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	11/30/2022

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 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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 41107 Based on records reviewed, review of video surveillance camera footage, and interviews, for one of three sampled residents (Resident #1) who was severely cognitively impaired and was dependent on staff for care, the Facility failed to ensure he/she was free from physical and mental abuse when he/she was restrained and taunted by staff. Review of surveillance camera footage provided by the Facility, indicated that on 11/09/22, Resident #1 was seated in a wheelchair behind the nurses' station, and was restrained by staff to prevent him/her from getting up. In the video staff members draped a blanket over the front of Resident #1 from his/her neck down to his/her waist, and then secured it (tied it in a knot and/or held it tightly in place) behind him/her. Staff can be seen taunting and adding to Resident #1's agitation while he/she was being restrained. Although several staff members can be seen walking by or sitting next to Resident #1, and looking at how the blanket is secured, no one removed or untied the blanket, and Resident #1 remained confined to his/her wheelchair for almost an hour. Findings include: Review of the Facility's Policy titled Abuse Prohibition Policy, undated, indicated that the Facility has the responsibility to ensure that each resident has the right to be free from abuse, mistreatment, and neglect. The Policy indicated it is the Facility's responsibility to identify, correct, and intervene in situations where abuse, mistreatment or neglect occur. The Policy indicated Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment resulting in physical harm, pain, or mental anguish. Review of the Facility's Policy titled Restraint Management, undated, defined a physical restraint as any manual, mechanical or physical device, material of equipment attached to, or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. The Policy also indicated that restraints also include devices used in conjunction with a chair, such as trays, tables, bars or belts, that resident cannot remove easily, that prevent the resident from rising. (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the Facility's Event Narrative Report and the report submitted by the Facility via Healthcare Facility Reporting System (HCFRS), dated 11/11/22, indicated that on 11/11/2022 at approximately 11:30 A.M., the 3:00 P.M. to 11:00 P.M. responsible person (later identified as Nursing Supervisor #1) and a Certified Nurse Aide (later identified as CNA #4) alerted the Unit B Manager (later identified as Unit Manager #1) of an incident on 11/09/2022 at approximately 8:42 P.M. where a resident (later identified as Resident #1) was confined to wheelchair by a sheet (blanket). Review of the Facility's Investigation Narrative Report, undated, indicated Resident #1 had been sitting at the nurses' station during the 7:00 A.M.-3:00 P.M. shift and the 3:00-11:00 PM shifts for safety related concerns. The Report indicated Resident #1 was assisted multiple times due to agitation and was placed on a 1:1 supervision. The Report indicated that while Resident #1 was on a 1:1, that CAN #1 said Nurse #1 told her (CNA #1) to hold up the blanket to keep it from falling off Resident #1, and she (CNA #1) lightly secured it in a knot to make sure it did not fall off. The Report indicated CNA #1 said Nursing Supervisor #1 came to the unit and told her (CNA #1) not to tell anyone what she did and left the unit. The Report indicated Nurse #1 did not report the incident because Nursing Supervisor #1 was the responsible person (that night) and she (Nurse #1) had not realized Resident #1 had a tied blanket on him/her. The Report indicated that on 11/10/22, Nursing Supervisor #1 told Unit Manager #1 that Resident #1 had behaviors with periods of anxiety throughout the evening shift (3:00 P.M.