

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225456	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2025
NAME OF PROVIDER OR SUPPLIER Oceanside Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 44 South Street Rockport, MA 01966	

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)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>Based on record review, observation and interviews, the facility failed to ensure one Resident (#36) out of a total sample of 18 residents did not self-administer medication without an assessment or physician's order.</p> <p>Findings include:</p> <p>Review of the facility policy titled Self-Administration of Medications dated as revised February 2021 indicated that as part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. Further review indicated that if it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan.</p> <p>Resident #36 was admitted to the facility with diagnoses including asthma, amputation of toe multiple sites and depression.</p> <p>Review of the Minimum Data Set assessment, dated 5/5/25, indicated that Resident #36 is cognitively intact as evidence by a score of 15 out of 15 on the Brief Interview for Mental Status exam. Further review indicated that Resident #36 requires set up assistance to substantial assistance for activities of daily living.</p> <p>On 6/8/25 at 7:55 A.M. and 1:41 P.M., the surveyor observed a Primatene mist inhaler (used for asthma), a bottle of calcium carbonate tablets (an antacid) and a tube of triamcinolone cream (a topical steroid) on the over the bed table, in full view.</p> <p>During an interview on 6/8/25 at 7:55 A.M., Resident #36 said nursing was not aware of the inhaler but that he/she has had the inhaler, and the antacid and the cream on the over the bed table for a while now.</p> <p>Review of the Resident's active care plan failed to indicate a plan of care for the self-administration of medications.</p> <p>Review of the physician's orders dated June 2025 failed to indicate an order for the self-administration of medication. Further review failed to indicate either an order for the inhaler or the calcium carbonate.</p> <p>(continued on next page)</p>

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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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the medical record failed to indicate that Resident #36 has been assessed for the ability to self-administer medications.</p> <p>During an interview on 6/8/25 at 1:48 P.M., Resident #36 said that he/she had had two meals delivered to him/her by staff so far today and had just had staff provide morning care. Resident #36 said the medications were visible at all times to staff and no one said anything about them.</p> <p>During an interview on 6/8/25 at 1:48 P.M., Nurse #1 said that Resident #36 should not have medications at the bedside. Nurse #1 said residents should be assessed for the ability to self-administer medications before the medications can be left with the resident.</p> <p>During an interview on 6/9/25 at 8:10 A.M., the Director of Nursing (DON) said that residents are to be assessed for self-administration of medication prior to having medications left at bedside. The DON then said that Resident #36 was not assessed for the ability to self-administer medications.</p> <p>During an interview on 6/9/25 at 12:20 P.M., Certified Nurse's Aide #5 said that he is Resident 36's regular CNA, but he didn't notice any medications on the Resident's over the bed table. CNA #5 then said that Resident #36 should not have medications at bedside, and he would have removed them if he had noticed them.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observations, record review, and interviews, the facility failed to ensure that respiratory care and services, consistent with professional standards of practice, were provided for one Resident (#27) out of sample of 18 residents. Specifically, for Resident #27, the facility failed to change oxygen tubing as indicated in the physician's orders and the facility failed to ensure staff consistently stored oxygen tubing in a sanitary manner when not in use.</p> <p>Findings include:</p> <p>Review of the facility policy titled, Oxygen Administration, dated as revised October 2010, indicated the purpose of this procedure is to provide guidelines for safe oxygen administration.</p> <p>Preparation</p> <p>1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.</p> <p>Resident #27 was admitted to the facility in April 2024 with diagnoses including chronic respiratory failure, chronic obstructive pulmonary disease (COPD), and dyspnea (difficulty breathing).</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 3/28/25, indicated that Resident #27 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This MDS indicated Resident #27 required oxygen therapy.