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	06/27/2024

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 36542 Based on interview and record review, the facility failed to promote the rights of one Resident (#26) to leave the facility, in a total sample of 19 residents. Specifically, the facility restricted Resident #26, who was their own responsible person, from leaving the facility with persons of their choice based on a history of substance use disorder. Findings include: Review of the facility's policy titled Leave of Absence, dated December 2015, indicated the following: -Nursing staff will obtain an order for leave of absence with responsible party for a resident/patient on admission. Responsible party may include self if the resident is his/her own responsible party -If a resident is their own responsible party, they may go on a leave of absence unattended Resident #26 was admitted to the facility in April 2019 with a history of substance use disorder. Review of the Minimum Data Set (MDS) assessment, dated 5/29/24, indicated Resident #26 scored 14 out of 15 on the Brief Interview for Mental Status (BIMS), indicating the Resident was cognitively intact. Review of the medical record indicated Resident #26 continued to be their own responsible person. During an interview on 6/24/24 at 4:30 P.M., Resident #26 said he/she was previously able to leave the facility with his/her significant other to attend support meetings and was no longer allowed to leave with the significant other, only with family members. Review of the Physician's Orders indicated the following orders were active as of 6/27/24: 11/1/23: may not have leave of absence at this time per physician 1/25/24: may go out for leave of absence with sisters per physician (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician's Orders included the following orders were completed or discontinued as of 6/27/24: 11/19/23: may have one time order for leave of absence for support meeting for two to three hours on 11/19/23 with responsible party. Resident must have belongings searched upon arrival back into the facility per physician and Administrator. 11/22/23: may go on leave of absence with significant other for one time, approved by Administrator on 11/22/23. May obtain urine and blood labs and search Resident when he/she comes back. 11/23/23: may go on leave of absence with significant other for one time, approved by Administrator on 11/23/23. May obtain urine and blood labs and search Resident when he/she comes back. 12/3/23: may go on leave of absence with sisters on 12/3/23 for not longer than four hours, approved by Administrator. 12/14/23: may go on leave of absence with friend (on 12/13/23) for two to four hours, physician and Administrator aware. Review of the progress notes indicated the following: 11/1/23: Resident requested to go out with a friend, nurse informed the Resident of the order from the physician indicating the Resident could not go on a leave of absence and did not allow the Resident to leave with his/her friend 11/1/23: Social Worker met with Resident and explained the Resident needed medical clearance to leave the facility due to recent events and toxicology report 11/14/23: nursing progress note indicated a new order for the Resident to resume leave of absence activities if cleared by the Social Worker, administration aware. 11/17/23: Family meeting held to discuss Resident's sobriety. Resident gained an LOA (leave of absence) to spend a few hours with family. 11/18/23: nursing progress note indicated the Resident requested to go on a leave of absence. The nurse indicated the order remained for no leave of absence and the Resident responded, I am grown, you can't keep me here. The nurse contacted the Resident's sister to talk to the Resident. The note indicated per the physician and the Administrator the Resident may attend a support group the following day for two to three hours and must be searched upon arrival back to the building. The note indicated the Resident was informed of order and agreeable to plan. 11/22/23: Resident went out with significant other; physician was contacted who said he was unable to give an order and the Social Worker and the Administrator make the decision and that any decision was okay by him. The Administrator gave the okay and agreed upon return that the Resident should be searched to rule out bringing any outside material and may obtain labs. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/23/23: nursing progress note indicated the Resident was out with their significant other and the Administrator gave the okay for a one-time order for 11/24/23 and may search upon return to rule out bringing in any material and may obtain labs. 11/25/23: Resident went out with significant other; Administrator approved one time order and may search upon return to rule out bringing in outside material and may obtain labs. 11/28/23: Social Worker indicated Resident #26's significant other was only permitted to enter the lobby to pick up and drop off the Resident and was not allowed inside the facility due to behavior. 11/29/23: Social Worker held a conference call with Resident and Resident's family. The Social Worker advised for leave of absences to be revoked, unless with family. Plan was in agreeance. The Social Worker spoke to the Administrator who agreed not to issue a 30-day notice of discharge and revoke leave of absence unless with family. 12/3/23: Resident requested to go to support meeting with family, nurse noted there was no order in place and called the Resident's family to confirm she was picking up the Resident. The nurse contacted the Administrator who approved a leave of absence with family on this date. 12/13/23: Resident out with friend for two to four hours, physician and Administrator aware. 2/5/24: substance use disorder counselor note indicated Resident complained about not being able to go out with significant other. The note indicated the writer reminded the Resident of safety precautions and encouraged Resident to focus on recovery and making safer decisions for him/herself. The Resident said he/she still did not agree with the decision. During an interview on 6/25/24 at 4:15 P.M., Resident #26 said the facility did not allow their significant other into the facility and did not allow Resident #26 to go out with their significant other. The Resident said he/she was only allowed to leave the facility with his/her family. Resident #26 said the only time he/she got to see their significant other was when they attended the same support meetings in the community. The Resident added it's put a real damper on my relationship. During an interview on 6/26/24 at 12:43 P.M., Certified Nursing Assistant #1 said the Resident only goes out with family. She said the Resident would previously go out with other people, but she was not sure what happened. During an interview on 6/26/24 at 12:45 P.M., Unit Manager #1 said Resident #26 could not go out with their significant other due to previously returning intoxicated. The Unit Manager said she thought the Resident could visit with the significant other in the lobby but was not sure. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/27/24 at 9:07 A.M., the Social Worker said Resident #26 had unsafe behavior, as demonstrated through positive toxicology reports, following leaving the facility with their significant other. She said the Resident had been out on leaves of absence with their significant other and had tested positive for cannabis days later, so the facility restricted the leave of absences with the significant other. The Social Worker said the significant other was not allowed inside the facility due to an altercation and threatening a staff member. She said the facility team had decided to restrict the leave of absences with the significant other because the Resident was not making good decisions. She further said, as the Resident was their own responsible person, that the Resident should have the right to go on a leave of absence with anyone. During an interview on 6/27/24 at 11:55 A.M., the Physician for Resident #26 said the process for orders for leave of absence was for the team to ensure a Resident was medically cleared to ensure they were physically able to leave the building. He said additional orders for leave of absence, not related to medical clearance were a team discussion based on the physician, the Administrator, the Social Worker and the nurses. He said, he as the physician was not the sole person to decide. He said there were a lot of long-term care residents at the facility who were medically cleared to leave the facility, but there were social factors (homelessness, substance use) that needed to be taken into consideration. He said if a resident was going to be safe, then they could go, but if they were going to go out and get drunk or have social issues like addiction they could not. He said the orders for leave of absence for Resident #26 were a team effort and the Resident cannot leave the facility with just anyone, he/she could only leave with family and there needed to be strong supervision.

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. 49424 Based on record review and staff interview, the facility failed to ensure the Resident Representative was fully informed in advance and given information necessary to make health care decisions to the extent required by the court for one Resident (#71), from a total sample of 19 residents. Findings include: Resident #71 was admitted to the facility in July 2023 with diagnoses that included schizoaffective disorder (a mental disorder in which a person experiences a combination of symptoms of schizophrenia and mood disorder). Review of the medical record indicated Resident #71 had been declared an incapacitated person and had a guardian appointed by the court in April 2023. The guardianship protects the rights of the person that is unable to make or communicate decisions about everyday health, care, and safety. The guardian is responsible for and must be consulted for all healthcare decisions and required consents. An alternative guardian was not assigned. During an interview on 6/27/24 at 2:18 P.M., the Resident Representative, who is the legal guardian, said she was upset the facility Social Worker had Resident #71 sign a consent form. The Resident Representative said she found this out after the Resident called the representative stating he/she was anxious about what he/she signed because he/she didn't understand the form. The Resident Representative said she emailed the Social Worker regarding this concern on 6/16/24 and informed her that all consents need to be obtained through the legal guardian. She said she was unsure if she wishes to have the Resident participate in the program for which he/she signed the consent form and did not understand. During an interview on 6/24/24 at 2:30 P.M., the Social Worker said that on 6/12/24 she had the Resident sign a consent for a community program which offers support with transitioning from a nursing home level of care and assists with obtaining housing. She said she was aware that the Resident had a legal guardian and that the legal guardian needed to sign all consents for the Resident's care including referrals to agencies. On 6/24/24 at 3:24 P.M., the Social Worker sent the consent form to the legal guardian for review and signature, 12 days after the Social Worker had the Resident sign the consent form.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 49424 Based on record review and staff interview, the facility failed to ensure for one Resident (#72), out of a sample of 19 residents that the Resident had the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he/she preferred. Specifically, the facility failed to inform the Resident of a toxicology screen (laboratory testing for substance use) being obtained. Findings include: Resident #72 was admitted to the facility in August 2023 with diagnoses that included hypertension and chronic diastolic heart failure. Review of the Minimum Data Set (MDS) assessment, dated 5/6/24, indicated Resident #72 scored 12 out of 15 on the Brief Interview for Mental Status (BIMS) assessment indicating moderate cognitive impairment. Review of the medical record indicated Resident #72 continued to be his/her own responsible party. During an interview on 6/25/24 at 3:02 P.M., Resident #72 said he/she was never made aware that toxicology labs had been obtained. The Resident said that when he/she was having blood drawn for laboratory work, staff told him/her it was routine laboratory orders and never informed him/her that they were testing for drugs. Resident #72 said he/she did not consent or agree to a drug screen being completed and was unaware of why this was done. He/She said they feel like their rights have been violated and no one talked to him/her about why a toxicology screen was obtained. Review of the medical record indicated Resident had a toxicology screen completed at the facility on 11/24/24 resulting in the Resident being found negative for all tested substances. During an interview on 6/27/24 at 9:39 A.M., the Social Worker said Resident #72 was not followed by the substance use disorder (SUD) counselor and was unsure why the Resident had a toxicology screen completed. She said she could not find documentation as to why this would have been done. During an interview on 6/27/24 at 2:21 P.M., the Director of Nurses (DON) said there was no documentation available for why a toxicology screen was completed. She said there should be supporting documentation if a toxicology screen is ordered. She said there was a physician's order to do so and was unsure if consent needed to be obtained prior for a toxicology screen to be obtained.