-7:00 P.M.) on 11/09/22. The Report indicated Unit Manager #1 called the Director of Nurses (DON) on 11/10/22 at 9:00 P.M. to request access to the surveillance camera footage on Resident #1's unit because Nursing Supervisor #1 was not giving her complete answers related to Resident #1's behaviors. The Report indicated that on 11/11/22, while viewing the surveillance camera footage, CNA #1 can be seen securing a blanket behind Resident #1's wheelchair and that there was also a question of Nurse #1 securing the blanket at one point. The Report indicated that the allegation of abuse was not substantiated. Review of a Police Report, dated, 11/11/22, indicated that on 11/09/22 at approximately 20:42 hours (8:42 P.M.), Resident #1 is seen on camera sitting in a wheelchair behind the nurses' station. The Report indicated CNA #1 and Nurse #1 are seen on camera taking a sheet (blanket), bringing it to neck height of Resident #1 and then tying a knot to restrain Resident #1 in the chair. The Report indicated an elder abuse form was filed. Resident #1 was admitted to the Facility in October 2022, and readmitted to the Facility in November 2022, diagnoses included dementia, depression, history of violent behaviors, and age-related cognitive decline. Review of Resident #1's Minimum Set Data (MDS) Admission Assessment, dated 11/19/22, indicated Resident had significant cognitive impairment and required two or more staff members to assist with transfers and ambulation, and he/she exhibited behaviors that significantly interfered with care. Review of Resident #1's Care Plan, dated 10/18/22, indicated the following: - he/she required assistance from two staff members for transfers and ambulation, -when Resident #1 exhibited agitation and aggression toward staff, they should assist the resident to identify triggers or events that may precipitate symptoms, and approach resident warmly and calmly, (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-when Resident #1 does not use assistive devices or ambulates or transfers unassisted, staff should accept Resident #1's right to refuse and show respect for his/her decision, -identify stressors that may contribute to inappropriate behavior, -anticipate care needs and provide them before Resident becomes overly stressed, and -provide opportunities for positive interaction or attention; stop and talk when passing by. Review of Resident #1's Restraint Evaluation, dated 10/18/22, indicated the only restraint devices in use for him/her was a bed alarm for safety. Review of Resident #1's Physician's Order, dated 10/18/22, indicated he/she should have a bed alarm in place at all times when in bed. During an interview on 11/30/22 at 3:38 P.M., the Administrator and the Surveyor reviewed the surveillance camera video footage dated 11/09/22 on the evening shift from Resident #1's unit. The Administrator said the surveillance video footage was not continuous and was broken up into clips of varying timeframe's. Review of the surveillance camera video footage clips from 11/09/22 19:59:59 to 21:59:51, provided by the Administrator, illustrated the following: 20:04:01, Resident #1 is seen seated in a wheelchair at the nurses' station with CNA #1 and CNA #2. There is no blanket on Resident #1 at this time. CNA #1 gets up from sitting on top of the nursing station desk and as she walks by Resident #1, she quickly pinches Resident #1's nose. Resident #1 flinches and pulls his/her face away. 20:05:18, Resident #1 attempts to stand up from his/her wheelchair. CNA #2 places a hand on Resident #1's left shoulder and holds him/her back in the wheelchair to prevent him/her from standing. 20:07:53, Resident #1 stands up from his/her wheelchair. CNA #2 puts her right hand on Resident #1's left arm, then moves it away. CNA #1 then comes from behind Resident #1 and places her hands on Resident #1's shoulders and forces him/her to sit back down in the wheelchair. Resident #1 reaches back with his/her right hand to remove CNA #1's hand from his/her left shoulder and tries to stand again. CNA #1 pulls on Resident #1 so his/her shoulders are back against the wheelchair seat back. Resident #1 uses his/her left hand to remove CNA #1's hand from his/her right shoulder. 20:09:15, CNA #1 is touching Resident #1's right arm and Resident #1 repeatedly keeps trying to move away from CNA #1. 20:10:13, CNA #1 wiggles her fingers on Resident #1's right arm and Resident #1 pulls his/her arm away. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	20:11:22 - 20:11:36, CNA #1 and CNA #2 are sitting on either side of Resident #1. Resident #1 is leaning forward in the wheelchair trying to stand and CNA #1 places her hand on Resident #1's right shoulder to hold him/her down. Resident #1 attempts to stand repeatedly and CNA #1 holds him/her back, so he/she cannot stand. Resident #1 hits CNA #1 and appears frustrated at being held back. CNA #2 intermittently places her right hand on Resident #1's left shoulder to push him/her back in his/her wheelchair. 