Printed: 02/22/2025 Form Approved OMB No. 0938-0391

		1	1
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/21/2022
NAME OF PROVIDER OR SUPPLIE	NAME OF PROVIDER OR SUPPLIER		P CODE
Tremont Rehabilitation & Skilled Care Center		605 Main Street Wareham, MA 02571	
For information on the nursing home's	plan to correct this deficiency, please cont	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	 etc.) that affect the resident. 15203 Based on interviews and records reactivated Health Care Proxy and or psychiatric and medical evaluation representative/Health Care Agent (the Facility. Findings include: Review of the Admission Agreement representative of a resident's disch would initiate discharge and indicated buring an interview on 10/07/22 at Proxy was activated 6/24/22. Review of Resident #1's Health Care Agent. Review of Resident #1's medical reactive Assessment (MDS), dated as complimpaired. Review of Resident #1's Progress I 12:55 P.M., Resident #1 became c shoulder. The Note indicated that F Member #1 was notified. During an interview on 9/20/22 at 9 	esident's doctor, and a family member of eviewed, for one of five sampled reside n 8/14/22 required transfer to the Hosp for a possible change in mental status (Family Member #1) was notified that h nt, undated, indicated that the Facility of targe. The Agreement indicated the circle ted that the resident had the right to ap 8:30 A.M., the Director of Nurses said are Proxy Form indicated Family Memb ecord indicated that the most recent Ad pleted 6/30/22, indicated that his/her co Note, dated 8/14/22 written by Nurse # ombative with another resident and hit Resident #1 was sent to the Hospital. T 0:05 A.M., Family Member #1 (Residen notified her that Resident #1 was sent ses station.	ents (Resident #1), who had an ital Emergency Department for a , the Facility failed to ensure his/her ie/she had been discharged from would notify the resident's cumstance for which the Facility peal the Facility's discharge. that Resident #1's Health Care er #1 was Resident #1's Health mission Minimum Data Set ognitive patterns were severely and indicated that at approximately the other resident on the right he Note indicated that Family t #1's Health Care Agent), said that

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

(X6) DATE

Facility ID: 225488

Printed: 02/22/2025 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/21/2022
NAME OF PROVIDER OR SUPPLIER Tremont Rehabilitation & Skilled Care Center		STREET ADDRESS, CITY, STATE, ZI 605 Main Street Wareham, MA 02571	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	l tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	 told her that the Facility was not will Member #1 said no one from the Facility Member #1 said no one from the Facility Member #1 said that on 8/1 Director of Social Services. Family discharged over the weekend and the she told the Administrator that no of they notified her that he/she was be received paperwork from the Faciliti on 8/24/22 the Ombudsman emailed dated 8/14/22. During an interview on 9/22/22 at 1 Family Member #1 on 8/14/22 whe During an interview on 9/21/22 at 1 said she notified Family Member #1 	Resident #1 arrived at the Hospital Eme ling to allow Resident #1 to return and acility told her that Resident #1 was dis 6/22 she went to the Facility and met w Member #1 said that the Administrator that the Facility had mailed her paperw ne at the Facility told her that Resident eing transferred to the hospital. Family by in the mail related to Resident #1's d ad her a copy of the Notice of Intent No 0:32 A.M., the Director of Social Servic n the Facility discharged Resident #1 to 2:05 P.M., Nurse #1 said that she work 1 of Resident #1's transfer to the Hospi dent #1 was being discharged by the Fa	had discharged him/her. Family charged , and would not be ith the Administrator and the told her that Resident #1 had been ork. Family Member #1 said that #1 was being discharged when Member #1 said she never ischarge. Family Member #1 said t to Readmit Resident #1 that was es said that she did not speak to the hospital. and at the Facility on 8/14/22 and tal. Nurse #1 said that she did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/21/2022
NAME OF PROVIDER OR SUPPLIER Tremont Rehabilitation & Skilled Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 605 Main Street Wareham, MA 02571	
For information on the nursing home's	plan to correct this deficiency, please con	act the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0626 Level of Harm - Actual harm Residents Affected - Few	 bed-hold policy. 15203 Based on interviews and records readmitted to the Facility with a histor reacting aggressively in loud and mereacting aggressively in loud and meresident altercation. As a result of the resident altercation. As a result of the remained in the Hospital ED for 19 Findings include: Review of the Resident [NAME] of 1 remain in the Facility and would not Policy indicated that Federal and Sineeds and welfare cannot be met ir and safety of other residents is end Review of Resident #1's medical in stay at a Geriatric Psychiatric Hosp contained in Resident #1's screenir following: The Emergency Department Docu department from a nursing home af the special for behavioral problems ov his/her previous nursing home for sing Resident #1's behavior was so differed behavior was situational rather The Hospital Nursing Progress No patients at times and became upse The Hospital Discharge Summary, aphasic (a disorder which affects her for his/her name, date of birth, and 	dicated that he/she was admitted to the ital. Review of documents from the Ge ig by the Facility, prior to his/her admis ment, dated 6/13/22, indicated Reside ter having punched a nursing home re 14/22 indicated that Resident #1 had a er the past few years and had been se triking a resident. The History and Phy rent at the hospital (happy and conten	hts (Resident #1), who been residents and had a history of mit Resident #1 to return to the n 8/14/22 following a resident to o return to the Facility, he/she alternative placement for him/her. ed that residents had the right to it as provided by Federal law. The or discharge when the resident's h has improved or when the health e Facility during June 2022 after a riatric Psychiatric Hospital ssion to the Facility, revealed the int #1 presented to the emergency sident in the face. a number of admissions to the int to the hospital on 6/13/22 from rsical indicated that because t), it was suspected that his/her ent #1 was noted to dislike other ner at times. was pleasantly confused and e, was able to answer yes and ok ical speech and a few clear words.

