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	05/14/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure one Resident (#69) was free from unnecessary psychotropic medications by ensuring a reassessment of an as needed (PRN) dose of trazodone after 14 days, out of a total sample of 26 residents. Findings include: Review of the facility policy titled 'Psychotropic PRN Medication Use', dated September 2024, indicated the following: - Policy: the following requirements are in place to safeguard the health of our residents, ensure PRN orders for psychotropic medications do not remain in place for an extended period of time without being reviewed by the resident's physician and ensure that benefits and side effects of these medications are evaluated between required physician visits. -Type of PRN order: PRN orders for psychotropic medications excluding antipsychotics. Time Limitations: 14 days. Exception: Order may be extending past 14 days if the physician or prescribing practitioner believes it is appropriate to extend the order. Required actions: Attending physician or prescribing practitioner should document the rationale for the extended time period in the medical record and indicate the specific duration. Resident #69 was admitted to the facility in August 2024 with diagnoses including Alzheimer's Disease and adjustment disorder with mixed anxiety and depressed mood. Review of Resident #69's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status (BIMS) score of 7 out of a possible 15, which indicated he/she has severe cognitive impairment. During an interview on 5/13/25 at 8:08 A.M., Resident #69 said he/she was feeling well. The Resident was unable to answer specific questions about his/her medical diagnoses or medications. Review of Resident #69's physician orders indicated the following order initiated on 12/5/24: - Trazodone HCl (hydrochloride) Oral Tablet (a mood stabilizing medication), give 12.5 mg (milligrams) by mouth every 6 hours as needed (PRN) for anxiety, without a stop date. (continued on next page)

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Administration Records (MAR) for December 2024 through May 2025 indicated Resident #69 was given the PRN dose of trazodone 19 times on the following days: - In December: 12/19/24, 12/22/24, 12/29/24, 12/30/24 and twice on 12/31/24, - In January: 1/13/25, 1/17/25, 1/19/25, 1/22/25 and 1/30/25, - In February: 2/7/25 and 2/13/25, - In April: 4/26/25 and 4/29/25, - In May: 5/2/25, 5/4/25, 5/9/25 and 5/11/25. Review of the Psychiatric Nurse Practitioner note, dated 1/28/25, indicated the following: -PRN trazodone has been utilized with positive effect and Would recommend adding stop/re-eval date to PRN Trazodone. Review of the Physician and Nurse Practitioner notes from December 2024 to May 2025 failed to indicate any notes that the PRN trazodone was reassessed, or a reassessment date was added to the order. During an interview on 5/13/25 at 12:51 P.M., Nurse #1 said all PRN psychoactive medications need to be reassessed after 14 days and then an end date placed on the order so continued reassessment can be completed. During an interview on 5/13/25 at 12:59 P.M., Unit Manager #1 said all PRN psychoactive medications need to be reassessed after 14 days and then an end date placed on the order so continued reassessment can be completed. During an interview on 5/13/25 at 1:26 P.M., the Director of Nursing said all PRN psychotropic medications need to be reassessed after the first 14 days and then need an end date or reassessment date added to the order to ensure continued reassessment occurs.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations, interviews, and record review, the facility to ensure that services provided met professional standards for one Resident (#43), out of 26 total sampled residents. Specifically, the facility failed to obtain and implement a physician's order for Resident #43's skin tear for approximately three days. Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice, dated as revised April 11, 2018, indicated the following: - Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. Review of the facility policy titled 'Care and Treatments: Skin/Wound Care: 2-Documentation Guidelines', dated as reviewed September 2024, indicated: - Physician orders will be in place for wounds requiring treatment. Resident #43 was admitted to the facility in April 2020 with diagnoses including Parkinson's disease and dementia. Review of the most recent Minimum Data Set (MDS) assessment, dated 3/6/25, indicated Resident #43 had severe cognitive impairment as evidenced by a Brief Interview for Mental Status exam score of 2 out of 15. On 5/13/25 at 8:27 A.M. and on 5/14/25 at 8:07 A.M., the surveyor observed Resident #43 with an undated foam dressing on his/her right forearm. The foam dressing was visibly soiled with what appeared to be drainage. Resident #43 was unable to say how he/she injured him/herself or when this foam dressing had been applied. Review of Resident #43's medical record, including physician's orders, progress notes, and plan of care, dated 5/10/25 to 5/14/24, failed to indicate the presence of a right arm skin tear, any physician order for the treatment of a right arm skin tear, or documentation that any wound treatment was implemented for a right arm skin tear. During an interview on 5/14/25 at 8:13 A.M., Certified Nurse Assistant (CNA) #2 said Resident #43 recently injured their right arm resulting in a skin tear and the nurse put a dressing on it. CNA #2 was unsure when this injury occured. During an interview on 5/14/25 at 8:15 A.M., Nurse #3 said a few days ago Resident #43 had a skin tear and a nurse put a dressing on it. Nurse #3 said there was not an order for the dressing but there should have been. Nurse #3 was unaware if the dressing had been changed since it was applied a few days ago. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/25 at 10:21 A.M., the surveyor observed Resident #43's right forearm wound with Nurse #3. Under the visably soiled undated dressing, there was an approximately half inch triangular wound with a red wound bed and dried dark red drainage. During an interview on 5/14/25 at 9:06 A.M., Unit Manager #2 said Resident #43 sustained a skin tear over the weekend on his/her right forearm and the nurse applied a dressing. Unit Manager #2 said a physician's order for the wound treatment was not obtained until this morning, which was at least three days after the skin tear had occurred, and after the surveyor brought it to the facilities' attention. Unit Manager #2 said that the treatment order should have been obtained when the dressing was first applied. Unit Manager #2 further said the danger of not obtaining a physician order for a wound treatment is that the dressing would not be implemented daily as required or completed correctly if it had been done. During an interview on 5/14/25 at 9:56 A.M., the Director of Nursing (DON) said wound treatments, such as dressings, for skin tears require a physician's order.