20:11:53 -20:12:08, CNA #1 and CNA #2 are sitting on either side of Resident #1 and can be seen taking turns poking Resident #1 on his/her torso and arms, while he/she is sitting in a wheelchair behind nurses' station. Resident #1 crosses his/her arms in front of him/herself as they continue to poke him/her. 20:13:24, CNA #1 stands up and touches Resident #1 on what appears to be his/her right hip, and Resident #1 jumps, leans forward and appears to fight back, moving his/her hand toward CNA #1 quickly. CNA #2 is sitting on Resident #1's left side and holds onto Resident #1's left arm as CNA #1 quickly pulls Resident #1's right shoulder back and upper torso back into the wheelchair. 20:14:14, Nurse #1 covers Resident #1 with blanket once he/she is seated in the wheelchair. 20:15:29, Resident #1 is seated in the wheelchair with a blanket up to his/her neck with his/her arms tucked underneath the blanket. Nurse #1 secures the blanket behind Resident #1's wheelchair, and can be seen as she tugs up and pulls forcefully on the ends of the blanket. CNA #2 then helps Nurse #1 by tugging on a secured piece of the blanket, and is seen throwing her head back laughing. Nurse #1 widens her stance for leverage and uses forceful arm movements to secure the blanket. Nurse #1 is seen holding a piece of the blanket, lifting it up high, and pulling at it as if she were tying it. 20:22:00, Nurse #1 is seen untying the blanket and Resident #1 leans forward immediately. However, Nurse #1 then grabs the right and left sides of the blanket with two hands from behind and pulls Resident #1 back in the wheelchair, preventing him/her from getting up. 20:22:11, Resident #1 leans forward in wheelchair, Nurse #1 pulls him/her back into the wheelchair with the blanket which is still covering his/her body up to his/her neck, and limits movement of Resident #1's torso and arms. 20:23:35, Resident #1 leans forward in the wheelchair, Nurse #1 pulls the blanket from behind and repositions Resident #1 back in the wheelchair, and then she (Nurse #1) holds two pieces of the blanket together behind Resident #1's wheelchair. 20:23:56, Nurse #1 stands behind Resident #1, who remains seated in the wheelchair, holds the blanket with two hands, and braces herself with a widened stance for leverage. 20:24:24, Nurse #1 twists the blanket behind Resident #1 which tightens around Resident #1 and holds Resident #1 back in the wheelchair. The blanket is covering the top half of Resident #1's body, up to his/her neck. 20:41:59, CNA #1 puts both her hands on Resident #1's shoulders and Residents #1 pushes her hands away. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	20:42:50, Nurse #1 is standing behind Resident #1 holding him/her back in the wheelchair with the blanket. Nurse #1 releases the blanket from her grip, and Resident #1 pushes the blanket down off the upper part of his/her body. 20:42:59, CNA #1 is pulling the blanket up over Resident #1's body, and he/she leans forward and grabs the blanket out of CNA #1's hands. CNA #1 pulls Resident #1 back in the wheelchair with her hands as Resident #1 fights to get CNA #1's hands off him/her. Resident #1 appears frustrated. 20:43:11, CNA #1 pulls the blanket up over Resident #1's arms and torso up to his/her neck and ties the blanket behind Resident #1's wheelchair. Nurse #1 watches CNA#1 tie the blanket. CNA #1 finishes tying the blanket, and looks at Nurse #1 who gives her the okay hand gesture. 20:44:12, CNA #1 is looking at her cell phone as she sits next to Resident #1. Resident #1 attempts to move the blanket to lean forward, and CNA #1 immediately adjusts the secured blanket. 20:44:51, CNA #1 is sitting at the nurses' station with Resident #1. CNA #4 walks by and looks at Resident #1 and CNA #1. CNA #1 holds up a piece of the blanket, which appears to be tied from behind Resident #1's wheelchair and shows it to CNA #4. CNA #4 continues walking by and does not intervene. 20:49:04, CNA #1 touching (wiggling her fingers) on Resident#1's neck while Resident #1's arms and body are restrained under the blanket. 20:51:13, CNA # 2 is sitting behind Resident #1 (while he/she is restrained by the blanket). 20:51:48, Resident #1 is pushing his/her hands against the blanket from underneath while it is secured behind him/her. Resident #1's eyebrows are furrowed and his/her eyes are closed. 21:00:19, Resident #1 still restrained under blanket (arms included), CNA #1 is wiggling her fingers on Resident #1's neck. Resident #1 appears annoyed by CNA #1's touch, and repeatedly moves away from her (CNA #1). 21:00:45, Resident #1 remains restrained under blanket (arms included), CNA #1 again can be seen wiggling her fingers Resident #1's neck and Resident #1 flinches. 21:01:37, CNA #1 is touching Resident #1's face, Resident #1 appears irritated, and is unable to get his/her arms out from underneath the blanket. 21:04:30 - 21:05:06, CNA #1 pokes Resident #1's neck several times and Resident #1 jumps. 