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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225529	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of the North Shore	111 Birch Street Lynn, MA 01902

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 36797 Based on observations, record review and interviews the facility failed to ensure a dignified existence for three Residents (#23, #45 and #97) out of a total sample of 24 residents. Specifically for Residents #23, #45 and #97 the facility failed to assist with the removal of unwanted chin hair. Findings include: Review of the facility policy titled Dignity, dated as reviewed 9/25/23, indicated that each resident has the right to be treated with dignity and respect. Review of the facility policy titled Activities of Daily Living (ADLs), dated reviewed 2/12/24, indicated that the resident will receive assistance as needed to complete ADLs. 1. Resident #23 was admitted to the facility in July 2009 with diagnoses including traumatic brain injury and post traumatic stress disorder. Review of the most recent Minimum Data Set (MDS) assessment, dated 3/29/24, indicted that Resident #23 scored a 9 out of 15 on the Brief Interview for Mental Status exam, indicating moderate cognitive impairment. The MDS further indicated Resident #23 requires moderate assistance with personal hygiene. Resident #23's current Activities of Daily Living care plan indicates Resident #23 requires assist of one staff member to complete personal hygiene. The care plan failed to indicate that Resident #23 refuses care. Review of the progress notes dated March 2024 and April 2024 failed to indicate Resident #23 refused care. On 4/16/24 at 9:45 A.M., Resident #23 was observed in the day room with a significant amount of chin hair. On 4/17/24 at 7:10 A.M., Resident #23 was observed in the main dining room eating breakfast. Resident #23 was observed to continue to have a significant amount of chin hair. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/17/24 at 10:28 A.M., Resident #23 said the chin hair was embarrassing and he/she hates it. Resident #23 said that staff does not offer to remove the chin hair. During an interview on 4/18/24 at 9:45 A.M., Certified Nursing Assistant (CNA) #4 said that it is the responsibility of the CNA's to remove unwanted chin hair daily with morning care. During an interview on 4/18/24 at 9:46 A.M., Nurse (#3) said that it is the responsibility of the CNA's to remove unwanted chin hair daily with morning care. 2. Resident #45 was admitted to the facility in October 2023 with diagnoses including osteoarthritis, weakness and depression. Review of the most recent Minimum Data Set (MDS) assessment, dated 3/14/23, indicated that Resident#45 scored a 12 out of 15 on the Brief Interview for Mental Status exam, indicting moderate cognitive impairment. The MDS further indicated Resident #45 requires substantial assistance with personal hygiene. Resident #45's current Activities of Daily Living care plan, dated as revised 10/19/23, indicated that Resident #45 requires an assist of one to complete person hygiene tasks. Review of the progress notes dated March 2024 and April 2024 failed to indicated that Resident #45 refuses care. On 4/16/24 at 7:50 A.M., the surveyor observed Resident #45 with a significant amount of chin hair. On 4/17/24 at 8:10 A.M., and 2:55 P.M., the surveyor observed Resident #45 with a significant amount of chin hair. During an interview on 4/17/24 at 3:20 P.M., Resident #45 said he/she doesn't like having chin hair and would like it removed. Resident #45 then said that usually his/her daughter removes the chin hair but she hasn't been in lately and the staff doesn't remove it. During an interview on 4/18/24 at 9:45 A.M., Certified Nursing Assistant (CNA) #4 said that it is the responsibility of the CNA's to remove unwanted chin hair daily with morning care. During an interview on 4/18/24 at 9:46 A.M., Nurse (#3) said that it is the responsibility of the CNA's to remove unwanted chin hair daily with morning care. 46339 3. Resident #97 was admitted to the facility in March 2024 with diagnoses including drug induced polyneuropathy and muscle weakness. Review of Resident #97's most recent Minimum Data Set (MDS) assessment, dated 3/14/24, indicated the Resident scored a 12 out of a possible 15 on the Brief Interview for Mental Status exam, indicating moderate cognitive impairment. The MDS further indicated that Resident #97 required partial assistance of one person for personal hygiene. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 4/16/24 at 8:35 A.M., the surveyor observed Resident #97 lying in his/her bed with a thick layer of facial hair on his/her chin. Resident #97 said he/she would like the chin facial hair removed and said staff had not offered. On 4/17/24 at 8:11 A.M., the surveyor observed Resident #97 lying in his/her bed with a thick layer of facial hair on his/her chin. On 4/17/24 at 11:40 A.M., the surveyor observed Resident #97 lying in his/her bed with a thick layer of facial hair on his/her chin. The Resident said he/she does not like to have the facial hair. On 4/17/24 at 2:56 P.M., the surveyor observed Resident #97 lying in bed with thick facial hair chin hair. On 4/18/24 at 9:33 A.M., the surveyor observed Resident #97 lying in bed with thick layer of facial hair on his/her chin. Review of Resident #97's medical record failed to indicate refusal of care. During an interview on 4/18/24 at 9:40 A.M., Certified Nursing Assistant (CNA) #4 said the CNAs are suppose to offer to shave all the residents during morning care. CNA #4 said Resident #97 moved to the unit a few days ago and had not refused activities of daily living care.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 36797 Based on observations, record review, policy review and interviews, the facility failed to ensure two Residents (#81 and #102) were free from restraints out of a total sample of 24 residents. Specifically, the facility failed to identify and assess the use of pillows under a fitted sheet as a potential restraint for Residents #81 and #102. Findings include: The facility policy titled Physical Restraint Use, dated as revised 12/29/23, indicted that a physical restraint is any manual method or physical or mechanical device, equipment, or material that meets the following criteria: a. Is attached or adjacent to the resident's body b. Cannot be removed easily by the resident (meaning it can be removed intentionally by the resident in the same manner as it was applied by staff); and c. Restricts the resident's freedom of movement or normal access to his/her body. 1. Resident #81 was admitted to the facility in September 2023 with diagnoses including stroke with residual left sided hemiplegia (paralysis) and hemiparesis (muscle weakness). Review of the most recent Minimum Data Set (MDS) assessment, dated 3/25/24, indicated that Resident #81 was unable to complete the Brief Interview for Mental Status exam and had severe cognitive impairment. The MDS further indicted Resident #81 requires substantial assistance for bed mobility, is unable to stand and does not use restraints. Review of the nursing progress notes indicated the following: -A note, dated 12/27/23, indicated that Resident #81 slid out of bed. -A note, dated 1/14/24, indicated that Resident #81 was found sitting on the edge of the bed all night, active and restless and did not sleep. -A note, dated 3/22/24, indicated that Resident #81 continued to attempt to climb out of bed. Review of Resident #81's care plan failed to indicate a care plan for the use of restraints or for the placement of pillows under the fitted sheet. Review of the record failed to indicate: -An assessment for the use of a restraint. -A consent had been obtained for the use of a restraint. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A physician's order for the use of a restraint. On 4/16/24 at 9:26 A.M., the surveyor observed Resident #81 in bed. There were pillows under the fitted sheet on both sides of Resident #81's body, extending the the length of the bed. On 4/17/24 at 7:20 A.M., the surveyor observed Resident #81 in bed. There were pillows under the fitted sheet on both sides of Resident #81's body, extending the length of the bed. On 4/18/24 at 7:12 A.M., the surveyor observed Resident #81 in bed. There were pillows under the fitted sheet on both sides of Resident #81's body, extending the length of the bed. During an interview on 4/18/24 at 7:10 A.M., Certified Nursing Assistant (CNA) #3 said that the night staff put the pillows there because the Resident had been trying to get out of bed. CNA #3 said that placing the pillows under the fitted sheet acts as a restraint and prevents the Resident from climbing out of bed. During an interview on 4/18/24 at 7:12 A.M., Nurse (#4) said that the pillows act as a restraint and had been placed there by the night shift staff. 41105 2. Resident #102 was admitted to the facility in July 2023 and had diagnoses including syncope and collapse and repeated falls. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/24/24, indicated that Resident #102 was rarely or never understood and had moderately impaired cognition. The MDS further indicated that Resident #102 did not utilize restraints. Review of Resident #102's Fall Risk evaluation, dated 3/14/24, indicated the following: -Resident #102 scored an 18, indicating that he/she was at high risk for falls. (10 or above, interventions to address the fall risk should be initiated). Review of Resident #102's current care plans failed to indicate a care plan for the use of a restraint. Review of the record failed to indicate: -An assessment for the use of a restraint. -A consent had been obtained for the use of a restraint. -A physician's order for the use of a restraint. Review of falls reports for Resident #102 indicated he/she had experienced falls from his/her bed on 9/7/23 and 3/14/24. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/16/24 at 8:07 A.M., Resident #102 was observed in bed asleep. There was a fall mat on the right side of the bed and a pillow tucked snuggly underneath the fitted sheet, running the length of the right side of Resident #102's body. On 4/17/24 at 7:02 A.M., Resident #102 was observed in bed asleep. There was a fall mat on the right side of the bed and two pillow tucked snuggly underneath the fitted sheet, running the length of the right side of Resident #102's body. On 4/17/24 at 9:17 A.M., Resident #102 was observed in bed eating breakfast. There was a fall mat on the right side of the bed and two pillows tucked snuggly underneath the fitted sheet, running the length of the right side of Resident #102's body. On 04/18/24 at 6:50 A.M., Resident #102 was observed in bed asleep. There was a fall mat on the right side of the bed and a pillow tucked snuggly underneath the fitted sheet, running the length of the right side of Resident #102's body. During an interview on 4/18/24 at 6:54 A.M., Certified Nursing Assistant (CNA) #1 she said that at night time Resident #102 requires total care and that Resident #102 has behavior of kicking his/her legs and trying to climb out of bed. CNA #1 explained that is why we put the pillow under the sheet, to stop him/her from getting out of bed. CNA #1 said that the pillow is under the sheet on the right side of the bed and the fall mat on the right side of the bed, because that is the side of the bed that Resident #102 tries to get out of. During an interview on 4/18/24 at 6:59 A.M., Nurse (#1) said that Resident #102 has had falls and that he implemented the fall mat on the right side of the bed because that's the side of the bed that Resident #102 tries to get out of. The Surveyor and Nurse #1 then observed Resident #102 in bed asleep with the pillow under the fitted sheet, running the length of Resident #102's body. Nurse #1 said that he was not aware that the pillow was put there and that he was not sure if a pillow under a fitted sheet, to prevent a resident from getting out of bed, should be assessed as a potential restraint. During an interview on 4/18/24 at 9:40 A.M., the Director of Nursing (DON) said that the facility is restraint free and that staff should not be putting pillows under the fitted sheet to prevent a resident from getting out of bed. The DON said that if she knew staff were doing this she would have assessed the resident for the use of a restraint.

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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. 48671 Based on observations, interview, and record review, the facility failed to meet professional standards of quality for one Resident (#8), out of a total sample of 24 residents. Specifically for Resident #8 the facility failed to communicate the appropriate diet and assess the diet texture for Resident #8 upon readmission from a hospital stay. Findings include: Review of the facility policy titled: Hydration and Nutrition, dated 8/24/23, indicated the following: -Is offered a therapeutic diet when there is a nutritional problem, and the health care provider orders a therapeutic diet. -Consultation with dietary and therapy personnel is performed on admission and as needed. Review of the facility policy titled: 'Easy to Chew Diet, dated as revised 2/28/22, indicated the following: -The Easy to Chew Diet is a modification in texture of the Regular Diet, designed to not include food that is hard, tough, chewy, fibrous, stringy and/or crunchy. -The Easy to Chew diet is used for individuals having difficulty chewing. Individuals likely to benefit from and Easy to Chew Diet are residents with poor or missing dentition, and/or neurological or anatomical impairment impacting the ability to chew and swallow. Resident #8 was admitted in May 2013 with diagnoses including anoxic brain injury, dysphagia, unspecified protein calorie malnutrition, hemiplegia, dementia and aphasia. Review of Resident #8's most recent Minimum Data Set (MDS) assessment, dated 3/12/24, indicated Resident #8 had a Brief Interview for Mental Status exam score of 13 out of a possible 15, indicating intact cognition. The MDS further indicated that Resident #8 is on a therapeutic diet. Resident #8 was evaluated by speech therapy on 12/20/23, and Resident #8's diet was downgraded to Regular- easy to chew texture, thin consistency. Further review of speech therapy discharge summary dated 1/10/24 indicated the following: -Regular Diet, Easy to Chew (ETC), Thin Liquids -Pt (Patient) need to be boosted prior to meals, will hang up sign. -Pt on ETC thin, given recent difficulty with mastication/limited dentition, pt will remain on ETC. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #8's care plan indicated the following: -Provide, serve diet as ordered: Regular diet, no salt packet- inner Lip Plate with all meals. Monitor intake and record q meal. Dated as revised on 4/11/2024. -Observe and report PRN (as needed) and s/sx (signs or symptoms) of dysphagia: Pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals. Dated 6/5/19. Review of the facility nutritional care manual indicate the following: Level 7 Easy to chew diet is a textured modified diet that is used when a patient has mild chewing concerns and is not for patients with swallowing issues. It is prescribed to people who may have difficulty chewing hard, tough, stringy, or crunchy foods. The Level 7 Regular Easy to chew diet may include soft, tender moist foods, should be able to bite off food and chew without tiring easily, avoid hard, tough, stringy, or crunch foods, there are no food size restrictions but may benefit from foods cut up at service. Level 7 Regular foods are normal everyday foods of various textures. No restriction, this is not a textured modified diet. Review of the clinical record indicated that Resident #8 was transferred to the hospital on 1/27/24, for abnormal vital signs. Review of the nursing home to hospital transfer form indicated Resident #8 had difficulty chewing and swallowing. The transfer form failed to indicate that Resident #8 was receiving a therapeutic diet, Regular- Easy to chew, thin liquid diet. Review of Resident #8's re-admission paperwork dated 1/31/24 indicated the following: -Feeding assistance: Needs assistance -Diet Order: Regular Review of Resident #8's medical record indicated a diet order was dated 1/31/24 -Regular diet- Regular texture, thin consistency, no salt packet lip plate. Review of the medical record failed to indicate Resident #8 was assessed by speech therapy after Resident #8 was readmitted to the facility with a diet upgrade to a regular diet. During an observation on 4/16/24 at 8:23 A.M., Resident #8 was observed sitting up in bed eating 2 whole sausages, scrambled eggs, orange juice, coffee, cereal with milk and oatmeal. Resident #8 was struggling to cut up one sausage using one hand with the fork. The Resident was not using a lip plate. During an observation on 4/17/24 at 8:28 A.M., Resident #8 was observed sitting up in bed eating breakfast in bed with a lip plate. Observed on the wall directly across from the Residents bed were two printed signs taped to the closet door: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Sign one: Staff/Caregivers: PLEASE READ BEFORE GIVING PATIENT FOOD/DRINK. THANK YOU SPEECH THERAPIST. Sign two: Safe swallow strategies regular, no beef thin liquids, NSG (nursing) to cut up food into bite sized pieces. -Small amounts- *please cut up food into bite sized pieces* During an interview on 4/17/24 at 8:44 A.M., Nurse #2 said Resident #8 can eat alone but needs food cut up because she had a choking issue a couple months ago and was seen by speech therapy. During an interview on 4/17/24 at 11:19 A.M., Rehabilitation Services Staff (RSS) #2 said a Regular Easy to Chew diet is a therapeutic diet that means meat it ground up, nothing sticky or difficult to chew and requires an assessment by speech therapy. RSS #2 said a speech assessment is necessary to upgrade a diet to Regular. During an interview on 4/18/24 at 8:38 A.M., the Director of Nursing (DON) said residents who are new admissions or readmissions are reviewed during group meetings and any new orders or recommendations are assessed and updated. The DON said readmission paperwork should be reviewed to ensure orders, care plans and Kardex information is accurate. The DON said Resident #8's transfer from to the hospital was not accurate and should have indicated that he/she was on a therapeutic diet. The DON said she would expect the transfer form to be accurate and include dietary information. The DON said a speech evaluation should have been completed on Resident #8 when he/she returned from the hospital on a regular diet due to his/her history of choking and speech evaluation on 1/10/24. During an interview on 4/18/24 at 11:01 A.M., the DOR said regular easy to chew texture is different from a regular diet and that a regular diet is an upgrade and requires an assessment. The DOR said Resident #8 was not evaluated in the hospital or in the facility after 1/10/24.