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to prevent a decline in range of motion leading to the development of a contracture for one Resident (#46) out of a total sample of 26 residents. Findings include: Review of the facility policy titled 'Resident Mobility and Range of Motion, dated September 2024, indicated the following: - Residents will not experience an avoidable reduction in range of motion (ROM). - Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in (ROM). - Interventions may include therapies, the provision of necessary equipment, and/or exercises and will be based on professional standards of practice and be consistent with state laws and practice acts. Resident #46 was admitted to the facility in November 2020 with diagnoses including dementia, apraxia, polymyalgia rheumatica (a condition that causes muscle pain and stiffness), and abnormal posture. Resident #46's diagnosis list did not include a diagnosis of arthritis. Review of Resident #46's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident scored a 5 out of a possible 15 on the Brief Interview for Mental Status (BIMS) which indicated he/she has severe cognitive impairment. Section GG of this MDS indicated Resident #46 has no impairment to his/her range of motion of his/her bilateral upper and lower extremities. On 5/13/25 at 7:53 A.M., Resident #46 was observed lying in bed with his/her right hand in a closed fisted position. When the surveyor asked the Resident to open his/her hand, the Resident was able to straighten his/her thumb and pointer finger and the third through fifth fingers remained bent. The Resident then attempted to straighten these fingers using his/her left hand and was unable to, saying it was painful, and a facial grimace was observed during the attempt. Resident #46 said his/her fingers have been like this for a while. Review of Resident #46's medical record failed to indicate that the Resident had a documented limit of range of motion of the right hand in any physician, nurse practitioner, or nursing notes or in any nursing assessments. On 5/14/25 at 7:43 A.M., the surveyor again observed Resident #46 lying in bed. The Resident was again observed with his/her right third through fifth fingers bent in a claw position. Resident #46 said his/her right hand hurt, again attempted to open his/her fingers on his/her own and was unable to. The Resident again winced in pain with attempted movement of those fingers. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/14/25 at 7:45 A.M., Certified Nursing Assistant (CNA) #1 said Resident #46 is able to fully open his/her hand sometimes and that the hand is not always stuck closed. CNA #1 then entered Resident #46's room and with the Resident's permission attempted to straighten the Resident's right hand fingers. The Resident grimaced in pain when CNA #1 began to move the fingers, pulled his/her hand back and would not let CNA move the fingers anymore. During an interview on 5/14/25 at 7:51 A.M., Unit Manager #1 said Resident #46 was recently seen by occupational therapy for a change in range of motion to his/her right hand. Unit Manager #1 said the Resident was fully able to open his/her hand at that time. Unit Manager #1 said she was unaware that at this point in time the Resident was unable to open three fingers on his/her right hand. Unit Manager #1 said if any resident were to experience a change in range of motion, the nursing staff should make a referral to therapy and notify the nurse practitioner of this change. On 5/14/25 at 8:05 A.M., the Director of Rehabilitation (DOR) provided the surveyor with a therapy screen completed on 2/3/25. The screen indicated that Resident #46 was referred to therapy for splinting needs and contractures for his/her right ring finger. The screen further indicated that at this time the Resident was able to have full range of motion of the right ring finger and no evaluation or therapy was indicated. The DOR said she was unaware Resident #46 was unable to straighten three fingers during today's observation and said she would have an occupational therapist assess him/her today. On 5/14/25 at 12:25 P.M., the surveyor was provided with an occupational therapy evaluation completed on this date. The evaluation indicated the following: - Reason for referral: pt (patient) is an [AGE] year old (male/female) resident of this setting. pt referred to skilled intervention to address contracture management of right dominant hand. pt was previously screened in 2/25 due to middle right trigger finger. At the time pt was able to perform AROM (active range of motion) of all digits without c/o (complaints of) pain. At this time pts condition has exacerbated involving digits (fingers) 3-5/ pt demonstrates no pain in resting position and is able to use dominant hand for self feeding and other tasks using digits one and two. Pt at this time will benefit from skilled intervention to address decline through positioning, education and manual therapy as pt tolerates. (sic) - Medical history and complexities: Contracture right hand digits 3-5. - UE (upper extremity) ROM: impaired - Clinical impressions: skilled OT (occupational therapy) to address right dominant hand contracture in digits 3-5. (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	During an interview with the DOR and the Occupational Therapist (OT) on 5/14/25 at 12:25 P.M., the DOR said the OT evaluated Resident #46 this morning and found a new contracture to the Resident's right hand. The OT said there was a definite new contracture of Resident #46's third through fifth fingers. The OT said she did not know the cause of the contracture, that he/she previously had a trigger finger and that the Resident does not have a diagnosis of arthritis. The OT said she made a goal for the Resident to tolerate a hand carrot (an orthotic in the shape of a carrot that gets progressively wider at the top of the orthotic. The carrot is labeled in stages, with the wider top being a higher number) and that during the evaluation, the Resident was able to tolerate the carrot at a level 6, but as soon as she attempted to move the carrot to level 7 (increased the opening of the fingers) the Resident experienced pain and removed the carrot. The OT said she recommended skilled intervention to treat the new contracture. During a follow-up interview on 5/14/25 at 12:36 P.M., Unit Manager #1 said she had not noticed Resident #46's hand had gotten worse since February. During an interview on 5/14/25 at 12:54 P.M., Resident #46's Health Care Proxy (HCP) said she had noticed the Resident was unable to open his/her right ring finger about two months ago. The HCP said that therapy saw the Resident at this point and although they said she could straighten his/her finger, his/her hand never fully open. The HCP said that she had noticed that Resident #46's hand had become more claw-like in the past few weeks and she had reported this to the nursing staff. Resident #46's HCP said she was told that the Resident had arthritis but said she has known the Resident for 47 years and has never known him/her to have arthritis. Resident #46's HCP said she has also noticed this decline in range of motion has also affected the Resident's ability to use the hand for everyday tasks such as self-feeding. She said that over the past weekend she noticed the Resident was unable to use a fork and was eating green beans like french fries. During an interview on 5/14/25 at 12:55 P.M., Nurse Practitioner #1 said she expects to be notified of any change in status with residents and was not notified of a change to Resident #46's range of motion of the right hand until today. Nurse Practitioner #1 said Resident #1 does not have a diagnosis of arthritis, but she feels this is a flare up of arthritis. Nurse Practitioner said it was unfair to call it a contracture until you attempted to treat the decline in range of motion, however said that could just be semantics because Resident #46 has had a definite new change in range of motion to his/her right hand. During an interview on 5/14/25 at 1:17 P.M., the Director of Nursing said she would expect any change in status, including a change in range of motion, to be referred to therapy and the Nurse Practitioner to be notified.