</p> <p>On 6/8/25 at 7:23 A.M., the surveyor observed Resident #27 receiving oxygen from a nasal canula from an oxygen concentrator. The oxygen tubing was undated. There was a bag attached to the concentrator dated 5/23/25. There was a portable oxygen concentrator resting on top of a pile of books, on top of a plastic storage unit, this oxygen tubing was undated, and the tubing was resting on books and a container of bird seed (not stored in a sanitary manner). Resident #27 said that nursing staff are supposed to change his/her oxygen tubing weekly and they (nursing staff) have not changed his/her oxygen tubing in a few weeks, and this is not that first time that they haven't changed his/her tubing weekly.</p> <p>On 6/8/25 at 12:22 P.M. and on 6/9/25 at 8:15 A.M., the surveyor observed Resident #27 receiving oxygen via a nasal canula from a concentrator and tubing was undated, the bag on the concentrator was dated 5/23/25. Resident #27's portable oxygen concentrator oxygen tubing was resting on top of a pile of books, on top of a plastic storage unit, this oxygen tubing was undated, and the tubing was resting on books and a container of bird seed.</p> <p>On 6/9/25 at 10:33 A.M., the surveyor observed Resident #27's receiving oxygen and the tubing was dated as 6/4/25, the bag on the oxygen concentrator was dated 5/23/25. The oxygen tubing for the portable oxygen concentrator was unlabeled and not stored in a bag and the tubing was resting on top of a pile of books on a plastic storage unit. Resident #27 said that staff did not change his/her oxygen tubing today nor did they change the tubing on 6/4/25 and said the tubing has not been changed in a few weeks.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/9/25 at 2:27 P.M., the surveyor along with the Director of Nursing (DON) observed Resident #27's portable oxygen tubing stored on top of a pile of books on a plastic storage unit, the tubing was undated, and the tubing was not stored in a plastic bag and the nasal cannula was up against the wall.</p> <p>Review of Resident #27's grievance form, dated 4/11/25, indicated:</p> <p>Section 1 - Nature of the Concern: that the facility had received a fax from the Nurse Practitioner who did a visit with the Resident and that Resident stated the oxygen tubing was not changed.</p> <p>Section 2 - Department Head Review: Physician order to change oxygen tubing weekly on Wednesday when regular staff is working.</p> <p>Review of Resident #27's physician's order, dated 4/1/24, indicated:</p> <p>- Oxygen (O2) via nasal cannula (NC) continuously at 2 liters per minute (LPM) to maintain saturation (SAT) at or above 94%, every shift.</p> <p>Review of Resident #27's physician's order, dated 5/13/25, indicated:</p> <p>- Change oxygen (O2) tubing weekly, every night shift on every Wednesday for infection control, label with date and initial, provide respiratory bag for storage when not in use.</p> <p>Review of Resident #27's Treatment Administration Record (TAR), dated 5/28/25 and 6/4/25, indicated nursing implemented the physician's order indicating Nurse #3 changed, labelled, and dated the oxygen tubing and provided a respiratory bag, as ordered by the physician.</p> <p>During an interview on 6/9/25 at 3:41 P.M., Certified Nursing Assistant #4 said she used Resident #27's portable oxygen concentrator during the Resident's shower on 6/8/25.</p> <p>During an interview on 6/9/25 at 3:35 P.M., Nurse #2 said that oxygen tubing should be changed weekly on the night shift, the oxygen tubing should be dated, and the tubing should be stored in a bag when not in use.</p> <p>During an interview on 6/9/25 at 2:27 P.M. the DON said she was aware of Resident #27's oxygen tubing concerns, and she had filed a grievance in the past for staff not changing Resident #27's oxygen tubing. The DON said that on 6/9/25 she noticed that Resident #27's oxygen tubing was not labelled with the date and the DON said that she looked at the TAR and she put a piece of tape on the oxygen tubing with the date the tubing was last supposed to be changed (6/4/25) and she dated the tubing that Resident #27 was currently using. The DON said that nursing should implement the physician's order and change the tubing and date the tubing in accordance with the physician's order. The DON said that oxygen tubing should be stored in a sanitary manner when not in use.</p> <p>On 6/9/25, 6/10/25, and 6/11/25, the surveyor attempted to interview Nurse #3 but she was unable to be reached.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>Based on observation, record review, and interview, the facility failed to serve what was listed on the menu or provide a substitution for two lunch meals. Specifically, on 6/8/25 the facility failed to serve sour cream with the baked potato during the lunch meal and on 6/9/25 the facility failed to add meat to the baked ziti according to the facility's recipe during the lunch meal.