STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305055	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oceanside Skilled Nursing and Rehabilitation	22 Tuck Road Hampton, NH 03842

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to implement water management control measures for hot water tanks, potentially exposing 104 residents to waterborne pathogens. The facility failed to implement policies and procedures for Enhanced Barrier Precautions (EBP) for 2 of 6 residents observed for EBP (Resident identifiers are #12 and #32.), The facility failed to implement Transmission Based Precautions (TBP) for 3 of 6 residents reviewed for TBP (Resident identifiers are #62, #109, and #110). The facility failed to perform hand hygiene and use proper glove use for 1 of 3 residents reviewed for pressure injuries (Resident identifier is #12). Findings include: Review on 1/29/26 of the facility's policy titled, Transmission Based Precautions, revision date 5/1/25, revealed .The Center will use standard approaches, as defined by the Center for Disease Control and Prevention (CDC), for Transmission Based Precautions: Airborne, Contact, and Droplet Precautions.8. Initiating Transmission Based Precautions: 8,1 Nursing staff may place patients with suspected or confirmed infectious diarrhea, influenza, or symptoms consistent with a communicable disease on Transmission Based Precautions/isolations empirically while awaiting confirmation.8.5 Signage that includes instruction for use of specific PPE will be placed in a conspicuous location outside of patient's room.9 Contact Precautions:.9.3 Healthcare personnel caring for patients on contact precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. 9.4 Donning PPE [Personal Protective Equipment] upon room entry and discarding before exiting the room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination (e.g., vancomycin resistant enterococcus (VRE), Clostridium difficile, noroviruses and other intestinal tract pathogens, respiratory syncytial virus (RSV) . Review on 1/29/26 of the CDC website titled, Appendix A: Type and Duration of Precautions Recommended for Selected Infections and Conditions, dated 2/7/25, revealed .Gastroenteritis C. [Clostridium] difficile.Type of Precaution.Contact + [plus] Standard.Precautions/Comments .Handwashing with soap and water preferred because of the absence of sporicidal activity of alcohol in waterless antiseptic handrubs.Gastroenteritis Noroviruses.Type of Precaution.Update: Contact + Standard.Precautions/Comments.Use of Contact Precautions for a minimum of 48 hours after resolution of symptoms or to control institutional outbreaks. Review on 1/27/26 of facility's policy titled IC310 Special Contact and Droplet Precautions, revised 2/24/25, revealed .4. Wear proper PPE [personal protective equipment] including respiratory protection (N95 respirator), gown, and gloves prior to entering the room of those who require Special Contact and Droplet Precautions.8. The duration of these transmission-based precautions will be determined per Centers for Disease Prevention & Control (CDC) guidance for discontinuing precautions for persons with COVID.Refer to:.Appendix A: Type and Duration of Precautions Recommended for Suspected Infections and Conditions. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review on 1/27/26 of CDC Appendix A: Type and Duration of Precautions Recommended for Selected Infections and Conditions, revised 2/7/25, provided by the facility, revealed .Infection/ Condition: Severe acute respiratory syndrome (SARS), Type of Precautions: Airborne + [plus] Droplet + Contact + Standard, Duration of Precautions: Duration of illness plus 10 days after resolution of fever, provided respiratory symptoms are absent or improving. Resident #62 Review on 1/27/26 of Resident #62's SARS-CoV-2 (Severe Acute Respiratory Syndrome-Coronavirus-2) antigen report, collected date of 1/23/26, revealed a positive result, indicating COVID-19 infection. Observation on 1/27/26 at approximately 9:30 a.m. of Resident #62's room revealed a Special Contact and Droplet precautions sign at entry. Further observation revealed Staff A (housekeeper) inside Resident #62's room cleaning the room and bathroom while wearing an N95 respirator, without gloves and a gown. Staff A exited the room without performing hand hygiene and proceeded to the housekeeping cart in the hallway. Interview on 1/27/26 at approximately 9:30 a.m. with Staff D (Licensed Practical Nurse (LPN)) stated that Staff A did not speak English and they only had precaution signs in English. Staff D confirmed that Resident #62 was on special contact and droplet precautions for testing positive for COVID-19. Resident #109 Observation on 1/29/26 at approximately 9:23 a.m of Resident #109's room revealed a enteric contact precaution sign posted outside of the room indicating to wash hands with soap and water when leaving the room. Further observation revealed that Staff L (Registered Nurse (RN)) left Resident #109's room and performed hand