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to identify and address a significant weight loss for one Resident (#14) out of a total of 26 sampled residents. Findings include: Review of the facility policy title 'Determining and Addressing Significant Weight Changes', dated September 2024, indicated: - Purpose: The nutritional and hydration status of residents will be maximized with appropriate and timely intervention. 1. A resident experiencing weight loss or gain per guidelines: a. 5% in one month, b. 10% in six months. should be referred to the dietitian for further monitoring. 2. The nurse will notify [Occupational therapy / Speech therapy] for screening as necessary and appropriate recommendations will be communicated by the nursing staff to the physician. Physician orders will be obtained for an evaluation if indicated and for all interventions. Resident #14 was admitted to the facility in December 2023 with diagnoses including unspecified dementia and cognitive communication deficit. Review of the Minimum Data Set Assessment (MDS), dated [DATE], indicated that Resident #14 was severely cognitively impaired as evidenced by a score of 00 out of a possible 15 on the Brief Interview for Mental Status Exam (BIMS). The MDS also indicated Resident #14 was dependent on staff assistance for meals. On 5/14/25 at 7:31 A.M., the surveyor observed Resident #14 resting in bed. Resident #14 appeared thin and frail and was unable to participate in the interview process. Review of Resident #14's care plans, initiated 12/22/23, indicated the following: - Focus: The resident has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) pain, generalized weakness. - Interventions: The resident needs set up/clean up assistance with eating. Review of Resident #14's physician orders indicated the following: - Magic Cup (a nutritional supplement) with meals breakfast, lunch, dinner, initiated 10/30/24. - Ensure Enlive, three times a day, initiated 9/5/24. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Fortified Cereal, with meals Super cereal with breakfast and super potato with lunch and supper; initiated 5/28/24. - Mirtazapine Give 15 mg by mouth one time a day for mood and appetite, initiated 9/20/24. Review of Resident #14's weights indicated: - 12/26/24: 126.3 lbs (pounds). - 1/6/25: 123.2 lbs. - 2/24/25: 116.2 lbs; a total loss of 8% of his/her total body weight since 12/26/25. - 3/13/25: 119.8 lbs. - 4/7/25: 114.2 lbs. Review of Resident #14's clinical record indicated Resident #14 was not assessed by the Dietitian for weight loss until 4/4/25; 39 days after Resident #14's significant weight loss was first documented. Review of the Dietitian's note, dated 4/4/25, indicated: - Gradual wt (weight) loss since mid-Dec. Wt fluctuations noted the past few weeks. Variable PO (by mouth) intake at meals, poor at times. Averages ~50-75% this past week. Staff to provide encouragement for adequate intake. Poor acceptance of ONS (ordered nutritional supplements) 25%. Rt (resident) is prescribed medications with known s/e (side effects) of inc (increased) appetite and wt (weight) gain. May need 1:1 supervision at meals for adequate intake. During an interview on 5/14/25 at approximately 8:30 A.M., Certified Nursing Assistant (CNA) #2 said that she did not think Resident #14 had any weight loss. CNA #2 said that Resident #14's appetite and intake would go up and down and within the past two months and that CNA's had started to cue or provide physical assistance to Resident #14 during meals. During an interview on 5/14/25 at approximately 8:35 A.M., Unit Manager #2 said that when a resident experiences weight loss, staff will re-weigh to verify and then the weight is put in the electronic medical record. Unit Manager #2 said that the Dietitian runs a report of the weights and would then assess and put in interventions to address the weight loss. Unit Manager #2 said that there is not much verbal communication regarding weight loss between nursing and the Dietitian because she can access the weights and reports electronically. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interviews on 5/14/25 at 9:06 A.M., and 9:38 A.M., the Dietitian said that she gets reports from the electronic record or verbally from staff when a Resident loses weight. The Dietitian said that within 24-48 hours she will assess the resident, ask for a re-weight, review possible interventions to address the weight loss and document in a progress note. The Dietitian said that Resident #14 was previously reviewed during risk meetings for weight loss but when he/she stabilized, he/she came off risk. The surveyor and the Dietitian reviewed Resident #14's weights and nutritional progress notes and assessments. The Dietitian was not aware that Resident #14 had a significant weight loss in February 2025 and that he/she had not been assessed for weight loss until April 2025. The Dietitian said that she missed Resident #14's February 2025 weight loss.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to ensure that one Resident (#96) was free from significant medication errors out of a total sample of 26 residents. Specifically, the facility failed to ensure medications were not administered when the Resident #96's blood pressure was not within the parameters prescribed by the physician. Findings include: Resident #96 was admitted to the facility in July 2024 with diagnoses including congestive heart failure. Review of Resident #96's most recent Minimum Data Set (MDS), dated [DATE], indicated the Resident had a Brief Interview for Mental Status exam score of 8 out 15 which indicated the Resident had moderate cognitive impairment. The MDS also indicated Resident #96 requires partial to moderate assistance with functional daily tasks. Review of Resident #96's physician orders indicated the following orders: - Lasix Oral Tablet (a diuretic medication) 20 MG (milligrams). Give 20 mg by mouth one time a day for edema Hold for SBP (systolic blood pressure) < (less than) 110 AND Give 20 mg by mouth as needed for edema add 20mg to the scheduled 20mg to equal 40mg if not resolved within 3-5 days, contact the physician, initiated on 11/15/24. - Spironolactone (a blood pressure medication) Oral Tablet 25 MG. Give 25 mg by mouth one time a day for edema related to essential hypertension. Hold for BP less than 110 systolic, initiated on 11/21/24. Review of Resident #96's Medication Administration Report (MAR) for November 2024 indicated the following: - On 11/20/25, Resident #96 had a blood pressure of 102/62 and was given his/her dose of lasix. Review of Resident #96's Medication Administration Report MAR for December 2024 indicated the following: - On 12/12/25, Resident #96 had a blood pressure of 105/49 and was given his/her dose of lasix. - On 12/23/25, Resident #96 had a blood pressure of 99/60 and was given his/her dose of lasix and spironolactone. - On 12/31/25, Resident #96 had a blood pressure of 108/70 and was given his/her dose of lasix and spironolactone. Review of Resident #96's Medication Administration Report MAR for January 2025 indicated the following: (continued on next page)

