STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225293	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southbridge Rehabilitation & Health Care Center	84 Chapin Street Southbridge, MA 01550

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 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. Based on interviews, and record review, the facility failed to ensure one Resident (#107) out of a total sample of 26 residents, was seen by a Physician at the required regulatory frequency for physician visits.Specifically, the facility failed to ensure Resident #107 was seen by a Physician:-for the Resident's initial visit following admission to the facility.-for alternating visits with the Nurse Practitioner (NP) every 30 days for the first 90 days following admission to the facility.-for alternating visits with the NP every 60 days, after the Resident was in the facility for 90 days. Findings include:Resident #107 was admitted to the facility in October 2025 with diagnoses including Chronic Respiratory Failure, Heart Failure, and Hypertension. Review of Resident #107's clinical record on 4/3/26 failed to indicate any evidence the Resident was seen by a Physician since the Resident was admitted to the facility in October 2025 (greater than five months). During an interview on 4/3/26 at 11:00 A.M., the Assistant Director of Nursing (ADON) said resident physician notes were located in the electronic health record (EHR). At this time, the ADON reviewed Resident #107's EHR and said that she could not locate any Primary Care Physician (PCP) and Primary NP visit notes in the Resident's EHR. During an interview on 4/3/26 at 11:04 A.M., the Director of Nursing (DON) said she thought Resident #107's Physician completed paper visit notes and that she thought the paper visit notes were located in the Resident's paper medical record on the unit. The surveyor alerted the DON that the surveyor did not observe any evidence of Physician visits with Resident #107 in the Resident's paper medical record on the unit and requested evidence that the required Physician visits were provided for Resident #107. During an interview on 4/3/26 at 12:00 P.M., the Administrator said he contacted Resident #107's PCP office and that the office was going to fax evidence of the required Physician visits to the facility. During an interview on 4/3/26 at 1:00 P.M., the Administrator provided evidence of two NP notes to the surveyor and said that the PCP office was still faxing Physician visit notes to the facility. During an interview on 4/3/26 at 1:15 P.M., during the survey exit conference, the Administrator said the facility would fax evidence of the required Physician visits for Resident #107 to the surveyor when the facility received the Physician notes. Review of Resident #107's faxed documents, dated 4/6/26, did not include any evidence that the Physician performed:-an initial visit with the Resident following the Resident's admission to the facility.-alternating visits with the NP every 30 days for the first 90 days following the Resident's admission to the facility.-alternating visits with the NP every 60 days, after the Resident was in the facility for 90 days. During an interview on 4/7/26 at 9:44 A.M., following the survey exit, the Administrator said that the Physician had not performed any visits with Resident #107 since the Resident was admitted to the facility.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225293	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southbridge Rehabilitation & Health Care Center	84 Chapin Street Southbridge, MA 01550

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, records reviewed and interviews, the facility failed to provide a clean, sanitary or homelike environment for three Residents (#73, #9 and #52) out of a total sample of 26 residents, and in five rooms on two units (Second Floor and Third Floor) out of three resident units to prevent the potential for the spread of infection and maintain resident safety. Specifically, the facility failed to: 1. for Resident #73, clean and maintain a wheelchair in good condition on the Third Floor unit. 2. maintain privacy curtains in a clean and sanitary manner for three rooms out of twelve rooms observed on the Second Floor unit. 3. for Resident #9 and Resident #52,ˆensureˆwindow curtainsˆwereˆmaintainedˆinˆhomelike conditionˆon the Third Floor unit. ˆ Findings include: Review of the facility policy for Environmental Cleaning and Rounds, last reviewed 1/2026, indicated: -it is the policy of this facility to reduce and/or prevent the spread of infection through indirect contact by cleaning, sanitizing and disinfecting resident equipment, medical devices and the environment.ˆˆ -it is the policy of this facility that the Infection Preventionist (IP), Charge Nurses or Supervisors, complete nursing unit rounds on a regular basis, but at least quarterly.