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	04/13/2026

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and records reviewed, for three of four sampled residents (Residents #1, #3 and #4), who had court appointed legal representatives or health care agents, the Facility failed to ensure it honored requests for copies of medical record information within two working days, when their representatives requested copies of documentation from their medical records verbally and/or through email correspondence, but were not provided with copies in accordance with federal regulations.Findings include: Review of the Facility Medical Record Policy and Procedure, dated January 2020, indicated it was the policy of the Facility to honor a resident's right of access to inspect and obtain a copy of their protected health information.Resident #1's clinical record indicated he/she was admitted to the Facility during July 2023 and his/her diagnoses included schizoaffective disorder.Resident #1's clinical record contained documentation which indicated the court appointed him/her a legal Guardian in April 2023.Review of Resident #1's most recent Quarterly Minimum Data Set (MDS) Assessment, dated 1/16/26, indicated Resident #1 cognitive patterns were intact.During a telephone interview on 4/13/26 at 10:09 A.M., Resident #1's Guardian said that it was difficult to obtain copies of documents from Resident #1's clinical records from the Facility. The Guardian said that the Facility response to requests for clinical records took longer than it should and caused unnecessary delays.Review of email correspondence, dated 3/03/26, from Resident #1's Guardian to the Facility Social Worker indicated that the Guardian requested copies of Resident #1's medications and treatments sheets.Review of the Facility's Internal Investigation, dated 3/10/26, indicated the medication and treatment sheets were emailed to Resident #1's Guardian on 3/10/26, 7 days after they were initially requested.During an interview on 4/13/26 at 4:00 P.M., the Administrator said that there had been issues with the Facility's timely response to the Guardian's request for documents from Resident #1's clinical record.Resident #3's clinical record indicated he/she was admitted to the Facility during June 2025 and his/her diagnoses included bipolar disorder.Review of Resident #3's most recent Quarterly MDS Assessment, dated 1/09/26, indicated Resident #3 cognitive patterns were intact.During a telephone interview on 04/13/26 at 9:10 A.M., Family Member #1 said she was Resident #3's Health Care Agent. Family Member #1 said Resident #3 was completing a disability application which required documentation from the his/her clinical records and that she and his/her Attorney requested medical records from the Facility during 2025 which the Facility did not provide.During a telephone interview on 04/15/26 at 2:40 P.M., the Attorney said that on 12/01/25 he made a written request, which he provided to the Facility via fax, for documents from Resident #3's clinical record. The Attorney said that on 12/12/25, the Facility notified him that he needed to complete a specific form to make the request and he provided the completed form as required, via fax. The Attorney said that the Facility did not respond to his request or provide the requested documents.During an interview on 4/13/26 at 3:42 P.M., the Director of Nursing said that she was not aware that there had been requests for copies from Resident #3's medical record and, when she checked with medical records, they were unable to locate documentation for a response to the Attorney's request.Resident #4 was admitted to the Facility in November 2021, diagnoses include (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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Parkinson's Disease, bipolar disorder, Hepatitis C, and repeated falls.Review of Resident #4's Quarterly MDS dated [DATE], indicated that his/her Brief Interview for Mental Status (BIMS) score was a three (3), indicating severe cognitive impairment (13-15 indicates cognitively intact, 8-12 indicates moderately impaired cognition, and 0-7 indicates severe cognitive impairment).Review of Resident #4's Physician's Orders, dated 3/2026, indicated that on 12/12/24 his/her Health Care Proxy (HCP) was invoked.During a telephone interview on 04/15/26 at 8:58 A.M., Resident #4's Health Care Agent (HCA) said that she requested copies of his/her medical records in September 2025. The HCA said that she was given and had completed the necessary paperwork to obtain the records.The HCA said that she has requested the copies of records numerous times and the Facility continues to say that they will look into it. The HCA said that she has yet to receive any copies of Resident #4's medical records.