During an interview on 3/18/24 at 12:44 P.M., Unit Manager #1 said resident testing is an issue, she said she tries to oversee it but if it is not documented in the binder, it was not done. She said staff should also write progress notes in the medical record, but they do not always get the notes in. She said they did not do the testing on 3/17/24 and she would initiate the testing for the unit today. During an interview on 3/18/24 at 1:19 P.M., Nurse #7 said Unit 1 has a new black binder, but she did not know where it was, but she thought the IP had it. Additionally, she said she did not know when the residents were tested last or when they were due for testing. The IP was not available for interview on 3/19/24. The Director of Nurses was not available for interview on 3/18/24 or 3/19/24. During an interview on 3/19/24 at 3:39 P.M., Consulting Staff #1 said resident outbreak testing should be documented on the sheets in the binders and should have a note in the medical record. Those logs are incomplete and indicate testing was not done as required. Additionally, Consulting Staff #1 said resident testing should have been done on 3/17/24 and it was not done until the afternoon of 3/18/24. 2. Review of the facility's policy titled Outbreak Management, dated as last revised 3/14/23, indicated but was not limited to the following: -Follow Personal Protective Equipment (PPE) guidance based on resident identifier per policy. -Post precaution signs immediately outside of resident rooms indicating appropriate infection control and prevention precautions. Review of the facility's policy titled COVID-PPE Guidance, dated as last revised 3/14/23, indicated but was not limited to the following: PPE Guidance based on resident case/type: -COVID-19 Negative: facemask/surgical mask. -COVID-19 Positive: Full PPE: Fit tested N95 respirator or alternate, face shield/goggles, gown, gloves, change gown/gloves between residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled Isolation Precautions, dated as last revised 2/2023, indicated but was not limited to the following: -Transmission based precautions (TBP) shall be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to others. -If a resident is identified as being infected with an infectious organism that requires TBP, the nurse implements the precautions as soon as possible. -Precautions are maintained for as long as necessary to prevent the spread of infection, but no longer. -The IP will monitor all residents on TBP and monitor for compliance with appropriate precautions. -Place an isolation sign at the door of resident's room, identifying type of infection, location of infection, and type of precaution required. -Residents will remain on appropriate precautions until the Attending Physician or the IP orders them discontinued. -The IP has the authority to order and discontinue Isolation Precautions when necessary. The IP shall consult the Attending Physician and/or Medical Director and Infection Control Committee regarding such decisions. -The nursing staff will inform the IP (or designee) when an order for discontinuing isolation has been received from the Attending Physician. Review of the COVID-19 positive log from 3/1/24 through 3/13/24 indicated 18 cases had been identified. Review of a random sample, including the most current COVID-19 positive residents' medical records including physician orders, treatment administration records (TAR), and progress notes indicated the following: RESIDENT #109: tested positive on 3/3/24; an order for isolation precautions every shift was obtained on 3/4/24 effective 3/4/24 through 3/15/24. -Surveyor Observations on 3/13/24 and 3/14/24 indicated Resident #109 did not have a PPE supply cart or sign on the door to his/her room. -The TAR for Resident #109 had been signed off 3/13/24 and 3/14/24 indicating isolation precautions had been administered/maintained. -Facility failed to maintain precautions per active physician order on 3/13/24 and 3/14/24 or to obtain a physician's order to discontinue isolation precautions after Resident #109 tested negative on 3/7/24. RESIDENT #28: tested positive on 3/8/24; PPE cart and sign were at the door to resident's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-During an interview on 3/13/24 Nurse #3 said Resident #28 was negative and the precautions were for the roommate Resident #46 who had tested positive on 2/28/24. -Surveyor Observation: 3/13/24 at 9:25 A.M., PPE supplies were available near the door of room, isolation sign was on the door (but failed to indicate who the precautions were for), Resident #46 was not in the room and Resident #28 was sitting in his/her wheelchair looking out the window -Nurse #3 was unable to identify which resident was on precautions for COVID-19 with the sign at the door or when she looked at the electronic medical record. RESIDENT #54: tested positive on 3/9/24; no physician's order for isolation precautions; PPE cart and sign were at the door to resident's room. -Surveyor Observation: 3/13/24 at 9:30 A.M., PPE supplies were available near the door of the resident's room, isolation sign was on the door (but failed to indicate who the precautions were for). RESIDENT #70: tested positive on 3/11/24; physician's order for isolation precautions effective 3/11/24 through 3/21/24. -Surveyor Observation: 3/13/24 and 3/14/24 PPE cart and sign were at the door to resident's room. RESIDENT #110: tested positive on 3/12/24; no physician's order for isolation precautions; PPE cart and sign were at the door to resident's room. -Surveyor Observation: 3/14/24 at 9:24 A.M., PPE cart and sign were at the door to resident's room (but failed to indicate who the precautions were for). RESIDENT #326: tested positive on 3/12/24; no physician's order for isolation precautions; PPE cart and sign were at the door to resident's room. -Surveyor Observation: 3/14/24 at 9:24 A.M., PPE cart and sign were at the door to resident's room (but failed to indicate who the precautions were for). RESIDENT #57: tested positive on 3/12/24; no physician's order for isolation precautions; PPE cart and sign were at the door to resident's room. -Surveyor Observation: 3/14/24 at 9:24 A.M., PPE cart and sign were at the door to resident's room (but failed to indicate who the precautions were for). During an interview on 3/13/24 at 9:18 A.M., CNA #3 said they know who is on precautions based on the sign on the door. She said the cart is usually near the door as well. IP was not available for interview on 3/19/24. The Director of Nurses was not available for interview 3/18/24 and 3/19/24. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Pleasant Bay of Brewster Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 383 South Orleans Road Brewster, MA 02631	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/19/24 at 3:39 P.M., Consulting Staff #1 said when a resident tests positive for COVID-19 the expectation is to initiate isolation precautions by putting the sign up at the door, putting the PPE supply cart by the door, notify the physician and writing a physician's order for isolation precautions, then the nurses would sign off the precautions on the TAR every shift until they are discontinued. She said the four residents should have had an order for isolation precautions written and Resident #109 should have had the order for precautions discontinued when they removed them from the room. 3. Review of the facility's policy titled Infection Control Surveillance, dated as last revised 2/2023, indicated but was not limited to the following: -The Infection Preventionist (IP) should conduct ongoing surveillance for Healthcare-Associated Infections (HAI) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. -The purpose of the surveillance is to identify both individual cases and trends of epidemiologically significant organisms and HAI, to guide appropriate interventions, and to prevent future infections. -The IP will determine if the infection is reportable. -When transmission of HAIs continues despite documented efforts to implement infection control and prevention measures, the appropriate state agency and/or specialist in infection control and epidemiology should be consulted for further recommendations. DATA COLLECTION AND RECORDING: -For residents with infections that meet the criteria for definition of infection for surveillance, collect data as appropriate. -Using current suggested criteria for HAI, determine if the resident has a HAI. -For targeted surveillance using facility-created tools, follow these guidelines: a. Daily: (as indicated) record detailed information about the resident and infection on an individual infection report. b. Monthly: collect information from individual resident infection reports. c. Monthly: summarize monthly data for each unit by site and by pathogen. d. Monthly/Quarterly: identify predominant pathogens or sites of infection among residents. e. Monthly/Quarterly: compare incidence of current infections to previous data to identify trends and patterns. CALCULATING INFECTION RATES: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Obtain the month's total resident days to calculate the monthly infection rate. INTERPRETING SURVEILLANCE DATA: -Compare the rates to previous months to identify seasonal trends. Review of the facility's Infection Surveillance Line List for January 2024-current indicated but was not limited to the following: -COVID-19 Infections during current outbreak period (2/5/24-3/19/24: total 31 cases Review of COVID-19 positive log from the current outbreak indicated 35 cases. Comparison of the Line List and the COVID-19 positive log for the current outbreak indicated two residents were on the line list and not the COVID-19 positive log and seven residents were on the COVID-19 positive log that were not on the line list. Further Review of the facility Infection Surveillance Line List for January 2024-current indicated but was not limited to the following: -19 entries where the culture date was prior to the date of onset. -multiple entries were the symptoms of a urinary tract infection (UTI) were coded as O (other) with nothing else noted or U (urgency) with no other symptoms coded. -Six entries had conflicting symptoms in their respective progress notes. -McGeer Criteria assessments could not be located in the medical record for randomly selected residents with UTI entries. No monthly data analysis for January or February was available to review. The IP was not in the building and the reports were not in the binder with the line list. Consulting Staff #1 was unsure where they might be if not in the binder. The IP was not available for interview on 3/19/24. The DON was not available for interview on 3/19/24. During an interview on 3/19/24 at 3:39 P.M., Consulting Staff #1 said the nurse taking the order should be completing the McGeer's assessment in the electronic medical record. She said she would expect to see the symptoms documented appropriately to meet criteria and not just writing an order for urine for a fall or behaviors as that is not following the policy. She said the line list and COVID list should match, and the culture dates should not be before the symptom onset dates. Additionally, she said it appears the IP needs some education and training on how to complete the line list accurately.