hygiene with alcohol-based hand sanitizer and did not wash their hands with soap and water. Interview on 1/29/26 at approximately 9:25 a.m. with Staff L confirmed the above findings. Review on 1/29/26 of Resident #109's physician's orders revealed an order, dated 1/21/26, for Infection Precautions- Contact. Resident #110 Interview on 1/27/26 at approximately 8:30 a.m. with Staff H (Director of Nursing) revealed that the facility has a norovirus outbreak on the east unit. Observation on 1/28/26 at approximately 8:22 a.m. during Resident#110's medication administration revealed an enteric contact precaution sign posted outside of Resident #110's room that indicated to wear gown and gloves. Staff M (LPN) entered Resident #110's room without donning gown and gloves, then proceeded to give Resident #110's scheduled morning medications. Interview on 1/28/26 at approximately 8:40 a.m. with Staff M confirmed the above findings for Resident #110. Staff M revealed that Resident #110 was experiencing diarrhea the evening of 1/27/26. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review on 1/28/26 of Resident #110's medical record revealed an active physician order and care plan for contact precautions, dated 1/28/26. Review on 1/28/26 of the facility's norovirus outbreak list revealed that Resident #110 date of onset of diarrhea was on 1/27/26. Observation on 1/28/26 at approximately 2:16 p.m. in Resident #110's room revealed that Resident #110 was in the bathroom. Staff J (RN) entered the room wearing a mask but did not don a gown and gloves. Further observation revealed that Staff J was positioned less than two feet from Resident #110 while supervising Resident #110 back to their room. Staff J assisted the Resident #110 into bed by touching their back. Before exiting the room, Staff J used an alcohol-based hand rub and did not wash their hands with soap and water. Interview on 1/28/26 at approximately 2:20 p.m. with Staff J confirmed the above observation for Resident #110. Resident #32 Observation on 1/28/26 at approximately 1:00 p.m. revealed an EBP sign posted outside Resident #32's room. Staff M entered the room wearing a mask and gloves but did not don a gown. Staff M proceeded to prepare and administer IV Ampicillin (antibiotic) by connecting the IV bag to the tubing, priming the tubing, flushing the PICC (Peripherally Inserted Central Catheter) line with normal saline, confirming blood return, connecting the IV tubing, and setting up the IV pump for infusion. Interview on 1/28/26 at approximately with Staff M confirmed the above observation for Resident #32. Staff M revealed that Resident #32 was on EBP for their PICC line. Review on 1/28/26 of Resident #32's medical record revealed an active physician order and care plan for EBP related to the PICC line. Review on 1/29/26 of the facility's policy titled, Enhanced Barrier Precautions, revision date 5/1/25, revealed .Precautions.Enhanced Barrier Precautions.Applies To.All patients with any of the following:.Chronic wounds and/or indwelling medical devices (e.g., central line, urinary catheter, enteral feeding tube.PPE Used for These Situations.During high contact patient care activities:.Device care or use of central line, urinary catheter enteral feeding tube.Wound care; any skin opening requiring a dressing.Required PPE.Gown, gloves prior to high contact care activity (Change PPE before caring for another patient) (Face protection may also be needed if performing activity with risk of splash or spray). Resident #12 Observation on 1/28/26 at approximately 2:16 p.m. revealed an EBP sign posted outside Resident #12's room. Following the administration of medication via the PEG (Percutaneous Endoscopic Gastrostomy) tube, Staff M proceeded to replace the old gauze dressing at the PEG tube insertion site with a new gauze dressing. During this procedure, Staff M was wearing gloves, a mask, and no gown. Interview on 1/28/26 at approximately with Staff M confirmed the above observation for Resident #12. Staff M revealed that Resident #12 was on EBP for the PEG tube. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review on 1/28/26 of Resident #12's care plan revealed a care plan indicated that Resident #12 was at risk for MDRO (Multidrug-Resistant Organism) colonization or infection due to the presence of an indwelling device, specifically a PEG tube, and includes an intervention for EBP. Observation on 1/29/26 at approximately 11:30 a.m. with Staff N (LPN) revealed Staff donned a gown and gloves to change Resident #12's sacral dressing. Staff N did not perform hand hygiene when changing from used gloves to new gloves in between the following procedures: removing the old sacral dressing, cleansing the wound with saline spray, applying Triad cream, and covering the wound with a new sacral foam dressing. Further observation revealed that Staff N performed hand washing prior to changing Resident #12's left heel dressing and donned new gloves. Staff M did not change their gloves in between the following procedures: removing the left heel old dressing, cleansing the wound with saline spray, cutting and applying calcium alginate dressing to the left heel wound, covering the wound with heel foam dressing, and wrapping with Kerlix. Interview on 1/29/26 at approximately with Staff N confirmed the above Resident #12's wound dressing observation. Review on 1/29/26 of Resident #12's medical record revealed active physician orders for wound treatments to the pressure injuries located on the sacral area and left heel. Review on 1/29/26 of the facility's policy titled, Procedure Wound Dressing: Aseptic, revision date 2/24/25, revealed .10. Perform hand hygiene. 