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	225567	A. Building B. Wing	05/14/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 1/2/25, Resident #96 had a blood pressure of 106/86 and was given his/her dose of lasix. - On 1/3/25, Resident #96 had a blood pressure of 108/68 and was given his/her dose of lasix and spironolactone. - On 1/13/25, Resident #96 had a blood pressure of 102/65 and was given his/her dose of spironolactone. - On 1/14/25, Resident #96 had a blood pressure of 102/65 and was given his/her dose of lasix and spironolactone. - On 1/18/25, Resident #96 had a blood pressure of 108/68 and was given his/her dose of spironolactone. - On 1/20/25, Resident #96 had a blood pressure of 108/72 and was given his/her dose of spironolactone. - On 1/25/25, Resident #96 had a blood pressure of 102/70 and was given his/her dose of lasix and spironolactone. Review of Resident #96's Medication Administration Report MAR for February 2025 indicated the following: - On 2/1/25, Resident #96 had a blood pressure of 108/68 and was given his/her dose of lasix and spironolactone. - On 2/8/25, Resident #96 had a blood pressure of 88/52 and was given his/her dose of lasix. Review of Resident #96's Medication Administration Report MAR for March 2025 indicated the following: - On 3/15/25, Resident #96 had a blood pressure of 109/60 and was given his/her dose of lasix and spironolactone. - On 3/26/25, Resident #96 had a blood pressure of 108/72 and was given his/her dose of lasix and spironolactone. - On 3/27/25, Resident #96 had a blood pressure of 108/72 and was given his/her dose of lasix and spironolactone. Review of Resident #96's Medication Administration Report MAR for April 2025 indicated the following: - On 4/4/25, Resident #96 had a blood pressure of 108/68 and was given his/her dose of lasix and spironolactone. - On 4/24/25, Resident #96 had a blood pressure of 108/72 and was given his/her dose of lasix and spironolactone. (continued on next page)

