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	03/18/2025

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 15203 Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who was alert and oriented, the Facility failed to ensure he/she was treated in a dignified and respectful manner, when on 2/24/25, after being found a second time with a vape pen (electronic cigarette is a handheld device consisting of a battery attached to a cartridge filled with a liquid solution that is vaporized and simulates tobacco or marijuana smoking) in his/her possession, the Assistant Director of Nurses (ADON) asked Resident #1 to come to her office, accompanied by two other staff members for a skin check, during which Resident #1 was instructed to and removed his/her upper body clothing items, as part of a strip search. Findings include: Review of the Facility Notice of Resident Rights Policy, most recently revised 1/01, indicated the Facility must promote and protect the rights of residents. Review of the Facility Room Entry and Search Policy, dated April 2016, indicated the Facility may enter and search a resident room if there is reason to believe that an illegal activity or a health and safety threat is occurring or has occurred in the resident room. The Policy indicated that the resident is allowed to be present for room searches. Review of Resident #1's clinical record indicated that he/she was admitted to the Facility during February 2025 for rehabilitation of injuries sustained as a pedestrian involved in a traffic accident. His/her diagnosis included polysubstance abuse, post-traumatic stress disorder and anxiety disorder. Review of Resident #1's most recent Minimum Data Set (MDS) Assessment, dated 2/06/25, indicated his/her cognitive patterns were intact and he/she used tobacco. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 2/26/25, indicated that Resident #1 reported that the ADON and a certified nurse aide (CNA) strip searched him/her. (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 3/18/25 at 10:15 A.M., Resident #1 said that while a resident at the Facility, one of the nurses found two vape pens (electronic cigarette is a handheld device consisting of a battery attached to a cartridge filled with a liquid solution that is vaporized and simulates tobacco or marijuana smoking) hidden under his/her shirt. Resident #1 said that after being found [a second time] with a vape pen, when staff searched his/her room, took the vape pen away from him/her, and that the ADON and CNA #1 strip searched him/her in the ADON's office. During an interview on 3/18/25 at 1:00 P.M., the ADON said that on 2/24/25 one of the nurses reported to her that Resident #1 had been found with two vape pens. The ADON said that she asked the Security Officer and Social Worker #1 to complete a room search, per the Facility Room Search Policy. The ADON said that during the room search Resident #1 became upset and was yelling about the room search in the hallway. The ADON said that following the room search she asked Resident #1 to come to her office to discuss having been found with vape pens and the resulting room search. The ADON said that Social Worker #1, the Security Officer and CNA #1 came to her office with Resident #1. The ADON said that once in her office, she informed Resident #1 that a skin check needed to be conducted. The ADON said that she thought skin checks were required per facility policy for all Facility residents' when room searches were conducted. The ADON said once inside her office, that Resident #1 just ripped off his/her shirt and told the ADON they could complete the skin check in her office so that he/she (Resident #1) could get his/her vape pens back. The ADON said that CNA #1 removed Resident #1's bra and held up his/her (Resident #1's) shirt in front of him/her to cover his/her chest area. The ADON said that they did not remove Resident #1's leggings, but stretched the waistband away from his/her body to look inside of them. The ADON said that she removed Resident #1's shoes and checked his/her feet. During a telephone interview on 3/27/25 at 1:40 P.M., CNA #1 said that on 2/24/25 the ADON approached her while she was caring for a resident to ask for her assistance with Resident #1's skin check. CNA #1 said that she suggested that the ADON ask Resident #1's assigned CNA, however, a few minutes later, the Security Officer told her that the ADON was looking for her. CNA #1 said that she went to Resident #1's room, but Resident #1 was not there and Social Worker #1 told her that Resident #1 and the ADON were in the ADON's office. CNA #1 said that when she and Social Worker #1 went to the ADON's office, the ADON asked Resident #1 whether he/she wanted to go to his/her room and conduct the skin check in the ADON's office. CNA #1 said that Resident #1 said that it was fine to do the skin check in the office and Resident #1 proceeded to remove his/her shirt. CNA #1 said that Resident #1 removed his/her bra and she (CNA #1) held Resident #1's shirt over his/her (Resident #1's) chest area to offer Resident #1 privacy because the shade in the ADON's office window was partly open. CNA #1 said that she checked Resident #1's chest, back and arms without any unusual finding. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #1 said that the ADON told her to remove Resident #1's pants and CNA #1 said that she told the ADON that she could not because Resident #1 was not able to stand. CNA #1 said that Resident #1 said that he/she could stand and proceeded to stand on one leg and lean on the arm of his/her wheelchair. CNA #1 said that she did not remove Resident #1's leggings because she thought it would be too difficult for Resident #1 to remain standing for very long and she looked inside the waist band of Resident #1's leggings without finding anything. CNA #1 said that the ADON asked her to remove and check Resident #1's shoes, but she did not. CNA #1 said she checked Resident #1's ankles without any finding. CNA #1 said that Resident #1 was upset during the skin check. During an interview on 3/18/25 at 11:15 A.M., the Director of Nursing (DON) and Administrator said that on 2/26/25 they became aware of an allegation that the ADON had strip searched Resident #1 following an incident in which vape pens were confiscated from him/her by nursing staff. The Director of Nursing and Administrator said that during the Facility investigation of the allegation, the ADON told them that she conducted a skin check on Resident #1 following his/her room search because she thought skin checks were required, per facility policy, following confiscation of contraband items. The Director of Nursing and Administrator said that Facility did not have a policy or procedure which instructed staff to complete skin checks or strip searches following room searches or the discovery of residents possessing contraband and the ADON should not have completed a skin check or strip search of Resident #1 in his/her office on 2/24/25. On 3/18/24 the Facility was found to be in past non-compliance. The Facility provided the Surveyor with a plan of correction which addressed the concern as evidenced by: A. On 2/26/25, the ADON, CNA #1 and Social Worker #1 received verbal reprimands, in-servicing and education regarding Resident #1's skin check/strip search on 2/24/25. B. Resident #1 was seen by the Director of Social Services on 2/26/25 for support related to the alleged incident and continued to receive regular supportive visits with the Substance Use Disorders Counselor until his/her discharge in March 2025. C. On 2/27/25, the Staff Development Coordinator/designee initiated education and training for all Facility staff on abuse reporting and including the need to report uncomfortable/unusual events immediately to the Administrator, Director of Nursing or Compliance Officer. D. On 2/26/25, the ADON received one to one training from the Director of Nursing on the Facility Skin Check and Room Search Policies and initiated a 12 week training course on substance use disorder programs. E. On 2/27/25, the Director of Nursing reviewed the circumstance of the sole other room search that the ADON had participated in since her employment (for a previously discharged resident) without identifying any resident rights concerns. F. The circumstance of the incident were reviewed to determine need for an immediate Ad-Hoc QAPI meeting and the correction plans will be reviewed by the Quality Assurance Committee in March 2025. G. The Administrator and/or designee are responsible for overall compliance.