 Symptoms, a goal for fewer symptoms, and interventions included assessing internal and external contributors. Review of the Resident to Resident Investigation Reports for Resident #1 indicated he/she was involve the following resident to resident incidents while at the Facility: on 7/27/22, Resident #1 hit Resident #4 in the face with a pillow, on 8/11/22, Resident #1 slapped Resident #5's face, and, on 8/14/22, Resident #1 hit Resident #2 on the right shoulder. During an interview on 9/20/22 at 9:05 A.M., Family Member #1 (Resident #1's Health Care Agent), s on 8/14/22, Facility staff members notified her that Resident #1 was being transferred to the hospital the/she swatted at a resident standing near the nurses station. Family Member #1 said that once Resi was in the ED and did not require hospitalization , the Facility was unwilling to allow Resident #1 re Family Member #1 said that on 8/16/22 she went to the Facility and spoke to the Administrator, who the facility and spoke to the Administrator. 	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/21/2022	
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) F 0626 (Each deficiency must be preceded by full regulatory or LSC identifying information) F 0626 Indicated that his/her cognitive patterns were severely impaired and he/she ambulated with supervisit MDS indicated that his/her cognitive patterns were severely impaired and he/she ambulated with supervisit MDS indicated that Resident #1 was sometimes able to understand others and could sometimes make him/herself understood by others. Review of Resident #1's Baseline Care Plan, dated 6/24/22, identified a concern regarding Behaviora Symptoms, agoal for fewer symptoms, and interventions included assessing internal and external contributors. Review of the Resident to Resident Investigation Reports for Resident #1 indicated he/she was involu- the following resident to resident incidents while at the Facility: - on 7/27/22, Resident #1 hit Resident #4 in the face with a pillow, - on 8/14/22, Resident #1 hit Resident #2 on the right shoulder. During an interview on 9/20/22 at 9:05 A.M., Family Member #1 (Resident #1's Health Care Agent), s on 8/14/22, Resident #1 hit Resident #2 on the right shoulder. During an interview on 9/20/22 at 9:05 A.M., Family Member #1 said that on core Resi was in the Emergency Department (ED), hospital staff said that although Resident #1 had no behavior is uses in the ED and rid (or tequire hospital istaff) and though Resident #1 had no behavior was in the Emergency Department (ED), hospital staff said that although Resident #1 had no behavior is uses a boot that's Cognitive deficits and aphasia limited the degree to which he/she could exprein- enanguish spending that			605 Main Street		
(Each deficiency must be preceded by full regulatory or LSC identifying information) F 0626 Level of Harm - Actual harm Resident #1's most recent Admission Minimum Data Set Assessment (MDS), dated as completed 9/3 indicated that his/her cognitive patterns were severely inpaired and he/she ambulated with supervisit MDS indicated that his/her cognitive patterns were severely inpaired and he/she ambulated with supervisit MDS indicated that his/her cognitive patterns were severely inpaired and he/she ambulated with supervisit MDS indicated that his/her cognitive patterns were severely inpaired and he/she ambulated with supervisit MDS indicated that his/her cognitive patterns were severely inpaired and he/she and cold sometimes make him/herself understood by others. Review of Resident #1's Baseline Care Plan, dated 6/24/22, identified a concern regarding Behaviora Symptoms, an goal for fewer symptoms, and interventions included assessing internal and external contributors. Review of the Resident to resident Investigation Reports for Resident #1 indicated har hyper resident to resident the facility: on 7/27/22, Resident #1 hit Resident #4 in the face with a pillow, on 8/11/22, Resident #1 hit Resident #2 on the right shoulder. During an interview on 9/20/22 at 9/05 A.M., Family Member #1 (Resident #1's Health Care Agent), is so (11/422, Facility aff members notified her that Resident #1 was being transferred to the hospital tait he/she swatted at a resident standing near the nurses station. Then you multing to allow Resident #1 had been discharged to the hospital staff said that although Resident #1 had no behavior is uses in the ED and did not require hospital staff said that although Resident #1 had been discharged to the hospital staff said that a	or information on the nursing home's p	plan to correct this deficiency, please cont	tact the nursing home or the state survey	agency.	