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	05/14/2025

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #96's Medication Administration Report MAR for May 2025 indicated the following: - On 5/3/25, Resident #96 had a blood pressure of 108/72 and was given his/her dose of spironolactone. - On 5/4/25, Resident #96 had a blood pressure of 109/61 and was given his/her dose of lasix. During an interview on 5/13/25 at 12:52 P.M., Nurse #1 said if a parameter is written in the physician's order, it would show up when the nurse is providing medications to ensure the parameter is being followed. Nurse #1 said providing lasix and blood pressure medications when a resident's blood pressure is below the parameter could be dangerous because it could further lower the resident's blood pressure. During an interview on 5/13/25 at 1:00 P.M., Unit Manager #1 said nurses are expected to check the parameters of medications prior to administrating the medication. Unit Manager #1 said Resident #96 had parameters for his/her blood pressure and diuretic medications and these should have been followed. During an interview on 5/13/25 at 1:28 P.M., the Director of Nursing said she expects any medications with parameters to be held if the parameters are not met. The Director of Nursing said a resident with low blood pressure has a risk of their blood pressure dropping more if given blood pressure or diuretic medications.

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	225567	A. Building B. Wing	05/14/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to store all drugs and biologicals in accordance with currently accepted professional principles on one of three units. Specifically, the facility failed to secure drugs and biologicals on one of three units during a medication pass when medication was left unattended at the nurse's station. Findings include: Review of facility policy titled 'Medication Management-Medication Storage', dated as revised September 2024, indicated: - The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. 2. The nursing staff shall be responsible for maintaining medication storage and preparation areas and a clean safe and sanitary manner. 8. Drugs shall be stored in an orderly manner in cabinets drawers carts or automatic dispensing systems. On 5/14/25 at 7:28 A.M., the surveyor observed Nurse #4 prepare medications during a morning med pass on the Atlantic [NAME] Unit. Nurse #4 mixed miralax (laxative/stool softener) with a cup of water and placed the cup on top of her medication cart and proceeded to remove medication pills into a medication cup to be administered. The unlabeled cup of water containing the miralax was clear and looked like a clear cup of water. Nurse #4 said she would go back to administer the medication because the Resident was in the restroom and not available to take his/her medications. At 7:32 A.M., Nurse #4 proceeded to pick up the cup of water containing miralax and place it on top of the counter at the nurses' station directly in front of Nurse #4's medication cart. Nurse #4 then poured water into a new cup, picked up the medication cup containing pills and walked back to the Residents room and administered the pills with the cup of water that did not contain the miralax. The cup containing the miralax remained on the counter at the nurses' station and there were no staff present at the nurses station or in the hall. The surveyor continued to make observations from 8:02 A.M. to 8:26 A.M. and the cup containing miralax was left unattended throughout the observation period. The surveyor observed three residents walk by the cup containing miralax. The surveyor observed one resident walking behind the nurses' station and proceeded to touch items on the counter. The surveyor then informed Nurse #4 about the unattended miralax cup at the nurse's station. During an interview on 5/14/25 at 9:11 A.M., Nurse #4 said she did not realize she gave the resident water and said she remembers pouring a new fresh cup of water. The surveyor then pointed out the clear cup of miralax that was placed on the counter at the nurses' station and Nurse #4 said I can tell you if that is miralax or not, and proceeded to take a drink from the cup and said I messed up, I gave him/her water I can taste it, it's miralax. Nurse #4 said she did not give the miralax and said she should not have left the miralax unattended on the counter because residents or staff could have mistaken it for water and said medications must not be left unattended. (continued on next page)

