STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225491	A. Building B. Wing	11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shrewsbury Rehabilitation and Nursing at Southgate	40 Julio Drive Shrewsbury, MA 01545

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had a history of urinary retention (bladder does not empty completely or at all), the Facility failed to ensure he/she was provided with quality of care that met professional standards of practice, when he/she did not receive a physician ordered treatment for the monitoring and treatment of his/her urinary retention, placing him/her at risk for the development of complications associated with this condition.Findings include:Review of the Facility's policy, titled Charting and Documentation, with a revision date of 07/2017, indicated the following:-All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, or functional condition, shall be documented in the resident's medical record. -The following information is to be documented in the resident medical record: treatments and services as performed.Resident #1 was admitted to the facility in October 2025, diagnoses included obstructive and reflux uropathy (a blockage in the urinary system that prevents normal urine flow, while reflux uropathy involves urine flowing backward from the bladder to the kidneys).Review of Resident #1's Nursing Progress Note, dated 10/19/25, indicated Resident #1 removed his/her indwelling urinary catheter (a tube placed in the bladder to allow the flow of urine) and the Physician was notified.Review of Resident #1's Physician's Orders for the month of October 2025 indicated he/she had an order, dated 10/19/25, for a post void residual (PVR- a bladder scan that determines the amount of urine left in the bladder after urinating voluntarily) every shift and if the residual is greater than 500 milliliters (ml), to [use a] straight catheterization (an intermittent flexible tube used to drain urine from the bladder).Review of Resident #1's Medication Administration Record (MAR) for the month of October 2025, related to nursing documentation for his/her PVR indicated the following:-On 10/20/25 day shift (7:00 A.M. to 3:00 P.M.) Resident #1's PVR was 100 ml.-On 10/20/25 evening shift (3:00 P.M. to 11:00 P.M.) Resident #1's PVR was 200 ml.-On 10/20/25 night shift (11:00 P.M. to 7:00 A.M.) the boxes for nursing to sign off that his/her PVR was done and also the amount of urine that was retained in Resident #1's bladder, were left blank.Review of Resident #1's medical record indicated there was no documentation to support that his/her PVR was checked by nursing on the 10/20/25 night shift, as ordered by the physician.-On 10/21/25 day shift (7:00 A.M. to 3:00 P.M.) Resident #1's PVR was 605 ml, and he/she was catheterized for 1000 ml of urine output.During a telephone interview on 11/04/25 at 2:10 P.M., Nurse #1 said she was on duty for the 10/20/25 night shift. Nurse #1 said she was supervising Nurse #2 who was on orientation. Nurse #1 said at the end of their shift, Nurse #2 asked her if they could do Resident #1's PVR. Nurse #1 said she asked Nurse #2 if Resident #1 had voided. Nurse #1 said she did not know if Nurse #2 ever provided her the answer and that she did not do Resident #1's PVR with Nurse #2.Nurse #1 said if the PVR had been completed, it would have been signed off on Resident #1's MAR as being completed and would also have included the amount of urine retained in his/her bladder.The Surveyor was unable to interview Nurse #2, as she did not respond to the Department of Public Health's telephone or letter requests for an interview.During a telephone interview on 11/05/25 at 11:09 A.M., the Staff Development Coordinator (SDC) said when a nurse is on orientation she should stay side by side with her preceptor. The SDC said Nurse #2 was a recent graduate of nursing school. The SDC said that the preceptor should have ensured that all the treatments and medications were done as ordered and that the documentation was complete and accurate. The SDC said Nurse #1 should have known what her role was as a preceptor because she had been working at the facility for a long time.During a telephone interview on 11/05/25 at 3:33 P.M., the Director of Nurses (DON) said that if Resident #1's PVR was done as ordered on the night shift of 10/20/25, nursing would have signed it off as being completed on Resident #1's MAR or would have written a nursing progress note.