Level of Harm - Actual harm indicated that his/her cognitive patterns were severely impaired and hei/she jambulated with supervisit. Residents Affected - Few Review of Resident #1's Baseline Care Plan, dated 6/24/22, identified a concern regarding Behaviora Symptoms, a goal for fewer symptoms, and interventions included assessing internal and external contributors. Review of the Resident to Resident Investigation Reports for Resident #1 indicated he/she was involv the following resident to resident incidents while at the Facility: - on 8/11/22, Resident #1 hit Resident #2 on the right shoulder. During an interview on 9/20/22 at 9:05 A.M., Family Member #1 (Resident #1's Health Care Agent), s on 8/14/22, Resident #1 hit Resident #2 on the right shoulder. During an interview on 9/20/22 at 9:05 A.M., Family Member #1 (Resident #1's Health Care Agent), s on 8/14/22, Facility staff members notified her that Resident #1 was benident #1 had no behavior issues in the ED and did not require hospital atfi said that although Resident #1 had no behavior issues in the ED for 19 days while the ED searched for alternate placement. Although Resident #1 had been discharged to the hospital atfi said that ellowing resident #1 said Res remained in the ED for 19 days, an unimparied individual would experience anguish spending that length of time in a Hospital Emergency Department, which is not intended or d for long-term care placement of a resident than existen the reality discharged Resident #1 was beinger discharged bin/her/22 at 0.10 A.M., the Administrator, who the the ED on 8/14/22. Following his/her third resident to resident incident at the Facility. The Administrator, who the ED on 8/14/22 aresident #1 was a young resident whore quise musing home care. <td>4) ID PREFIX TAG</td> <td colspan="2"></td> <td>on)</td>	4) ID PREFIX TAG			on)	
 Review of Resident #1's Baseline Care Plan, dated 6/24/22, identified a concern regarding Behaviora Symptoms, a goal for fewer symptoms, and interventions included assessing internal and external contributors. Review of the Resident to Resident Investigation Reports for Resident #1 indicated he/she was involute following resident to resident incidents while at the Facility: on 7/27/22, Resident #1 hit Resident #4 in the face with a pillow, on 8/14/22, Resident #1 slapped Resident #5's face, and, on 8/14/22, Resident #1 hit Resident #2 on the right shoulder. During an interview on 9/20/22 at 9:05 A.M., Family Member #1 (Resident #1's Health Care Agent), s on 0/14/22, Facility slaff members notified ther that Resident #1 was being transferred to the hospital the/she swatted at a resident standing near the nurses station. Family Member #1 said that once Resile is in the Emergency Department (ED), hospital staff said that although Resident #1 had been discharged to the hospital over the weekend. Family Member #1 said Res remained in the ED for 19 days while the ED searched for alternate placement. Although Resident #1's cognitive deficits and aphasia limited the degree to which he/she could exprese his/her feelings about having been in the ED for 19 days, an unimpaired individual would experience anguish spending that length of time in a Hospital resident state the Facility. The Administrater deficits and synage resident incident at the Facility. The Administrater that because Resident #1 was a younger resident, was strong, able to ambulate independently, and for alternative on 9/20/22 at 11:50 A.M., the Director of Nursing said that the Facility and specified regarding his/her feelings about having been in the ED for 19 days, an unimpaired individual would experience in anguish spending that length of time in a Hospital Erreference in anguish spending that length of time the resident funcient at the Facility. The Administrater tha because R	evel of Harm - Actual harm	indicated that his/her cognitive patte MDS indicated that Resident #1 wa	erns were severely impaired and he/sh	e ambulated with supervision. Th	
 the following resident to resident incidents while at the Facility: on 7/27/22, Resident #1 hit Resident #4 in the face with a pillow, on 8/11/22, Resident #1 slapped Resident #5's face, and, on 8/14/22, Resident #1 hit Resident #2 on the right shoulder. During an interview on 9/20/22 at 9:05 A.M., Family Member #1 (Resident #1's Health Care Agent), s on 8/14/22, Resident #1 hit Resident #2 on the right shoulder. During an interview on 9/20/22 at 9:05 A.M., Family Member #1 (Resident #1's Health Care Agent), s on 8/14/22, Facility staff members notified her that Resident #1 was being transferred to the hospital her/she swatted at a resident standing near the nurses station. Family Member #1 said that once Resi was in the Emergency Department (ED), hospital staff said that although Resident #1 had no behavior issues in the ED and did not require hospitalization, the Facility and spoke to the Administrator, who t that Resident #1 had been discharged to the hospital over the weekend. Family Member #1 said Res remained in the ED for 19 days while the ED searched for alternate placement. Although Resident #1's cognitive deficits and aphasia limited the degree to which he/she could expret his/her feelings about having been in the ED for 19 days, an unimpaired individual would experience i anguish spending that length of time in a Hospital Emergency Department, which is not intended or d for long-term care placement of a resident who requires nursing home care. During an interview on 9/20/22 at 10:10 A.M., the Administrator said that the Facility discharged Resit to the ED on 8/14/22 following his/her third resident to resident incident at the Facility. The Administrat that because Resident #1 was a younger resident, was strong, able to ambulate independently, and Facility and discharged him/her to the ED. During an interview on 9/21/22 at 11:50 A.M., the Director of Nursing said she was not aware of the documentation in Resident#1's medi					