ˆˆ -The focus of this program is to observe practices carried out by nursing personnel that increase the risk of infection or pose a resident safety concern. -Environmental rounds will be an integral part of daily routine and also will be performed regularly throughout the entire facility, with detailed reporting to all units and departments as needed.ˆ ˆ ˆ 1. Resident #73 was admitted to the facility in August 2022 with diagnoses including Dementia, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. ˆReview of Resident #73's Minimum Data Set (MDS) dated [DATE], indicated: -was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of five out of a total possible score of 15. -required substantial/maximal assistance with Activities of Daily Living (ADL's). -was diagnosed with cerebral infarction and difficulty walking. Review of the facility's wheelchair cleaning schedule for January 2026 through March 2026 indicated that Resident #73 had his/her wheelchair cleaned monthly on: 1/13/26, 2/10/26, and 3/13/26. On 3/31/26 at 9:04 A.M., 4/1/26 at 9:43 A.M., and 4/1/26 at 2:59 P.M., the surveyor made the following observations of Resident #73's wheelchair: -the wheelchair armrests were cracked and worn, with padding exposed on the left and right sides (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225293	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southbridge Rehabilitation & Health Care Center	84 Chapin Street Southbridge, MA 01550

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and a smeared gray substance on the right armrest. -the seat of the wheelchair was cracked and peeling on the left and right corners. -all four wheels of the wheelchair were covered in a layer of gray and white speckled dust. -the right wheel bearing was wrapped in long multicolored strands of hair with multiple dust balls inside. On 4/2/26 at 8:10 A.M., the surveyor and the Infection Preventionist (IP) observed Resident #73's wheelchair while he/she was sitting in the day room and the Resident's wheelchair condition remained unchanged.^ During an interview at the time, the IP said that the Resident's wheelchair did not appear to have been cleaned and maintained and it should have been.^The IP also said that the concern with the ripped/torn areas of the wheelchair was the potential for skin tears to the Resident.^^ 2.On 3/31/2026 at 8:05 A.M. the surveyor observed the following on the Second Floor nursing unit: - a privacy curtain in room [ROOM NUMBER] was soiled with two large brown stains. -a privacy curtain in room [ROOM NUMBER] was soiled with four dark brown smudge stains. -a privacy curtain in room [ROOM NUMBER] was soiled with two large yellow stains and a smaller brown stain. On 4/2/26 at 8:08 A.M., the surveyor and Nursing Supervisor #1 observed the soiled privacy curtains Rooms 204, 208 and 210. During an interview at the time, Nursing Supervisor #1 said that the housekeeping department is responsible for maintaining the privacy curtains in resident rooms and that any staff member can call housekeeping to let them know about a soiled privacy curtain. Nursing Supervisor #1 said that the privacy curtains in rooms [ROOM NUMBER] were dirty and should be changed and cleaned and she would make housekeeping staff aware that the curtains needed to be cleaned. During an interview on 4/2/26 at 8:25 A.M., the Housekeeping Director (HD) said he relies on all staff to let him know when a privacy curtain is soiled and needs to be changed. The HD said that the facility doesn't have extra stock of privacy curtains and housekeeping staff are required to take down the curtain that is soiled, wash it, and hang it back up. The HD also said that the privacy curtains should not be hanging if they are stained and soiled. 3a. Resident #9 was admitted to the facility in September 2020 with diagnoses including Parkinson's Disease, Dementia and Psychotic Disorder.^^ Review of the Minimum Data Set (MDS) Assessment, dated 2/25/26, indicated Resident #9 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of 1 out of 15. On 3/31/26 at 10:08 A.M., the surveyor observed Resident #9's right sided window curtain was detached from the curtain rod hardware and not in good working condition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225293	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southbridge Rehabilitation & Health Care Center	84 Chapin Street Southbridge, MA 01550

