STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225488	A. Building B. Wing	09/21/2022

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

For information on the nursing home's plan to correct this deficiency, please contact 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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 15203 Based on interviews and records reviewed, for one of five sampled residents (Resident #1), who had an activated Health Care Proxy and on 8/14/22 required transfer to the Hospital Emergency Department for a psychiatric and medical evaluation for a possible change in mental status, the Facility failed to ensure his/her representative/Health Care Agent (Family Member #1) was notified that he/she had been discharged from the Facility. Findings include: Review of the Admission Agreement, undated, indicated that the Facility would notify the resident's representative of a resident's discharge. The Agreement indicated the circumstance for which the Facility would initiate discharge and indicated that the resident had the right to appeal the Facility's discharge. During an interview on 10/07/22 at 8:30 A.M., the Director of Nurses said that Resident #1's Health Care Proxy was activated 6/24/22. Review of Resident #1's Health Care Proxy Form indicated Family Member #1 was Resident #1's Health Care Agent. Review of Resident #1's medical record indicated that the most recent Admission Minimum Data Set Assessment (MDS), dated as completed 6/30/22, indicated that his/her cognitive patterns were severely impaired. Review of Resident #1's Progress Note, dated 8/14/22 written by Nurse #1, indicated that at approximately 12:55 P.M., Resident #1 became combative with another resident and hit the other resident on the right shoulder. The Note indicated that Resident #1 was sent to the Hospital. The Note indicated that Family Member #1 was notified. During an interview on 9/20/22 at 9:05 A.M., Family Member #1 (Resident #1's Health Care Agent), said that on 8/14/22, Facility staff members notified her that Resident #1 was sent to the Hospital after he/she swatted at a resident standing near the nurses station. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Family Member #1 said that after Resident #1 arrived at the Hospital Emergency Department, hospital staff told her that the Facility was not willing to allow Resident #1 to return and had discharged him/her. Family Member #1 said no one from the Facility told her that Resident #1 was discharged , and would not be allowed to return. Family Member #1 said that on 8/16/22 she went to the Facility and met with the Administrator and the Director of Social Services. Family Member #1 said that the Administrator told her that Resident #1 had been discharged over the weekend and that the Facility had mailed her paperwork. Family Member #1 said that she told the Administrator that no one at the Facility told her that Resident #1 was being discharged when they notified her that he/she was being transferred to the hospital. Family Member #1 said she never received paperwork from the Facility in the mail related to Resident #1's discharge. Family Member #1 said on 8/24/22 the Ombudsman emailed her a copy of the Notice of Intent Not to Readmit Resident #1 that was dated 8/14/22. During an interview on 9/22/22 at 10:32 A.M., the Director of Social Service said that she did not speak to Family Member #1 on 8/14/22 when the Facility discharged Resident #1 to the hospital. During an interview on 9/21/22 at 12:05 P.M., Nurse #1 said that she worked at the Facility on 8/14/22 and said she notified Family Member #1 of Resident #1's transfer to the Hospital. Nurse #1 said that she did not notify Family Member #1 that Resident #1 was being discharged by the Facility to the hospital.

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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 0626 Level of Harm - Actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. 15203 Based on interviews and records reviewed for one of five sampled residents (Resident #1), who been admitted to the Facility with a history of physical aggression toward other residents and had a history of reacting aggressively in loud and noisy situations, the Facility failed to permit Resident #1 to return to the Facility after an evaluation in the Hospital Emergency Department (ED) on 8/14/22 following a resident to resident altercation. As a result of the Facility not permitting Resident #1 to return to the Facility, he/she remained in the Hospital ED for 19 days, while the Hospital searched for alternative placement for him/her. Findings include: Review of the Resident [NAME] of Rights Policy, dated July 2021, indicated that residents had the right to remain in the Facility and would not be discharged from the Facility except as provided by Federal law. The Policy indicated that Federal and State law permitted involuntary transfer or discharge when the resident's needs and welfare cannot be met in the Facility, when the resident's health has improved or when the health and safety of other residents is endangered. Review of Resident #1's medical 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: -The Emergency Department Document, dated 6/13/22, indicated Resident #1 presented to the emergency department from a nursing home after having punched a nursing home resident in the face. -The History and Physical, dated 6/14/22 indicated that Resident #1 had a number of admissions to the hospital for behavioral problems over the past few years and had been sent to the hospital on 6/13/22 from his/her previous nursing home for striking a resident. The History and Physical indicated that because Resident #1's behavior was so different at the hospital (happy and content), it was suspected that his/her bad 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. -The Hospital Discharge Summary, dated 6/24/22, indicated Resident #1 was pleasantly confused and aphasic (a disorder which affects how a person communicates) at baseline, was able to answer yes and ok for his/her name, date of birth, and responded to questions with non-sensical speech and a few clear words. During an interview on 10/07/22 at 8:30 A.M., the Director of Nursing said that Resident #1's Health Care Proxy was activated 6/24/22. (continued on next page)

