STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225597	A. Building B. Wing	01/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southwood at Norwell Nursing Ctr	501 Cordwainer Drive Norwell, MA 02061

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review, and interviews, the facility failed to ensure for one Resident (#12), out of a sample of 25 residents, that respiratory care was provided consistently with professional standards of practice. Specifically, the facility failed to ensure oxygen liter flow was being administered as ordered and to record the date and time of as needed (PRN) oxygen administration.Findings include:Review of the facility's policy titled Oxygen Administration, last revised October 2010, included but was not limited to:Preparation- Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.Procedure-Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered.DocumentationAfter completing the oxygen set up or adjustment, the following information should be recorded in the resident's medical record:-The date and time that the procedure was performed.-The name and title of the individual who performed the procedure.-The rate of oxygen flow, route, and rationale.-The frequency and duration of treatment.-The reason for PRN administration-The signature and title of the person recording the dataLIPPINCOTT NURSING PROCEDURES, 8th editionoxygen .all oxygen delivery systems should be checked at least once each day-verify the practitioner's order for the oxygen therapy, because oxygen is considered a medication or therapy and should be prescribedDOCUMENTATION record the date and time of oxygen administration, the type of delivery device, the oxygen flow rate, the patient's vital signs, skin color, respiratory effort and breath sounds.Resident #12 was admitted to the facility in October 2023 with diagnoses including congestive heart failure (CHF-a long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply).Review of the comprehensive Minimum Data Set (MDS) assessment, dated 9/9/25, indicated Resident #12 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status score of 9 out of 15, and received oxygen therapy.Review of the medical record indicated Resident #12 was admitted to the hospital in July 2025 for altered mental status, lethargy and low oxygen levels.Review of Physician's Orders included but was not limited to:-Oxygen continuously at 2 liters (L) per minute via nasal cannula (NC- small, flexible tube that contains two open prongs intended to sit just inside your nostrils), as needed (7/14/25)-Oxygen at 2L/min NC to maintain SATs above 90% as needed for shortness of breath (7/14/25)-Monitor Oxygen Saturation and Respirations, Document total amount of minutes used during respiratory assessment every shift (7/14/25)Review of comprehensive care plans indicated but was not limited to:-Focus: Resident has oxygen therapy related to CHF, Respiratory failure (7/12/24; last revised 7/28/25)-Interventions: Give medications as ordered by physician. Monitor/document side effects and effectiveness; Oxygen settings: O2 via nasal prongs at 2L continuous (7/28/25)-Goal: Resident will have no signs/symptoms of poor oxygen absorption through the review date (7/28/25; Target Date: 2/23/26) During an observation with interview on 12/30/25 at 9:46 A.M., the surveyor observed Resident #12 lying in bed asleep. An oxygen concentrator was at the bedside, was on, and set to a liter flow of 1.5 L/min per minute and not 2 L according to physician's orders. Oxygen tubing was attached to the concentrator and was connected to a nasal cannula that was in place in the Resident's nose.On 12/31/25 at 8:56 A.M., the surveyor observed Resident #12 sitting upright in bed eating breakfast. The oxygen concentrator was at the (continued on next page)

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bedside, was on, and set to a liter flow of 1.5 L/min and not 2 L according to physician's orders. Oxygen tubing was attached to the concentrator and was connected to a nasal cannula that was in place in the Resident's nose.During an interview on 12/31/25 at 1:35 P.M., Resident #12's family member said the Resident has utilized oxygen continuously for quite a while. She said Resident #12 has a history of having pneumonia and the physician ordered oxygen so he/she can be more comfortable. Resident #12 was present during the interview and was observed sitting upright in bed. An oxygen concentrator was at the bedside, was on, and set to a liter flow of 1.5 L/min and not 2 L according to physician's orders.Review of the December 2025 Medication/Treatment Administration Records (MAR/TAR) failed to indicate nursing staff verified Resident #12 was receiving oxygen at 2 L/min according to physician's orders on the dates and times the surveyor observed the oxygen concentrator set at 1.5 L/min.During an interview with observation on 12/31/25 at 2:00 P.M., Nurse #1 and the surveyor observed Resident #12 sitting upright in bed. An oxygen concentrator was at the bedside, was on, oxygen tubing was attached to the concentrator and connected to a nasal cannula that was in place in the Resident's nose. Nurse #1 looked at the oxygen concentrator setting and said the liter flow was set to 1.5 L and should be set to 2 L. The nurse reviewed the MAR/TARs from July 2025 to December 2025 and said nursing staff did not document confirmation that the oxygen liter flow was set according to physician's orders and did not document its use.During an interview on 12/31/25 at 2:20 P.M., Unit Manager #1 said the nurses are supposed to confirm the liter flow and document the oxygen flow rate is set according to physician's orders as well as when it is in use. She said Resident #12 is supposed to be on 2 L/min and not 1.5 L/min.