 - on 8/11/22, Resident #1 slapped Resident #5's face, and, - on 8/14/22, Resident #1 hit Resident #2 on the right shoulder. During an interview on 9/20/22 at 9:05 A.M., Family Member #1 (Resident #1's Health Care Agent), s on 8/14/22, Facility staff members notified her that Resident #1 was being transferred to the hospital a he/she swatted at a resident standing near the nurses station. Family Member #1 said that once Resive was in the Emergency Department (ED), hospital staff said that although Resident #1 had no behavior issues in the ED and did not require hospitalization , the Facility was unwilling to allow Resident #1 had no behavior issues in the ED for 19 days while the ED searched for alternate placement. Although Resident #1's cognitive deficits and aphasia limited the degree to which he/she could experension in the ED for 19 days, an unimpaired individual would experience i anguish spending that length of time in a Hospital Emergency Department, which is not intended or d for long-term care placement of a resident who requires nursing home care. During an interview on 9/20/22 at 10:10 A.M., the Administrator said that the Facility discharged Resident to the ED on 8/14/22 following his/her third resident to resident incident at the Facility. The Administrat that because Resident #1 was a younger resident, was strong, able to ambulate independently, and h known triggers for his/her aggressive behaviors, that they determined he/she could not be cared for a Facility and discharged him/her to the ED. During an interview on 9/21/22 at 11:50 A.M., the Director of Nursing said she was not aware of the documentation in Resident#1's medical record from the referring hospital regarding his/her history of aggression toward other residents. The Director of Nursing said that she became aware of Resident #1 with a pilow. The Director of Nurses said that the even no known triggers for Resident #1 sedical record from the referring hospital regarding his/her histo		Review of the Resident to Resident Investigation Reports for Resident #1 indicated he/she was involved in the following resident to resident incidents while at the Facility:			
 on 8/14/22, Resident #1 hit Resident #2 on the right shoulder. During an interview on 9/20/22 at 9:05 A.M., Family Member #1 (Resident #1's Health Care Agent), s on 8/14/22, Facility staff members notified her that Resident #1 was being transferred to the hospital he/she swatted at a resident standing near the nurses station. Family Member #1 said that once Resident standing near the nurses station. Family Member #1 said that once Resident standing near the nurses station. Family Member #1 said that on behavior issues in the ED and did not require hospitalization , the Facility was unwilling to allow Resident #1 ned behavior issues in the ED and did not require hospitalization , the Facility and spoke to the Administrator, who t that Resident #1 had been discharged to the hospital over the weekend. Family Member #1 said Res remained in the ED for 19 days while the ED searched for alternate placement. Although Resident #1's cognitive deficits and aphasia limited the degree to which he/she could experience in system fact graving been in the ED for 19 days, an unimpaired individual would experience in anguish spending that length of time in a Hospital Emergency Department, which is not intended or d for long-term care placement of a resident who requires nursing home care. During an interview on 9/20/22 at 10:10 A.M., the Administrator said that the Facility. The Administrat that because Resident #1 was a younger resident, was strong, able to ambulate independently, and h known triggers for his/her aggressive behaviors, that they determined he/she could not be cared for a Facility and discharged him/her to the ED. During an interview on 9/21/22 at 11:50 A.M., the Director of Nursing said she was not aware of the documentation in Resident#1's medical record from the referring hospital regarding his/her history of aggression toward other residents. The Director of Nursing said that the became aware of Resident # potential for aggressive behavior toward other residents aft		- on 7/27/22, Resident #1 hit Resident #4 in the face with a pillow,			
 During an interview on 9/20/22 at 9:05 A.M., Family Member #1 (Resident #1's Health Care Agent), s on 8/14/22, Facility staff members notified her that Resident #1 was being transferred to the hospital a he/she swatted at a resident standing near the nurses station. Family Member #1 said that once Resi was in the Emergency Department (ED), hospital staff said that although Resident #1 had no behavior issues in the ED and did not require hospitalization , the Facility was unwilling to allow Resident #1 re Family Member #1 said that on 8/16/22 she went to the Facility and spoke to the Administrator, who t that Resident #1 had been discharged to the hospital over the weekend. Family Member #1 said Res remained in the ED for 19 days while the ED searched for alternate placement. Although Resident #1's cognitive deficits and aphasia limited the degree to which he/she could exprese his/her feelings about having been in the ED for 19 days, an unimpaired individual would experience i anguish spending that length of time in a Hospital Emergency Department, which is not intended or d for long-term care placement of a resident who requires nursing home care. During an interview on 9/20/22 at 10:10 A.M., the Administrator said that the Facility discharged Reside to the ED on 8/14/22 following his/her third resident to resident incident at the Facility. The Administration that because Resident #1 was a younger resident, was strong, able to ambulate independently, and I known triggers for his/her aggressive behaviors, that they determined he/she could not be cared for a Facility and discharged him/her to the ED. During an interview on 9/21/22 at 11:50 A.M., the Director of Nursing said she was not aware of the documentation in Resident#1's medical record from the referring hospital regarding his/her history of aggression toward other residents. The Director of Nursing said that she became aware of Resident #1 because avait of the residents. The Director of Nursing said that she be		- on 8/11/22, Resident #1 slapped F	Resident #5's face, and,		