21:08:04, CNA #1 is patting Resident #1's head, Resident #1 attempts to move his/her hands but is unable because the blanket is secured and won't allow him/her to. 21:10:07, CNA #1 shows Nursing Supervisor #1 the secured blanket behind Resident #1. Nursing Supervisor #1 is behind nurses' station at med cart, which is behind and to the right of Resident #1. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	21:19:46, Nurse #1 checks the secured blanket behind Resident #1's wheelchair and then walks away from the Nurses Station, leaving Resident #1 alone with his/her arms underneath the secured blanket which is up to his/her neck. 21:20:29, Resident #1 is sitting in wheelchair, looks like he/she has slid down attempting to lean forward and use his/her arms, but is restricted by the blanket. 21:20:34, Nurse #1 returns to the nurses' station with CNA #6 who sits down next to Resident #1. 21:20:39, CNA #4 returns to the B Unit and is walking with Nurse #3. They walk by and both look at Resident #1. Nurse #3 continues to look at Resident #1 as she's walking around the outside of the nurses' station. Resident #1 is sitting with his/her eyes closed, the blanket is still covering him/her and it looks to still be secured. 21:24:37, Resident #1 gets his/her left hand out from under the secured blanket but is only able to get it out at the neck level because the blanket is restricting him/her from moving his/her arms any further. 21:29:30, Resident #1 is moving his/her hands under the blanket and is struggling. CNA #6 is sitting next to Resident #1, but does not intervene or help him/her. 21:30:14, CNA #2 is sitting next to Resident #1 behind the nurses' station. 21:30:02, Resident #1 lifts bottom portion of blanket up over his/her head and is moving underneath it. Resident #1's head is covered by the blanket, he/she is moving his/her arms under the blanket, and looks like he/she is struggling to free him/herself from under the blanket. 21:32:25, The blanket is now loosely draped over Resident #1. From the video surveillance footage, it is unable to be determined who loosened the blanket, and when. Nurse #1 is playing with Resident #1's hair and CNA #2 is sitting next to Resident #1. 21:33:03, Nurse #1 reaches behind Resident #1 and boosts him/her back in the wheelchair. The blanket is loose, at chest level, and Resident #1's arms free. 21:34:59, Resident #1 stands, Nurse #1 is standing with him/her and CNA #3 puts her hands on Resident #1's hips and pulls him/her back into the wheelchair. Resident #1 pushes CNA #1 away. CNA #3 moves Resident #1's wheelchair back quickly to remove Resident #1 from the nurses' station. Resident #1 is transported away from the nurses' station, his/her is head down and in his/her left hand. Review of Nursing Supervisor #1's Written Witness Statement, dated 11/11/22, indicated that on 11/09/22 at approximately 8:45 P.M., she saw Resident #1 tied to his/her wheelchair with a blanket. The Statement indicated that she (Nursing Supervisor #1) told Nurse #1 and CNA #1 she could not believe what she was seeing, and this could be considered a restraint and told them (Nurse #1 and CNA #1) to untie the blanket. The Statement indicated that she (Nursing Supervisor #1) was under the impression that Nurse #1 and CNA #1 would untie Resident #1 so she left the nurses' station and returned to the conference room. The Statement indicated that when she (Nursing Supervisor #1) returned to Resident #1's unit later in the shift and Resident #1 was in bed. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/30/22 at 1:17 P.M., and review of CNA #1's written statement, CNA #1 said she sat with Resident #1 on 11/09/22 at the nurses' station because he/she had been repeatedly trying to stand up since 3:00 P.M. CNA #1 said on 11/09/22, Resident #1 sat behind the nurses' station from 3:00 P.M. until 9:00 P.M. CNA #1 said when Nurse #1 asked her to sit with Resident #1, she saw Nurse #1 holding a blanket wrapped around Resident #1 from behind, and Resident #1's arms were underneath the blanket. CNA #1 said Nurse #1 was holding the blanket tightly like she was trying to hold Resident #1 back in the wheelchair. CNA #1 said Nurse #1 told her to make sure the blanket did not come off Resident #1. CNA #1 said she tied two pieces of the blanket together, and lightly secured the blanket with a knot behind Resident #1's wheelchair. CNA #1 said Nursing Supervisor #1 came onto the B Unit at some point during the shift but had not said anything to her. CNA #1 said she felt uncomfortable after her shift, and said she was going to report that Nurse #1 was holding a blanket tightly around Resident #1, but she