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	12/18/2024

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

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review, it was determined that the facility failed to ensure that grievances from Resident Council were acted upon (Resident identifiers are #16, #21, and #99). Findings include: Review on 12/16/24 of the Resident Council Meeting Minutes dated 8/19/24, facilitated by Staff E (Regional Activities Director), in the section titled Dietary, revealed: Residents are concerned snacks aren't consistently available when they ask for them. Interview on 12/16/24 at approximately 11:00 a.m. with Resident Council (13 residents attended the group meeting) revealed that they had a food committee and no changes ever happen after they voice their concerns about snacks. Interview on 12/18/24 at 8:00 a.m. with Resident #99 revealed that he/she was not provided snacks when they would like at bedtime. Interview on 12/18/24 at approximately 9:07 a.m. with Resident #16 revealed snacks were not always available. Resident #16 also stated that on the evening of 12/15/24, he/she requested a cookie, which was unavailable, and that the staff left without offering an alternative snack. Interview on 12/18/24 at approximately 1:00 p.m. with Resident #21 revealed that he/she was not provided snacks when they would like at bedtime.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, it was determined that the facility failed to ensure that the provider reviewed irregularities identified by the pharmacist during the monthly Pharmacy Medication Regimen Review (MRR) timely for 1 of 8 residents reviewed for unnecessary medications (Resident Identifier #62). Findings include: Review on 12/18/24 of the facility's policy titled, Medication Regimen Review and Reporting, dated 1/24, revealed: .The nurse care center follows up on the recommendations should be acted upon within 30 calendar days or per facility specific protocols. a. For those issues that required physician intervention, the attending physician either accepts and acts upon the report and recommendations or rejects all or some of the report and should document his or her rationale of why the recommendations is rejected in the resident's record . Review on 12/18/24 at approximately 10:00 a.m. of Resident # 62's Pharmacy MRR, dated 8/22/24, revealed a recommendation to adjust the total daily dose of Gabapentin to stay within recommended dosing guidelines. Further review of the MRR revealed that the physician did not address the recommendation until 10/2/24 (more than 30 days from the MRR recommendation of 8/22/24).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. Based on record review, interview, and policy review, it was determined that the facility failed to follow the established smoking policy for 1 out of 1 resident reviewed for smoking in a final sample of 23 residents (Resident Identifier #92). Findings include: Review on 12/18/24 of the facility's policy titled, OPS137 Smoking, revision date 5/01/24, revealed: Policy . Patients/Residents will be assessed on admission, quarterly, and with change in condition for the ability to smoke safely . Review on 12/18/24 of Resident #92's medical record revealed that Resident #92 was a smoker. Further review of the medical record revealed that the most recent smoking assessment was a smoking evaluation on 6/17/24. Interview on 12/18/24 at 11:00 am with Staff A (Director of Nursing) confirmed the above findings. Interview with Staff A confirmed that smoking evaluations were completed upon admission, quarterly, and with a change in condition. Staff A stated that Resident #92 was due for a quarterly smoking evaluation to be completed in September of 2024.