</p> <p>Findings include:</p> <p>Review of the policy titled, Food Presentation, undated, indicated the following:</p> <ul style="list-style-type: none"> - Foods are prepared according to standard recipes. <p>During the resident group meeting on 6/8/25 at 1:30 P.M. the surveyor met with Residents and the following complaints were made by four residents:</p> <ul style="list-style-type: none"> - Menus were not always followed. - Should have condiments like sour cream with a baked potato. <p>On 6/8/25 at 12:10 P.M., the surveyor observed lunch being delivered to residents' rooms. The main lunch meal consisted of a slice of pork, brussels sprouts, a baked potato, margarine, and watermelon.</p> <p>Review of the recipe for lunch, 6/8/25, indicated the baked potato was to be served with sour cream.</p> <p>During an observation of lunch on 6/8/25 12:13 P.M., two residents reported wanting sour cream with their baked potatoes and did not receive it.</p> <p>On 6/9/25 at 11:45 A.M., the Food Service Director (FSD)/cook was observed plating baked ziti with plain tomato sauce (without meat), a tossed salad, garlic toast, and a fruit cup.</p> <p>Review of the recipe for lunch, 6/9/25, indicated the baked ziti was to be served with meat sauce, breadsticks, and gelatin.</p> <p>On 6/9/25 at 12:39 P.M. through 12:49 P.M., the surveyor interviewed two Residents who were eating their lunch, and the Residents told the surveyor the following:</p> <ul style="list-style-type: none"> - Usually I love pasta, but this pasta has no flavor and no meat. - Lunch was lousy, the ziti with the sauce was plain. <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/9/25 at 2:57 P.M., the Food Service Director said she was not in the facility on Sunday, but the menu should have been followed, and sour cream should have been provided to the residents with the baked potato. The Food Service director said there was no meat sauce served with the baked ziti today because the meat was not thawed out in time and she did not have a substitute protein to provide to the residents for lunch.</p> <p>During an interview on 6/10/25 at 8:28 A.M., the Administrator said that food should be prepared according to the recipe, and she was unaware the kitchen did not have beef for the pasta for lunch on 6/9/25 until after lunch had concluded. The Administrator said that the FSD should have notified her so they could have come up with an alternate protein or they could have gone to the store to get some beef for the lunch meal.</p> <p>During an interview on 6/10/25 at 9:38 A.M., the Dietitian said following the menu is extremely important, the beef is an important part of the recipe because it adds a combination of protein, fat, and iron to the Residents diet. The Dietitian said she was not aware of the change to the meal prior to lunch being prepared and served and said there should have been a substitute for the lack of beef. The Dietitian also said that sour cream should have been served with the baked potato for Sunday lunch.</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to serve food that was palatable, and at a safe and appetizing temperature, on two of two units.</p> <p>Findings include:</p> <p>Review of the facility policy titled, Food Serving Temperatures, not dated, indicated that foods will be maintained at proper holding temperatures to ensure food safety. The temperature of potentially hazardous cold foods will not be greater than 45 F (degrees Fahrenheit) when served to the resident.</p> <p>Review of the facility policy titled, Food Presentation, not dated, indicated that foods will be served at proper temperatures. Hot foods hot and cold foods cold.</p> <p>During the initial tour of the facility on 6/8/25 the surveyors met with residents. Thirteen residents voiced dissatisfaction with the temperature and/or taste of the food served at the facility.</p> <p>During the resident group meeting on 6/8/25 at 1:30 P.M. the surveyor met with Residents and the following complaints were made by four residents:</p> <ul style="list-style-type: none"> - The foods that were cold were not always served cold. - The foods that were hot were not always served hot. - Menus were not always followed. - They should be served condiments like cranberry sauce with hot turkey sandwiches or sour cream with a baked potato. <p>Review of the sign titled, Monday Lunch Menu, indicated the following:</p> <ul style="list-style-type: none"> - Ziti Baked - Tossed Salad with Dressing - Garlic Bread - Gelatin <p>On 6/9/25 at 12:47 P.M., the surveyor completed a test tray on the [NAME] Unit to determine palatability and temperature of the food served, the results were as follows:</p> <ul style="list-style-type: none"> - Pasta in tomato sauce- 142 degrees Fahrenheit and hot, bland taste - Mixed green salad- 98 degrees