STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225215	A. Building B. Wing	09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southshore Health Care Center	115 North Avenue Rockland, MA 02370

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 43963 Based on record reviews and interviews for three of three sampled residents (Resident #1, #2 and #3), the Facility failed to ensure nursing provided care and services that met professional standards of practice, when upon admission to the Facility, their medications and/or treatments were not accurately reconciled, and as result not all medications and/or treatments were administered in accordance with what was indicated on the Hospital Discharge Summary, as ordered by the physician and in accordance with facility policy. Findings include: Review of the Facility Policy titled, Medication Reconciliation, dated as last revised 08/04/22, indicated that medication reconciliation involves collaboration with the resident/representative and multiple disciplines, including admissions liaisons, licensed nurses, physicians, and pharmacy staff. The policy indicated the following steps are part of the pre-admission process; -Obtain current medication list from the referral source (i.e. hospital, home health, hospice, or primary care provider); -Obtain current medication/admission orders; -Verify resident identifiers; and -Forward to the nursing unit accepting the resident. The policy further indicated the following steps are part of the admission process; -Verify resident identifiers on the information received; -Compare orders to hospital records, etc, Obtain clarification orders as needed; -Transcribe orders in accordance with producers for admission orders; -Have a second nurse review transcribed orders for accuracy and cosign the orders, indicating the review; (continued on next page)

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

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Obtain home list of medications from resident/representative. Place on chart for physician to review and revise medication regimen if warranted. 1) Resident #1 was admitted to the Facility in September 2024, diagnoses included status post a lumbar microdiscectomy secondary to severe spinal stenosis at lumbar level four and five (L-4 and L-5), morbid obesity, anxiety, depression, urinary incontinence, and constipation. Review of Resident #1's Hospital Referral, dated 09/10/24, indicated that the following medication was being administered while hospitalized ; -Lovenox (enoxaparin, anticoagulant) 40 mg subcutaneously every 12 hours; (last dose 09/09/24 at 11:55 P. M.) Review of Resident #1's Hospital Discharge Summary, dated 09/10/24, indicated to utilize an incentive spirometer to increase the expansion of his/her lungs and to apply ice to his/her back for up to 30 minutes at a time for pain relief. However, review of Resident #1's Medical Record, indicated that there was no documentation to support that the administration of lovenox, utilization of an incentive spirometer or the use of ice for pain relief were reviewed with his/her attending physician. Further review of Resident #1's Medical Record indicated that a Medication Reconciliation was not completed upon admission, in accordance with Facility Policy. During an interview on 09/23/24 at 1:31 P.M., Nurse #1 said that she completed Resident #1 admission evaluations and put his/her orders for medications into the computer after reviewing them with the physician. Nurse #1 said that she reviewed all the medications lists Resident #1 included with his/her Hospital Discharge paperwork. Nurse #1 said however that she only read off the medications listed on Resident #1's After Visit Summary Report to the physician for review. Nurse #1 said that she was trained to do admission medications that way and said the nurses do not use medication reconciliation forms. During an interview on 09/23/24 at 3:14 P.M., the Staff Development Coordinator (SDC) said that Resident #1's lovenox was not on the Hospital Discharge Summary but was noted on his/her medications while hospitalized list and said nursing should have asked his/her physician for clarification on the lovenox. During an interview on 09/23/24 at 4:04 P.M., the Director of Nurses (DON) said that she was not aware that Resident #1 was being administered lovenox while hospitalized and said she would have expected nursing to recognize that and bring it to the physician's attention to clarify what was to be done with the medication. The DON said she was not aware that Resident #1 had not had a physician's order for an incentive spirometer or to utilize ice to his/her back to help with pain. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) Resident #2 was admitted to the Facility in September 2024, diagnoses included respiratory failure, Chronic Obstructive Pulmonary Disease (COPD), morbid obesity, and hypertension. Review of Resident#2's Hospital Discharge Summary, dated 09/11/24, indicated his/her discharge medication list included the following: -Prazosin (anti-hypertensive) 1 mg capsule, (two capsules) for a total of 2 mg by mouth every night. However, review of Resident #2's Facility Physician Orders, dated 09/11/24, indicated nursing to administer; -Prazosin 1 mg capsule, take 1 mg by mouth every night. (1 mg less than what was indicated in DC summary). Review of Resident #2's Medical Record, indicated that there was no documentation to support that a Medication Reconciliation was completed upon admission by nursing, in accordance with Facility Policy. 3) Resident #3 was admitted to the Facility in September 2024, diagnoses included COPD, polysubstance abuse, alcohol cirrhosis, and pneumonia. Review of Resident #3's Hospital Discharge Summary, dated 09/12/24, indicated his/her discharge medication list included the following; -Lasix (furosemide, a diuretic) 20 mg tablet, take 1 tablet by mouth daily as needed (PRN) for weight gain. However, review of Resident #3's Facility's Physician's Orders, dated 09/12/24, indicated nursing to administer; -Furosemide 20 mg tablets, give 1 tablet by mouth daily for weight gain. (medication was therefore scheduled for administration daily and not PRN per the his/her DC summary instructions). Review of Resident #3's Medical Record, indicated that there was no documentation to support that a Medication Reconciliation was completed by nursing upon admission, in accordance with Facility Policy. During a telephone interview on 09/25/24 at 12:49 A.M., Nurse #3 said that there is no form they use to reconcile medications and said she takes a picture of the Hospital Discharge Summary medications and sends it to the physician for approval, rejection, or that may require changes. Nurse #3 said that no one really looks over the medications for accuracy. Nurse #3 said that she really only looks at the medications and that the DON or Assistant Director of Nurses (ADON) will read the discharge summary and should review the new admissions charts the following day. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/23/24 at 3:14 P.M., the SDC said that she does not know when the last time that the facility utilized the medication reconciliation forms, but said that per facility policy, medications/treatments needed to be reconciled upon admission. The SDC said it is expected that nurses obtain a list of all medications in relation the resident, a home medication list, medications administered in the hospital and recommended medications upon discharge from the hospital. The SDC said the nurse should compare all medications, review the medications with another nurse and then call the physician for approval, rejection, or to make changes in medication orders. During an interview on 09/23/24 at 2:38 P.M., the ADON said that it is the Facility's expectation that all medication lists for a resident be reviewed, compared, and approved by a physician upon admission. The ADON said that the Unit Manager had been responsible for double checking new admissions medications, however, the Unit Manager position has been vacant. The ADON said that the DON, SDC, and herself were responsible for review new admission records in the absence of a Unit Manger and said she had not recalled ever double checking the records for accuracy. During an interview on 09/23/24 at 4:04 P.M., the DON said it is the Facility's expectation that all medications be reconciled according to the Facility Policy and that two nurses must be signing off on the medication orders for accuracy once approved by the physician.