STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225688	A. BUILDING _____ B. WING _____	**06/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SEA VIEW CONVALESCENT AND NURSING HOME	**50 MANSION DRIVE ROWLEY, MA 01969**

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 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.** Based on record review and interview for one of three sampled residents (Resident #1), the Facility failed to ensure a complete and accurate medical record was maintained for Resident #1, including containing a copy of his/her completed Health Care Proxy form. Findings include: Review of Resident #1's medical record indicated it included the following; Documentation of Resident Incapacity, Pursuant to Massachusetts Health Care Proxy (HCP) Act MGLC 201D, dated 07/26/19, which indicated the Medical Director had determined Resident #1 was unable to make his/her own decisions, indefinitely, due to dementia, and that Resident #1's Review of Resident #1's medical record indicated there was no documentation to support that the facility had a completed copy of the Health Care Proxy form. During an interview on 06/03/20 at 12:07 P.M., the Medical Director said he had reviewed Resident #1's HCP form when he completed the Documentation of Resident Incapacity form, dated 07/26/19, to activate Resident #1's HCP. During an interview on 06/01/20 at 11:00 A.M., The Director of Nurses and Administrator said they were unable to locate Resident #1's Health Care Proxy form within the medical record.

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

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.