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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. 49424 Based on interview and record review, the facility failed to ensure one Resident (#72), out of a total sample of 19 residents, was treated with dignity and respect. Specifically, the facility failed to treat the Resident's belongings with respect during a room search. Findings include: Resident #72 was admitted to the facility in August 2023 with diagnoses that included hypertension and chronic diastolic heart failure. Further review of the Minimum Data Set (MDS) assessment, dated 5/6/24, indicated Resident #72 scored 12 out of 15 on the Brief Interview for Mental Status (BIMS) assessment indicating moderate cognitive impairment. Review of the medical record indicated Resident #72 continued to be his/her own responsible party. During an interview on 6/25/24 at 3:02 P.M., Resident #72 said that on two occasions staff had searched their room without any rationale or reason and without his/her consent. The Resident said he/she did not have a history of substance use disorder. Resident #72 said he/she thought the staff only searched rooms of people who had a history of substance use disorder and did not understand why he/she was being searched. The Resident said the room searches occurred in February 2024 and November 2023. The Resident said the second time he/she was very upset because staff took all of his/her personal belongings out of the drawers and closet and did not put them back after searching his/her room. The Resident said the room was left a mess after the search. The Resident said he/she was told it was a random search. He/She said that the Director of Nurses (DON) was present and did not put any of his/her belongings back after searching the room. Resident #72 said they felt like their rights had been violated and no one talked to him/her about why their room was searched. Review of the medical record indicated that the Resident had a physician's order on 2/28/24 for a one time room search. During an interview on 6/27/24 at 9:35 A.M., the facility's Security staff person said part of his duties included checking resident and visitor belongings when returning to the facility and conducting room searches. He said the process was to approach a resident and say, We have to check your room. He said he did not recall Resident #72 saying he/she did not agree with the room search. He said he did remember searching the Resident's room because there was suspicion of other residents sharing medications and he could not remember how this specifically involved Resident #72. During an interview on 6/27/24 at 9:39 A.M., the Social Worker said Resident #72 was not followed by the substance use disorder (SUD) counselor and was unsure why the Resident's room was searched on either occasion. She said she could not find documentation as to why this would have been done. She said there should have been a discussion with the Resident and permission should have been obtained and the search should be conducted in a respectful manner of the resident's belongings. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/27/24 at 2:21 P.M., the DON said that there was no documentation available for why a room search was completed. She said there should be supporting documentation if a resident room is searched. She said that she can recall Resident #72's room being searched but was unable to recall the details surrounding the rationale for the forced room search.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 49424 Based on a resident group meeting, staff interviews, and document review, the facility failed to ensure grievances and concerns from the Resident Council were documented to ensure they were acted upon timely and included the facility response and rationale for response. Findings include: Review of facility's policy titled Resident Council, dated 10/15, indicated but was not limited to: -Notify department heads in writing of concerns that come up during the meeting. -Retain a copy of the resolutions that address each concern. During the Resident Group meeting held on 6/24/24 at 11:00 A.M., the Resident Council President said that every month the same concerns are brought up again and again with no resolution. In addition, multiple residents said they voice their concerns month after month with no improvement in the issues they bring up. Review of Resident Council minutes from March 2024 indicated but was not limited to the following concerns brought up by residents: -The noise level of staff in hallway is too loud on the 3-11 shift on the [NAME] unit. -Medication room is not stocked. -Residents still complain about mice in living room and rooms. Review of Resident Council minutes from April 2024 indicated but was not limited to the following concerns brought up by residents: -Several residents stated nurses wait too long until the last medication to re-order. -Residents on [NAME] complain that 3-11 shift are too loud in hallway. -Residents complain that mice are still a big issue. -Lack of washcloths and towels on the unit. Review of Resident Council minutes from May 2024 indicated but was not limited to the following concerns brought up by residents: -Residents on [NAME] complain that 3-11 staff are too loud in hallway on [NAME] unit. -Several residents state the nurses wait too long to re-order medication. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Residents still complain that they see mice in their rooms. -No washcloths or towels are available when needed. During an interview on 6/25/24 at 12:42 P.M., the Recreation Director said after each group meeting, she writes up concerns and distributes them to the responsible department head. She said she expects the department heads to update their resolution on the form and return to her. She said she keeps copies of them and said there are some forms with no resolution from the department head. She said she does not review the resolution with the Resident Council Group, but they do review previous Resident Council minutes. She said she was unaware that there was no resolution for the nursing concerns brought forth in March. The resolution and signature sections were blank. Review of the resolution forms indicated that there was no follow-up or resolution identified from the nursing department in March 2024. The resolutions identified by nursing in April and May were the same and included: -Re-education of staff and talking with staff to keep noise level to a minimum. During an interview on 6/27/24 at 10:23 A.M., the Director of Nurses (DON) said she completes the concern follow-up and resolution forms as she receives them after the Resident Council group meeting and will complete staff education as needed for resolutions. There were no additional documents available for review to corroborate the education completed in March, April, and May.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 49424 Based on observation and interviews, the facility failed to maintain a clean, safe, comfortable, and homelike environment for the residents at the facility, for 2 of 2 nursing units, and throughout areas of the facility used by residents. Findings include: Review of the facility's policy titled Preventative Maintenance and Testing, last reviewed 5/05, indicated but was not limited to the following: -The facility provides a functional, sanitary, and comfortable environment for residents, personnel, and public. -Daily Building inspection includes but is not limited to inspection of hallways and exit access corridors and stairwells and ensure they remain free and unobstructed of debris; no storage should be permitted in these areas. -Inspect corridor, lobby, and public areas for obvious defects, i.e. loose handrails, peeling paint/wall covering, broken/missing ceiling assembly and floor tiles, etc. East Unit: On 6/21/24 at 8:00 A.M., and on all days of the survey, the surveyor smelled a foul, musty odor throughout the East Unit. The surveyor observed the green carpets on the East unit to have many black stains scattered throughout. On 6/26/24 at 5:19 A.M., the surveyor observed trash on the floor of the East wing. There were snacks on the bottom of a two-tiered, plastic cart with wheels with a trash bag tied to hand railing. There were open beverages and snacks and wrappers on the plastic cart. On 6/26/24 at 5:54 A.M., the surveyor observed the East tub room to have broken floor tiles and trash under the baseboards. On 6/26/24 at 5:57 A.M., the surveyor observed brown, stained ceiling tiles and peeling wallpaper on East wing and duct tape on parts of rug that were frayed and pulling away from floor. On 6/26/24 at 7:59 A.M., the surveyor observed Resident #25's room to have a dirty, soiled floor and radiator. The surveyor also observed that the tube feed pump was dirty with yellowish-brown colored tube feed formula dried on the front underside of the pump. On 6/26/24 at 8:07 A.M., Resident #52 reported that the ceiling in his/her room leaks during heavy rains. The Resident said that he/she reported the leak to nursing staff, however it had not been repaired. The Resident pointed to a small, yellow water stain where the water comes in on the ceiling tile in the middle of the room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/26/24 at 8:27 A.M., the surveyor observed dead ants and a large, dried, dark brown stain on the floor to the right of Resident #76's bed. West Unit: On 6/21/24 at 9:57 A.M., and throughout all days of survey, there was a stale, musty odor permeating throughout the [NAME] unit hallways. The surveyor observed the carpet to have multiple dark stains throughout the survey. On 6/21/24 at 10:17 A.M., the surveyor observed mouse droppings in Resident #72's bedside drawer and on the surrounding floor. During an interview on 6/24/24 at 2:06 P.M., the Ombudsman said there is a strong urine smell throughout the building that is correlated to the carpets which are visibly soiled. The Ombudsman also said she receives reports from residents of environmental concerns such as mold, loose tiles, dirty ceiling tiles, bathrooms in disrepair, and the carpet. During an interview on 6/26/24 at 5:33 A.M., Resident #46 said it always smells bad like this. During an interview on 6/26/24 at 5:35 A.M., Resident #22 said it smells bad and was unable to identify the odor. During an interview on 6/26/24 at 5:50 A.M., Nurse #1 said there is a strong smell of urine in the air on this unit. During an interview on 6/26/24 at 1:24 P.M., the Director of Housekeeping said the carpet starts to hold odors and stains because of its age and they cannot get them out even with scheduled cleanings and professional shampooing throughout the building. During an interview on 6/27/24 at 7:52 A.M., Certified Nursing Assistant (CNA) #2 said the stains do not come out of the rug, the rug smells and needs to be changed. During an interview on 6/27/24 at 7:58 A.M., Hospice Aide #1 said they have been coming to the facility for a few months and that the stains do not improve. She said the odor permeates the hallways and the rooms throughout the day. On 6/26/24 at 5:20 A.M., the surveyor observed the shower room on the [NAME] wing to have baseboards that were peeling away from wall exposing black stains on the wall behind the baseboard and on floor. On 6/21/24 at 9:57 A.M. through 6/26/24 at 10:10 A.M., the surveyor observed a wheelchair placed at the end of the hallway, in front of an emergency exit with two trash bags filled with clothing on top of the wheelchair and a basin with personal items. During an interview on 6/26/24 at 10:17 A.M., the Unit Manager said those items do not belong in the hallway and they belong to a resident who passed away last week. (continued on next page)

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Southshore Health Care Center	115 North Avenue Rockland, MA 02370

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation with an interview on 6/26/24 at 9:47 A.M., the Maintenance Director said they used to use an electronic system called TELS to alert him to environmental needs on the units. He said that the TELS system has not been in use for three or four months and that he relies on word of mouth from staff to update him on maintenance requests. There is no work order system in place currently. He said that he rounds on the floors daily but was unaware of these identified concerns including the broken baseboard and tiles. During an interview on 6/27/24 at 8:39 A.M., the Regional Director of Operations said environmental rounds should be implemented, and preventative issues should be identified. He said staff become used to things looking a certain way and may not see things everyone else sees. He said the odors, carpets, holes, and damaged doors are concerns that need to be addressed and audited. He said the sanitation issues will not assist in remediating the pest problem that has been identified. 15214

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 36542 Based on interviews and record review, the facility failed to implement policies and procedures for potential misappropriation of resident property for one Resident (#15), out of 19 sampled residents. Specifically, the facility failed to investigate and report an allegation of a stolen wallet for Resident #15. Findings include: Review of the facility's policy titled Grievance Policy, undated, indicated the following: -if the grievance involves an allegation of abuse, neglect, mistreatment, misappropriation of property, exploitation or injuries of unknown source, the incident or allegation shall be investigated and reported pursuant to the facility policy on Abuse Prohibition. Review of the facility's policy titled Abuse Prohibition Policy, dated September 2020, indicated but was limited to the following: -Misappropriation of Resident Property: is the deliberate misplacement, exploitation or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. -An alleged violation involving abuse, neglect, exploitation or mistreatment, and misappropriation of resident property are reported immediately, but not later than 24 hours to the Administrator and the State Survey Agency. -The incidents require an incident report, supervisory follow-up and a comprehensive internal facility investigation which shall be performed with subsequent timely notification to the appropriate agencies, as warranted. -The investigative process includes but is not limited to: interviewing the resident further if needed or other resident witnesses as indicated; interviewing staff witnesses or other available witnesses. -The investigation will be completed within 5 days of the incident. Resident #15 was admitted to the facility in August 2023. Review of the most recent Minimum Data Set (MDS) assessment, dated 5/29/24, indicated Resident #15 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating the Resident was cognitively intact. Review of the grievance book included a Grievance Log (a list of grievances filed for each month) which indicated the Social Worker received a grievance on 4/3/24 with a Nature of Complaint of misappropriation of wallet, which was indicated as resolved on 4/8/24. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a grievance form indicated that on 4/3/24 Resident #15 completed the form with the following: lost or stolen wallet (with description) including debit card and insurance cards. The form indicated the grievance was received by the Social Worker on 4/3/24. The Social Worker completed the Follow Up Response or Plan of Action which indicated the following: Resident reports paid for food with $50, change was $30. Wallet was left in dining room (last place remember having it). Director of Nurses looked for wallet, unable to locate. Room searched, unable to locate it. The grievance form included a Check Request form indicating Resident #15 would be reimbursed $30.00. There was no additional information included. During an interview on 6/27/24 at 12:31 P.M., Resident #15 said their wallet was stolen from the facility. He/she said someone attempted to use their debit card for a $16 charge. The Resident said he/she thought they knew who stole the wallet. Review of the medical record included a Social Service progress note, dated 4/9/24, that indicated a family member of Resident #15 took the Resident to the bank to replace the debit card and the bank reported that someone tried to use the debit card locally, but no money was on the card. During an interview on 6/27/24 at 1:55 P.M., the Social Worker said there was no additional information or investigation for the allegation of the stolen wallet because the plan was to reimburse the Resident the $30. During an interview on 6/27/24 at 2:31 P.M., the Director of Nurses said there was no additional information or investigation regarding the allegation of the stolen wallet (with money and debit card) and the allegation was not reported to the state agency.

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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. 36542 Based on interviews and record review, the facility failed to ensure potential misappropriation was reported to the Department of Public Health (DPH) no later than 24 hours in accordance with federal guidelines, for one Resident (#15), out of 19 sampled residents. Specifically, the facility failed to report an allegation of a stolen wallet for Resident #15. Findings include: Review of the facility's policy titled Grievance Policy, undated, indicated the following: -if the grievance involves an allegation of abuse, neglect, mistreatment, misappropriation of property, exploitation or injuries of unknown source, the incident or allegation shall be investigated and reported pursuant to the facility policy on Abuse Prohibition. Review of the facility's policy titled Abuse Prohibition Policy, dated September 2020, indicated but was not limited to the following: -Misappropriation of Resident Property: is the deliberate misplacement, exploitation or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. -An alleged violation involving abuse, neglect, exploitation or mistreatment, and misappropriation of resident property are reported immediately, but not later than 24 hours to the Administrator and the State Survey Agency. Resident #15 was admitted to the facility in August 2023. Review of the most recent Minimum Data Set (MDS) assessment, dated 5/29/24, indicated Resident #15 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating the Resident was cognitively intact. Review of the grievance book included a Grievance Log (a list of grievances filed for each month) which indicated the Social Worker received a grievance on 4/3/24 with a nature of complaint of misappropriation of wallet, which was resolved on 4/8/24. Review of the grievance form indicated that on 4/3/24 Resident #15 completed the form with the following: lost or stolen wallet (with description) including debit card and insurance cards. The form indicated the grievance was received by the Social Worker on 4/3/24. The Social Worker completed the Follow Up Response or Plan of Action which indicated the following: Resident reports pay for food with $50, change was $30. Wallet was left in dining room (last place remember having it). Director of Nurses looked for wallet, unable to locate. Room searched, unable to locate it. The grievance form included a Check Request form indicating Resident #15 would be reimbursed $30.00. There was no additional information included. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/27/24 at 12:31 P.M., Resident #15 said their wallet was stolen from the facility. He/she said someone attempted to use their debit card for a $16 charge. The Resident said he/she thought they knew who stole the wallet. Review of the medical record included a Social Service progress note, dated 4/9/24, that indicated a family member of Resident #15 took the Resident to the bank to replace the debit card and the bank reported that someone tried to use the debit card locally, but no money was on the card. During an interview on 6/27/24 at 1:55 P.M., the Social Worker said there was no additional information or investigation for the allegation of the stolen wallet. During an interview on 6/27/24 at 2:31 P.M., the Director of Nurses said the allegation of the stolen wallet (with money and debit card) was not reported to the state agency.