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/1/26 at 2:03 P.M., the surveyor observed Resident #9's right sided window curtain was detached from the curtain rod hardware and not in good working condition. During an interview at the time, Resident #9 asked the surveyor to close the window curtain, but the surveyor was unable to move the curtain or close it completely. On 4/2/26 at 8:09 A.M., the surveyor observed Resident #9's right sided window curtain remained detached from the curtain rod hardware and not in good working condition. During an interview on 4/2/26 at 2:31 P.M., the Assistant Maintenance Director said that if someone tries to open or close Resident #9's curtains, the curtains pull down off the rod and should not be like that. During an interview on 4/2/26 at 2:49 P.M., Certified Nurse Aide (CNA) #2 said she was unsure how long the curtains had been in disrepair but did not think that it was homelike for Resident #9. During an interview on 4/2/26 at 2:53 P.M., the Housekeeping Director said that he had been aware Resident #9's curtains were in disrepair, and the facility did not have approval to purchase replacement curtains at this time. 3b. Resident #52 was admitted to the facility in December 2019 with diagnoses including Dementia and Depression. Review of the MDS assessment dated [DATE], indicated Resident #52 was moderately cognitively impaired as evidenced by a BIMS score of 5 out of 15. On 3/31/26 at 10:38 A.M., the surveyor observed Resident #52 sitting in his/her room beside the window with the curtains pulled closed. The surveyor observed two large holes to the right sided curtain. During an interview at the time, Resident #52 said that the curtains should not be ripped and staff should have fixed it. On 4/1/26 at 2:28 P.M., the surveyor observed Resident #52 sitting in his/her room beside the window with the curtains pulled closed and the right sided curtain had two large holes. During an interview at the time, Resident #52 said he/she was uncertain how long the curtain had been damaged but thinks it had been there since he/she moved into the room. Resident #52 said he/she felt annoyed that the curtains were ripped, and staff knew about the ripped curtain and were supposed to have fixed it. During an interview on 4/2/26 at 2:33 P.M., the Assistant Maintenance Director said that Resident #52's curtains should not have holes in them and that the housekeeping department oversaw the curtains. During an interview on 4/2/26 at 2:53 P.M., the Housekeeping Director said that he was aware that Resident #52's curtains have had holes for about one year and said the facility did not have approval to purchase replacement curtains.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225293	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southbridge Rehabilitation & Health Care Center	84 Chapin Street Southbridge, MA 01550

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observations, interviews, and record review, the facility failed to ensure a grievance was initiated for prompt resolution relative to missing personal items for one Resident (#39) out of a total sample of 26 residents. Specifically, the facility failed to assist Resident #39 in appropriately filing a grievance when he/she reported missing two personal blankets to staff, staff was unable to find the missing blankets and did not report the Resident's complaint and missing personal items to the facility grievance officer as required. Findings include:Review of the facility's Grievance Policy, undated, indicated the following:-Residents have the right to voice grievances .-The facility will make prompt efforts to resolve any grievances in accordance with this policy.-Upon receipt of a grievance, the staff person receiving the grievance shall immediately notify the grievance officer. Resident #39 was admitted to the facility in November 2025 with mild neurocognitive disorder. Review of Resident #39's Minimum Data Set (MDS) Assessment, dated 2/20/26, indicated:-has clear speech.-is understood and understands others. During an interview on 4/1/26 at 8:59 A.M., Resident #39 said he/she received two blankets (one brown and one blue and white) as gifts from family members and that both blankets were missing. Resident #39 said the blankets had been missing for a couple of weeks, that he/she told staff members the blankets were missing, and he/she could not recall the names of the staff members he/she told. Resident #39 said staff did not offer assistance to file a grievance for the missing blankets and staff said they could not find the blankets. Review of the facility's 2026 Grievance Book did not include any evidence that a grievance had been filed relative to Resident #39's report of the two missing blankets. Review of the facility's 2025-2026 Missing Items Book did not include any evidence a missing item report had been filed relative to Resident #39's report of two missing blankets. During an interview on 4/1/26 at 11:19 A.M., Certified Nurse Aide (CNA) #4 said Resident #39 had two personal blankets and that the Resident told CNA #4 on 3/31/26 that both blankets were missing. CNA #4 said the blankets were probably in the laundry and that she had not checked the laundry yet for the blankets. CNA #4 said if she could not locate the blankets in the laundry, then she would alert administration. The surveyor observed a posting on the wall across from the nurses' station as follows:-How to file a grievance or complaint: -Grievance forms located on each unit and with the social service department. -Please return grievance to staff