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	12/09/2024

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 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to choose his or her attending physician. 43963 Based on record review and interviews, for one of three sampled residents (Resident #1), who had an activated Health Care Proxy with his/her Health Care Agent (HCA) making his/her medical decisions, and had requested a change in attending Physician's for him/her in early October 2024, the Facility failed ensure they honored the residents right to change attending physicians in a timely manner, when the requested was not facilitated until two months later. Findings include: Review of the Commonewealth of Massachusetts Notice of Nursing Facility Resident's Rights, dated as last revised 01/2001, indicated that when one enters a nursing facility, you do not lose your rights as an individual and the nursing home must protect and promote your rights and the rights of each resident. - The Notice also indicated that all residents have the right to choose a personal physician. Resident #1 was admitted to the Facility in July 2023, diagnoses include metabolic encephalopathy (problem in the brain caused by a chemical imbalance), schizoaffective disorder, seizure disorder, a history of urinary tract infections, and his/her Health Care Proxy was invoked with his/her HCA (Family Member #1) making health care decisions on his/her behalf. During a telephone interview on 12/09/24 at 10:01 A.M., Family Member #1/ (HCA), said that she had made a request to change Resident #1's attending physician back in October 2024. The HCA said the physician assigned to him/her did not even know Resident #1, and was very rude to deal with. Review of Resident #1's Social Service Progress Note, dated 10/04/24, indicated that a meeting had been held with Resident #1, his/her HCA, the Nurse Manager, and the Director of Social Services. The Note further indicated that the HCA requested to change Resident #1's attending physician. Review of Resident #1's Medical Record, including but not limited to all progress notes and physician orders, indicated that there was no documentation to support that the facility attempted to contact Resident #1's attending physician to obtain an order to change physicians or facilitate the change as requested by Resident #1's HCA. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/09/24 at 1:14 P.M., the Director of Social Services said that she was aware that Resident #1's HCA had requested to change his/her attending physician and said that the Unit Manager had also been aware of the request. The Director of Social Services said that it should not take two months to change physicians. During multiple in-person interviews on 12/09/24 starting at 2:02 P.M., through 4:00 P.M., Nurses #1, #2, and #3, said that they were not aware that Resident #1's HCA had requested a change in physician services. During an interview on 12/09/24 at 3:15 P.M., the Unit Manager said that she had been aware that Resident #1's HCA wanted to change his/her physician a few months back. The Unit Manager said there were only two physicians to provide care for all 83 residents residing at the Facility, that when she spoke to the other physician (the only other option), the physician said he was full and could not take on another resident. During an interview on 12/09/24 at 4:14 P.M., the Director of Nurses (DON) said that she was not aware that Resident #1's HCA had requested to change Physician's. The DON said that she called Physician #2 on 12/09/24 and was able to change Resident #1's services from Physician #1 to Physician #2. The DON said that it is the Facility's expectation that any Resident or Resident's legal representative be allowed the right to change physicians when requested.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 43963 Based on records reviewed, interviews and observations, for two of two sampled nursing units (Unit #1 and Unit #2), the Facility failed to ensure nursing staff properly secured all medications (prescription and over the counter), when on 12/09/24, the [NAME] Units' medication room door was observed to be open and unlocked, and the East Units' medication room door was found to be unlocked, therefore leaving medications unsecured. Findings include: Review of the facility Policy titled, Medication Storage Room/Medication Cart, dated 02/2018, indicated that the facility provides pharmaceutical services that are conducted in accordance with accepted ethical and professional standards of practice and that meet Federal, State, and Local Laws, rules and regulations. The Policy further indicated that medications are stored primarily in a locked mobile medication cart, however storage for other medications will be limited to a locked medication room. During an observation on 12/09/24 at 11:56 A.M., the Surveyor observed the medication room door on Unit #1 was open, unlocked and access to medications was not secured. At the time of the observation, there were two nurses working on unit, however neither of the nurses were at the nurses station or in the surrounding area for approximately 10 minutes. During an interview on 12/09/24 at 12:10 A.M., Nurse #1 said she did not know that the medication room door was open and said she did not have a key to the medication room. Nurse #1 said that the medication room door should be closed and locked at all times. During an observation on 12/09/24 at 12:17 P.M., the Surveyor observed that the medication room door on the Unit #2 was unlocked and that access to medications was not secured. During an interview on 12/09/24 at 12:18 P.M., Nurse #3 said she did not know that the medication room door was unlocked. Nurse #3 said that the nurses were having difficulty with the key when trying to open the door, and that it had been reported to facility maintenance. Nurse #3 said that the medication room door should always be kept locked. During an interview on 12/09/24 at 12:25 P.M., the Maintenance Director said that no one had ever reported to him that the lock/key to the medication room door on Unit #2 had not been working properly. During an interview on 12/09/24 at 4:14 P.M., the Director of Nurses (DON) said that it is the Facility's expectation that all medications room doors be locked and medications always secured.