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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 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. Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were stored in accordance with professional standards of practice. Specifically, the facility failed to:1. Ensure the medications were administered under direct supervision of a licensed nurse and not left at the bedside for Resident #6; and2. Ensure a medication cart remained locked when not in view/proximity of the nurse. Findings include:Review of the facility's policy titled Medication Administration-General Guidelines, dated January 2024, indicated but was not limited to the following:-Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so.-When medications are administered by mobile cart taken to the resident's location, medications are administered at the time they are prepared.-The resident is always observed after administration to ensure that the dose was completely ingested.-When administering as needed (PRN) medications at times other than the medication pass, the dose may be prepared in the medications cart storage area and taken to the resident's bedside, leaving the cart locked and secured.-During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse.1. Resident #6 was admitted to the facility in March 2021 with diagnoses which include major depressive disorder, osteoarthritis, and fibromyalgia.Review of the medical record indicated Resident #6 was advised of their right to self-administer medication on 8/22/21 and indicated he/she wished for the nursing staff to administer their medications.During an interview with observation on 12/30/25 at 9:51 A.M., the surveyor observed Resident #6 in bed and on the overbed table there was a medication cup containing least twelve (12) medications (one round green tablet, one blue and white capsule, one yellow capsule, two oval white tablets, one red oval tablet, one red round tablet, one pink round tablet, one peach round tablet, one beige round tablet, one white capsule, and one white round tablet). Resident #6 said, new nurses stay and make sure I take my medications, but some nurses just leave them. The x-ray technician just left my room, so I still need to take my medications.During an interview with observation on 12/30/25 at 3:08 P.M., the surveyor observed Resident #6 sitting in bed and on the overbed table there was a medication cup containing four medications (one yellow capsule, 2 white oval tablets, one small white oval tablet). Resident #6 said he/she takes one Gabapentin, two Tylenol, and one Tramadol in the afternoon for pain. Resident #6 said some nurses just leave the medications and some will stay and watch to be sure he/she takes all the medications.Review of the December 2025 Medication Administration Record (MAR) indicated Resident #6 had an order to administer the following medications at 8:00 A.M.:-Bupropion HCl ER (SR) Tablet Extended Release 12 Hour 150 MG (antidepressant) Give 1 tablet by mouth two times a day-Docusate Sodium Oral Capsule 100 MG (stool softener) Give 100 mg by mouth two times a day-Duloxetine HCl Oral Capsule Delayed Release Sprinkle 60 MG (antidepressant) Give 1 capsule by mouth two times a day for depression-Gabapentin Oral Capsule 300 MG (anticonvulsant) Give 1 capsule by mouth two times a day Review of the December 2025 MAR indicated Resident #6 had an order to administer the following medications at 9:00 A.M.:-Acidophilus Oral Capsule (Lactobacillus probiotic) Give 1 capsule by mouth in the morning for supplement-Aspirin Oral Tablet Chewable 81 MG (pain reliever) Give 1 tablet by mouth one time a day-Cholecalciferol Oral Tablet 25 MCG (1000UT) (Vitamin D3) Give 1 tablet by mouth one time a day-Clopidogrel Bisulfate Oral Tablet 75 MG (antiplatelet) Give 1 tablet by mouth one time a day-Cranberry Oral Tablet 400 MG (supplement) Give 1 tablet by mouth one time a day-Multivitamin Oral Tablet Give 1 tablet by mouth-Entresto Oral Tablet 24-26 MG (treats heart disease) Give 50 mg by mouth two times a day for hypertension-Tramadol HCl Tablet 50 MG (pain reliever) Give 1 tablet by mouth three times a day for back pain Review of the December 2025 MAR indicated Resident #6 had an order to be administered the following medications at 2:00 P.M.:-Acetaminophen Oral Capsule (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	500MG (pain reliever), Give two capsules by mouth three times a day for pain. Review of the December 2025 MAR indicated Resident #6 had an order to administer the following medications at 3:00 P.M.:-Gabapentin Oral Capsule 300 MG Give 1 capsule by mouth two times a day-Tramadol HCl Tablet 50 MG Give 1 tablet by mouth three times a day for back pain Review of the December 2025 MAR indicated Nurse #2 administered all medications to Resident #6 at times indicated as ordered.During an interview on 12/30/25 at 3:23 P.M., Nurse #2 said she left the medications at the bedside and was not aware the Resident had not taken his/her morning medications right away. Nurse #2 said the Resident needed to use the restroom during afternoon medications so she left the medication at the bedside and told the Resident she would be back. Nurse #2 said Resident did not have an order for self-administration.During an interview on 12/30/25 at 3:43 P.M., Unit Manager #2 said medications should not have been left at the Resident's bedside.During an interview on 12/31/25 at 9:09 A.M., the Director of Nursing said medications should not have been left at the bedside.2. On 12/30/25 at 3:05 P.M., 3:20 P.M., 3:47 P.M., and 4:10 P.M., the surveyor observed the medication cart on Hall N of the Rosewood Unit to be unlocked and out of Nurse #2's line of sight.The medication cart had remained unlocked for a total of 1 hour and 5 minutes before it was secured by Nurse #2. During an interview on 1/2/26 at 12:34 P.M., Unit Manager #2 said the expectation is the medication cart will always be locked when not in use.During an interview on 1/2/26 at 12:44 P.M., the Assistant Director of Nursing said the facility's expectation is that the medication cart should always be locked.