or reception. -Grievance Officer is the Social Worker (SW) #1. During an interview on 4/1/26 at 12:30 P.M., CNA #4 said she went to the laundry and could not locate the blankets. CNA #4 said she would let someone in administration know that Resident #39's blankets were missing. During an interview on 4/2/26 at 11:08 A.M., Resident #39 said staff had not come to speak with him/her about his/her missing blankets after the Resident told the surveyor his/her blankets were missing on 4/1/26. During an interview on 4/2/26 at 12:37 P.M., SW #1 said she had not been alerted by staff that Resident #39 reported his/her blankets missing. SW #1 said when residents alerted staff of missing personal items, staff were required to fill out a Missing Items Form and give the form to her. SW #1 said CNA #4 should have completed a Missing Items Form and given the form to her on 4/1/26, when CNA #4 was unable to locate Resident #39's blankets after the Resident reported the blankets missing. SW #1 said a Missing Items Form had not been completed and provided to her relative to Resident #39's missing blankets, as required.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225293	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southbridge Rehabilitation & Health Care Center	84 Chapin Street Southbridge, MA 01550

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review the facility failed to ensure one Resident (#129) out of a total sample of 26 Residents, was free from physical restraints. Specifically, the facility failed to ensure Resident #129's wheelchair brakes were unlocked while he/she was seated at a table when the Resident was unable to release the wheelchair brakes independently and was unable to move him/herself from the table. Findings include: Review of the facility policy titled Restraint Management revised August 2018, indicated a physical restraint is any manual, mechanical or physical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. Also included as restraints are facility practices that meet the definition of a restraint, such as: -using devices in conjunction with a chair, such as trays, tables, bars or belts, that the resident cannot remove easily, that prevent the resident from rising. Resident #129 was admitted to the facility in April 2023 with diagnoses including Metabolic Encephalopathy, Aphasia, Wernicke's Encephalopathy, and acquired absence of right leg below the knee. Review of the Fall Care Plan initiated on 5/10/23, indicated the Resident was at risk for a fall-related injury secondary to a history of self-transfers, losing balance, refusal to ask for help, and remained determined to self-transfer independently. Review of the Velcro Seatbelt Care Plan revised on 6/18/25, indicated Resident #129 used an alarmed Velcro seatbelt: Remove seatbelt during all meals, and included the following interventions: -check for self-release of Velcro seatbelt per order - review use at least quarterly to ensure least restrictive device is being utilized. Review of the Resident #129's Restraint Assessment, last completed on 6/30/25 indicated: -no restraints were in use at the time -he/she was able to self-release the seatbelt Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #129: -has severe cognitive impairment as evidenced by a Brief Interview of Mental Status (BIMS) score of 2 out of 15. -utilized a wheelchair for mobility. -did not utilize restraints. On 3/31/26 at 3:26 P.M., the surveyor observed Resident #129 self-propelling in a wheelchair in the activity room. Resident #129 was placed by a staff member at a table, and the staff member locked the Resident's wheelchair brakes. Resident #129 was observed to repeatedly make attempts to push the wheelchair away from the table using his/her left leg, causing the wheelchair to tip backward. The Resident's wheelchair was observed to have an anti-tipping device which prevented the wheelchair from tipping backwards and an anti-rollback device on the wheels, which was preventing the Resident from moving the wheelchair. Resident #129 became agitated, was using profanities, and released his/her Velcro seatbelt which started alarming. Resident #129 was then approached by a staff member who re-fastened the seatbelt. During an interview on 3/31/26 at 3:26 P.M., Certified Nurse Aide (CNA) #3 said Resident #129 had the ability to self-propel in the wheelchair, release the seatbelt and had the ability to release the wheelchair brakes. On 4/1/26 at 1:57 P.M., the surveyor observed Resident #129 seated in a wheelchair at a table with his/her wheelchair brakes engaged, an alarmed Velcro seatbelt around his/her waist and anti-rollback device on the wheels and anti-tipping devices. On 4/2/26 at 8:04 A.M., the surveyor observed Nurse #1 assisting Resident #129 into the dining room and placed him/her at a table and locked the wheelchair brakes. Resident #129 was observed wearing an alarmed Velcro seatbelt. The Resident's wheelchair was placed with the