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	225567	A. Building B. Wing	05/14/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/14/25 at 9:30 A.M., Unit Manager #1 said medications should not be left unattended or on the counter at the nurses' station and said staff should not taste medication to confirm what type of medication it is if the medication is found or left unlabeled. The Unit Manager said residents on this unit have dementia and often wander around and could mistake the cup for water. During an interview on 5/14/25 at 11:25 A.M., the Director of Nursing (DON) said medication must be in stored appropriately in locked medication carts and not left out unattended where residents or staff could have access to them. The DON said it is her expectation that nurses would not taste or consume any medication to confirm what it is and said the medication should have been thrown out instead of left unattended on the counter.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interviews, and record review, the facility failed to ensure that staff accommodated food preferences for one Resident (#65), out of a total sample of 26 residents. Specifically, the facility failed to honor Resident #65's preferences and served the Resident foods he/she disliked, including eggs, white bread, toast, and broccoli. Findings include: Review of the facility policy titled 'Resident Food Preferences and Choice, dated as reviewed September 2024, indicated: - Individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. - When possible, staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes. - Facility staff may document the residents' significant food and eating preferences in the care plan. During a telephone interview on 5/13/25 at 9:43 A.M., the ombudsman said there is an ongoing concern at the facility regarding food choices being made available to residents. Resident #65 was admitted to the facility in November 2024 with diagnoses including protein-calorie malnutrition and dysphagia (difficulty swallowing). Review of the most recent Minimum Data Set (MDS) assessment, dated 2/19/25, indicated Resident #65 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status exam score of 12 out of 15. Review of Resident #65's plan of care related to nutrition, revised 3/11/25, indicated Resident #65 was at nutritional risk related to a diagnosis of protein-calorie malnutrition and a history of significant weight loss and dysphagia. This care plan indicated the following intervention: - Provide meals in keeping with resident's preferences. Review of Resident #65's assessment titled 'Nutritional Assessment', dated 11/29/24, indicated a problem of unplanned significant weight loss and the following nutrition intervention: - Honor food preferences as able. Review of Resident #65's diet slip, which was visible on the Resident's breakfast and lunch meal trays when they were delivered on 5/13/25, indicated: - Dislikes: broccoli, cheese, corn, eggs group, peas, sausage patty, scrambled egg, spinach, toast, white bread. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/25 at 8:11 A.M., the surveyor observed Resident #65 eating breakfast. Resident #65 said he/she was upset because he/she often gets food he/she dislikes. Resident #65 was noted to have scrambled eggs and white bread toast that was untouched on his/her meal tray. Resident #65 said he/she was not asked what they would like for breakfast but would never ask for eggs or toast because he/she does not like them. Resident #65 further said eggs cause him/her stomach upset and diarrhea. Resident #65 said staff knows he/she does not like these items and does not offer any substitutions. Resident #65 said he/she does not ask for a substitution because he/she does not want to be a bother. There was a meal slip present on the meal tray that indicated Resident #65 dislikes scrambled eggs, white bread, and toast. On 5/13/25 at 12:17 P.M., the surveyor observed Resident #65 eating lunch. Resident #65 was noted to have broccoli on his/her meal tray. Resident #65 said he/she does not like broccoli and that staff know this because it's written right on my tray. Resident #65 said he/she did not request broccoli. Resident #65 took a bite of broccoli, then spit it out and said he/she does not like broccoli at all. There was a meal slip present on the meal tray that indicated Resident #65 dislikes broccoli. During a follow up interview on 5/14/25 at 8:34 A.M., Resident #65 said he/she wishes the facility would honor his/her food preferences. Resident #65 said foods listed as a dislike on his/her meal slip are served to him/her at least three to four times every week. During an interview on 5/14/25 at 8:37 A.M., Certified Nurse Assistant (CNA) #2 said all residents' food preferences should be honored. CNA #2 said food items listed as a dislike on Resident #65's meal slip should not be served to him/her. CNA #2 said nurses are supposed to check all meal trays to ensure dislikes are not served before they are delivered to the Resident. CNA #2 said disliked food items are sometimes missed and served to residents, and if that happens the staff is expected to send a slip down to the kitchen to remind them not to include it on the meal tray. During an interview on 5/14/25 at 8:46 A.M., Unit Manager #2 said all residents' food preferences should be honored. Unit Manager #2 said a nurse is supposed to check each meal slip to make sure a disliked food is not served to the residents, unless the resident requests that food item. Unit Manager #2 said disliked foods are sometimes missed and served to residents, and if that happens the staff is expected to send a slip down to the kitchen to remind them not to include it on the meal tray. During an interview on 5/14/25 at 9:25 A.M., Dietary Staff #1 said he was responsible for checking disliked foods before putting food on each resident's tray. Dietary Staff #1 said all residents' food preferences should be honored. Dietary Staff #1 said if a food indicated as a dislike on a resident's meal slip then it should not be served to the resident. During an interview on 5/14/25 at 9:46 A.M., the Dietitian said all resident's food preferences should be honored. The Dietitian said Resident #65 doesn't like broccoli, white bread, or toast and that these are listed as dislikes on his/her meal slip. The Dietitian said he/she prefers muffins. The Dietitian was unaware that Resident #65 had concerns of the upset stomach or diarrhea with eggs but said eggs should not have been served because it was listed as a dislike on his/her meal slip. During an interview on 5/14/25 at 9:54 A.M., the Director of Nursing (DON) said food preferences should be honored. The DON said if a food was listed as a dislike on any resident's meal slip then it should not have been served. (continued on next page)

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	225567	A. Building B. Wing	05/14/2025

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview on 5/14/25 at 11:04 A.M., the Dietitian said there were no food shortages on 5/13/25 that would have affected what Resident #65 was served.