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interviews and records reviewed, for two of three sampled residents (Residents #1 and #3) the facility failed to ensure it protected and facilitated the resident's right to communicate with individuals and entities external to the facility, when staff failed to answer the Facility telephone on multiple days, leaving the telephone to ring and ring unanswered. Findings include: Resident #1's clinical record indicated he/she was admitted to the Facility during July 2023 and his/her diagnoses included schizoaffective disorder. Resident #1's clinical record contained documentation which indicated the court had appointed him/her a legal Guardian in April 2023.Review of Resident #1's most recent Quarterly Minimum Data Set (MDS) Assessment, dated 1/16/26, indicated Resident #1's cognitive patterns were intact.During a telephone interview on 4/13/26 at 10:09 A.M., Resident #1's Guardian said that on multiple dates, when she called the Facility, the phone often rang and rang and went unanswered. The Guardian said that although Resident #1 had a telephone in his/her room, if he/she did not answer the phone, she called the Facility to assist her in getting in touch with Resident #1, however, the Facility phone was often not answered. The Guardian said that during these times, she would call the Facility repeatedly and allow the phone to ring and ring, however, her call would go unanswered.Resident #3's clinical record indicated he/she was admitted to the Facility during June 2025 and his/her diagnoses included bipolar disorder.Review of Resident #3's most recent Quarterly MDS Assessment, dated 1/09/26, indicated Resident #3 cognitive patterns were intact.During a telephone interview on 04/13/26 at 9:10 A.M., Family Member #1 said she was Resident #3's Health Care Agent (HCA). Family Member #1 said that when she called the Facility to speak to Resident #3, it was difficult getting someone in the Facility to answer the telephone. Family Member #1 said that on multiple occasions when she called the Facility repeatedly and the phone rang and rang and was not answered.During a telephone interview on 04/15/26 at 12:20 P.M., the Case Manager said that she was Resident #3's case manager. The Case Manager said that on occasion when she called the Facility to speak to Resident #3 or to speak to staff about Resident #3, the phone was not answered.During an interview on 4/13/26 at 4:22 P.M., the Administrator said on 2/24/26, she had received complaints about the facility's telephones not being answered, from Resident #1's Guardian, as well as other family members, and initiated an investigation. On 4/13/26, the Facility was found to be in Past Noncompliance and presented the Surveyor with a plan of correction, with an effective date of 3/10/26, which addressed the area(s) of concern as evidenced by:A) On 2/26/26, training of all Facility nurses was initiated by the Staff Development Coordinator/designee on phone protocols.B) On 2/26/26, the hours worked by the Receptionist (who managed the Facility telephone) were expanded to include coverage of the phones until 8:00 P.M.C) On 3/09/26, the Administrator offered Resident #1's Guardian a schedule of weekly telephone calls in order to enhance simplicity of contacting Resident #1 or Facility staff. D) By 3/09/26, portable telephone handsets had been provided to all Facility units to enable nurses to monitor the phones when away from the nursing station.E) By 3/09/26, wall mounted phones were installed and/or repaired on the Facility units to increase the ability of staff to hear the telephone ringing when away from the nursing station.F) During the March 2026 Resident Council Meeting, Residents were asked about telephone access and no issues were reported.G) Starting 2/26/26, the Administrator and/or the Director of Nursing monitored any grievances and complaints related to telephone access by residents, response to incoming calls by facility staff, as reported by residents/responsible persons and there have been no issues reported.H) The Administrator, Director of Nursing and/or their designee(s) are responsible for overall compliance.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews for one of four sampled residents (Resident #4), the Facility failed to ensure they reported an injury of unknown origin to the State Survey agency. On 03/11/26, Resident #4 was observed with an injury of unknown origin and was transferred to the Hospital Emergency Department (ED) for evaluation, however the injury was not reported to their State Agency as required.Findings include:Review of the Facility Policy titled Abuse, Neglect, and Exploitation, dated 2023, indicated the Facility will develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property and establish policies and procedures to investigate any such allegations.The Policy indicated reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within a specific time frame:-Immediately, but no later than two (2) hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or-Not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in bodily injury.Resident #4 was admitted to the Facility in November 2021, diagnoses include Parkinson's Disease, bipolar disorder, Hepatitis C, and repeated falls.Review of Resident #4's Quarterly Minimum Data Set (MDS) dated [DATE], indicated that his/her Brief Interview for Mental Status (BIMS) score was a three (3), indicating severe cognitive impairment (13-15 indicates cognitively intact, 8-12 indicates moderately impaired cognition, and 0-7 indicates severe cognitive impairment).Review of Resident #4's Physician's Orders, dated 3/2026, indicated that his/her Health Care Proxy (HCP) was invoked on 12/12/24.Review of Resident #4's Nurse Progress Note (written by Unit Manager #1), dated 03/12/26, indicated he observed a red bump on his/her forehead with a split in the skin. The Note indicated there was no witnessed fall and he/she was transferred to the Hospital Emergency Department (ED) for evaluation. Review of Resident #4's ED Discharge summary, dated [DATE], indicated he/she presented from the Facility with a small hematoma and laceration on his/her forehead, increased somnolence