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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. 36542 Based on interviews and record review, the facility failed to investigate potential misappropriation of resident property for one Resident (#15), out of 19 sampled residents. Specifically, the facility failed to investigate an allegation of a stolen wallet for Resident #15. Findings include: Review of the facility's policy titled Grievance Policy, undated, indicated the following: -if the grievance involves an allegation of abuse, neglect, mistreatment, misappropriation of property, exploitation or injuries of unknown source, the incident or allegation shall be investigated and reported pursuant to the facility policy on Abuse Prohibition. Review of the facility's policy titled Abuse Prohibition Policy, dated September 2020, indicated but was limited to the following: -Misappropriation of Resident Property: is the deliberate misplacement, exploitation or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. -The incidents require an incident report, supervisory follow-up and a comprehensive internal facility investigation which shall be performed with subsequent timely notification to the appropriate agencies, as warranted. -The investigative process includes but is not limited to: interviewing the resident further if needed or other resident witnesses as indicated; interviewing staff witnesses or other available witnesses. -The investigation will be completed within 5 days of the incident. Resident #15 was admitted to the facility in August 2023. Review of the Minimum Data Set (MDS) assessment, dated 5/29/24, indicated Resident #15 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating the Resident was cognitively intact. Review of the grievance book included a Grievance Log (a list of grievances filed for each month) which indicated the Social Worker received a grievance on 4/3/24 with a Nature of Complaint of misappropriation of wallet, which was indicated as resolved on 4/8/24. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a grievance form indicated that on 4/3/24 Resident #15 completed the form with the following: lost or stolen wallet (with description) including debit card and insurance cards. The form indicated the grievance was received by the Social Worker on 4/3/24. The Social Worker completed the Follow Up Response or Plan of Action which indicated the following: Resident reports paid for food with $50, change was $30. Wallet was left in dining room (last place remember having it). Director of Nurses looked for wallet, unable to locate. Room searched, unable to locate it. The grievance form included a Check Request form indicating Resident #15 would be reimbursed $30.00. There was no additional information included. During an interview on 6/27/24 at 12:31 P.M., Resident #15 said their wallet was stolen from the facility. He/she said someone attempted to use their debit card for a $16 charge. The Resident said he/she thought they knew who stole the wallet. Review of the medical record included a Social Service progress note, dated 4/9/24, that indicated a family member of Resident #15 took the Resident to the bank to replace the debit card and the bank reported that someone tried to use the debit card locally, but no money was on the card. During an interview on 6/27/24 at 1:55 P.M., the Social Worker said there was no additional information or investigation for the allegation of the stolen wallet because the plan was to reimburse the Resident the $30. During an interview on 6/27/24 at 2:31 P.M., the Director of Nurses (DON) said there was no additional information or investigation regarding the allegation of the stolen wallet (with money and debit card).

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 48084 Based on interview and record review, the facility failed to ensure a Minimum Data Set (MDS) assessment was accurately completed to reflect the status for one Resident (#50), in a total sample of 19 residents. Specifically, the facility failed to ensure the MDS accurately reflected that the Resident had been receiving dialysis treatments. Findings include: Resident #50 was admitted to the facility in March 2024 with diagnoses including end stage renal disease and dependent on renal dialysis. Review of the medical record indicated Resident #50 had dialysis three times weekly. Review of the MDS assessment, dated 5/7/24, failed to indicate Resident #50 received dialysis treatments. During an interview on 6/27/24 at 9:30 A.M., the MDS Nurse said she was unsure why she did not code the dialysis on the MDS as Resident #50 does in fact go out for dialysis and it should have been coded on the MDS. It was an error and a modification needed to be done.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48084 Based on observations, interviews, and record reviews, the facility failed to ensure quality of care was provided, according to facility protocols and professional standards of practice for one Resident (#50), out of 19 sampled residents. Specifically, the facility failed to ensure preventative skin care treatments were implemented, wound care treatments were implemented when a break in the skin was discovered, non-pressure ulcer evaluations were completed weekly and weekly skin checks were completed, and to ensure a care plan was developed and implemented for a non-pressure wound, resulting in worsening of a non-pressure ulcer on the left heel from a split with slight darkness to unstable eschar (type of necrotic (dead) tissue that can develop on severe wounds. Typically dry, black, firm and usually attached to wound bed). Findings include: Review of the facility's policy titled Skin and Wounds, dated as last revised March 2024, indicated but was not limited to the following: Pressure Injury/Non-Pressure Wound Risk Management -Residents identified to be at risk through comprehensive assessment or who have actual skin impairment are provided with care to address their individual risk factors and goals of treatment. -Heels are extremely vulnerable and must be elevated completely off the bed and/or chair surface. Use pillows, positioning devices, and/or suspension boots devices. -Residents identified as at risk will have an order in place to offload heels. -Skin prep will be initiated twice daily on all new admissions/readmissions. Non-Pressure Wound Assessment -If a resident presents with a venous, arterial, or diabetic ulcer, the wound will be assessed on a weekly basis. -Residents with non-pressure wounds are assessed, documented, and provided appropriate treatment to promote healing. -Care plans are developed based on individual resident's goals for treatment. -Diabetic, vascular, and arterial ulcers are evaluated and documented at least weekly and with significant change in the wound until it is resolved. -Documentation of non-pressure ulcers include location, measurement, type of wound, partial (superficial only first/second layers of skin)/full thickness (deep wounds extending beyond the first two layers of skin), drainage amount/color, odor, appearance of wound bed, edges, and peri wound, pain and effectiveness of treatment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Weekly Body Audit -All residents will have a body audit to address any skin issues on a weekly basis. If an alteration in skin integrity (bruise, pressure injury, non-pressure wound, rash, abrasion, skin tear, reddened area, etc.) is discovered, it will be documented on the weekly skin audit form. Monitoring of any area will continue until area is resolved. -All residents with skin integrity issues will have this addressed on their plan of care. Skin Care-Measurements of Wounds -Wounds will be measured when identified, weekly and with a significant change in wound status. -Using disposable measurement devices measure the length, width, and depth. Review of the facility's policy titled Diabetic Foot Care, dated June 2015, indicated but was not limited to the following: -Diabetic foot care is provided by qualified nursing staff. -Procedure includes washing feet thoroughly, examining feet carefully for evidence of discoloration, redness, blisters, or skin tears, massage foot with lotion, and apply clean footwear. -Report irregularities to charge nurse. -Document all appropriate information in medical records including foot assessment. Assessment will be completed on admission and with routine skin assessment. Resident #50 was admitted to the facility in March 2024 with diagnoses including end stage renal disease, dependent on renal dialysis, and diabetes mellitus. Review of the Minimum Data Set (MDS) assessment, dated 5/7/24, indicated Resident #50 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact and was at risk for skin breakdown, had no pressure or non-pressure ulcers, and had no ointment or dressing treatments to the feet. Review of the Comprehensive Care Plan indicated but was not limited to the following: FOCUS: Resident has potential alteration in skin integrity related to comorbidities, decreased/impaired mobility or function, nutrition, and risk assessment. (Date Initiated 6/19/24) GOAL: Resident will not develop further complications from altered peripheral perfusion. Skin will be free of infection. Skin will remain intact. INTERVENTIONS: -Assess pain/comfort level every shift and as needed prior to dressing change. Change and medicate per physician order. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Assess skin under splint devices, orthotics, braces, cervical collars, or footwear. -Complete skin condition at 24 hours and then weekly. -Follow physician orders for skin care and treatments. -Heels offloaded in bed. -House barrier cream to hips, buttocks, and/or heels. -Pressure risk assessment upon admission and quarterly. -Skin Prep to heels as ordered. -Triad cream, apply before placing dressing. FOCUS: Actual alteration in skin integrity related to diabetic ulcer. (Date Initiated 6/25/24) GOAL: Wound will be free of infection. Resident left heel diabetic ulcer will have improved skin integrity as evidenced by signs and symptoms of healing. INTERVENTIONS: -Assess pain/comfort level every shift and as needed prior to dressing change. Change and medicate per physician order. -Consult and treatment by Certified Wound Doctor. -Follow physician orders for skin care and treatments. (Utilize best practice guidelines) -Heels offloaded in bed. -House barrier cream to hips, buttocks, and/or heels. -Inspect feet daily with care and moisturize. -Monitor for signs and symptoms of infection and report to physician. -Skin check assessment weekly. FOCUS: Diabetes-Insulin Dependent Diabetes Mellitus. (Date Initiated 6/25/24) GOAL: Remains free of complications of diabetes and/or signs and symptoms of hyper/hypoglycemia for 90 days. INTERENTIONS: -Diabetic foot care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Skin audits per facility protocol. Resident #50 was admitted to the facility in March 2024, was hospitalized for three weeks and readmitted in April 2024. The facility failed to develop and implement a care plan for being at risk for skin breakdown until 6/19/24. Additionally, the facility failed to develop and implement a care plan for actual skin breakdown and diabetes management until 6/25/24 (during survey). MARCH 2024 Review of the nursing progress notes indicated but were not limited to the following: -3/30/24: splits on right and left heel. Review of the Admission Skin Check, dated 3/30/24 indicated but was not limited to the following: -Are there any skin impairments? YES, if yes, indicate type: New Non-Pressure skin impairment. -Right Heel: split on heel with slight darkness. -Left Heel: split on heel with slight darkness. Review of the Non-Pressure Wound Evaluations, dated 3/30/24, indicated but was not limited to the following: -Right heel: split in right heel with split change in color, partial thickness, Measurements: length: 1 centimeter (cm) x width: not applicable (N/A), x depth: N/A, Current treatment: Start of Treatment, Comments; split heel needing moisturization no dressing needed. -Left heel: split in right (sic) heel with slight change in color, partial thickness, Measurements 2 cm x N/A x N/A, Current treatment: Start of Treatment, Comments; split heel needing moisturization no dressing needed. Review of the March 2024 Physician's Orders indicated but were not limited to the following: -Observe fit of socks and shoes for any pressure area (enter supplementary codes) Wash feet with warm water and soap. Do not soak the feet. Completely dry the feet. Apply lotion to feet. Licensed nurse skin integrity evaluation of the entire foot, ankle, heel, interdigital spaces, and nails for discoloration, swelling, cuts, blisters, corns, callouses, dry skin, and eschar; enter supplementary skin code, every evening shift for diabetes. (Diabetic Foot Care) -Skin prep to heels twice daily for 14 days. -Off -load heels every shift as tolerated every shift for skin integrity. The facility identified skin breakdown on the admission skin check and failed to obtain orders for treatment and monitoring of the right and left heel non-pressure wounds. The physician's orders contained only the routine house policy orders for diabetic foot care and the at risk for skin breakdown prevention orders. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	APRIL 2024 Resident #50 was hospitalized unrelated to the wounds on heels for three weeks (3/31/24-4/22/24) and was readmitted in April 2024. Review of the re-admission skin check, dated 4/23/24, indicated but was not limited to the following: -Are there any skin impairments? YES, if yes, indicate type: New Non-Pressure skin impairment. -Right Heel: scabbing around heel area. -Left Heel: scabbing around heel area. The facility failed to complete the Non-Pressure Wound Evaluations for the right and left heel. Review of the April 2024 Physician's Orders indicated but were not limited to the following: -Diabetic Foot Care. (Start 3/30/24/End 4/18/24) -Weekly Skin Check on Thursday. (Start 4/4/24/End 4/18/24) -Skin Protocol: Norton Plus (risk assessment for skin breakdown) upon admission and weekly for 4 weeks. (Start 4/4/24/End 4/18/24) -Skin prep to heels twice daily for 14 days. (Start 3/30/24/End 4/18/24) -Off -load heels every shift as tolerated every shift for skin integrity. (Start 3/30/24/End 4/18/24) Further review of the April 2024 orders indicated the orders above were active from the initial admission, the orders were discontinued on 4/18/24. The facility identified skin breakdown on the re-admission (4/23/24) and failed to obtain orders for treatment and monitoring of the right and left heel non-pressure wounds and failed to obtain orders for the routine house policy orders for Diabetic Foot Care and the at risk for skin breakdown prevention orders. Resident #50 had no wound care or preventative treatment orders from 4/23/24-4/29/24. Resident #50 was hospitalized on [DATE] unrelated to the wounds and remained at the hospital until 5/2/24. MAY 2024 Review of the hospital paperwork from the 4/29/24-5/2/24 stay indicated but was not limited to the following: (continued on next page)