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48084 Based on record review, policy review, and interview, the facility failed to implement policy and procedures to ensure residents/resident representatives were educated on benefits and potential side effects of immunizations, documented consent, or refusal of the immunization, and offered and administered the influenza and pneumococcal immunization in a timely manner for one out of five residents sampled. Specifically, the facility failed for Resident #32, to educate on benefits and potential side effects, offer the immunizations, and document in the medical record consent/refusal for the influenza and pneumococcal vaccines. Findings include: Review of the facility's policy titled Influenza Vaccination/Control, dated as last revised 2/2023, indicated but was not limited to the following: -The facility follows current guidelines and recommendations for the prevention and control of seasonal influenza. -The Infection Preventionist (IP)/designee will educate, promote, and oversee the administration program of seasonal influenza vaccine. -Flu Vaccination will be available to all employees/residents during the entire flu season. Unless contraindicated, all residents and staff will be offered the vaccine. a. Residents who decline the influenza vaccine will have this documented. -The IP/designee will keep data regarding the vaccination status of all employees and others associated with the facility. Review of the facility's policy titled Pneumococcal Vaccination, dated as last revised 2/2023, indicated but was not limited to the following: -All residents will be offered the pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. -This facility will offer pneumococcal vaccination to all admitted residents [AGE] years of age and older, unless such resident has already received the vaccination, is not in need of a booster, or is a person whom is medically contraindicated. PROCEDURE: -Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Assessments of pneumococcal vaccination status will be conducted within five (5) working days of the resident's admission if not conducted prior to admission. -The resident or legal representative shall receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Provision of such education shall be documented in the resident's medical record. -Residents/representatives have the right to refuse vaccination. If refused, appropriate entries will be documented in each resident's medical record indicating the date of the refusal of the pneumococcal vaccination. Resident #32 was admitted to the facility in January 2023 with diagnoses which included hypertension (high blood pressure), diabetes mellitus, heart failure, and cardiomyopathy. Review of the Minimum Data Set (MDS) assessment, dated 1/10/24, indicated Resident #32 scored 7 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she had moderate impairment. Additionally, the MDS indicated the Resident's Pneumococcal Vaccination status was not up to date and reason code was not offered. Review of the current Physician's orders indicated but was not limited to the following: -May have annual Flu vaccine per order. (1/25/23) -May have Pneumovax vaccine per order. (1/25/23) Review of the medical record including the consent section of the chart indicated but was not limited to the following: -Consent for Immunization, dated 1/25/23, signed by Resident #32, was incomplete. a. The Consent for Immunization form had an area for Influenza and Pneumonia Vaccines which included boxes to check for consent, already received the vaccine, and refusal. Additionally, the bottom of the form had a box to check acknowledging receipt of the current Influenza and Pneumococcal Vaccine information Statements (VIS). (All of the boxes were unchecked) Review of the Immunization Record for Resident #32 failed to indicate Resident #32 had received or refused the Influenza Vaccine for the 2022-2023 season and failed to indicate he/she had received or refused the pneumococcal vaccine. During an interview on 3/14/24 at 12:44 P.M., the IP said she does not track all the vaccines or when residents are due for vaccines. She said consents are obtained on admission and the nurses put the orders in. Additionally, she said they collect flu vaccine data when it is due in April. The surveyor requested any additional immunization documents the IP could locate for Resident #32. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/14/24 at 2:32 P.M., the IP provided the surveyor with a Consent for Immunization, dated 1/25/23, signed by Resident #32. The Influenza Section had the box indicating he/she had already received the influenza vaccine for this season. The Pneumococcal Vaccine section had the box indicating he/she had already received the pneumococcal vaccine checked off and the refusal of the vaccine. Additionally, the acknowledgement of receiving the influenza and pneumococcal VIS's box was checked off. During an interview on 3/14/24 at 3:40 P.M., the IP said the nurse upstairs today said the Resident did not want them/already had them, so I just checked off the boxes on the form. Additionally, she said the Resident has never had the pneumonia vaccine, as it is not in the data base, so it was assumed he/she didn't want it, but I should not have checked the boxes off on the form today. She said she checked the VIS box off because all residents are supposed to get the VIS sheets in the admission packet but could not confirm if the Resident was provided the VIS sheets on admission. She said she never actually spoke to Resident #32 regarding vaccination status. She said Resident #32 was not offered the vaccines and there was no follow up to the blank consent in his/her chart that she can see anywhere in the record. The IP said all vaccine history should be documented in the electronic medical record under immunizations. The Director of Nurses was not available for interview on 3/18/24 or 3/19/24. During an interview on 3/19/24 at 3:39 P.M., Consulting Staff #1 said vaccines should be ordered and administered as soon as possible after the consent is signed. She said Resident #32's consent form was incomplete, and staff should have re-addressed the consent form with him/her and it should not have been filed in the medical record incomplete. Additionally, she said the IP is responsible for the oversight of the vaccine program and should have a tracking method to follow up on consents and vaccines for the residents, and all vaccines should be documented in medical record whether the resident consents, already had it, or refused it and there was not any documentation in Resident #32's medical records regarding these two vaccines.