and confusion.Review of Resident #4's Medical Record, indicated there was no documentation to support the injury of unknown origin was reported to the State Survey Agency as required.During a telephone interview on 04/15/26 at 8:58 A.M., Resident #4's Health Care Agent (HCA) said that a staff nurse called her on 03/12/26 to inform her Resident #4 had a bump on his/her forehead. The HCA said the nurse told her they were unaware of how he/she sustained the bump, but that he/she was going to be transferred to the ED for evaluation.During an interview on 04/13/26 at 12:58 P.M., Certified Nurse Aide (CNA) #4 said that she was the CNA assigned to Resident #4 on 03/12/26 and said the bump was not there while providing him/her with morning care.CNA #4 said she noticed the bump on his/her head around lunch time and reported it to the Nurse.During a telephone interview on 04/21/26 at 11:03 A.M., Nurse # 9 said on 03/12/26, Resident #4 had been at an activity and when he/she returned the staff member informed her that a bump was noted on Resident #4's head.Nurse # 9 said that there was a small bump on his/her head and we sent him/her out for evaluation because we did not know what it was. During an interview on 04/13/26 at 1:38 P.M., Unit Manager #1 said on 03/18/26, a bump was noted on Resident #4's forehead and he/she was sent out to the ED for evaluation.During an interview on 04/13/26 at 3:41 P.M., the Director of Nurses (DON) said that she was not made aware of the bump found on Resident #4's until days after the injury had been discovered.The DON said that when she had found out about the incident, she said it should have been reported as an injury of unknown origin to the State.The DON said that it is the Facility's expectation that if an injury of unknown origin is discovered by the staff, it must be immediately reported to the DON and Administrator and if the circumstances warrant, the incident will be reported to the DPH and any other agency as required.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records reviewed and interviews for one of four sampled residents (Resident #4), who on 03/12/26 was found with an injury of unknown origin (bump on Resident #4's forehead), the Facility failed to ensure they conducted and maintained evidence of an investigation into the injury.Findings include:Review of the Facility Policy titled Accidents/Incidents, dated 04/2015, indicated that it is the responsibility of the staff to report all accidents and incidents which occur at the Facility.The Policy indicated that all accidents and incidents must be reported to the supervisor and appropriate documentation must be completed and every attempt will be made to ascertain the cause of the occurrence.Review of the Facility Policy titled Abuse, Neglect, and Exploitation, dated 2023, indicated that an immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, or exploitation occur. The Policy indicated that an alleged violation is a situation or occurrence that is observed or reported by staff, but has not yet been investigated, and if verified, could be an indication of non-compliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown origin. Resident #4 was admitted to the Facility in November 2021, diagnoses include Parkinson's Disease, bipolar disorder, Hepatitis C, and repeated falls.Review of Resident #4's Quarterly Minimum Data Set (MDS) dated [DATE], indicated that his/her Brief Interview for Mental Status (BIMS) score was a three (3), indicating severe cognitive impairment (13-15 indicates cognitively intact, 8-12 indicates moderately impaired cognition, and 0-7 indicates severe cognitive impairment).Review of Resident #4's Physician's Orders, dated 3/2026, indicated that his/her Health Care Proxy (HCP) was invoked on 12/12/24.Review of Resident #4's Hospital Emergency Department (ED) Discharge summary, dated [DATE], indicated he/she presented from the Facility with a small hematoma and laceration on his/her forehead, with increased somnolence and confusion.Review of Resident #4's Medical Record indicated and the facility was unable to provide any documentation to support the injury of unknown origin was investigated as required.Review of Resident #4's Nurse Progress Note (written by Unit Manager #1), dated 03/12/26, indicated he had observed a red bump on his/her forehead with a split in the skin. The Note indicated there was no witnessed fall and he/she was transferred to the ED for evaluation. During a telephone interview on 04/15/26 at 8:58 A.M., Resident #4's Health Care Agent (HCA) said that a staff nurse called her on 03/12/26 to inform her that Resident #4 had a bump on his/her forehead. The HCA said the nurse told her they were unaware of how he/she sustained the bump, but that he/she was going to be transferred to the ED for evaluation.During an interview on 04/13/26 at 12:58 P.M., Certified Nurse Aide (CNA) #4 said that she was the CNA assigned to Resident #4 on 03/12/26 and said the bump was not there while providing him/her with morning care.CNA #4 said she noticed the bump on his/her head around lunch time and reported it to the Nurse.During a telephone interview on 04/21/26 at 11:03 A.M., Nurse #9 said on 03/12/26, Resident #4 had been in an activity and when he/she returned the staff member informed her that a bump was noted on Resident #4's head.Nurse #9 said that Unit Manager #1 was made aware of the injury. Nurse #9 said she did not fill out an incident report and did not think an investigation of how the injury occurred was completed. During an interview on 04/13/26 at 1:38 P.M., Unit Manager #1 said on 03/18/26, a bump was noted on Resident #4's forehead and he/she was sent out to the ED for evaluation.Unit Manager #1 said that he did not initiate an investigation and he did not fill out an incident report related the discovery of an injury of unknown origin. During an interview on 04/13/26 at 3:41 P.M., the Director of Nurses (DON) said that she was not made aware of the bump found on Resident #4's until days after the injury had been discovered.The DON said that it is the Facility's expectation that if an injury of unknown origin is discovered by the staff, it must be immediately reported to the DON and Administrator and so an investigation could have been conducted timely.