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	225567	A. Building B. Wing	05/14/2025

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to document urinary output as ordered for one Resident (#93) out of a total sample of 26 residents. Findings include: Review of the facility's Nursing Service Documentation, dated September 2024 indicated; 5. Nursing documentation is performed as required by each person responsible for the care of the resident. 6. Every entry is noted by complete date, time and signature. Each set of initials used shall correspond to a complete signature. Review of the facility's policy titled 'Catheter Care', dated September 2024, indicated: 1. Residents with indwelling catheters should have their urinary output assessed at regular intervals to ensure that adequate drainage is occurring. Resident #93 was admitted to the facility in February 2024 with diagnoses including venous insufficiency and polyuria (urinating more than usual). Review of the Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident #93 was cognitively intact as evidenced by a score of 15 out of a possible 15 on the Brief Interview for Mental Status Exam (BIMS). The MDS also indicated Resident #93 had an indwelling catheter. Review of Resident #93's physicians orders indicated the following orders: - Foley Catheter Size 16fr (french scale) Type 10 ml (milliliter) balloon, dated 3/26/24. - Check placement and provide foley catheter care every shift, dated 3/26/24. - Monitor urine output each shift BLADDER SCAN IF OUTPUT <200ML QSHIFT, dated 3/30/25. Review of Resident #93's Catheter care plan, dated 3/27/24, indicated the following intervention: - Monitor and document intake and output as per facility policy. Review of the April 2025 Treatment Administration Record (TAR) indicated Resident #93's output was not documented on the morning shift on 4/29/25, the evening shift on 4/2/25, and the night shift on 4/2/25, 4/3/25, 4/5/25, 4/6/25, 4/17/25, and 4/30/25. Review of the May 2025 TAR indicated Resident #93's output was not documented on the night shift on 5/4/25, the morning shift on 5/10/25, and the night shift on 5/11/25. (continued on next page)

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	05/14/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/14/25 at 10:16 A.M., the surveyor and Unit Manager #2 reviewed Resident #93's April 2025 TAR. Unit Manager #2 said staff should be documenting Resident #93's output as ordered.

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	225567	A. Building B. Wing	05/14/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interviews, and records reviewed the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, 1.) The facility failed to disinfect shared resident medical equipment and adhere to infection control guidelines during medication pass. 2.) For one Resident (#26) out of a total sample of 26 residents, the facility failed to implement Enhanced Barrier Precautions (EBP). Findings Include: Review of the facility policy titled 'Resident Care and Treatment- Diagnostic Testing Glucose Testing with Glucometer (Assure Platinum)', dated as revised September 2024, indicated: 14. Clean Assure Platinum according to manufacturer's guidelines. Meter shuts down after two minutes. Should use two wipes; the first to clean and the second to disinfect. Review of the manufacturers' guidelines for the Assure Prism Multi Use Glucometer indicated the following: - Cleaning and Disinfecting Procedures: Two disposable wipes will be needed for each cleaning and disinfecting procedure; one wipe for cleaning and a second wipe for disinfecting. Further review of the manufacturer's guidelines indicate only approved FDA (Food and Drug Administration) approved products are to be used on the glucometer and reference the CDC Guidelines for Fingerstick Devices. Review of the facility policy titled 'Infection Control Manual, Blood-Borne Pathogen Standards, Cleaning Equipment', dated as revised September 2024, indicated: 4. DME (durable medical equipment) must be cleaned and disinfected before use by another resident. 1.) On 5/14/25 at 7:34 A.M., the surveyor observed Nurse #4 pickup a white open container from on top of the medication cart, containing a glucometer, several lancets, and alcohol prep pads. Nurse #4 entered the Resident's room and placed the white open container directly on top of his/her uncleaned overbed table. Nurse #4 obtained the Resident's blood sugar and immediately put the glucometer back into the white container without cleaning it and potentially contaminating the contents of the container. Nurse #4 then returned to the medication cart and picked up the contaminated glucometer with her ungloved hand and placed the contaminated glucometer directly on top the medication cart. Nurse #4 obtained an alcohol hand wipe from a container located at the nurse's station and with her ungloved hand proceeded to wipe down the glucometer and placed it back into the white container that was potentially contaminated earlier. (continued on next page)