 on 8/14/22, Facility staff members notified her that Resident #1 was being transferred to the hospital a he/she swatted at a resident standing near the nurses station. Family Member #1 said that once Resi was in the Emergency Department (ED), hospital staff said that although Resident #1 had no behavior issues in the ED and did not require hospitalization , the Facility was unwilling to allow Resident #1 re Family Member #1 said that on 8/16/22 she went to the Facility and spoke to the Administrator, who t that Resident #1 had been discharged to the hospital over the weekend. Family Member #1 said Res remained in the ED for 19 days while the ED searched for alternate placement. Although Resident #1's cognitive deficits and aphasia limited the degree to which he/she could expres his/her feelings about having been in the ED for 19 days, an unimpaired individual would experience to anguish spending that length of time in a Hospital Emergency Department, which is not intended or d for long-term care placement of a resident who requires nursing home care. During an interview on 9/20/22 at 10:10 A.M., the Administrator said that the Facility discharged Resid to the ED on 8/14/22 following his/her third resident to resident incident at the Facility. The Administrat that because Resident #1 was a younger resident, was strong, able to ambulate independently, and f known triggers for his/her aggressive behaviors, that they determined he/she could not be cared for a Facility and discharged him/her to the ED. During an interview on 9/21/22 at 11:50 A.M., the Director of Nursing said she was not aware of the documentation in Resident#1's medical record from the referring hospital regarding his/her history of aggression toward other residents. The Director of Nursing said that she became aware of Resident # potential for aggressive behavior toward other residents after the incident on 7/27/22 in which Reside Resident #4 with a pillow. The Director of Nurses said that there were no		- on 8/14/22, Resident #1 hit Resident #2 on the right shoulder.			
 that Resident #1 had been discharged to the hospital over the weekend. Family Member #1 said Res remained in the ED for 19 days while the ED searched for alternate placement. Although Resident #1's cognitive deficits and aphasia limited the degree to which he/she could experience this/her feelings about having been in the ED for 19 days, an unimpaired individual would experience to anguish spending that length of time in a Hospital Emergency Department, which is not intended or d for long-term care placement of a resident who requires nursing home care. During an interview on 9/20/22 at 10:10 A.M., the Administrator said that the Facility discharged Reside to the ED on 8/14/22 following his/her third resident to resident incident at the Facility. The Administrat that because Resident #1 was a younger resident, was strong, able to ambulate independently, and h known triggers for his/her aggressive behaviors, that they determined he/she could not be cared for a Facility and discharged him/her to the ED. During an interview on 9/21/22 at 11:50 A.M., the Director of Nursing said she was not aware of the documentation in Resident#1's medical record from the referring hospital regarding his/her history of aggression toward other residents. The Director of Nursing said that she became aware of Resident # potential for aggressive behavior toward other residents after the incident on 7/27/22 in which Resider Resident #4 with a pillow. The Director of Nurses said that there were no known triggers for Resident 		on 8/14/22, Facility staff members r he/she swatted at a resident standin was in the Emergency Department	notified her that Resident #1 was being ng near the nurses station. Family Mer (ED), hospital staff said that although I	transferred to the hospital after nber #1 said that once Resident # Resident #1 had no behavioral	
 his/her feelings about having been in the ED for 19 days, an unimpaired individual would experience of anguish spending that length of time in a Hospital Emergency Department, which is not intended or d for long-term care placement of a resident who requires nursing home care. During an interview on 9/20/22 at 10:10 A.M., the Administrator said that the Facility discharged Resid to the ED on 8/14/22 following his/her third resident to resident incident at the Facility. The Administrat that because Resident #1 was a younger resident, was strong, able to ambulate independently, and h known triggers for his/her aggressive behaviors, that they determined he/she could not be cared for a Facility and discharged him/her to the ED. During an interview on 9/21/22 at 11:50 A.M., the Director of Nursing said she was not aware of the documentation in Resident#1's medical record from the referring hospital regarding his/her history of aggressive behavior toward other residents after the incident on 7/27/22 in which Reside Resident #4 with a pillow. The Director of Nurses said that there were no known triggers for Resident 		Family Member #1 said that on 8/16/22 she went to the Facility and spoke to the Administrator, who told her that Resident #1 had been discharged to the hospital over the weekend. Family Member #1 said Resident # remained in the ED for 19 days while the ED searched for alternate placement.			