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Southshore Health Care Center	115 North Avenue Rockland, MA 02370

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Skin Assessment, dated 5/1/24, scabs/redness on heels. The facility failed to complete a re-admission skin check on 5/2/24. Review of the Non-Pressure Wound Evaluation, dated 5/2/24, indicated but was not limited to the following: -Left heel: wound on left heel. Old scar present the surrounding area is red, Measurements: 2.1 x 1.6 x 0 cm, small amount of drainage/moist wound, drainage color: serous (thin/clear bloody-thin/bright red serosanguinous-watery), surrounding skin: unhealthy (red-warm-swollen-macerated/white-abraded/denuded) Current Treatment: Start of treatment, Comments: soft boots. Review of the nursing progress notes indicated but were not limited to the following: -5/3/24: wound on left heel, MD aware. Review of the Non-Pressure Wound Evaluation, dated 5/10/24, indicated but was not limited to the following: -Left heel: Scubbing (sic) wound on the L heel, Measurements 1.9 x 1.5 x 0 cm, Comments regarding current Treatment: Alginate (highly absorbant dressing), gauze and kerlix (type of bandage), soft booties while in bed. Resident #50 was hospitalized unrelated to the heel wound from 5/10/24-5/12/24 and again 5/14/24-5/21/24. Review of the nursing progress notes indicated but were not limited to the following: -5/12/24: left heel pressure wound was dressed; the dressing was changed with no new appearance to the wound. Small scab noted on bottom and right side of right heel (sic). Both scabs 1cm or less and closed. The facility failed to complete a re-admission skin check on 5/12/24 or 5/21/24. Review of the Non-Pressure Wound Evaluation, dated 5/21/24, indicated but was not limited to the following: -Left heel: (description left blank), Measurements 1.2 x 1 x 0.01 cm, 75% healthy tissue/25% eschar Current Treatment: effective, Comments regarding current Treatment: (left blank). Review of the nursing progress notes indicated but were not limited to the following: -5/24/24: dressing on heel reapplied, wound is largely crusted over with slight soreness. -5/28/24: left heel monitoring with dry crust noted at the peri wound. Review of the Non-Pressure Wound Evaluation, dated 5/28/24, indicated but was not limited to the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Left heel: (description left blank), Measurements 0.01 x 0.01 x 0 cm, 75% healthy tissue/50% eschar (sic), Comment: Crust, Current Treatment: effective, Comments regarding current Treatment: (left blank), Education: encourage to keep soft booties on while in bed and keep foot elevated. Review of the May 2024 Physician's Orders indicated but was not limited to the following: -Treatment: clean with normal saline, pat dry, apply alginate, cover with gauze, Location left heel, every shift for wound. (Start 5/3/24/End 5/6/24) -Treatment: clean with normal saline, pat dry, apply alginate, cover with gauze, and wrap with kerlix, Location left heel, every shift for wound. (5/6/24) -Soft Booties while in bed: Location Bilateral heels. (5/5/24) -Monitor Dressing Site: (left blank) every shift. (5/10/24) -Diabetic Foot Care. (5/11/24) The facility identified skin breakdown on the re-admission 5/2/24 and a treatment was initiated, soft booties were not initiated until 5/5/24, the facility failed to obtain orders for the routine Diabetic Foot Care until 5/11/24. JUNE 2024 Review of the nursing progress notes indicated but were not limited to the following: -6/4/24: Treatment clarified, daily dressing change. The facility failed to complete weekly skin checks for the month of June. Review of the Non-Pressure Wound Evaluation, dated 6/4/24, indicated but was not limited to the following: -Left heel: (description left blank), partial thickness, Measurements 0.8 x 0.8 x 0.1 cm, 75% healthy tissue/25% eschar, Current Treatment: effective. Review of the Non-Pressure Wound Evaluation, dated 6/11/24, indicated but was not limited to the following: -Left heel: (description left blank), partial thickness, Measurements 0.6 x 0.1 x 0 cm, Comment: Crust, Eschar 50%, Current Treatment: effective, Education: Encourage resident to keep soft booties on with feet elevated when in bed. Review of the Non-Pressure Wound Evaluation, dated 6/24/24, indicated but was not limited to the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Left heel: Diabetes Mellitus (DM), full thickness, Measurements 0.7 x 0.6 x Unable to Assess (UTA) cm, Comment: Crust, Eschar 100%, Comment: 100 unstable eschar, Drainage: Moderate/wound wet, Current Treatment: effective, Comments regarding current Treatment: add adaptic (a non-adhering dressing to help protect regenerating tissue by minimizing wound trauma during dressing changes). Change daily and as needed. Suggest pre-medicate 30 minutes prior to dressing change. Review of the June Physician's Orders indicated but were not limited to the following: -Soft Booties while in bed. Location: Bilateral Heels for wound. (5/5/24) -Diabetic Foot Care. (5/11/24) -Treatment: Clean with normal saline, apt dry, apply alginate, cover with a gauze, and wrap with [NAME] kling. Change daily. Location: left heel. (Start 6/4/24 - End 6/25/24) -Treatment: Clean with normal saline, apt dry, adaptic, apply alginate, cover with a gauze, and wrap with [NAME] kling. Change daily and as needed. Location: left heel. (6/26/24) -Monitor Dressing: Site: (left blank) every shift. (Start 5/10/24 - End 6/25/24) -Monitor Dressing: Site: Left heel every shift. (6/25/24) -Moisturize (with house stock) bilateral lower extremities daily. (6/26/24) Further review of the Physician's Orders indicated an order as follows: -Wound Consult as needed for left heel. (6/4/24) Review of the medical record indicated Resident #50 was not seen by the Wound Physician until 6/24/24. Review of the Wound Physician's progress note, dated 6/24/24, indicated but was not limited to the following: -Diabetic Foot Ulcer (full thickness wound) of the left heel. -Wound size 0.7 x 0.6 x non-measurable depth. There is callous of the peri wound. -Drainage: Moderate amount of serous exudate. Wound bed is 100% unstable eschar. -There is no odor, no peri wound redness, no swelling, and no other signs of infection. -Procedure: Excisional debridement of subcutaneous tissue. Devitalized/non-viable tissue needs to be removed to promote optimal wound healing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor obtained consent from Resident #50 to observe wound care. On 6/25/24 and 6/27/24, when the Resident was not out for dialysis, staff were advised the surveyor had consent to observe the dressing and requested they alert the surveyor before completing the dressing change. Staff changed the dressing without the surveyor present each time. During an interview on 6/27/24 at 3:00 P.M., Nurse #4 said she already did Resident #50's treatment and forgot the surveyor wanted to see the treatment. She said Resident #50 came into the facility with dry heels that kind of had a slit or crack in them. She said the evaluation said we were supposed to put moisturizer on them, but the order was never written. She said we are supposed to do weekly skin checks and weekly non-pressure evals for areas like that, but they don't appear to have been done. She said on 5/3/24 the left heel had developed a black area on it, and we started a treatment that day. Additionally, she said the area was a diabetic ulcer and had gotten a little worse but seems to be pretty much unchanged now. She said the wound doctor follows most of the residents with wounds and now sees Resident #50. She said she was unsure how long the Resident had been seeing the wound doctor, but said she was present on 6/24/24 when the doctor saw Resident #50 and debrided the area. She said there was no drainage, some redness around the area related to the debridement and the wound doctor debrided about 75% of the necrotic area and changed the treatment that had been in place. She said the Resident was experiencing pain to the left heel and a new order was obtained to medicate prior to wound rounds. During an interview on 6/27/24 at 12:48 P.M., the Director of Nurses (DON) said she did not know why Resident #50 did not have orders for wound care or why they were not seen by the wound doctor until this week. Additionally, she said the house orders should have been implemented on admission and each re-admission. The DON said the weekly skin checks should have had an order in the computer to ensure they got done and there was not an order, and they were not done, and some of the weekly non-pressure evaluations were missed. She said he/she was at the hospital a lot so perhaps the in and out created confusion with the orders initially, but they had had a treatment in place since return in May and they are followed by the wound doctor now. She said the ADON handles the wound rounds so she would perhaps have more insight. During an interview on 6/27/24 at 2:45 P.M., the Assistant Director of Nursing (ADON) said the ball was dropped. She said she was not sure how it was missed and there were no treatment orders written on admission. She said there should have been an order to apply moisturizer to both heels and to monitor them and there was not. The ADON said the skin checks and weekly non-pressure evaluations should have been done weekly and they were not. Additionally, she said Resident #50 was in and out of the hospital several times, is often non-compliant with diabetes management, and when the left heel got worse, the nurses told me, a recommendation was made, and treatment ordered. She said she did not see the wound right away; it was described to her and that is when the alginate order started. The ADON said the wound doctor comes in weekly and was unsure why the order was not put in until 6/4/24 but said the wound doctor does not see everyone. Additionally, she said she did not know why he/she was not seen for another three weeks after the order was put in. She said the wound doctor debrided the area and that was painful, so now there is an order for pain medication before weekly wound rounds. She said the wound doctor often debrides wounds to promote healing. She said Resident #50 was in and out of the hospital a lot over the last couple months and that likely added to the confusion with the orders for preventative and wound care. She said he/she should have been on the weekly round's worksheet since May, so she would look at the area weekly, but they did not make it to the list until this month when the wound doctor order was initiated.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48084 Based on observation, record review, and interview, the facility failed to provide adequate supervision to minimize the risk of falls for one Resident (#33), out of a total sample of 19 residents. Specifically, the facility failed to ensure that staff accurately assessed the Resident's risk for falls, falls were thoroughly investigated, and interventions were developed and implemented to mitigate the risk of future falls resulting in six falls in five months, one of which resulted in two skin tears and a left hip fracture. Findings include: Review of the facility's policy titled Falls Management, dated as last revised April 2024, indicated but was not limited to the following: -A fall risk evaluation will be conducted on each resident upon admission, with the quarterly Minimum Data Set (MDS) cycle, and when a significant change in status occurs (including a fall). -The Interdisciplinary team (IDT) will develop, initiate, and implement an appropriate individualized care plan based on the Fall Risk Evaluation Score. A score of 0-9 indicated no risk to low risk, while a score of 10+ indicated moderate to high risk. -Residents who are identified to be at risk on the admission fall risk evaluation will have a fall risk care plan developed. Residents who are identified to be at risk on subsequent fall evaluations will be evaluated in accordance with nursing, medical, and rehabilitation needs. Resident #33 was admitted to the facility in January 2024 with diagnoses which included protein calorie malnutrition, muscle weakness, unspecified abnormalities of gait and mobility, and need for assistance with personal care. Review of the MDS assessment, dated 4/26/24, indicated that Resident #33 scored 11 out of 15 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. Additionally, he/she required partial/moderate assistance with transfers between bed and chair and putting on footwear, was occasionally incontinent of urine, continent of bowels, not on a toileting program, and had a history of falls. Review of the Comprehensive Care Plan indicated the following: FOCUS: At risk for fall related injury due to generalized weakness and decline on comfort measures only. GOAL: Resident will not sustain a fall related injury by utilizing fall precautions through next review. INTERVENTIONS: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Invite, encourage, remind, escort to activity programs consistent with resident's interests to enhance physical strengthening needs. (2/1/24) -Provide environmental adaptations: low/platform bed, call light within reach, adequate glare free lighting, area free of clutter. (2/1/24) -Provide environmental adaptations: resident moved to B Bed. (6/13/24) -Provide/monitor use of adaptive devices: splint/brace, walker, wheelchair. (2/1/24) -Provide/monitor use of adaptive devices: wheelchair. (Revision 4/24/24) -Remind resident and reinforce safety awareness: lock brakes on bed, chair etc. before transferring, when rising from a lying position, sit on side of bed for a few minutes before standing, educate/remind resident to request assistance prior to ambulation, appropriate footwear. (2/1/24) -Report falls to physician and responsible party. (2/1/24) -Requesting from hospice 1x eval in wheelchair status post fall. (4/24/24) -Use fall risk screen to identify risk factors. (6/17/24) FOCUS: Resident has an activity of daily living (ADL) deficit related to recent illness/injury. GOAL: Resident will participate in ADLs as able. INTERVENTIONS: Needs intervention with the following areas: Toileting-assist. (2/29/24) FOCUS: Alteration in elimination related to bladder incontinence. GOAL: Resident will not develop any complications associated with incontinence. INTERVENTIONS: -Assess need for scheduled toileting. (2/1/24) -Provide intervention with toileting as indicated in ADL care plan. (2/1/24) Review of the Fall Risk Evaluation from admission indicated the following: -A score of 0-9 indicated no risk to low risk, while a score of 10+ indicated moderate to high risk. -1/24/24: Score 9, no history of falls in last 3 months, ambulatory/continent, uses assistive devices. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record indicated Resident #33 had six falls since admission in January 2024, four related to chair/wheelchair transfers and slipping and two related to bed transfer/falling out of bed. Additionally, two were related to transfers surrounding toileting needs. Review of the facility Incident Reports, nursing progress notes, and the Fall Risk Evaluation for the falls indicated the following: FALL 2/15/24: -Observed sitting on the floor next to the door of room. -He/she said they slipped off chair trying to get back into it. -The report failed to indicate if the chair was a stationary chair or a wheelchair. -There was water on the floor, and he/she may have spilt it; no additional predisposing factors were identified. -No witness statements were provided. -No injury was noted. -No intervention added to the care plan to prevent future falls/mitigate the risk of future falls. -Fall Risk Evaluation: 2/15/24 (post-fall): Score 3, no history of falls in last 3 months, ambulatory/continent. (Low risk score due to inaccurate coding of number of falls and assistive devices on assessment - had the assessment been completed accurately the score would have been high risk). FALL 4/23/24: -Observed sitting on the floor. -He/she said they were on the way to the bathroom via wheelchair and slid out of the wheelchair. -Predisposing factors indicated the Resident had improper footwear; no additional predisposing factors were identified. -Regular socks were replaced with gripper socks. -No witness statements were provided. -No injury was noted. -Care plan updated as follows: Requesting from hospice 1x eval in wheelchair status post fall. -Therapy evaluation of wheelchair use indicated he/she needed supervision for wheelchair mobility and cueing to lock the brakes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No intervention was added to prevent future falls/mitigate the risk of future falls as he/she had the wheelchair prior to the fall and remind him/her to lock the brakes was on the care plan prior to the fall. -Fall Risk Evaluation: 4/23/24 (post-fall): Score 5, no history of falls in last 3 months, ambulatory/continent. (Low risk score due to inaccurate coding of number of falls and assistive device on assessment - had the assessment been completed accurately the score would have been high risk). The facility identified that Resident #33 fell on [DATE] during a transfer to/from chair/wheelchair and he/she reported slipping. The facility failed to develop and implement additional interventions to prevent future falls/mitigate the risk of falls resulting in an additional fall during transfers to/from chair/wheelchair and he/she reported they slipped. FALL 5/3/24: -Observed sitting on the floor next to wheelchair. -He/she said they slipped off the wheelchair. -Predisposing factors indicated the Resident had gait imbalance and was using the wheelchair; no additional predisposing factors were identified. -No witness statements were provided. -No injury was noted. -No intervention was added to prevent future similar falls/mitigate the risk of future falls. -Fall Risk Evaluation: 5/3/24 (post-fall): Score 9, history of 1-2 falls in last 3 months, ambulatory/continent. (Low risk score due to inaccurate coding of number of falls on assessment - had the assessment been completed accurately the score would have been high risk). The facility identified Resident #33 fell on [DATE] and 4/23/24 during a transfer to/from chair/wheelchair and he/she reported slipping. The facility failed to develop and implement additional interventions to prevent future falls/mitigate the risk of falls resulting in an additional fall during transfers to/from chair/wheelchair and he/she reported they slipped. FALL 6/4/24: -Observed sitting on the floor. -He/she said they were getting up from the wheelchair and slipped. -Predisposing factors indicated: Other info: Hospice patient with decline in health and mobility; no additional predisposing factors were identified. -No witness statements were provided. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No injury was noted. -No intervention was added to prevent future similar falls/mitigate the risk of future falls. -Fall Risk Evaluation 6/4/24 (post-fall): Score 19, history of 1-2 falls in last 3 months, chair bound, unable to assess assistive devices. (Lower risk score due to inaccurate coding of number of falls on assessment - although the score indicated high risk, the score would have been higher had the assessment been completed accurately). The facility identified Resident #33 fell on [DATE], 4/23/24, and 5/3/24 during a transfer to/from chair/wheelchair and he/she reported slipping. The facility failed to develop and implement additional interventions to prevent future falls/mitigate the risk of falls resulting in an additional fall during transfers to/from chair/wheelchair and he/she reported they slipped. FALL 6/8/24: -Observed adjacent to bed lying on the floor. -Assisted back to bed, two skin tears noted to right elbow, limping on left leg, complained of pain, visible swelling noted. -Predisposing factors indicated diagnosis, medications, weakness/fainted; no additional predisposing factors were identified. -Transferred to hospital and diagnosed with left hip intertrochanter femur fracture (left hip fracture). -He/she was admitted to the hospital, surgical repair was done, and he/she returned to the facility 6/13/24. -Resident had been medicated with morphine approximately 30 minutes prior to the fall. -Investigation indicated he/she had non-skid socks on and was attempting to go the bathroom and slipped and fell . -Report indicated care plan updated to include close monitoring after morphine administration, toileting offered every two hours and urinal in reach at bedside. -The comprehensive care plan failed to indicate the above interventions (close monitoring after morphine administration, toileting offered every two hours and urinal in reach at bedside) were implemented. -The care plan was updated as follows: Provide environmental adaptations: Resident moved to B Bed. -Fall Risk Evaluation 6/12/24 (presumed post-fall from 6/8/24-resident still at the hospital on 6/12): Score 16, history of 1-2 falls in last 3 months, ambulatory/incontinent. (lower risk score due to inaccurate coding of number of falls on assessment - although the score indicated high risk, the score would have been higher had the assessment been completed accurately). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility identified on 4/23/24 Resident #33 slid/fell out of the wheelchair going to the bathroom. No additional interventions were developed and implemented to prevent future falls/mitigate the risk of falls related to transfers/toileting. Review of a nursing progress note, dated 6/2/24 at 4:41 A.M., indicated Resident #33, was observed holding the wall, a sheet was on the floor coming out of the bathroom, and he/she said they slipped but caught themselves. The facility identified Resident #33 had a near fall related to transfers/toileting/ambulation. No additional interventions were developed and implemented to prevent future falls/mitigate the risk of falls related to transfers/toileting/ambulation. On 6/8/24 Resident #33 fell during a transfer/ambulation from bed to the bathroom resulting in two skin tears and a left hip fracture. FALL 6/15/24: -Observed lying on the floor, pillow, and blankets on the floor. -He/she said they rolled off the bed trying to turn. -Predisposing factors indicated confusion, impaired memory, recent change in condition; no additional predisposing factors were identified. -No witness statements were provided. -The care plan was updated as follows: Use fall risk screen to identify risk factors. -No intervention was added to prevent future falls/mitigate the risk of future falls as using the fall risk screen was already facility policy. -Fall Risk Evaluation 6/15/24 (post-fall): Score 13, history of 3+ falls in last 3 months, chairbound, unable to assess assistive devices. The facility identified Resident #33 fell on [DATE] during a transfer from bed to toilet self, resulting in two skin tears and a left hip fracture, requiring inpatient hospitalization and surgical repair. No additional interventions were developed and implemented to prevent future falls/mitigate the risk of falls related to transfers/toileting/ambulation. On 6/15/24, (approximately 48 hours after returning from the hospital) Resident #33 had another fall out of bed, he/she said they rolled out of bed while trying to turn and the pillow/sheet was on the floor. During an interview on 6/25/24 at 2:45 P.M., Resident #33 said they have had a few falls, and on the last one my hip was busted. He/she said the staff are not very helpful taking me to the bathroom over there (pointing to the bathroom across the room) and there is nowhere else to go, there is a urinal, but it is on the windowsill, so it is not reachable anyhow. The surveyor made the following observations: (continued on next page)

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Southshore Health Care Center	115 North Avenue Rockland, MA 02370

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-6/25/24 at 2:45 P.M, urinal on windowsill, not in reach of Resident. -6/26/24 at 2:30 P.M, urinal on windowsill, not in reach of Resident. During an interview on 6/27/24 at 9:00 A.M., Nurse #5 said when a resident falls, they are assessed for injury and then assisted back to bed/chair or sent to the hospital based on injury. She said the nurses complete an incident report in the computer and deal with immediate safety needs. Additionally, she said they do not add new interventions to the care plan, she said the managers do that, so she was unsure why Resident #33 did not have interventions implemented after each fall. During an interview on 6/27/24 at 12:48 P.M., the Director of Nurses (DON) said when a fall occurs the nurse on the unit assesses the Resident and completes the incident report, calls the family, physician, and emergency room if needed. She said the nurse should be updating the care plan with a new intervention and then the managers review it at morning meeting. The DON said if it was not updated, we would update the care plan after morning meeting. She said she was unsure why the care plan had not been updated after each of these falls as it should have been. The DON said regarding the 4/23/24 fall, the hospice request for a therapy evaluation of the chair is just to ensure the chair is appropriate, which it was, so that doesn't add anything to prevent him/her from sliding from chair again. She said they should have added something like Dycem (nonskid grip material put on the seat to prevent sliding) or something to prevent the chair from moving if they were not locking the brakes. The DON said regarding the 6/8/24 fall with the hip fracture she recalled ordering a defined perimeter mattress for the bed but was unsure exactly when it went on the bed and why it was not on the care plan. She said he/she is back on Hospice, so the mattress was just swapped out this week with one of theirs. Additionally, she said it should have been on the care plan. The DON said regarding the interventions noted on the fall report that were to be added (closely monitor after morphine dose, toilet every 2 hours and urinal at bedside/in reach) she did not know why they were never added as they should have been added.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 48084 Based on interview and record review, the facility failed to ensure staff implemented dialysis care and services consistent with professional standards of practice for two Residents (#50 and #15), out of 19 sampled residents. Specifically, the facility failed: 1. For Resident #50, to assess and monitor a left Arteriovenous (AV) fistula (a surgically connected artery and vein used for long term dialysis) site, to assess and monitor for adverse reactions/complications, to provide ongoing communication between the nursing facility and dialysis facility, to consistently document assessments of the Resident's condition, to obtain weights for physician evaluation, and to develop a comprehensive care plan for dialysis; and 2. For Resident #15, to provide ongoing communication between the nursing facility and dialysis facility. Findings include: Review of the facility's policy titled Hemodialysis, dated April 2015, indicated but was not limited to the following: -To provide comprehensive care to residents/patients that receive hemodialysis treatments. -Obtain physician orders for dialysis center, days, and the care and monitoring of the access site. -Access Site: signs/symptoms of infection, pain, swelling, redness, tenderness, exudate (drainage). -AV Fistula: Listen for bruit and thrill (feeling and sound heard at the AV fistula site indicating blood flow). CARE OF THE AV FISTULA: -Do not take blood pressure readings or perform venipuncture on the access arm. -Do not put excessive pressure on the access arm. -Assess AV fistula every shift for the following: pain, scab formation, signs/symptoms of infection, color, motion, and sensitivity of access arm, palpate (feel) fistula for a thrill, auscultate (listen) for a bruit. -Documentation of the assessment will be kept in the medical record. FLUID BALANCE: -If resident is placed on a fluid restriction, monitor intake. -Monitor weights per physician order. Review pre- and post-dialysis weights. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Monitor for increased edema. -Monitor for signs/symptoms of decreased intravascular volume (dizziness, vital sign changes, leg cramps, and headaches). WEIGHTS: -Pre- and Post-weights will be obtained from the dialysis center. -Weights will be monitored per physician order. COMMUNICATION: -Communication between the facility and the hemodialysis center will occur using a communication book/sheet that consists of: Vital Signs, Copy of the Medication Administration Record (MAR), and any change of condition from last Hemodialysis treatment (changes in weight, medications, behavior, appetite, and falls). -Documentation will be completed prior to dialysis treatment. -The communication book/sheet will be reviewed upon return from dialysis. EMERGENCY CARE: -Accidental removal of a catheter dressing. a. Check insertion site for bleeding or signs of dislodgement. If present, proceed to accidental dislodgement procedure. b. Apply dressing over the catheter insertion site and notify the hemodialysis center. -Accidental dislodgement or removal of catheter. a. Clamp the catheter using a non-serrated clamp. b. Apply direct pressure with an occlusive dressing at the insertion site and transfer resident/patient to an area hospital for treatment. c. Notify the physician immediately. d. Notify the hemodialysis center. e. Notify the family/responsible person of change in condition. -Bleeding from the AV Fistula. a. Apply direct pressure with an occlusive dressing at the fistula site and transfer resident/patient to an area hospital for treatment. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Notify the physician immediately. c. Notify the hemodialysis unit. e. Notify the family of change in condition. 1. Resident #50 was admitted to the facility in March 2024 with diagnoses including end stage renal disease, dependent on renal dialysis, and diabetes mellitus. Review of the Minimum Data Set (MDS) assessment, dated 5/7/24, failed to indicate Resident #50 received dialysis treatments. Review of the Physician's Orders indicated Resident #50 had dialysis three times weekly. Further review of the Physician's Orders indicated but were not limited to the following: -Site of AV shunt check bruit and thrill every shift. (4/23/24) -Weekly weight Thursday every day-shift. (5/10/24) -1000 milliliter (ml) fluid restriction. (6/4/24) The physician orders failed to indicate any additional orders for the care of the AV fistula, fluid balance, weights, communication, or emergency care per policy. Review of the Comprehensive Care Plan failed to indicate a care plan for the care and treatment of a dialysis resident had been developed. Review of the Dialysis Communication Book from 3/30/24 through 6/26/24 indicated there were 38 scheduled dialysis days with the following communication information between the facility and the Dialysis Center: -The first entry in the dialysis communication book was dated 5/6/24. -Three days the dialysis communication sheet was completed by the facility and the Dialysis Center. -Ten days there was no communication by either facility or dialysis. -Six days only the facility filled out the communication sheet. -Three days only the Dialysis Center completed the communication form. -Sixteen days the Resident was MLOA and did not attend dialysis. The facility failed to communicate MLOA dates or the nature of the required hospitalization to the Dialysis Center in the communication book. -The Physician Order Summary Report in the binder was dated 5/6/24 and did not reflect Resident #50's current physician's orders. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 5/29/24, the dialysis center made a medication change recommendation to increase Calcitriol on the communication form. -On 6/10/24, the dialysis center indicated labs were drawn on the communication form. Review of the nursing progress notes failed to indicate the facility had reached out to the Dialysis Center to obtain the missing resident report information from the binder. Review of the Physician's orders and Nursing progress notes failed to indicate the 5/29/24 recommendation to increase the Calcitriol had been addressed or that the physician did not agree with the recommendation. Review of the medical record including, the communication book, progress notes, and laboratory results section failed to indicate the results of the 6/10/24 lab work done at the Dialysis Center had been communicated to the facility and incorporated into the medical record. Review of the Weekly Weights log for June 2024 indicated two of four weights were documented. Review of the electronic medical record, weights section, failed to indicate the weekly weights had been obtained and documented. During an interview on 6/25/24 at 3:00 P.M., Resident #50 said since admission to the facility, they do not always give him/her the communication book, so he/she leaves without it. Additionally, Resident #50 said when he/she returns from dialysis there is a dressing in place, and he/she removes it themselves the next morning. During an interview on 6/27/24 at 9:00 A.M., Nurse #5 said the Dialysis Communication Book should be filled out and sent with the resident every visit. The Dialysis Center should complete the bottom half, but if they do not fill it out, then it would be assumed they had nothing to say. She said if they have recommendations, they write them, and we would obtain orders from the physician. Nurse #5 said she did not know why the book was missing documentation or why the recommendation to increase the Calcitriol was not addressed. She said there should be orders pertaining to dialysis care, monitoring, weights, checking the book upon return, etc. She said she was not sure about Resident #50's dressing upon return and thought it was just left open to air but was not sure. Additionally, she said she did not know why the Resident did not have a care plan in place because it should have been done on admission. During an interview on 6/27/24 at 9:30 A.M., the MDS Nurse said a care plan for dialysis should have been developed on admission and it was not. Additionally, she said the Dialysis order set which has orders for monitoring, the clamp, dressing, etc. should have been implemented and were not. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/27/24 at 12:48 P.M., the Director of Nurses (DON) said the Dialysis Care Plan should have been developed on admission and it was not, and the Dialysis Communication Book should have been developed on admission and the documentation should have been completed for each visit and it was not. She said she was unsure why the Communication Book was not set up until 5/6/24. Additionally, the DON said there should be orders for monitoring, emergency care, weights etc. and there are not. She said her expectation is that the communication book is reviewed upon return, the center called if no documentation was provided, and the physician notified with any recommendations. She said the contents of the communication book from both our facility and the dialysis center are important to providing continuity of care for the Resident. 41106 2. Resident #15 was admitted to the facility in March 2024 with a diagnosis of end stage renal dialysis requiring dialysis. Review of the Physician's Orders indicated Resident #15 had orders for: -Hemodialysis on Tuesday, Thursday, and Saturday. -Hemodialysis: Ensure resident returns with Hemodialysis Book. Review for any new findings/recommendations. Notify MD if applicable. Review of the Dialysis Communication Book from 5/7/24 through 5/25/24 indicated there were 22 scheduled dialysis days with the following communication information between the facility and the Dialysis Center: -Three days the dialysis communication sheet was completed by the facility and the Dialysis Center. -Eight days there was no communication by either facility or dialysis. -Three days only the facility filled out the communication sheet. -Five days the communication sheet top and bottom was filled out by the dialysis Center. -One day only the dialysis Center completed the communication form. -One day the communication was in the nursing notes. -One day the Resident did not attend dialysis. During an interview on 6/27/24 at 11:21 A.M., Unit Manager (UM) #1 said the nurses are supposed to be filling out the top section and the Dialysis Center should be filling out the bottom section of the dialysis communication sheet. She said if the Resident returns from Dialysis without the bottom portion filled out, then they should be calling the dialysis Center for an update. UM #1 said if the Dialysis Center is closed, then they should be leaving her a note to call in the morning. The surveyor and the UM #1 reviewed the Dialysis Communication Binder and found only three communication sheets that were filled out completely. UM #1 said the top and bottom of the form should be filled out every dialysis day.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 46862 Based on interviews and record review, the facility failed to ensure a monthly Medication Regimen Review (MRR) recommendation to obtain an A1c (blood test that measures an average blood sugar level over a period of two to three months) made by the pharmacy consultant was addressed timely and maintained as part of the permanent medical record for one Resident (#8), out of a total sample of 19 residents. Findings include: Review of the facility's policy titled Consultant Pharmacist Reports, revised December 2019, indicated but was not limited to the following: -The consultant pharmacist performs a comprehensive review of each resident's medication regimen and clinical record at least monthly. The medication regimen review (MRR) includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and preventing or minimizing adverse consequences related to medication therapy. All findings and recommendations are reported to the Director of Nursing and the attending physician, the medical director and the administrator. -Resident-specific irregularities and/or clinically significant risks resulting from or associated with medications are documented in the resident's active record and reported to the Director of Nursing, Medical Director and/or prescriber as appropriate. -If no irregularities are found, consultant pharmacist also documents this in the resident's active record or in a separate report and signs and dates the document. -Prescriber accepts and acts upon suggestion or rejects and provides an explanation for disagreeing. Resident #8 was admitted to the facility in December 2023 with diagnoses including type 2 diabetes mellitus. Review of the medical record indicated the consultant pharmacist made recommendations for Resident #8 in March 2024 and generated a report to be acted upon and reported to the physician. Further review of the medical record failed to include the March 2024 MRR report with the recommendations to be acted upon and reported to the physician. During an interview on 6/26/24 at 10:45 A.M., Nurse Manager (NM) #1 said she would place the consultant pharmacist recommendations in the physician's communication books to be reviewed on their next visit. The surveyor requested a copy of the report for review. On 6/26/24 at 12:02 P.M., the Director of Nursing (DON) provided the surveyor with a printed copy of the March report, dated 3/15/24, and said the recommendation had not been addressed. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 3/15/24 Consultant Pharmacist Recommendations to Prescriber report for Resident #8 indicated the following recommendation: -Resident is currently receiving Lantus, Jardiance. Please consider obtaining an A1c level with next routine labs to monitor therapy. Review of current Physician's Orders included the following medications: -Lantus Solution 100 Unit/milliliter (ml) (insulin Glargine) Inject 20 units subcutaneously in the morning related to type 2 diabetes mellitus, dated 1/18/2024 -Jardiance tablet 10 milligrams (mg) give one tablet by mouth on time a day related to type 2 diabetes, dated 2/1/2021 Further review of the medical record failed to indicate the physician addressed the consultant pharmacist's recommendation by ordering an A1c. During an interview on 6/27/24 at 12:03 P.M., the DON said once a recommendation was received the NM would place it in the physician's folder for review. The DON said either the physician would agree or disagree, and the NM would make the needed changes. The DON said the recommendation should have been addressed in a timely manner, within a week, but was missed.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. 41106 Based on record review and interview, the facility failed to ensure that the resident's medication regimen was free from unnecessary medication without adequate monitoring for two Residents (#1 and #25), out of a total sample of 19 residents. Specifically, the facility failed: 1. For Resident #1, to ensure the May 2024 Pharmacy Nursing Recommendation was acted upon in a timely manner to prevent Resident #1 was not receiving a weekly double dose of Alendronate (Fosamax-slows bone loss and prevents fractures in osteoporosis) 70 milligrams for five weeks; and 2. For Resident #25, to monitor for signs/symptoms of adverse consequences (i.e., side effects) of a prescribed anticoagulant agent (blood thinner). Findings include: 1. Resident #1 was admitted to the facility in March 2024 with diagnoses which included age related osteoporosis (a condition that weakens bones and increases the risk of fractures). Review of the Consultant Pharmacist Recommendations to Nursing, dated 5/27/24, indicated but was not limited to the following: -Resident #1: Resident has duplicate orders for Alendronate 70 milligrams (mg) every week (one on Wednesday, one on Friday). Please review and discontinue duplicate order. Review of the Manufacturer's Label on the Food and Drug Administration (FDA) website indicated the recommended dosage is: -One 70 mg tablet once weekly; or, -One bottle of 70 mg oral solution once weekly; or, -One 10 mg tablet once daily. Review of Physician's Orders indicated but was not limited to the following: -Alendronate tablet 70 milligrams (mg) give one tablet orally one time a day every Wednesday. Order start date 10/4/23 and was discontinued 6/26/24. -Alendronate sodium oral tablet 70 mg, give 70 mg by mouth one time a day every Friday. Order start date 5/17/24. Review of the Medication Administration Record (MAR) for May 2024 indicated: Alendronate tablet 70 mg was administered twice a week, 5/22/24 (Wednesday) and 5/24/24 (Friday), and 5/29/24 (Wednesday) and 5/31/24 (Friday). Resident #1 received a weekly double dose of Alendronate 70 mg for two weeks. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MAR for June 2024 indicated: Alendronate tablet 70 mg was administered twice a week, 6/5/24 (Wednesday) and 6/7/24 (Friday), 6/12/24 (Wednesday) and 6/14/24 (Friday), and 6/19/24 (Wednesday) and 6/21/24 (Friday). Resident #1 received a weekly double dose of Alendronate 70 mg for three weeks. Review of nursing note, dated 5/15/24, indicated Alendronate tab 75 mg. Medication unavailable ordered. During an interview on 6/26/24 at 12:05 P.M., the Director of Nursing (DON) said the Nurse Manager should have completed the Pharmacy Nursing Recommendation when it was received, and the medication error corrected immediately. She said the medication was not available on Wednesday (5/15/24), the nurse wrote the new order for the medication to be given Friday (5/17/24). The DON said the nurse never discontinued the Wednesday order and it should have been, it was missed. 