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F 0626 Level of Harm - Actual harm Residents Affected - Few	Resident #1's most recent Admission Minimum Data Set Assessment (MDS), dated as completed 6/30/22, indicated that his/her cognitive patterns were severely impaired and he/she ambulated with supervision. The 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 Behavioral 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 involved in 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), said that on 8/14/22, Facility staff members notified her that Resident #1 was being transferred to the hospital after he/she swatted at a resident standing near the nurses station. Family Member #1 said that once Resident #1 was in the Emergency Department (ED), hospital staff said that although Resident #1 had no behavioral issues in the ED and did not require hospitalization , the Facility was unwilling to allow Resident #1 return. 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 #1 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 express his/her feelings about having been in the ED for 19 days, an unimpaired individual would experience mental anguish spending that length of time in a Hospital Emergency Department, which is not intended or designed 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 #1 to the ED on 8/14/22 following his/her third resident to resident incident at the Facility. The Administrator said that because Resident #1 was a younger resident, was strong, able to ambulate independently, and had no known triggers for his/her aggressive behaviors, that they determined he/she could not be cared for at the 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's potential for aggressive behavior toward other residents after the incident on 7/27/22 in which Resident #1 hit Resident #4 with a pillow. The Director of Nurses said that there were no known triggers for Resident #1's aggression toward other residents. (continued on next page)

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F 0626 Level of Harm - Actual harm Residents Affected - Few	Although the Administrator and Director of Nurses said that the Facility discharged Resident #1 to the ED because Resident #1's aggression was without any kind of trigger, staff members said that his/her aggression toward other residents was triggered by loud sounds, noises or commotion. 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. Resident #1's medical record contained a Care Plan related to Behavior Problems and diagnosis of dementia. The Care Plan indicated it was dated as initiated 7/17/22 and several interventions were dated as having been initiated on 7/17/22. 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. 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 - approaching in a calm manner (continued on next page)

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F 0626 Level of Harm - Actual harm Residents Affected - Few	- diverting attention - removing from situations and take to another location as needed. 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 during times Resident #1 spent in the dining room - educate Resident #1 and his/her responsible party on the causal factors of behaviors and planned interventions - discuss behaviors - reinforce why behaviors are unacceptable. Despite having admitted Resident #1 with a known history of aggression toward residents and staff having identified that his/her aggression was triggered by loud sounds, noises or commotion, the Facility refused to allow Resident #1 to return from the ED on 8/14/22 following an evaluation and he/she remained in the ED for 19 days while the hospital looked for alternate placement.

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F 0656 Level of Harm - Minimal harm or potential for 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. 15203 Based on interviews and records reviewed, for one of five sampled residents (Resident #1) who per staff interviews exhibited aggressive behaviors toward residents in response to loud sounds, noises or commotion, during July and August 2022, the Facility failed to ensure Resident #1's Comprehensive Care Plan included the identified triggers, and that interventions were developed and implemented related to these triggers, in an effort to meet Resident #1's mental and psychosocial care needs. 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: -The Emergency Department Document, dated 6/13/22, indicated Resident #1 presented to the emergency department from a nursing home after having punched a resident in the face. -The Hospital History and Physical, dated 6/14/22 indicated that Resident #1 had a number of admissions to the hospital for behavioral problems over the past few years and had been sent to the hospital on 6/13/22 from his/her previous nursing home for striking a resident. The History and Physical indicated that because Resident #1's behavior was so different at the hospital (happy and content), it was suspected that his/her bad 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. -The Hospital Discharge Summary, dated 6/24/22, indicated Resident #1 was pleasantly confused and aphasic (a disorder which affects how a person communicates) at baseline and was able to answer yes and ok for his/her name and date of birth and responded to questions with non-sensical speech and a few clear words. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Review of Resident #1's medical record indicated that the most recent Admission Minimum Data Set Assessment (MDS), completed 6/30/22, indicated that his/her cognitive patterns were severely impaired and he/she ambulated with supervision. The MDS indicated that Resident #1 was sometimes able to understand 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 person who screened Resident #1 for admission to the Facility and said she was unaware of the documentation in his/her clinical record from the referring hospital regarding his/her history of behavioral problems, including aggression toward residents. The Director of Nursing said that she was not aware of Resident #1's potential for aggressive behaviors directed toward other residents until he/she was involved in a resident to resident incident on 7/27/22. Review of the Resident to Resident Investigation Report, dated 7/27/22, indicated that Resident #1 was observed hitting Resident #4 in the face with a pillow. During an interview on 9/20/22 at 1:30 P.M., the Scheduler said that she witnessed an incident in which Resident #1 hit Resident #4 in the face with a pillow. The Scheduler said that she thought Resident #1 hit Resident #4 in the face with a pillow because Resident #4 mumbled and Resident #1 wanted Resident #4 to be quiet. Resident #1's medical record contained a Care Plan related to Behavior Problems and diagnosis of dementia. The Care Plan indicated it was dated as initiated 7/17/22 and several interventions were dated as having been initiated on 7/17/22. However, the Director of Nursing said Resident #1's Care Plan was dated incorrectly, that she reviewed the Care Plan related to Behavior Problems in Resident #1's electronic health record and confirmed that it was in fact initiated on 7/17/22, but that the interventions dated as initiated on 7/17/22, were actually put into place (initiated) 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)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- approaching in a calm manner - diverting attention - removing from situations and take to another location as needed. Review of the Resident to Resident Investigation Report, dated 8/11/22, indicated that Resident #1 was observed to slap Resident #5 across the face. 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 during times Resident #1 spent in the dining room - educate Resident #1 and his/her responsible party on the causal factors of behaviors and planned interventions - discuss behaviors - reinforce why behaviors are unacceptable. 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)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/22/22 at 9:40 A.M., the Administrator said that he believed that there was no known triggers for Resident #1's aggression and resident to resident altercations.