 to the ED on 8/14/22 following his/her third resident to resident incident at the Facility. The Administrat that because Resident #1 was a younger resident, was strong, able to ambulate independently, and h known triggers for his/her aggressive behaviors, that they determined he/she could not be cared for a Facility and discharged him/her to the ED. During an interview on 9/21/22 at 11:50 A.M., the Director of Nursing said she was not aware of the documentation in Resident#1's medical record from the referring hospital regarding his/her history of aggression toward other residents. The Director of Nursing said that she became aware of Resident #4 with a pillow. The Director of Nurses said that there were no known triggers for Resident 		his/her feelings about having been anguish spending that length of tim	in the ED for 19 days, an unimpaired in e in a Hospital Emergency Departmen	ndividual would experience menta t, which is not intended or designe	
documentation in Resident#1's medical record from the referring hospital regarding his/her history of aggression toward other residents. The Director of Nursing said that she became aware of Resident # potential for aggressive behavior toward other residents after the incident on 7/27/22 in which Reside Resident #4 with a pillow. The Director of Nurses said that there were no known triggers for Resident		to the ED on 8/14/22 following his/h that because Resident #1 was a yo known triggers for his/her aggressiv	ner third resident to resident incident at unger resident, was strong, able to am /e behaviors, that they determined he/s	the Facility. The Administrator saturation but the facility. The Administrator saturate independently, and had no	
		documentation in Resident#1's med aggression toward other residents. potential for aggressive behavior to Resident #4 with a pillow. The Direct	dical record from the referring hospital The Director of Nursing said that she to ward other residents after the incident	regarding his/her history of became aware of Resident #1's on 7/27/22 in which Resident #1	
(continued on next page)		(continued on next page)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/21/2022	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE	
Tremont Rehabilitation & Skilled Care Center		605 Main Street Wareham, MA 02571		
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		ion)	
F 0626 Level of Harm - Actual harm	because Resident #1's aggression	bugh the Administrator and Director of Nurses said that the Facility discharged Resident #1 to the ED use Resident #1's aggression was without any kind of trigger, staff members said that his/her ession toward other residents was triggered by loud sounds, noises or commotion.		
Residents Affected - Few	During interviews on:			
	- 9/20/22 at 11:40 A.M. with CNA #	1,		
	- 9/20/22 at 12:05 P.M. with Nurse #1,			
	- 9/20/22 at 12:51 P.M. with the Unit Manager,			
	- 9/20/22 at 1:30 P.M. with the Scheduler, and			
	- 9/21/22 at 9:35 A.M. with Nurse #2,			
	CNA #1, Nurse #1, the Unit Manager, the Scheduler and Nurse #2 said Resident #1's aggression was triggered by noises, loud sounds or circumstances when there was a lot of commotion.			
	The Director of Nurses said that following the altercations between Resident #1 and other residents on 7/27/22 and 8/11/22, the Facility implemented additional care plan interventions for Resident #1.			
		ined a Care Plan related to Behavior F it was dated as initiated 7/17/22 and s	0	
	The Director of Nursing said that she reviewed the Care Plan related to Behavior Problems in Resident #1's electronic health record and confirmed that it was initiated 7/17/22, but said the interventions dated as initiated on 7/17/22, were actually put into place and initiated on 7/27/22.			