Fahrenheit, warm to taste and the cucumber was bitter, served on the same plate as the pasta. <p>(continued on next page)</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - Garlic toast- hard and unable to chew. - Milk- 65 degrees Fahrenheit, warm to taste. - Fruit cup- 72 degrees Fahrenheit and warm to taste. - Coffee- 140 degrees Fahrenheit and hot. <p>On 6/9/25 at 12:24 P.M., the food truck arrived at the Seaside Unit at 12:29 P.M. and the surveyor completed a test tray to determine palatability and temperature of the food served, the results were as follows:</p> <ul style="list-style-type: none"> - Pasta in a tomato sauce- 138 degrees Fahrenheit, bland taste. - Mixed green salad- 98 degrees Fahrenheit, warm to taste, wilted, and the cucumber was bitter, and served on the same plate as the pasta in tomato sauce. - One piece of garlic toast, too hard to chew, crouton texture. - One piece of white toast, too hard to chew, crouton texture. - Cranberry juice 58 degrees Fahrenheit, lukewarm taste. - Canned fruit 60 degrees Fahrenheit, lukewarm taste. <p>During an interview on 6/9/25 at 12:38 P.M., several staff members at the Seaside Unit said that the kitchen usually serves cold salad on the plate with the hot pasta. The staff said that this meal usually has meat mixed in the pasta.</p> <p>On 6/9/25 between 12:39 P.M. through 12:49 P.M., the surveyor interviewed six Residents who were eating their lunch, and the Residents told the surveyor the following:</p> <ul style="list-style-type: none"> - I didn't like the vegetables (salad), they were too bitter and warm - Usually, I love pasta, but this pasta has no flavor and no meat, we shouldn't have a cold salad on a plate with hot pasta, it makes the salad warm, the cucumbers are bitter when warm and the cucumber skin is bitter warmed up - I didn't like the warm salad - Lunch was lousy, got a bunch of salad that was warm, the ziti with the sauce was plain - I got one piece of garlic bread, and I got one piece of dry white bread, it was hard as rock and difficult to chew - I couldn't eat the salad, it was warm <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/9/25 at 1:25 P.M., the Administrator said that the salad should be served in a separate bowl/container to prevent the temperature from going above 42 degrees. The administrator also said that the milk and fruit cup should be kept at no more than 42 degrees.</p> <p>During an interview on 6/9/25 at 1:25 P.M., the Corporate Nursing Director said that the salad should be served in a separate bowl/container, not on a hot plate, to prevent the salad from becoming too hot.</p> <p>During an interview on 6/9/25 at 1:27 P.M., the Food Service Director (FSD) said that there was no meat to add to the pasta today. The FSD said she did not thaw out meat to use with the meal, so she just served the pasta as it is without a meat substitution.</p> <p>During an interview on 6/10/25 at 9:34 A.M., the Dietitian said the cold salad should have been served separately in a bowl and not on a plate containing hot foods.</p> <p>During a follow up interview on 6/10/25 at 8:27 A.M., the Administrator said temperature safety and palatability is important for the residents and for the kitchen to serve food at the correct temperatures. The Administrator said the salad should have been stored separately to keep it at the correct temperature and the cook should have followed the recipe for the baked ziti.</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>Based on observation, record review and interview, the facility failed to consistently accommodate resident food allergies for one Resident (#26) out of a total sample of 18 residents. Specifically, for Resident #26 a. the facility failed to ensure the kitchen did not serve the Resident eggs which were listed as an allergy on his/her diet ticket, and eggs are served/offered 17 times during a 28 day menu cycle and b. the facility failed to consistently document food allergies in the medical record and on the diet ticket, including an allergy to peaches on his/her diet ticket which is offered as a dessert five times during a 28 day menu cycle.</p> <p>Findings include:</p> <p>Review of the facility policy titled, Food Allergies, undated, indicated during hours of food service operation, the kitchen will make reasonable accommodations for patients with life threatening allergies and all other food allergies.</p> <ol style="list-style-type: none"> 1. Obtain copy of diet prescription order form with specific food allergies from nursing services. 2. Dietary services will list food allergies on tray card. 3. Dietary services will make modifications, under the directions of the Food and Nutrition Services Director and/or Dietitian, to meals and snacks. <p>Resident #26 was admitted to the facility in June 2023 with diagnoses including diabetes, hypertension, and dementia.