46862 2. Review of the National Library of Medicine which endorses Medline Plus, URL of this page: https://medlineplus.gov/druginfo/meds/a613032.htm, indicated some side effects from Apixaban can be serious and should be reported to the physician immediately or get emergency medical treatment: -bleeding gums -nosebleeds -heavy vaginal bleeding -red, pink, or brown urine -red or black, tarry stools -coughing up or vomiting blood or material that looks like coffee grounds -chest pain or tightness -trouble breathing Resident #25 was admitted to the facility in February 2024 with diagnoses which included atrial fibrillation (an irregular, often rapid, heart rate that commonly causes poor blood flow). Review of the Minimum Data Set (MDS) assessment, dated 5/10/24, indicated Resident #25 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which is indicative of intact cognition. Further review of the MDS also indicated Resident #25 had received anticoagulant medications. Review of Resident #25's current Physician's Orders indicated but was not limited to: -Apixaban (anticoagulant) 5 milligrams (mg) by Gastrostomy tube twice daily, dated 12/26/23 Review of Resident #25's June 2024 MAR indicated he/she was administered Apixaban as ordered. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the June MAR indicated the monitoring of adverse consequences to anticoagulation medication was not being documented. During an interview on 6/27/24 at 8:42 A.M., Nurse #2 said when someone was on an anticoagulant there should be an order to monitor for signs and symptoms of bleeding every shift. Nurse #2 reviewed the medical record and said there should be an order in place to monitor for bleeding, but she was unable to locate the order. During an interview on 6/27/24 at 12:06 PM, the DON reviewed the physician's orders and MAR for the use of an anticoagulant. The DON confirmed there was no order to monitor for the side effects for the administration of an anticoagulant. The DON said her expectation was monitoring for signs and symptoms of bleeding be completed every shift and documented on the MAR when a resident was on an anticoagulant.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41106 Based on observation and interview, the facility failed to follow professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to ensure the main kitchen dry food storage was maintained in a sanitary condition. Findings include: Review of the 2022 Food Code by the U.S. Food and Drug Administration (FDA) indicated, but was not limited to: -6-501.111 Controlling Pests. Insects and other pests are capable of transmitting disease to humans by contaminating food and food-contact surfaces. Effective measures must be taken to eliminate their presence in food establishments. -6-501.111 Controlling Pests. The PREMISES shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the PREMISES by: -(B) Routinely inspecting the PREMISES for evidence of pests -(D) Eliminating harborage conditions. On 6/21/24 at 8:30 A.M., the surveyor observed the main kitchen dry food storage area and made the following observations: -On the left side of the room there were multiple shelves of canned goods with a large amount of mouse droppings on top of the cans. -White containers of dried potatoes with mouse droppings and brown dried liquid stains. -Underneath the shelves there was dirt, debris and large amount of mouse droppings. -In between the last metal shelf of canned goods and the crates of water, there was a large dark colored stain on the floor, which was still partially wet and surrounded by mice droppings. -Multiple small black flies were on the walls and the boxes. On 6/21/24 at 8:30 A.M., [NAME] #1 said they did have a mouse problem, but he has not seen a mouse in a couple of weeks. (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/21/24 at 8:45 A.M., the Food Service Director (FSD) said he was not aware of the mice droppings in the dry food storage area. The surveyor and the FSD observed the dry food storage area and the FSD said there should not be mice droppings in the food storage area and the floor needs to be cleaned. On 6/26/24 at 4:23 P.M., the surveyor observed the main kitchen dry food storage area and made the following observations: -On the left side of the room there were a small amount of mice droppings on top of multiple cans. - In between the last metal shelf of canned goods and the crates of water, there was a small amount of water leaking out from the crates of water. Along the line of the crates, there were still remnants of the previous large dark stain on the floor. -The surveyor pulled out a stack of the crates containing the water and observed under the shelving unit against the wall had dirt, debris, and a large amount of mice droppings. During an interview on 6/26/24 at 4:25 P.M., the FSD said when we cleaned the food service area he did not clean where the crates of water were stored. He said he should have pulled out the crates and cleaned behind them.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 48084 Based on record review and interview, the facility failed to administer the Influenza and Pneumococcal Vaccinations per the Centers for Disease Control and Prevention (CDC) recommendations and/or document refusal in the medical record and facility policy for three Residents (#33, #50, #55), out of a total sample of five residents. Specifically, the facility failed: 1. For Resident #33, to document refusal of the influenza vaccine in the electronic medical record; 2. For Resident #50, to administer the pneumococcal vaccine after consent had been obtained (4/22/24); and 3. For Resident #55, to administer the pneumococcal vaccine after consent had been obtained (10/22/21). Findings include: Review of the facility's policy titled Vaccine, dated as last revised 3/2024, indicated but was not limited to the following: -All eligible residents will be offered the influenza and pneumococcal vaccines unless medically contraindicated. The resident or the resident's legal representative will be provided education regarding the pros and cons of the vaccine prior to administration. -If the vaccine is not given, record the reason(s) for non-receipt of the vaccine (i.e. medical contraindication, resident refusal). 1. Resident #33 was admitted to the facility in January 2024. Review of the Minimum Data Set (MDS) assessment indicated he/she had scored 11 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she had moderate cognitive impairment. Resident #33's Health Care Proxy (DHCP) had not been invoked and he/she made their own medical decisions. Review of the Resident Admission Vaccination Education Form, undated, indicated Resident #33 had refused the influenza vaccine. Review of the electronic medical record, specifically the immunization section, failed to indicate Resident #33 had declined the influenza vaccine. 2. Resident #50 was admitted to the facility in April 2024. Review of the MDS assessment indicated he/she had scored 15 out of 15 on the BIMS indicating he/she was cognitively intact. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Resident Admission Vaccination Education Form, dated 4/22/24, indicated he/she had consented to receive the pneumococcal PCV20 vaccine. Review of the electronic medical record, specifically the immunization section, failed to indicate Resident #50 had received the pneumococcal PCV20 vaccine or why it was not administered. 3. Resident #55 was admitted to the facility in October 2021. Review of the MDS assessment indicated he/she had scored 15 out of 15 on the BIMS indicating he/she was cognitively intact. Resident #55's DHCP had been invoked. Review of the Resident Admission Vaccination Education Form, dated 10/22/21, indicated Resident #55's legal representative had consented for the Resident to receive the pneumonia vaccines (PPSV23 and PCV13). Review of the electronic medical record, specifically the immunization section, failed to indicate Resident #55 had received either pneumonia vaccine or why they were not administered. During an interview on 6/27/24 at 8:20 A.M., the nurse on the west unit deferred all questions related to vaccinations to Unit Manager #1. During an interview on 6/27/24 at 8:20 A.M., Unit Manager #1 said all vaccinations, consent and/or refusals should be documented in the electronic medical record under immunizations. She reviewed the residents' records and said she did not know why they were not documented in the electronic records. Unit Manager #1 deferred further questions regarding vaccinations to the Infection Preventionist (IP). During an interview on 6/27/24 at 8:25 A.M., the IP said she was not sure why they (Residents #50 and #55) had not received the vaccines since they had consented to receive them. Additionally, she said the vaccine should have been ordered when consent was obtained and then administered. Additionally, she said the consent is usually signed on admission and then reviewed annually. During an interview on 6/27/24 at 9:00 A.M., Nurse #5 said the IP and Director of Nurses (DON) usually handle the vaccines. She said consent is obtained on admission and they (IP/DON) follow up. Additionally, she said the consent form should be in the paper chart and documented in the electronic medical record under immunizations. Additionally, she said she was unsure why the vaccines for Residents #50 and #55 were not administered after consent was obtained as they should have been. During an interview on 6/27/24 at 1:42 P.M., the DON said all consents, declinations, and administrations should be documented in the electronic medical record under immunizations. Additionally, she said she was unsure why Residents #50 and #55 had not been administered the vaccine after consent was obtained or why the declination for Resident #33 had not been documented in the immunization section as they should have been.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 48084 Based on record review and interview, the facility failed to assess, educate, and administer the COVID-19 vaccine and/or booster in a timely manner and/or to document refusal in the medical record for four Residents (#33, #79, #76, and #50), out of five residents sampled. Specifically, the facility failed: 1. For Resident #33, to educate, offer, and administer the COVID-19 vaccine, and document in the medical record consent/refusal; 2. For Resident #79, to administer the COVID-19 vaccine after consent had been obtained (5/1/24); 3. For Resident #76, to educate, offer, and administer the COVID-19 vaccine, and document in the medical record consent/refusal; and 4. For Resident #50, to document refusal of the COVID-19 vaccine in the electronic medical record. Findings include: Review of the facility's policy titled Vaccine, dated as last revised 3/2024, indicated but was not limited to the following: -It is the policy of this facility to minimize the risk of acquiring, transmitting, or experiencing complications from COVID-19 by offering our residents immunization to COVID-19. -Residents receiving the COVID-19 vaccine, or their legal representative, will be required to sign a consent form prior to the administration of the vaccine. -The resident's medical record will include documentation that the resident and/or the resident's legal responsible party was provided education. The documentation will also include if a resident received or did not receive the immunization due to medical contraindications or refusal. 1. Resident #33 was admitted to the facility in January 2024. Review of the Minimum Data Set (MDS) assessment indicated he/she had scored 11 out of 15 on the Brief Interview for Mental Status (BIMS) indicating he/she had moderate cognitive impairment. Resident #33's Health Care Proxy (HCP) had not been invoked and he/she made their own medical decisions. Review of the Resident Admission Vaccination Education Form, undated, indicated he/she had received the COVID-19 primary vaccine series, however failed to indicate if Resident #33 had consented or declined the current 2023/2024 COVD-19 vaccine. Review of the electronic medical record, specifically the immunization section, failed to indicate if Resident #33 consented or declined the current 2023/2024 COVID-19 vaccine. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #79 was admitted to the facility in May 2024. Review of the MDS assessment indicated he/she had scored 12 out of 15 on the BIMS indicating he/she was cognitively intact. Review of the Resident Admission Vaccination Education Form, dated 5/1/24, indicated he/she had consented to receive the current 2023/2024 COVID-19 vaccine. Review of the electronic medical record, specifically the immunization section, failed to indicate Resident #79 had received the current 2023/2024 COVID-19 vaccine or why it was not administered. 3. Resident #76 was admitted to the facility in November 2023. Review of the MDS assessment indicated he/she had scored 7 out of 15 on the BIMS indicating he/she had severe cognitive impairment. Resident #76's HCP had been invoked. Review of the Resident Admission Vaccination Education Form, dated 11/13/23, failed to indicate his/her legal representative had consented to or declined the COVID-19 vaccine or if he/she already received the vaccine. (The COVID-19 section was left blank, no boxes were checked off.) Review of the electronic medical record, specifically the immunization section, failed to indicate Resident #76 had consented and received or declined the COVID-19 vaccine. 4. Resident #50 was admitted to the facility in April 2024. Review of the MDS assessment indicated he/she had scored 15 out of 15 on the BIMS indicating he/she was cognitively intact. Review of the Resident Admission Vaccination Education Form, dated 4/22/24, indicated he/she had declined the current 2023/2024 COVID-19 vaccine. Review of the electronic medical record, specifically the immunization section, failed to indicate Resident #50 had declined the current 2023/2024 COVID-19 vaccine. During an interview on 6/27/24 at 8:20 A.M., the nurse on the west unit deferred all questions related to vaccinations to Unit Manager #1. During an interview on 6/27/24 at 8:20 A.M., Unit Manager #1 said all vaccinations, consent and/or refusals should be documented in the electronic medical record under immunizations. She reviewed the residents' records and said she did not know why they were not documented in the electronic records. Unit Manager #1 deferred further questions regarding vaccinations to the Infection Preventionist (IP). During an interview on 6/27/24 at 8:25 A.M., the IP said she was not sure why they had not received the vaccines since they had consented to receive them. Additionally, she said the vaccine should have been ordered when consent was obtained and then administered. Additionally, she said the consent is usually signed on admission and then reviewed annually. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/27/24 at 9:00 A.M., Nurse #5 said the IP and Director of Nurses (DON) usually handle the vaccines. She said consent is obtained on admission and they (IP/DON) follow up. Additionally, she said the consent form should be in the paper chart and documented in the electronic medical record under immunizations. Nurse #5 said she was unsure why these consent forms were incomplete. She was unable to provide any additional follow-up documentation. Additionally, she said she was unsure why the vaccines were not administered after consent was obtained as they should have been. During an interview on 6/27/24 at 1:42 P.M., the DON said all consents, declinations, and administrations should be documented in the electronic medical record under immunizations. Additionally, she said she was unsure why these residents had not been administered the vaccine after consent was obtained or why the declinations had not been documented in the immunization section as they should have been. Additionally, she said the consent forms that were incomplete should have been followed-up on and she was unsure why they were left incomplete.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36542 Based on observation, interview, and documentation review, the facility failed to implement an effective pest control program, as evidenced by sanitation concerns, mice sightings, and mice droppings on two of two units and the kitchen. Findings include: Review of the Pest Control Program Description indicated the following: -Depending on specific pest concerns there will be variation in control methods used. Methods used will consider the following options in the order listed: -inspection- technicians will inspect relevant areas -sanitation- these needs will always be communicated to you. Issues may seem small but select pests do not need much to survive. Review of the Resident Council minutes indicated the following: March 2024: Residents still complain they see mice in their rooms and living room. Residents complain the mice are a big issue and residents can hear the mice in the ceiling. Review of the response indicated the pest company was in on 3/25/24 and residents need to keep their food in plastic containers. April 2024: Residents still complain they see mice in their rooms and living room. Residents complain the mice are still a big issue and can often times hear them in the ceiling. Review of the response indicated the pest company was in on 4/23/24 and staff were informed they may see an increase in activity during the next several weeks. May 2024: Residents still complain they see mice in their rooms and living room. Review of the response indicated we've issued bins with lids for residents to store food in (which was indicated as a preventative measure in March 2024) and housekeeping had been informed to report mice droppings and note in the pest logbook. During a group meeting with 17 residents on 6/25/24 at 11:00 A.M., the residents immediately asked if the state surveyors could help with the pest problems. The residents said the mice problem had increased over time and was not improving. They said the mice were coming out during the day and there were often mice droppings in their rooms. They said the mice could be heard in the ceiling at night. They said the mice were coming up on to their beds. During an interview on 6/24/24 at 2:05 P.M., the Ombudsman said the number one problem at the facility was the mice. She said she frequently received reports of mice from residents including mice being on the residents' beds. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the survey process the following interviews with observations were conducted with residents regarding mice: -6/21/24 at 9:25 A.M., Resident #66 said that he/she sees mice in the facility on a regular basis and it definitely needs to be addressed. -6/21/24 at 9:47 A.M., Resident #47 said the facility had a mouse problem and the mice come out of his/her closet and are in his/her drawers. The surveyor observed a large amount of mice droppings in the Resident's closet. -6/21/24 at 11:00 A.M., Resident #52 said that there are a lot of mice in the facility and reported seeing mice in his/her room and the living room regularly. Resident #52 said that he/she has told the facility about the mice problem. -6/21/24 at 11:20 A.M., Resident #138 said that there's a mice problem and he/she regularly sees mice in his/her room on the floor near the radiator. He/She said that in recent days he/she saw a mouse near his/her bed that looked up at him/her and ran away. -6/21/24 at 1:21 P.M., Resident #137 said they were concerned about seeing mice in their room quite often. He/she said there was definitely a rodent problem. The surveyor observed mouse droppings in the closet and a large hole in the wall behind the Resident's door. -6/24/24 at 10:10 A.M., Resident #72 said the mouse problem had been going on for about eight to nine months with no resolution or improvement. The mice had been in the Resident's drawer and had chewed through a bag. The surveyor observed mouse droppings in the drawer of the bedside nightstand and mice droppings on the floor. -6/25/24 at 10:20 A.M., Resident #8 said the mice come in from under the air conditioner and crawl down the cord, every night. -6/25/24 at 10:34 A.M., Resident #63 said he/she has had mice on their bed twice and has had mouse feces on their sheet. Review of the Pest Control Logs on 6/26/24 indicated the last entry for the East unit was 6/2/24 and the last entry for the [NAME] unit was 6/14/24. Review of the Pest Control Service reports from December 2023 through June 2024 indicated the following: 12/2/23: added bait stations to two resident rooms; mice activity in exterior rodent stations by receiving areas (back door) and entry ways. 12/24/24: added bait stations to ceiling. Please have employees use pest logbook to communicate. 1/16/24: added traps to kitchen storage, added traps to five resident rooms, break rooms, hallway and central supply office. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2/24/24: added bait stations to eight resident rooms, ceiling, day rooms, nurses' station, living rooms. 3/21/24: added bait stations and glue traps to eight resident rooms, kitchen and stock room. 4/24/24: added bait stations to 10 rooms, more traps to the kitchen. The report indicated most complainant's rooms had clutter or sanitation issues and to keep on top of hoarding so that the bait traps will work better. 5/10/24: added bait traps to nine resident rooms, the day room, living room, dry food storage room. 5/31/24: added bait station/traps to nine resident rooms, the ceiling, and kitchen storage room. 6/4/24: swept up old droppings behind refrigerator in the main kitchen and kitchenette. There was food debris building up under shelves to the right of food storage. On 6/21/24 at 8:30 A.M., the surveyor observed the main kitchen dry food storage area and made the following observations: -On left side of the room there were multiple shelves of canned goods with large amount of mouse droppings on top of the cans. -White containers of dried potatoes with mouse droppings and brown dried liquid stains. -Underneath the shelves there was dirt, debris, and a large amount of mouse droppings. -In between the last metal shelf of canned goods and the crates of water, there was a large dark colored stain on the floor, which was still partially wet surrounded by mice droppings. -Multiple small black flies were on the walls and the boxes. On 6/25/24 at 4:15 P.M., the surveyor observed some mouse droppings behind the nourishment room refrigerator. On 6/26/24 at 4:23 P.M., the surveyor observed the main kitchen dry food storage area and made the following observations: -On the left side of the room there were a small amount of mice droppings on top of multiple cans. -In between the last metal shelf of canned goods and the crates of water, there was a small amount of water leaking out from the crates of water. Along the line of the crates, there were still remnants of the previous large dark stain on the floor. -The surveyor pulled out a stack of the crates containing the water and observed under the shelving unit against the wall had dirt, debris, and a large amount of mice droppings. On 6/26/24 at 5:07 A.M., the surveyor observed a mouse running across the floor in room [ROOM NUMBER]. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/26/24 at 5:19 A.M., the surveyor observed a mouse coming out of the heater in the [NAME] unit day room. The day room was observed to have a maroon bowl with one peach slice in it on one of the tables and a sugar packet on the floor. During an interview on 6/26/24 at 5:22 A.M., Nurse #2 said she normally works the overnight shift and continues to see mice and hear them in the ceiling. She said there used to be a book on the unit to write down mice sightings but was unable to locate it. The nurse was observed to pick up the binder with the logo of the pest control company and place it back, without recognizing that the binder was to log pest sightings. On 6/26/24 at 5:40 A.M., the surveyor observed the Nourishment Room (located between the two units and attached to the kitchen) to have four peanut butter and jelly sandwiches to be in plastic bags and left on top of the microwave. On 6/26/24 at 5:55 A.M., the surveyor observed the ice cart on the East unit to have snacks of cookies and crackers on the bottom shelf, not in a plastic container and an open soda can. On the ground next to the ice cart was a package of crackers and a sugar packet. On 6/26/24 at 8:07 A.M., Resident #52, reported seeing mice regularly in his/her room and in the living room. The Resident reported seeing a mouse the previous night on the floor between the bed and the bathroom. During an interview on 6/26/24 at 8:46 A.M., Resident #138 said that he/she saw a large mouse last night at around 9:30 P.M. He/She said the mouse appeared to come out from near the radiator to the right side of his/her bed. He/She said that the mouse peered up at him/her and then ran away. On 6/26/24 at 9:26 A.M., the surveyor observed two mice running under the bed in a resident room. During an interview on 6/26/24 at 10:50 A.M., Resident #8 said the Housekeeping Manager had come by today to clean the closet because the closet had been covered in mouse poop. He/she said the closets were not cleaned often. During an interview on 6/26/24 at 10:51 A.M., Resident #9 said the mouse comes in the room through the air conditioner. The surveyor observed the tape around the air conditioner to be loosely taped to the window, creating gaps. The surveyor observed a corner of the tape to be chewed, creating a hole. The Resident said the mouse comes in through that hole. The surveyor observed mouse droppings on the windowsill and behind the nightstand. During an interview on 6/26/24 at 1:50 P.M., the Pest Control technician said the regular technician was on vacation and this was his first time at the facility. He said he had just walked through the door, and he could tell that there were improvements that needed to be made to mitigate the mouse problem. He said the back door should not be propped open, as observed by the technician, the surveyor and the Maintenance Director at this time. He said he would complete rounds at the facility and follow up with the surveyors. (continued on next page)

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/26/24 at 2:11 P.M., the Pest Control technician said he observed resident rooms to have items of food and trash on the floor. He said mice can smell up to 300 yards and will come to the food source. He said once the mice find the food source they never have to leave. He said the facility needed to work on sanitation (eliminating sources of food) and isolating the inside from the outside (eliminating openings in which the mice could enter the building, such as the air conditioner tape, holes in the walls, propping open doors, and openings underneath doors). He said the Maintenance Director had added material to the bottom of the back door, but this was not done properly, and the mice could still get into the building from the back door. He said mice use their pheromones to mark their spot (including mice droppings) and the mouse droppings tell other mice that the area is safe. He said the technician from the pest control company has gone over this with the facility, had identified holes, and the sanitation concerns. During an interview on 6/27/24 at 7:35 A.M., the Maintenance Director said he had been here for 2.5 years, and this was the worst the mouse problem had ever been. He said the process was for the pest control company to come to the facility, complete the rounds based on the pest sighting logs and follow up with the maintenance director on any preventative measures the facility could do. He said he had asked the housekeeping staff and his assistant to make a list of any holes in the walls. Review of the list provided by the Maintenance Director indicated an audit was conducted on 6/19/24 and did not include all rooms in the facility. The Maintenance Director said none of the identified areas had been addressed yet. He said he knew some of the air conditioners were not completely sealed but had not gone around the facility to reseal the ones that were loose and allowed access for mice. During an interview on 6/27/24 at 10:25 A.M., the Housekeeping Manager said her staff tried to work on resident rooms with clutter but was not able to clean every area (such as closets) every day. She said the mice will come back to areas that have clutter and are not clean. She said there had not been any particular plan established with maintenance to work on the mice problem and they verbally tell each other about areas of concern or issues. During an interview on 6/27/24 at 8:40 A.M., the regional Administrator said sanitation and food sources should be maintained to assist in the mouse problem. The surveyor and the regional Administrator observed the East unit ice cart to continue to have cookies and crackers on the bottom shelf. The regional Administrator said this would not help the pest problem and could contribute to the problem. During an interview on 6/27/24 at 1:10 P.M., the regional Administrator and Director of Nursing (DON) said that the facility has conducted a Q.A. (quality assurance) plan to address the mice problem, going back to April 2024. The regional Administrator said that the mouse problem remained a significant problem in spite of the interventions implemented to address it. 15214