		Behavior Problems and diagnosis of do s, shoves, scratches, grabs, bites, kick		
	- administering medications			
	- monitoring the side effects of med	lication		
	- anticipating care needs before Resident #1 became overly stressed			
	- providing for care needs before Resident #1 became overly stressed			
	- explaining care in advance			
	- intervening to protect the rights and safety of others			
	- approaching in a calm manner			
	(continued on next page)			
	· · · · · · · · · · · · · · · · · · ·			

	1	1	1
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. Building	(X3) DATE SURVEY COMPLETED 09/21/2022
	225488	B. Wing	09/21/2022
NAME OF PROVIDER OR SUPPLI	ER	STREET ADDRESS, CITY, STATE, ZI	IP CODE
Tremont Rehabilitation & Skilled Care Center		605 Main Street Wareham, MA 02571	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by		CIENCIES full regulatory or LSC identifying informati	ion)
F 0626	- diverting attention		
Level of Harm - Actual harm	- removing from situations and take	e to another location as needed.	
Residents Affected - Few	Resident #1's Care Plan related to 8/11/22. Additional interventions in	Behavioral Problems indicated addition cluded the following:	nal interventions were initiated
	- to be sure staff were present duri	ng times Resident #1 spent in the dinin	ig room
	- educate Resident #1 and his/her interventions	responsible party on the causal factors	of behaviors and planned
	- discuss behaviors		
	- reinforce why behaviors are unacceptable.		
	identified that his/her aggression w	#1 with a known history of aggression f ras triggered by loud sounds, noises or e ED on 8/14/22 following an evaluatio ad for alternate placement.	commotion, the Facility refused to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/21/2022	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE	
Tremont Rehabilitation & Skilled Care Center		605 Main Street Wareham, MA 02571		
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		ion)	
F 0656 Level of Harm - Minimal harm or potential for actual harm	Develop and implement a complete care plan that meets all the resident's needs, with timetables and act that can be measured. 15203		needs, with timetables and actions	
Residents Affected - Few	interviews exhibited aggressive bel commotion, during July and August Plan included the identified triggers	eviewed, for one of five sampled reside haviors toward residents in response to t 2022, the Facility failed to ensure Res s, and that interventions were develope ent #1's mental and psychosocial care	o loud sounds, noises or sident #1's Comprehensive Care d and implemented related to these	
	Findings include:			
	Review of the Facility Care Plan-Baseline, undated, indicated that the Baseline Care Plan was developed within forty eight hours of admission based on information obtained during the admission process as a guide for care until the comprehensive care plan is developed. The Policy indicated that the Baseline Care Plan process included review of the inquiry and transfer information.			
	Review of the Facility Resident Assessment and Care Plan Policy, dated April 2015, indicated that the Facility is committed to providing residents with all necessary care and services to enable them to achieve the highest quality of life. The Policy indicated that assessments and care plans are oriented toward preventing avoidable decline in clinical and functional levels, and reflect resident preference and right to refuse certain services or treatment.			
	Review of Resident #1's medical record indicated that he/she was admitted to the Facility during June 2022 after a stay at a Geriatric Psychiatric Hospital. Review of documents from the Geriatric Psychiatric Hospital contained in Resident #1's screening by the Facility prior to his/her admission to the Facility revealed the following:			
		ment, dated 6/13/22, indicated Reside fter having punched a resident in the fa		
	the hospital for behavioral problems from his/her previous nursing home Resident #1's behavior was so diffe	e Hospital History and Physical, dated 6/14/22 indicated that Resident #1 had a number of admissions to hospital for behavioral problems over the past few years and had been sent to the hospital on 6/13/22 n his/her previous nursing home for striking a resident. The History and Physical indicated that because sident #1's behavior was so different at the hospital (happy and content), it was suspected that his/her behavior was situational rather than related to medications.		
	-The Hospital Nursing Progress Note, dated 6/16/22, indicated that Resident #1 was noted to dislike other patients at times and became upset with them for being too close to him/her at times.			
	aphasic (a disorder which affects h	, dated 6/24/22, indicated Resident #1 ow a person communicates) at baselin th and responded to questions with nor	e and was able to answer yes and	
	(continued on next page)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/21/2022	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE	
Tremont Rehabilitation & Skilled Care Center		605 Main Street Wareham, MA 02571		
For information on the nursing home's	plan to correct this deficiency, please con	l tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)	
F 0656 Level of Harm - Minimal harm or potential for actual harm	Review of Resident #1's Baseline Care Plan, dated as initiated 6/24/22, indicated a concern regarding Behavioral Symptoms, a goal for fewer symptoms, and interventions included assessing internal and external contributors.			