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 5/15/25, indicated that Resident #26 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 10 out of 15. This MDS indicated Resident #26 required setup or clean-up assistance with eating.</p> <p>Review of Resident #26's plan of care related to eating, dated as 6/20/23, indicated the following:</p> <p>- EATING: Resident is independent after set up.</p> <p>a. On 6/8/25 at 8:21 A.M., the surveyor observed Resident #26's breakfast tray. There was a hard-boiled egg cut in half on his/her plate. Resident #26's food ticket indicated the following: Allergy - Eggs. Resident #26 said that he/she is allergic to eggs, and he/she experiences belly upset and diarrhea, Resident #26 said he/she would not eat the eggs on his/her plate.</p> <p>Review of Resident #26's diet ticket indicated the following allergies:</p> <p>- Eggs, fish, nuts, pork, shellfish, raisin, pork, peanut butter, **see report**.</p> <p>The medical record failed to include documentation to support Resident #26 has an allergy to eggs.</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. Review of Resident #26's current allergies listed in the electronic health record included the following allergies and allergic response:</p> <ul style="list-style-type: none"> - Peach / severity: unknown - Peanut butter / severity: unknown - Pork / severity: unknown - Raisin / severity: unknown <p>Review of Resident #26's physician's order, dated 6/17/23, indicated:</p> <ul style="list-style-type: none"> - Regular diet, Regular texture, thin consistency, allergic to nuts, peanut butter flavor, peanut oil, pork/porcine products, shellfish. <p>Further review of the physician's order failed to indicate an allergy to eggs or peaches.</p> <p>Review of Resident #26's most recent assessment titled, Nutritional Risk Evaluation Quarterly - V2, dated 11/20/24, indicated:</p> <p>B. Relevant Medical History</p> <p>3. Food Allergies: RAISIN, PORK, PEANUT BUTTER, PEACH, SHRIMP</p> <p>4. Nutrition Plan: Provide preferred foods.</p> <p>Further review of the nutrition assessment failed to indicate an allergy to eggs.</p> <p>Review of the facility's four-week menu plan, dated 2025, indicated that the kitchen serves peaches as dessert on five occasions during the 28-day menu cycle and the kitchen serves eggs 17 times during the 28-day menu cycle.</p> <p>During a follow-up interview on 6/10/25 at 3:33 P.M., Resident #26's said he/she is allergic to peaches and that peaches cause stomach upset.</p> <p>During an interview on 6/9/25 at 10:43 A.M., Certified Nursing Assistant (CNA) #1 said that Resident #26 does not like eggs and that nurses will always check the trays to ensure the trays are correct before the CNAs can deliver the trays to residents.</p> <p>During an interview on 6/9/25 at 2:44 P.M., the MDS nurse said that nursing routinely checks the diet ticket for diet textures and allergies before staff pass out the trays.</p> <p>During an interview on 6/9/25 at 2:26 P.M., the Director of Nursing (DON) said allergies should be followed by the kitchen and checked by nursing prior to delivering the tray to the resident. The DON referenced the diet ticket and the Resident's allergies listed in the electronic health record and the DON said that there were discrepancies, and the allergies would need to be reviewed by the Dietitian.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225456	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2025
NAME OF PROVIDER OR SUPPLIER Oceanside Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 44 South Street Rockport, MA 01966	

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)
<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/9/25 at 2:30 P.M., the Food Service Director said the allergies should be checked by the kitchen staff and then again by nursing staff to ensure that Resident's do not receive foods they are allergic to, the FSD said that Resident #26's dining ticket doesn't list peaches on the diet ticket, and she wasn't aware of Resident #26's allergy to peaches. The FSD said the **see report** on the diet ticket does not have a report but it is an error on the diet ticket.</p> <p>During an interview on 6/10/25 at 9:42 A.M., the Dietitian said that there are a lot of eyes on trays before they get to the resident, and staff need to check allergies prior to providing trays. The Dietitian said she would review the inconsistencies during her next visit, and she said she does not refer to diet ticket allergies to those listed in the electronic health record during her assessments, but she should.</p> <p>During an interview on 6/10/25 at 8:33 A.M., the Administrator said the kitchen is responsible for checking allergies first and then when the food truck arrives at the unit the nurse who is checking the truck should check prior to delivering tray to the resident.</p>