did not. CNA #1 said she was also going to report that Nurse #1 had her wrap a blanket around Resident #1 and secure it, but she did not. Review of CNA #2's written Witness Statement, dated 11/11/22, indicated CNA #2 had worked on B Unit from 3:00 P.M. on 11/09/22 until 7:00 A.M. on 11/10/22. The Statement indicated she (CNA #2) helped with Resident #1's 1:1 supervision on and off that night, and saw he/she had a blanket around the top part of his/her body up to his/her neck but had not realized it was tied. During an interview on 12/12/22 at 2:37 P.M, although CNA #2 said she did not see or help Nurse #1 secure a blanket around Resident #1 and behind his/her wheelchair, her statements are suspect based on what can be seen on the video camera surveillance footage. CNA #1 and CNA #2 said they did not remember poking or teasing Resident #1. CNA #1 said she did not remember pushing Resident #1 back into his/her wheelchair or holding him/her back to prevent him/her from standing up. CNA #1 said Resident #1 can stand up by him/herself and had been repeatedly trying to stand up since 3:00 P.M. (greater than five hours). CNA #2 said CNA #1 told her she was going to tie Resident #1 to the wheelchair. During an interview on 12/14/22 at 9:16 A.M., and review of CNA #6's written Witness Statement, dated 11/15/22, indicated she (CNA #6) sat with Resident #1 on 11/09/22 at the nurses' station for 1:1 supervision for a very short period of time, but she did not see a blanket tied around him/her. Although written Witness Statements submitted by CNA #3 dated 11/11/22, , CNA #4 dated 11/11/22, CNA #5 dated 11/14/22, and CNA #6 dared 11/14/22, indicated in their written Witness Statements that they did not see Resident #1 secured to his/her wheelchair with a blanket, their statements seem suspect given based on what can be seen on the video surveillance footage, which depicts them either standing around or the nurses' station or sitting next to Resident #1 behind the nurses' station during the time he/she was restrained. Review of Unit Manager #1's written Witness Statement, dated 11/14/22, indicated on 11/10/22, Nursing Supervisor #1 told her (Unit Manager #1) that Resident #1 had difficult behaviors on 11/09/22 during the 3:00 P.M. to 11:00 P.M. shift. The Statement indicated when she watched the surveillance camera video footage, she saw Resident #1's blanket secured and tied behind him/her. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/30/22 at 1:53 P.M., Unit Manager #1 said when she and the DON viewed the surveillance camera video footage on 11/11/22, she saw Resident #1 sitting at the nurses' station with a blanket up over his/her shoulders and said she saw CNA #1 tie the blanket around the back of Resident #1's wheelchair, which was a restraint. Unit Manager #1 said even if there had been an order for a restraint (there was not), this was not an appropriate restraint device and tying Resident #1 to his/her wheelchair was considered abuse. During an interview on 11/30/22 at 2:58 P.M., the Director of Nurses (DON) said on 11/11/22, she watched the surveillance camera video footage from 11/09/22, and said she saw CNA #1 secure the blanket behind Resident #1. The DON said Nurse #1's role was in question because (based on the video) she had to have seen CNA #1 secure the blanket. The DON said if Resident #1 was confined to his/her wheelchair, that would be considered abuse. The DON said she had not watched any further video footage other than where CNA #1 secured the blanket around Resident #1. During an interview on 11/30/22 at 3:38 P.M., the Administrator said the first time he watched the surveillance camera video footage from the 3:00 to 11:00 shift on 11/09/22 was when he viewed it with the Surveyor on 11/30/22. While viewing the video footage with the Surveyor, the Administrator said he saw CNA #1 tie a blanket around and behind Resident #1's wheelchair, and that Nurse #1 had been present. On 12/05/22 at 12:48 P.M., the Administrator identified staff in the video footage for the Surveyor. The Administrator said he still had not had time to review all the surveillance camera footage from the 11/09/22 evening shift. The Surveyor asked the Administrator to review the footage from 20:15:29 and tell the Surveyor what he saw. The Administrator said it looked like Nurse #1 was tying the blanket around and behind Resident #1's wheelchair. During an interview on 12/07/22 at 1:23 P.M., the Administrator said after he watched more surveillance camera video footage, he substantiated abuse in both instances where Resident #1 is secured to his/her wheelchair with a blanket (once by Nurse #1 and again by CNA #1).