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on interviews and records reviewed, for two of four sampled residents (Residents #1 and #3) whose diagnoses included psychiatric disorders, the Facility failed to ensure they received and were provided appropriate Behavioral Health services that addressed and met their mental health needs.Findings include: The Facility Behavioral Management Guidelines Policy, dated April 2015, indicated it was the policy of the Facility to develop behavior plans and medication regimes, when appropriate, to optimize the functional abilities of residents.The Facility Assessment, dated as most recently updated 3/23/26, indicated the resident population served by the Facility included residents with psychiatric/mood disorders. The Assessment indicated the services provided by the Facility to address resident needs included consultant psychiatric services.The Behavioral Health Services Agreement between the Facility and the Psychiatric Service Agency, dated 9/21/23, indicated the Agency provided psychotherapeutic services to residents of the Facility.Resident #1's clinical record indicated he/she was admitted to the Facility during July 2023 and his/her diagnoses included schizoaffective disorder. Resident #1's clinical record contained documentation which indicated the court had appointed him/her a legal Guardian in April 2023.Review of Resident #1's most recent Quarterly Minimum Data Set (MDS) Assessment, dated 1/16/26, indicated Resident #1 cognitive patterns were intact.Review of Resident #1's Care Plan for Behavior-related to a diagnosis of schizoaffective disorder, initiated 1/23/24, indicated interventions including investigate/monitor the need for psychological/psychiatric support and provide services as ordered by the physician.Review of the Physician Orders indicated he/she had an order, dated 9/23/24, for psychiatric consult and treatment as indicated.Review of the Psychological Service Note, dated 11/20/25, indicated that Resident #1 was terminated from ongoing counseling with the therapist as the therapist was leaving the Agency.During an interview on 4/13/26 at 1:15 P.M., Resident #1 said that he/she had been asking Facility staff for a mental health therapist since his/her prior therapist left and the Facility had not provided one. Resident #1 said that he/she thought Facility staff did not understand why he/she wanted a therapist.During a telephone interview on 4/13/26 at 10:09 A.M., Resident #1's Guardian said that the therapist who had provided Resident #1 with therapy/counseling, left the Facility without notice during 2025 and since that time the Facility had not obtained a replacement therapist to provide counseling services to Resident #1.During a telephone interview on 4/13/26 at 11:17 A.M., the Psychiatric Nurse Practitioner said he worked for the Psychiatric Service Agency and saw Resident #1 monthly for psychotropic medication monitoring. The Psychiatric Nurse Practitioner said that the therapist left the Agency in November 2025, and the Agency had not replaced them. The Psychiatric Nurse Practitioner said that Resident #1 would benefit from on-going, weekly counseling.Resident #3's clinical record indicated he/she was admitted to the Facility during June 2025 and his/her diagnoses included bipolar disorder.Review of Resident #3's most recent Quarterly MDS Assessment, dated 1/09/26, indicated Resident #3 cognitive patterns were intact.Review of Resident #3's Care Plan for Alteration in Mood related to a diagnosis of bipolar disorder, dated as initiated 6/30/25, indicated interventions included one to one therapy per recommendations.Review of the Psychological Service Note, dated 11/20/25, indicated that Resident #3 was terminated from ongoing counseling with the therapist as the therapist was leaving the Agency.During an interview on 4/13/26 at 1:00 P.M., Resident #3 said that he/she had been seeing a mental health therapist at the Facility and he/she did not know the reason therapy stopped, however, he/she would resume counseling if it were available.During a telephone interview on 04/15/26 at 12:20 P.M., the Case Manager said that she was Resident #3's case manager. The Case Manager said that Resident #3 would absolutely benefit from counseling and the lack of counseling had been a point of contention with the Facility. The Case Manager said that she did not know the reason that the Facility stopped providing counseling services to Resident #3.During an interview on 4/13/26 at 4:22 P.M., the (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administrator said that the Psychiatric Service Agency had not been able to provide a therapist for the Facility residents, including Residents #1 and #3, since November 2025.