wall about one foot away from the wheelchair's rear wheel, restricting his/her movement away from the table. During an interview on 4/2/26 at 9:25 A.M., CNA #2 said Resident #129 was a wanderer in his/her wheelchair, so staff placed the Resident at a table and lock the wheelchair brakes. CNA #2 said Resident #129 tried to stand up a lot and the anti-rollback device on his/her wheelchair prevented the wheelchair from rolling backwards if he/she attempted to stand up unexpectedly. CNA #2 said she thought Resident #129 could release the wheelchair brakes. On 4/2/26 at 9:31 A.M., the surveyor observed Resident (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225293	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southbridge Rehabilitation & Health Care Center	84 Chapin Street Southbridge, MA 01550

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#129 seated in his/her wheelchair at a table with the left brake on the wheelchair engaged. The Staff Development Nurse was observed repeatedly asking Resident #129 to unlock the left brakes on his/her wheelchair, but the Resident was unable to follow direction and cues to release the brake. During an interview at the time, the Staff Development Nurse said Resident #129 was unable to move away from the table and having the wheelchair brake engaged restricted his/her freedom of movement and could be a restraint. During an interview on 4/2/26 at 9:47 A.M., Nurse #1 said staff should not engage the brakes on the wheelchair because Resident #129 was able to move around in the wheelchair independently. Nurse #1 said if Resident #129 could not release the brakes, it could restrain him/her from moving around independently. During an interview on 4/2/26 at 10:02 A.M., the Nurse Supervisor said Resident #129 should not have been seated at a table with the brakes engaged because it would limit him/her from moving away from the table which is a restraint. During an interview on 4/2/26 at 3:35 P.M., the Assistant Director of Nursing (ADON) said when Resident #129 was seated at a table with the wheelchair brakes engaged and was not able to release the brakes it would be a potential restraint.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225293	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southbridge Rehabilitation & Health Care Center	84 Chapin Street Southbridge, MA 01550

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interview, the facility failed to ensure that services were provided to maintain hearing abilities for one Resident (#108) out of a total sample of 26 residents. Specifically for Resident #108, the facility failed to assist with providing routine audiology care, when the Resident Representative consented to and requested audiology care services and the Resident was diagnosed with bilateral hearing loss. Findings include:ˆ Review of the facility's policy, titled Consultant Services, dated April 2015, indicated: -the facility will identify and facilitate consultant services to meet the resident's needs to ensure optimum care for each resident/patient through consultant services. -If a consultant is required in another specialty area, the Physician must specify the person he/she wishes to use. -once the consultant is identified by the Physician and after the family has been notified and given the permission for the consult, the staff will call the consultant to notify him/her of the request and document the response in the medical record. Resident #108 was admitted to the facility in April 2024 with diagnoses including Dementia and bilateral hearing loss. Review of Resident #108's medical record indicated: -Physician's order for Consults: Audiology Consult as needed, dated 4/22/24. -Request for Audiology Services Form, signed by the Resident's Representative on 4/22/24. -Decrease in Hearing Care Plan, last revised 7/22/25.ˆ -No documented evidence that the Resident had been seen by Audiology since his/her admission to the facility. Review of Resident #108's recent Minimum Data Set (MDS) assessment dated [DATE], indicated: -severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of two out of a total possible of 15. -hearing was highly impaired and did not have a hearing aid. -diagnosed with bilateral hearing loss. On 3/31/26 at 9:31 A.M., the surveyor observed Resident #108 in the day room eating breakfast and was yelling rather than talking in a normal level to his/her tablemates. When the surveyor attempted to engage in conversation with the Resident, he/she said that he/she could see the surveyor speaking but that he/she could not understand what the surveyor was saying. The surveyor did not observe any hearing devices in the Residents' ears or other means to communicate with the Resident at the breakfast table. During an interview on 4/1/26 at 9:08 A.M., the Director of Nursing (DON) said that Resident #108 should have been seen by Audiology and has not been seen by Audiology since his/her admission to the facility. ˆ ˆ