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 41107 Based on records reviewed, review of surveillance camera video footage, and interviews for one of three sampled residents (Resident #1), who was severely cognitively impaired and dependent on staff for his/her care needs, the Facility failed to ensure staff implemented and followed their abuse policy, when on 11/09/22 during the 3:00 P.M. to 11: 00 P.M., (based on review of surveillance camera video footage) a nursing supervisor and a certified nurse aide were aware that Resident #1 had a blanket tied around him/her physically restraining in his/her wheelchair, which prevented Resident #1 from getting up. However neither of them immediately reported the incident to the Administrator and/or Director of Nurses as required. Findings include: Review of the Facility's Policy titled Abuse Prohibition Policy, undated, indicated that in order to protect residents from harm, staff will immediately the resident from the alleged abused or remove the abuser from the resident, and immediately notify the supervisor who will then immediately notify the Administrator and/or Director of Nurses (DON). Review of Nursing Supervisor #1's written Witness Statement, dated 11/11/22, indicated that on 11/09/22 at approximately 8:45 P.M., she saw Resident #1 tied to his/her wheelchair with a blanket. The Statement indicated that she (Nursing Supervisor #1) told Nurse #1 and CNA #1 she could not believe what she was seeing and that this could be considered a restraint. The Statement indicated she (Nursing Supervisor #1) told them (Nurse #1 and CNA #1) to untie the blanket. The Statement indicated she (Nursing Supervisor #1) was under the impression Nurse #1 and CNA #1 would untie Resident #1 left the nurses' station and returned to the conference room. The Statement indicated that when she (Nursing Supervisor #1) returned to Resident #1's unit later in the shift, Resident #1 was in bed. There was no documentation to support that Nursing Supervisor #1 immediately reported the incident to the Administrator or the Director of Nurses, per facility policy. During an interview on 11/30/22 at 1:17 P.M., and review of CNA #1's written statement, CNA #1 said she sat with Resident #1 on 11/09/22 at the nurses' station because he/she had been repeatedly trying to stand up since 3:00 P.M. CNA #1 said on 11/09/22, Resident #1 sat behind the nurses' station from 3:00 P.M. until 9:00 P.M. CNA #1 said when Nurse #1 asked her to sit with Resident #1, she saw Nurse #1 holding a blanket wrapped around Resident #1 from behind, and Resident #1's arms were underneath the blanket. CNA #1 said Nurse #1 was holding the blanket tightly like she was trying to hold Resident #1 back in the wheelchair. CNA #1 said Nurse #1 told her to make sure the blanket did not come off Resident #1. CNA #1 said she tied two pieces of the blanket together, and lightly secured the blanket with a knot behind Resident #1's wheelchair. CNA #1 said Nursing Supervisor #1 came onto the B Unit at some point during the shift but had not said anything to her about Resident #1. CNA #1 said she felt uncomfortable after her shift, and said she was going to report that Nurse #1 was holding a blanket tightly around Resident #1, but she did not. CNA #1 said she was also going to report that Nurse #1 had her wrap a blanket around Resident #1 and secure it, but she did not. (continued on next page)

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	11/30/2022

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documentation to support that Certified Nurse Aide #1 immediately reported the incident to the Administrator or the Director of Nurses, per facility policy. During an interview on 11/30/22 at 1:53 P.M., Unit Manager #1 said on 11/10/22 sometime after 7:00 P.M., Nursing Supervisor #1 told her Resident #1 had been behavioral on 11/09/22 and was sitting at the nurses' station. Unit Manager #1 said Nursing Supervisor #1 told her she felt funny about the situation and did not think the staff handled it appropriated. Unit Manager #1 said Nursing Supervisor #1 had not given her any further details. Unit Manager #1 said she then called the DON and asked if they could view the surveillance camera video footage on Resident #1's unit to determine what was going on. Unit Manager #1 said she was able to watch the video the next day, on 11/11/22 with the DON, and saw CNA #1 tie a blanket around Resident #1 and his/her wheelchair which was restraining him/her. During an interview on 11/30/22 at 2:58 P.M., the Director of Nurses said Unit Manger #1 told her on 11/10/22 that Nursing Supervisor #1 had reported to her that day (11/10/22) that Resident #1 had increased behaviors on 11/09/22 at approximately 8:30 P.M., during the evening shift. The DON said Unit Manager #1 told her that she questioned whether staff had dealt with Resident #1's behaviors in the correct manner, given Nursing Supervisor #1's lack of detailed information. The DON said when she watched the surveillance camera footage on 11/11/22 with Unit Manager #1 and could see CNA #1 secure a blanket behind Resident #1, as a restraint. During an interview on 11/30/22 at 3:38 P.M., the Administrator said on 11/11/22 the DON notified him that she watched surveillance camera video footage and said there was a restraint issue that had not been reported.