11. Apply gloves and other PPE as indicated.14. Discard soiled dressing in the appropriate receptacle. 12. Remove and discard gloves. 16. Perform hand hygiene. Open dressing(s) without contaminating. Keep dressing(s) within the open packet and place directly on top of the barrier. 18. Prepare medication ointment, if indicated, by placing on barrier. 19. Perform hand hygiene. Apply gloves. 20. Cleanse or irrigate wound and periwound gently, as ordered.24. Remove gloves and perform hand hygiene. 25. Apply gloves. 26. Using sterile swab or applicator, apply treatment medication as ordered.28. Apply and secure clean dressing. 29. Remove gloves and discard in the appropriate receptacle.31. Perform hand hygiene. Review on 1/29/26 of the facility's policy titled, Hand Hygiene, revision date 5/1/25, revealed .The use of gloves does not replace hand hygiene. If a task requires gloves, perform hand hygiene before donning gloves and immediately after removing gloves.Perform Hand Hygiene: 1,.1 Before patient/resident (hereinafter patient care; 1.2 Before aseptic technique; 1.3 After any contact with blood or other body fluids, even if gloves are worn; 1.4 After patient care; After contact with patient's environment. 2. Hand hygiene techniques: 2.1 To wash hands with soap and water.2.2 To decontaminate hands with alcohol based rub. Review on 1/29/26 of facility's Water Management Plan, revised 1/2025, revealed Control Measures & Corrective Action.Hot water tanks should be at or above 140 degrees. Check for build up of biofilm . Further review revealed that there was no frequency for the monitoring of temperatures for the hot water tank. Interview on 1/29/26 at approximately 11:15 a.m. with Staff B (maintenance director) revealed that they failed to monitor and document the temperatures at the hot water tanks.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow physician's order for 1 resident in a final sample of 21 resident and for 1 of 5 residents observed for medication administration. (Resident Identifiers are #100 and #110.)Findings include:Resident #110 [NAME], [NAME] A., and [NAME]. Fundamentals of Nursing. 10th edition St. Louis, Missouri: Elsevier, 2021. Page 614, .It is essential to verify the accuracy of every medication you give to your patients with the patient's order. If the medication order is incomplete, incorrect, or inappropriate, or if there is a discrepancy between the original order and the information on the MAR [Medication Administration Record]. consult with the health care provider. Do not give a medication until you are certain that you can follow the seven rights of medication administration . Page 672 .seven rights of medication administration include right medication, right dose, right patient, right route, right time, right documentation and right indication . Review on 01/28/2026 of Resident #110's Electronic Medical Administration Record during Resident #110's medication administration observation with Staff M (Licensed Practical Nurse) revealed an order for Fluticasone Propionate 100 microgram/activated (MCG/ACT) inhaler (inhaled corticosteroid) give one puff orally two times a day with an order date of 1/26/26. The Fluticasone Propionate 100 MCG/ACT inhaler, which was scheduled to be given at 9:00 a.m. that morning. Observation on 1/28/26 at approximately 8:22 a.m. during Resident #110's medication administration with Staff M revealed that Staff M obtained a Fluticasone Propionate 50 MCG/ACT nasal spray bottle from the medication cart. Staff M went in Resident #110's room and handed the Fluticasone Propionate nasal spray bottle to Resident #110. Resident #110 self-administered the Fluticasone Propionate 50 MCG/ACT nasal spray with Staff M supervision. Review on 1/28/26 of the Fluticasone Propionate 50 MCG/ACT nasal spray box revealed a pharmacy label with instruction to administer 1 spray in both nostrils at bedtime. Review on 1/28/26 of Resident #110's physician orders revealed an order for Fluticasone Propionate 50 MCG/ACT nasal spray box revealed a pharmacy label with instruction to administer 1 spray in both nostrils at bedtime with an order date of 1/21/26. Interview on 1/28/26 at approximately 8:40 a.m. with Staff M confirmed the above findings and that they gave the wrong medication to Resident #110. Review on 1/29/26 of the facility policy titled, Medication Administration, dated 1/2025, revealed, .Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record [MAR]. Compare the medication and dosage scheduled on the resident's MAR with the medication label .Medications are administered in accordance with written orders of the prescriber . Resident #100 [NAME], [NAME] A., and [NAME]. Fundamentals of Nursing. 10th ed. St. Louis, Missouri: Mosby Elsevier, 2021. Page 994 Daily Weights and Fluid Intake and Output Measurement revealed, .Daily weights are an important indicator of fluid status (Flever, 2019c). Each kilogram (2.2.lb [pound]) of (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weight gained or losses indicate changes in the amount of total body fluid, usually ECF (extracellular fluid), but do not indicate shift between body compartments.Compare the weight of each day with that of the previous day to determine fluid gain or losses. Look at the weights over several days to recognize trends. Interpretation of daily weights guides medical therapy and nursing care . Review on 1/28/26 of Resident #100's physician's order, dated 12/31/25, revealed an order for daily weights for edema with a discontinued date of 1/9/26 and an order dated 1/10/26 for daily weights for edema and congested heart failure with a discontinued date of 1/23/26. Further review revealed an active order for daily weights. Review on 1/28/26 of Resident #100's January Medication Administration Record revealed that for 6 of 23 days weights were not documented (January 3, 4, 6, 7, 8, and 14). Interview on 1/29/26 at 10:24 a.m. with Staff H (Director of Nursing) confirmed that there was no documentation that the daily weights had been done on the above days. Staff H confirmed there was no documentation in Resident #100's record that the resident had refused to be weighed or that the physician had been notified of missing weights.

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F 0688 Level of Harm - Minimal harm or potential for 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. Based on observation, interview, and record review, the facility failed to ensure that residents have the appropriate equipment to prevent a decrease on Range of Motion (ROM) for 1 of 1 resident reviewed for Limited ROM in a final sample of 22 residents. (Resident identifier is #76.)Findings include: Observation on 1/27/2026 at approximately 1:53 p.m. at Resident #76's room revealed that Resident #76 was sitting in bed with their right hand clenched in a fist. Further observation revealed no hand splints or positioning devices on Resident #76's right hand or in their room. Interview on 1/27/26 at approximately 1:53 p.m. with Resident #76 revealed that he/she had a stroke and cannot move their right upper extremity. Resident #76 also revealed that he/she does not use a hand splint or positioning device for their right hand. Interview on 1/29/26 at approximately 9:30 a.m. with Staff J (Registered Nurse) revealed that Resident #76 does not currently have a hand splint, but they did before. Review on 1/29/26 of Resident #76's care plan, initiated date of 8/25/23, revealed the resident was at-risk for alteration in functional mobility with a goal to tolerate splints or palm guard on affected upper and lower extremity for ninety days and an intervention to wear splint on affected upper and lower extremity as ordered. Interview on 1/29/26 at approximately 9:28 a.m. with Staff I (Rehabilitation Director) revealed that Resident #76 had a palm protector and it should be worn daily when out of bed. Interview on 1/29/26 at approximately 11:42 a.m. with Staff K (Physician Assistant) revealed that Resident#76 should still have the hand splint applied as per the care plan.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. Based on observation, interview and record review it was determined that the facility failed to arrange for the provision of rehabilitative services for 1 of 2 residents reviewed for rehabilitation in a final sample of 22 residents. (Resident identifier is #25.) Findings include:Interview on 1/27/26 at approximately 10:42 a.m. with Resident #25 revealed that he/she was receiving injections for contractures and was told that he/she would have therapy after the injections. Resident #25 further revealed that he/she has not received therapy following his/her most recent injection.Review on 1/27/26 of Resident #25's care plan meeting note, dated 12/30/25, revealed that Resident #25 would be re-evaluated by PT/OT (Physical Therapy/Occupational Therapy) after his/her Botox injection.Review on 1/27/26 of Resident #25's consultation report, dated 1/15/26, revealed that Resident #25 was seen for left spastic hemiplegia. Further review revealed recommendations for Dysport (Botox) injections every three months and physical therapy to address range of motion, standing, stretching, and bracing.Interview on 01/29/26 at approximately 8:24 a.m. with Staff I (Rehabilitation Director) confirmed that Resident #25 had not been seen by therapy after Resident #25's consultation appointment on 1/15/26.