STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225567	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seacoast Nursing and Rehabilitation Center	292 Washington Street Gloucester, MA 01930

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 45763 Based on observation, interview, and record review, the facility failed to ensure that one Resident (#9) did not self-administer medications out of a total sample of 23 residents. Specifically, Resident #9 was not assessed to be able to safely self administer medication, and was observed self administering medication. Findings include: The facility policy, titled 11 - Self Administration of Medications, dated as reviewed 9/23, indicated the following: -It is the responsibility of the interdisciplinary team (IDT) to determine that it is safe for the resident to self-administer medications before the resident may exercise that right. Procedure: 1. Upon request, assess the resident's ability to meet the criteria outlined above and document outcomes on the form Assessment for the Self-Administration of Medication. 2. If determined that the resident is capable of self-administering medications, obtain order from the MD (Medical Doctor). 3. Document on the resident's care plan. Resident #9 was admitted to the facility in March 2022 with diagnoses including arthritis, heart failure and asthma. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/28/24, indicated that Resident #9 scored a 15 out of 15 on the Brief Interview for Mental Status exam, indicating that the Resident was cognitively intact. Review of Resident #9's active physician orders failed to indicate an order for self-administration of medication. The following orders were in place: (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Advair Diskus Aerosol Powder Breath Activated 100-50 Mcg (micrograms)/dose (Fluticasone-salmeterol) 1 puff inhale orally two times a day for COPD (Chronic Obstructive Pulmonary Disease) have resident rinse mouth after each use, initiated 2/21/24. -Biotene Dry Mouth/Throat liquid (mouthwashes) 30 mL (milliliters) by mouth two times a day for mild pain, initiated 2/2/24. -Lidocaine Patch 4% apply to left knee topically one time a day for pain, initiated 5/1/23 -Prostat one time a day for low pre albumin 30 cc (cubic centimeter) po (by mouth) daily, initiated 5/4/24. -Boost plus two times a day for weight loss 240 m boost plus or equiv (sic.), initiated 2/21/24. -Lasix tablet 40 Mg (milligrams) (Furosemide) give 1 tablet by mouth one time a day every Mon (Monday), Wed (Wednesday), Fri (Friday) for fluid retention related to edema, unspecified, initiated 5/1/23. -Aspirin tablet chewable 81 Mg give 1 tablet by mouth one time a day related to heart failure, unspecified, initiated 9/19/23. -Cyanocobalamin (a synthetic form of vitamin B12) Oral Tablet give 500 Mcg by mouth one time a day for supplement, initiated 5/1/23. -Losartan Potassium Tablet give 50 Mg by mouth one time a day related to essential (primary) hypertension, initiated 5/1/23. -Protonix Tablet Delayed Release 40 Mg (Pantoprazole Sodium) give 40 Mg by mouth one time a day for heartburn, initiated 5/1/23. -Norvasc Tablet (Amlodipine Besylate) give 10 Mg by mouth one time a day for HTN (hypertension), initiated 5/1/23. -Cymbalta Oral Capsule Delayed Release Particles 20 Mg (Duloxetine HCl) give 2 capsule (sic.) by mouth one time a day for mood/pain related to major depressive disorder, anxiety disorder, initiated 6/17/23 -Neurontin Capsule (Gabapentin) give 300 Mg by mouth three times a day for pain management, initiated 5/1/23. -Preservision AREDS (Age-Related Eye Disease Study) 2 Oral Tablet Chewable (multiple vitamins with minerals) give 1 tablet by mouth in the morning for vision loss, initiated 3/18/24. Review of Resident #9's most recent Self-Administration of Medication Assessment, dated 2/20/24, indicated that the Resident did not wish to administer his/her medication. Further review of the assessment indicated Resident #9 was not approved to self-administer medication. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #9's care plans failed to indicate a care plan for self-administration of medication. On 5/28/24 at 8:25 A.M., the surveyor observed Nurse #2 leave a cup full of medication, a supplemental shake, a small cup of yellow-orange liquid, a small cup of clear liquid, and an Advair inhaler in front of the Resident on a bedside table; Nurse #2 then left the room. The surveyor observed Resident #9 applying a white patch to his/her knee and self-administering medication from the cup without staff present. On 5/29/24 at 8:33 A.M., the surveyor observed Nurse #2 leave a cup full of medication, a supplemental shake, a small cup of yellow-orange liquid, a small cup of clear liquid, and an Advair inhaler on the Resident's bedside table, the Resident was exiting the bathroom; Nurse #2 then left the room. The surveyor observed Resident #9 self-administer his/her medications without staff present. Resident #9 intermittently coughed while swallowing the pills. During an interview on 5/29/24 at 9:50 A.M., Nurse #2 said Resident #9 self-administers all of his/her medication regularly, including self-applying a Lidocaine patch to his/her knee. Nurse #2 said she left the following medications on Resident #9's bedside table for the Resident to self-administer that morning: Advair, Biotene, a Lidocaine patch, Prostat, boost, Lasix, aspirin, Vitamin B12, Losartan potassium, Protonix, Norvasc, Cymbalta, Neurontin, and Preservision. During an interview on 5/29/24 at 8:44 A.M., Resident #9 said he/she self-administers medication without staff present every day. During a follow-up interview on 5/29/24 at 9:50 A.M., Nurse #2 said she did not know if Resident #9 had been assessed for self-administering medication. Nurse #2 said she would expect a resident to be assessed for the ability to self-administer medication before they do so, and that this should be documented in the Resident's physician orders. During an interview on 5/29/24 at 10:14 A.M., the Director of Nursing (DON) said a self-administration of medication assessment should be completed on admission, and quarterly; if a resident chooses to self-administer his/her medication they will be assessed to determine if this is appropriate. The DON said that the resident's care plan and physician's orders would be updated to specify that the resident was able to self-administer medication. During a follow-up interview on 5/29/24 at 10:38 A.M., the DON said a self-administration of medication assessment was completed for Resident #9 on 2/20/24 deeming the Resident unable to self-administer medication.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43846 Based on record reviews, observations and interviews, the facility failed to ensure resident centered care plans were implemented for two Residents (#36 and #59) out of a total sample of 23 residents. Specifically, 1. For Resident #36, the facility failed to implement thigh high TED hose (compression stockings) as ordered by the Physician. 2. For Resident #59, the facility failed to implement pressure relieving boots, as ordered by the Physician. Findings include: 1. Resident #36 was admitted to the facility in January 2024 with diagnoses that included nephrotic syndrome, orthostatic hypotension, and small cell b-cell lymphoma. Review of Resident #36's most recent Minimum Data Set (MDS) assessment, dated 4/17/24, indicated Resident #36 scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. On 5/28/24 at 1:12 P.M., the surveyor observed Resident #36 out of bed in a geri-recliner chair, not reclined. Resident #36 was not wearing compression stockings on his/her legs. On 5/29/24 at 12:44 P.M., the surveyor observed Resident #36 out of bed in a geri-recliner chair, not reclined. Resident #36 was not wearing compression stockings on his/her legs. Review of Resident #36's active physician order, dated 3/28/24, indicated Thigh high [NAME] hose (compression stockings) on before getting out of bed. Every day shift for BLE (bilateral lower extremity) edema, hypotension. Review of Resident #36's Nurse Practitioner progress note, dated 5/9/24, indicated the Resident remains weak, with fluctuating edema. +1 edema of the both lower legs. (sic.) Review of Resident #36's nursing progress notes from 5/27/24 to 5/30/24 did not indicate that the Resident refused to wear the compression stockings. During an interview on 5/30/24 at 7:31 A.M., Unit Manager #1 said the nurses should follow each residents plan of care. During an interview on 5/30/24 at 7:35 A.M., Nurse #1 said nurses should be following each resident's physician orders. Nurse #1 said if the Resident refuses anything then it should be documented in a nursing note. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/30/24 at 10:34 A.M., the Director of Nurses said she expects that the compression stockings are on as ordered when the Resident is out of bed. 2. Resident #59 was admitted to the facility in August 2023 with diagnoses that included Parkinson's disease, dysphagia, hemiplegia and hemiparesis. Review of Resident #59's Minimum Data Set (MDS) assessment, dated 3/17/24, indicated Resident #59 was assessed by nursing staff to have moderately impaired cognition. On 5/28/24 at 7:58 A.M., the surveyor observed Resident #59 in bed without pressure relieving boots on his/her feet. The boots were observed to be on the floor in the closet. On 5/29/24 at 7:43 A.M., the surveyor observed Resident #59 in bed without pressure relieving boots on his/her feet. The boots were observed to be on the floor in the closet. Review of Resident #59's physician order, dated 4/18/24, indicated Pressure relieving boots to bilateral feet AAT's (at all times) while in bed. Review of Resident #59's nursing progress notes from 5/22/24 to 5/30/24 failed to indicate that the Resident refused pressure relieving boots to his/her feet. Review of Resident #59's [NAME] Pressure Ulcer Risk Scale, dated 3/18/24, indicated Resident #59 scored an 11, indicating the Resident was at high risk for developing pressure ulcers. On 5/30/24 at 7:31 A.M., the surveyor and Unit Manager #1 observed Resident #59 in bed without pressure relieving boots on his/her feet. Unit Manager #1 said Resident #59 should have boots on while in bed as ordered by the Physician. Unit Manager #1 said the Resident has a history of having a pressure ulcer on his/her heel/ankle due to positioning issues and that is why the Resident needs boots on in bed. During an interview on 5/30/24 at 7:35 A.M., Nurse #1 said Resident #59 has an order to have pressure relieving boots on while in bed and they should be on while the Resident is in bed. Nurse #1 said if the Resident refuses anything then it should be documented in a nursing note. During an interview on 5/30/24 at 10:34 A.M., the Director of Nurses said she would expect Resident #59's pressure relieving boots on when the Resident is in bed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 43846 Based on observations, record review, policy review and interviews, the facility failed to provide assistance with Activities of Daily Living (ADLs), for one Resident (#59) out of a total sample of 23 residents. Specifically, the facility failed to provide assistance with meals as per the plan of care for Resident #59. Findings include: Review of the facility policy titled Activities of Daily Living (ADLs), dated 9/23, indicated Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: D. Dining (meals and snacks). Resident #59 was admitted to the facility in August 2023 with diagnoses that included Parkinson's disease, dysphagia, hemiplegia and hemiparesis. Review of Resident #59's Minimum Data Set (MDS) assessment, dated 3/17/24, indicated Resident #59 was assessed by nursing staff to have moderately impaired cognition. On 5/28/24 at 7:58 A.M., the surveyor observed Resident #59 in bed eating his/her breakfast. No staff were in the room to provide assistance or supervision. On 5/29/24 at 7:43 A.M. to 7:59 A.M., the surveyor observed Resident #59 in bed eating his/her breakfast. The Resident was observed to fall asleep at times. No staff were in the room to provide assistance or supervision. On 5/29/24 at 12:45 P.M., the surveyor observed Resident #59 seated in a wheelchair in his/her room eating lunch. No staff were in the room to provide assistance or supervision. On 5/30/24 from 7:27 A.M. to 7:31 A.M., the surveyor observed Resident #59 in bed eating his/her breakfast. No staff were in the room to provide assistance or supervision. Review of Resident #59's physician order, dated 9/1/23, indicated Feeding assistance with all meals for manipulation of utensils, opening containers, navigating tray, ID environmental barriers, and ability to bring utensils to his/her mouth for intake of proper nutrition. Review of Resident #59's current Activity of Daily Living care plan, indicated EATING: The resident requires physical assistance by (1) staff to eat. Review of Resident #59's current Nutrition care plan, indicated Pt (patient) has a dx (diagnosis) of Parkinson's, legally blind and requires staff assistance at meals. Provide staff assistance at meals per MD order. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #59's active Certified Nurse Aide (CNA) Kardex (resident specific care instructions), dated 5/30/24, indicated EATING: The resident requires physical assistance by (1) staff to eat. Provide diet as ordered: Mech (Mechanical) soft, thin liquids, one person assist. Provide staff assistance at meals per MD order. During an interview on 5/30/24 at 7:31 A.M., Unit Manager #1 said CNA's follow the Resident specific Kardex to know the needs of the Resident on how they eat, transfer, ADL needs etc. Unit Manager #1 said the nurses should follow each residents plan of care and doctors orders. During an interview on 5/30/24 at 10:34 A.M., the Director of Nurses said she would expect nursing to follow Resident #59's physician order and plan of care to be assisted with meals.