| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 225215 | A. Building<br>B. Wing | 01/28/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Southshore Health Care Center | 115 North Avenue<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on records reviewed and interviews, for one of three sampled residents (Resident #1), whose physicians orders included the administration of a controlled substance medication, the facility failed to ensure that medication was properly secured and under direct supervision of nursing staff, when on 01/06/26 after administering him/her the medication, Nurse #1 left the blister pack card containing oxycodone (narcotic medication) unattended in Resident #1's room.Findings include:Review of the Facility's Policy titled Medication Storage in the Facility-ID1: Storage of Medications, undated, indicated that medications and biologicals are stored safely, securely, and properly.Review of the Facility's Policy titled Medication Storage in the Facility-ID2: Controlled Substance Storage, undated, indicated the following:-medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility in accordance with federal, state and other applicable laws and regulations.-schedule II-V medications and other medications subject to abuse or diversion are stored in a permanently affixed, double-locked compartment separate from all other medications.Review of the Facility's Investigation Report, dated 01/09/26, indicated that on 01/06/26 a staff nurse (Identified as Nurse #1) brought Resident #1's blister pack card of medication (packaging system for multiple doses of a medication that consists of individual pockets or blisters that hold tablets or capsules sealed with a strong paper-backed or aluminum foil which is easily pushed through to dispense) to his/her room and administered the medication to him/her at approximately 7:30 P.M. The Report indicated that when exiting Resident #1's room the nurse forgot to pick up his/her medication blister pack from the bedside table.The blister pack card contained oxycodone 5 milligrams (mg) tablets, which had 34 tablets in total remaining on the card.The Report indicated that Nurse #1 then remembered she had forgotten the medication blister pack card on Resident #1's bedside table, she went back to Resident #1's room to retrieve it and noted that the medication blister pack card was no longer on Resident #1's bedside table.The Report further indicated that the Director of Nursing (DON) was made aware of the incident, staff conducted a search of Resident #1's room and the medication blister pack card was not found.Resident #1 was admitted to the Facility in December 2025, diagnoses included quadriplegia C1-C4 complete (loss of sensation and motor function in all four limbs caused by cervical spinal cord injury), muscle weakness, neuropathic bladder (nerve damage from spinal cord injuries causing urinary incontinence), seizures, and atrial fibrillation.Review of Resident #1's Physician Order, dated January 2026, indicated he/she had an order for Oxycodone 5 milligrams (mg) tablet, give (2 tablets) total of 10 mg by mouth every four hours as needed (PRN) for severe pain.Review of Resident #1's Nurse Progress Note (written by Nurse #1), dated 01/06/26, indicated that Resident #1 requested oxycodone for pain and his/her medication was administered. The Note indicated that Nurse #1 went to check on Resident #1 when she realized she had left the<br><br>(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 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | blister pack card in his/her room, asked Resident #1 if he/she saw the oxycodone and he/she denied seeing the blister pack. The Note further indicated that the DON was notified.During an interview on 01/28/26 at 2:54 P.M. (which included review of her written statement), Nurse #1 said she worked the 3:00 P.M. to 11:00 P.M. shift on 01/06/26 and was assigned to care for Resident #1. Nurse #1 said Resident #1 complained of overall body pain, requested oxycodone and that Resident #1 told her that he/she wanted to make sure she was going to give him/her the oxycodone.Nurse #1 said she checked Resident #1's physician orders, unlocked the narcotic drawer, took the whole medication blister card of oxycodone and a medication cup into Resident #1's room. Nurse #1 said she showed Resident #1 the medication blister card so he/she could see that he/she was going to receive two oxycodone tablets. Nurse #1 said after she dispensed two tablets into the medication cup, there were 34 tablets of oxycodone left on the card. Nurse #1 said she placed the medication card on the bedside table, administered the medication to Resident #1 and left his/her room.Nurse #1 said about thirty minutes later she went to administer a narcotic medication to another resident and saw that Resident #1's medication card of oxycodone was not in the narcotic draw. Nurse #1 said she told Nurse #3 that she had misplaced Resident #1's oxycodone, and they both searched the medication cart, but could not find it.Nurse #1 said she realized she had left the medication card in Resident #1's room, so she immediately went to his/her room to look for it but said that the medication card was not on the bedside table. Nurse #1 said she called the DON and reported to her that she had left Resident #1's medication in his/her room and that she could not find it.Nurse #1 said she should not have brought the whole medication card into Resident #1's room but said she did it to prove to Resident #1 that he/she was getting the right medication and dose.During an interview on 01/28/25 at 2:28 P.M. (which included review of her written statement), Nurse #3 said on 01/06/26 Nurse #1 informed her that she (Nurse #1) could not find Resident #1's medication blister card of oxycodone. Nurse #3 said she and Nurse #1 looked through the locked medication narcotic draw, then the whole medication cart and said they did not find Resident #1's oxycodone.Nurse #3 said she asked Nurse #1 when the last time was that she had seen the medication card. Nurse #3 said Nurse #1 told her that she (Nurse #1) brought the medication card into Resident #1's room, gave him/her the oxycodone and that she (Nurse #1) could not remember what she did with the medication card after that.Review of the Narcotic Book page number 114 for Resident #1, indicated that on 01/06/26 at 19:20 P.M. (7:20 P.M.) the oxycodone amount on hand was 36, amount used was two, amount left was 34 and signed by Nurse #1. During an in-person interview 01/28/26 at 4:42P.M. and a follow-up telephone interview on 02/03/26 at 3:09 P.M., the Director of Nurses (DON) said on 01/06/26 Nurse #1 notified her that she (Nurse #1) could not find Resident #1's blister card of oxycodone and that she and Nurse #3 had looked everywhere. The DON said she started her investigation and the following morning (01/07/26) she reviewed video footage from the previous night with the Maintenance Director. The DON said the video footage showed that Nurse #1 entered Resident #1's room carrying a medication card, cup of water and medication cup and said when Nurse #1 exited Resident #1's room the medication card was not seen in her hand.The DON said Nurse #1 told her that she brought the whole card of oxycodone into Resident #1's room because he/she was accusatory towards her related to not receiving his/her pain correct medication. The DON said Nurse #1 told her that she dispensed two oxycodone pills from the card, she put the medication card on the bedside table, administered the medication to Resident #1 and she (Nurse #1) left Resident #1's room without the medication card. The DON said it was not typical or best practice for nurses to bring a whole medication card into a resident's room and said nurses should not be doing so. The DON said nurses should only be bringing in the exact amount of medication to be administered to a resident.The DON said it is her<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | expectation that nurses prepare all medications at the medication cart, secure the medication card per facility policy, and said that any type of medication should not be left unattended at a resident's bedside. |