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 48084 Based on record review, policy review, and interview, the facility failed to implement policies and procedures to ensure residents/resident representatives were educated on benefits and potential side effects, documented consent or refusal of the immunization and offered and administered the COVID-19 immunization and/or booster in a timely manner for 1 out of 5 residents sampled. Specifically, the facility failed for Resident #61 to educate, offer, and administer the immunization, and document in the medical record consent/refusal. Findings include: Review of the facility's COVID-19 Vaccination policy, undated, indicated but was not limited to the following: -It is the policy of this facility to offer and encourage all residents to receive the COVID-19 vaccine per the Centers for Disease Control and Prevention (CDC), Centers for Medicare and Medicaid Services (CMS), and Department of Public Health (DPH) guidelines and recommendations. -The residents will be offered the vaccine upon admission and at intervals decided by their physician (MD) in accordance with the CDC, CMS, and DPH guidelines. -Vaccine: 2023-2024 Formula (Omicron XBB 1.5) 0.5 milliliters (ml) is the recommended vaccine by CDC because it is most effective against the Omicron variant which is prevalent now. -I wish to receive the COVID-19 vaccine offered to me at this time. -I have been offered the COVID-19 vaccine, education regarding the risks and benefits, have been given the opportunity to ask questions and I decline the vaccine at this time. Resident #61 was admitted to the facility January 2022, with diagnoses which included reduced mobility, kidney donor, history of COVID-19, hypertension (high blood pressure), and cerebral infarction (stroke). Review of the Minimum Data Set (MDS) Assessment, dated 11/21/23, indicated Resident #61 scored 14 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she was cognitively intact. Review of the current Physician's Orders indicated but was not limited to the following: -Health Care Proxy (HCP) invoked. (1/21/22) Review of the medical record including the consent section of the chart indicated but was not limited to the following: (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Consent for COVID-19 Immunization, dated 2/2/24, signed by Resident #61's HCP, consenting for Resident #61 to receive the COVID-19 vaccine. Review of the Immunization Record for Resident #61 failed to indicate the Resident had received the COVID-19 Vaccine for 2023-2024. The entry in the immunization log indicated consent refused. Review of the medical record for Resident #61 including progress notes failed to indicate when the vaccine was offered to the Resident, Resident had refused the vaccine, the HCP had been notified, or that education had been provided to the Resident and HCP. During an interview on 3/14/24 at 12:44 P.M., the Infection Preventionist (IP) said she does not track all the vaccines or when residents are due for vaccines. She said consents are obtained on admission and the nurses put the orders in. Additionally, she said when they did the COVID vaccine clinic consents were mailed or emailed to the HCPs and she did not track who had not returned them. During an interview on 3/14/24 at 2:32 P.M., the IP said she was not aware the consent for the COVID vaccine had been in the Resident's chart. She said it was signed 2/2/24 and someone must have just filed the consent in the chart when it was returned. She said Resident #61 had not received the COVID-19 vaccine and he/she should have already received it as this consent was signed about six weeks ago. Additionally, she said she does not track who wants the vaccine, who signed a consent, whose consent is pending etc. She said she did an audit in January 2024 when they had a vaccine clinic but has not followed up on it and should have. The IP said she did not know why the immunization tab had consent refused in the record, as the HCP signed the consent form, and there were not any notes indicating it was attempted and the Resident refused. The Director of Nurses was not available for interview 3/18/24 or 3/19/24. During an interview on 3/19/24 at 3:39 P.M., Consulting Staff #1 said Resident #61 had a signed consent for the COVID-19 vaccine in his/her chart. It was signed by the HCP and the vaccine should have already been administered. She said the vaccines should be ordered and administered as soon as possible and six weeks is not a reasonable time frame for administration unless documented supply issues are the concern and at this time that is not the case.

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F 0944 Level of Harm - Potential for minimal harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 36542 Based on interview and staff education review, the facility failed to ensure training on Quality Assurance and Performance Improvement (QAPI) was included as mandatory training for 11 out of 11 sampled staff members. Findings include: Review of the staff education/competency records failed to include mandatory training on the elements and goals of the QAPI program for the following staff: Nurse #1, Nurse #4, Nurse #6, Nurse #7 and Nurse #8 Certified Nursing Assistant (CNA) #2, CNA #9 and CNA #10 Activity Assistant #1, Activity Assistant #2 and Activity Assistant #3 During an interview on 3/15/24 at 12:34 P.M., the Staff Development Coordinator said she had not been providing staff with education on QAPI and this was not part of the orientation or the yearly in-service training.