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	225567	A. Building B. Wing	05/14/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 7:46 A.M., the surveyor observed Nurse #4 pickup the white open container from on top of the medication cart, containing the potentially contaminated glucometer, several lancets, and alcohol prep pads. Nurse #4 entered a second Resident's room and placed the white open container directly on top of his/her uncleaned overbed table. Nurse #4 proceeded to put on gloves and was about to obtain the Residents blood sugar when the surveyor had to intervene and stop Nurse #4 from using the potentially contaminated glucometer to obtain the Residents blood sugar. During an interview on 5/14/24 at 7:50 A.M., Nurse #4 said the facility has bleach wipes available for cleaning but she uses the alcohol hand wipes because they are easier on the hands and said she was not sure how or when to clean glucometers. Nurse #4 said she wipes the glucometers down with the alcohol wipes when she is finished with her glucose checks. On 5/14/25 at 8:06 A.M., the surveyor observed Nurse #4 pickup the white open container from on top of the medication cart, containing the potentially contaminated glucometer, several lancets, and alcohol prep pads, she removed the glucometer and placed it directly on top of the medication cart, and proceeded to remove the lancets and alcohol prep pads and discarded them into the trash. Nurse #4 used her bare hand to obtain one bleach wipe and proceeded to wipe down the now empty white container and proceeded to use the same bleach wipe to wipe down the glucometer. Nurse #4 placed the wet glucometer directly back into the white container and then added lancets and alcohol prep pads directly on top of the wet glucometer. Nurse #4 then placed the white container on top of her medication cart. During a follow up interview on 5/14/25 at 8:09 A.M., Nurse #4 said she was not aware that the glucometer, lancets and equipment could not go into the Residents rooms and said she was just told to use bleach wipes and to clean the glucometer. Nurse #4 said she was unaware of the contact time for the bleach wipes because she doesn't usually use them. During an interview on 5/14/25 at 9:27 A.M., Unit Manager #1 said staff must clean the glucometer with bleach wipes after each use and said containers containing glucometer equipment should not be taken into resident rooms or placed on bedside tables because they are contaminated. Unit Manager #1 said staff must follow the bleach wipes recommendations for contact time and said the glucometer should be placed on a paper towel and left to dry for two minutes. Review of the bleach wipes used in the facility indicated the following: Super Sani-Cloth Germicidal Disposable Wipe. Contact Time: Use Unfold a clean wipe and thoroughly wet surface. Allow surface to remain went for two minutes. Let air dry. During an interview on 5/14/25 at 11:21 A.M., the Director of Nurses (DON) said staff must use approved bleach wipes to clean and disinfect shared equipment and said she expects staff to follow manufacturer's instructions for wiping and cleaning. The DON said she expects all staff to follow infection control guidelines for proper cleaning and disinfection and said not following recommendations could increase the risk of blood borne pathogens between residents if equipment is not properly cleaned in between use. The DON said alcohol hand wipes should not be used to clean equipment and said bleach wipes must be used and said nurses must follow the contact time of two minutes to allow the surface to dry after wiping it with a bleach wipe. (continued on next page)

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	05/14/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/14/25 at 1:03 P.M., Nurse Practitioner (NP) #1 said she expects staff to follow infection control guidelines with cleaning and disinfecting according to policy and manufacturers guidelines to prevent the spread of infection. 2.) Review of the Centers for Disease Control (CDC) website indicated the following, dated June 28, 2024: -Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). Review of facility policy from the Infection Control Manual, under the subject 'Enhanced Barrier Precautions', dated as reviewed 4/29/24, indicated the following: - Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug- resistant organisms that employs targeted gown and glove use during high contact resident care activities. - EBP are indicated for residents with any of the following: wounds and/ or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO (multidrug resistant organism). Resident #26 was admitted to the facility in March 2024 with diagnoses that included adult failure to thrive, Chronic Obstructive Pulmonary Disease and localized edema. Review of Resident #26's most recent Minimum Data Set (MDS) Assessment, dated 3/12/25, indicated a Brief Interview for Mental Status exam score of 14 out of a possible 15, which indicated that the Resident had intact cognition. The MDS further indicated that the Resident had one stage 3 pressure ulcer that was not present on admission. On 5/13/25 at 7:46 A.M., Resident #26 was observed awake in bed. Resident #26 had an air mattress in place. Resident #26 said that he/she has a wound to his/her heel. There was no signage on the doorway of Resident #26's room indicating the use of Enhanced Barrier Precautions. On 5/14/25 at 6:58 A.M., Resident #26 was observed awake in bed. Resident #26 had a dressing to his/her right heel. There was no signage on the doorway of Resident #26's room indicating the use of Enhanced Barrier Precautions. On 5/14/25 at 7:18 A.M., the surveyor observed Nurse #2 perform a wound dressing change to Resident #26's right heel. Nurse #2 entered the Resident's room and sanitized her hands and applied gloves. The Nurse did not put on a gown during the wound dressing change. For the duration of the dressing change, the nurse utilized gloves only and did not put on a gown at any time. Review of the most recent wound consultant note, dated 5/12/25, indicated the following: - Resident #26 has a stage 3 pressure wound of the right heel, full thickness that measures 1.4 x 1.4 x 0.1 centimeters. (continued on next page)

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	05/14/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #26's active care plan indicated the following: - Resident has an unstageable on [his/her] right heel, and a skin tear to the right calf, dated as revised 5/2/25. Review of the Care plan failed to indicate the use of EBP. Review of Resident #26's physician's orders indicated the following: - Cleanse right heel with wound cleanser, apply calcium alginate and foam dressing, one time a day, dated 4/15/25. - Monitor dressing to right heel every shift, dated 4/8/25. Review of physician orders failed to indicate the use of EBP. During an interview on 5/14/25 at 7:25 A.M., Nurse #2 said that when a resident has a wound, they should be on Enhanced Barrier Precautions. Nurse #2 said that when she changed the dressing on Resident #26's wound, she should have worn a gown, but she did not. She said typically there is a physician's order for Enhanced Barrier Precautions. During an interview on 5/14/25 at 7:28 A.M., Unit Manager #2 said that Resident #26 did not need to be on Enhanced Barrier Precautions because the wound was not infected. He said residents with a wound that is not infected do not require Enhanced Barrier Precautions. During an interview on 5/14/25 at 10:34 A.M., the Director of Nursing said anyone with tubes, IV lines, pressure injuries or surgical incisions should be on Enhanced Barrier Precautions. She said that there is typically a physician's order in place for the use of EBP. The Director of Nurses further said that when changing the dressing for Resident #26's wound, the nurse should have worn a gown and gloves.