Residents Affected - Few	 Review of Resident #1's medical record indicated that the most recent Admission Minimum Data Assessment (MDS), completed 6/30/22, indicated that his/her cognitive patterns were severely in he/she ambulated with supervision. The MDS indicated that Resident #1 was sometimes able to others and could sometimes make him/herself understood by others. During an interview on 9/21/22 at 11:50 A.M., the Director of Nursing said that she was not the p screened Resident #1 for admission to the Facility and said she was unaware of the documental clinical record from the referring hospital regarding his/her history of behavioral problems, includ aggression toward residents. The Director of Nursing said that she was not aware of Resident # for aggressive behaviors directed toward other residents until he/she was involved in a resident incident on 7/27/22. 			
	Review of the Resident to Resident observed hitting Resident #4 in the	ndicated that Resident #1 was		
	During an interview on 9/20/22 at 1 Resident #1 hit Resident #4 in the 1 Resident #4 in the face with a pillow be quiet.	hat she thought Resident #1 hit		
	Resident #1's medical record conta dementia. The Care Plan indicated having been initiated on 7/17/22.			
	Care Plan related to Behavior Prob	owever, the Director of Nursing said Resident #1's Care Plan was dated incorrectly, that she reviewed the are Plan related to Behavior Problems in Resident #1's electronic health record and confirmed that it was in ict initiated on 7/17/22, but that the interventions dated as initiated on 7/17/22, were actually put into place nitiated) on 7/27/22.		
	Resident #1's Care Plan related to Behavior Problems and diagnosis of dementia indicated that Resident #1 could be physically abusive and hits, shoves, scratches, grabs, bites, kicks and slaps. Interventions included the following;			
	- administering medications			
	- monitoring the side effects of medication			
	- anticipating care needs before Resident #1 became overly stressed			
	- providing for care needs before Resident #1 became overly stressed			
	- explaining care in advance			
	- intervening to protect the rights and safety of others			
	(continued on next page)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. Building	(X3) DATE SURVEY COMPLETED
	225488	B. Wing	09/21/2022
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	
Tremont Rehabilitation & Skilled Care Center		605 Main Street Wareham, MA 02571	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		ion)
F 0656	- approaching in a calm manner		
Level of Harm - Minimal harm or potential for actual harm	- diverting attention		
' Residents Affected - Few	- removing from situations and take	e to another location as needed.	
	Review of the Resident to Resident observed to slap Resident #5 acros	t Investigation Report, dated 8/11/22, ir ss the face.	ndicated that Resident #1 was
	During interviews on 9/20/22 at 12:51 P.M. with the Unit Manager and on 9/21/22 at 9:35 A.M. with Nurse #2, the Unit Manager and Nurse #2 said that they saw Resident #1 slap Resident #5 on 8/11/22. The Unit Manager and Nurse #2 said Resident #5 had been crying loudly in the dining room before Resident #1 slapped him/her. The Unit Manager and Nurse #2 said they thought Resident #1 slapped Resident #5 because he/she was triggered by loud sounds and Resident #5 had been crying loudly. The Unit Manager said Resident #1 was irritated by sounds and was unable to verbalize his/her irritation due to aphasia. Nurse #2 said Resident #1 would become agitated in response to any commotion on the Unit.		
	Resident #1's Care Plan related to Behavioral Problems indicated additional interventions were initiated 8/11/22. Additional interventions included the following:		
	- to be sure staff were present durin	ng times Resident #1 spent in the dinin	g room
	- educate Resident #1 and his/her interventions	responsible party on the causal factors	of behaviors and planned
	- discuss behaviors		
	- reinforce why behaviors are unac	ceptable.	
	Review of the Resident to Resident Incident Report and Investigation, dated 8/14/22, indicated that Resident #1 hit Resident #2 on the right shoulder.		
	During interviews on 9/20/22 at 11:40 A.M. with CNA #1 and on 9/20/22 at 12:05 P.M. with Nurse #1, CNA #1 and Nurse #1 said they saw Resident #1 hit Resident #2 with a clothes hanger on his/her arm on 8/14/22. CNA #1 and Nurse #1 said that Resident #2 had been yelling and talking loudly at the nurses station and they thought Resident #1's aggressive behavior was triggered by Resident #2's loud sounds and yelling.		
	The Scheduler, the Unit Manager, Nurses #1 and #2 and CNA #1 said Resident #1's aggression was triggered by loud sounds, noisy environments or commotion.		
	Review of Resident #1's medical record, dated June 2022 through August 2022, indicated there was no documentation to support that the Facility developed a Care Plan to address Resident #1's potential for aggressive response to loud sounds, the noisy environment or commotion.		
	The Director of Nurses said that she was not aware that Resident #1's behaviors were triggered by loud sounds, noise or commotion.		
	(continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/21/2022
NAME OF PROVIDER OR SUPPLIER Tremont Rehabilitation & Skilled Care Center		STREET ADDRESS, CITY, STATE, ZI 605 Main Street Wareham, MA 02571	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying information	on)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few		:40 A.M., the Administrator said that he on and resident to resident altercations.	