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 41019 Based on observation, record review, and interview, the facility failed to follow a physician order for one Resident (#32) out of a total sample of 24 residents. Specifically, the facility failed to implement the use of TED (Thrombo Embolic Deterrent) stocking (stockings used to prevent edema and blood clots). Findings include: Resident #32 was admitted in November 2015 with diagnoses including hyperlipidemia and dementia. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/28/24, indicated that Resident #32 scored a 10 out of a possible 15 on the Brief Interview for Mental Status exam, indicating moderate cognitive impairment. The MDS further indicated that Resident #32 requires substantial to moderate assistance with lower body dressing. Review of the current physician orders indicated the following order: -Teds stocking on in AM off in PM During an observation on 4/16/24 at 9:26 A.M., Resident #32 was seated in a chair in his/her room with swelling on the lower right leg. Resident #32 was wearing non-skid socks, but not TED stockings. During an observation on 4/17/24 at 9:34 A.M., Resident #32 was seated in a chair in his/her room with swelling on the lower right leg. Resident #32 was wearing non-skid socks, but not TED stockings. During an observation on 4/18/24 at 9:26 A.M., Resident #32 was seated in a chair in his/her room with swelling on the lower right leg. Resident #32 was wearing non-skid socks, but not TED stockings. During an interview on 4/18/24 at 9:28 A.M., Nurse (#4) said that Resident #32 should be wearing TED stockings since they are ordered for the Resident. Nurse #4 said that the 11-7 shift should be putting the stockings on when Resident #32 gets ups.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 48671 Based on observations, record reviews and interviews, the facility failed to ensure two Residents (#91 and #97), out of a total sample of 24 residents, received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Specifically, 1. For Resident #91 the facility failed to implement interventions to prevent pressure ulcer development for a resident and is totally dependent on staff, placing him/her at increased risk for pressure ulcer development. The Resident developed a stage 2 pressure ulcer within 24 days of admission. 2. For Resident #97 the facility failed to implement Prevalon heel boots as ordered. Findings include: Review of facility policy titled Skin Integrity & Pressure Ulcer/Injury Prevention and Management, dated as reviewed March 2023, indicated the following: -A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. 1. For Resident #91, who readmitted to the facility with new skin issues, the facility failed to put interventions in place, to prevent further decline until 24 days later, when Resident #91 developed a pressure ulcer. Resident #91 was admitted to the facility in November 2021 with diagnoses including Alzheimer's dementia and muscle weakness. Review of the most recent Minimum Data Set (MDS) assessment, dated 2/16/2024, indicated Resident #91 had a Brief Interview of Mental Status exam score of 6 out of a possible 12, indicating severe cognitive impairment. The MDS further indicated Resident #91 is high risk for pressure ulcers and indicated one Stage 1 pressure ulcer (Intact skin with non-blanchable redness of a localized area usually over a bony prominence), three Stage 2 pressure ulcers' (Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister), and one Stage 3 pressure ulcer (Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling). Review of Resident #91's clinical record indicated he/she was readmitted to the facility in January 2024. The nursing admission assessment, dated 1/10/24, indicated the following skin conditions were observed: -Right heel- redness, Left heel-redness, and Coccyx Redness (blanchable) intact. (continued on next page)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At the time of admission, the record failed to indicate that a skin care plan was developed or interventions put in place, to address Resident #91's skin issues. Review of Resident #91's skin assessments indicated the following: -An assessment, dated 1/17/24: Redness blanchable bilateral heels. -An assessment, dated 2/2/24: Left Buttock open area stage 2 ulcer. Review or Resident #91's clinical progress note, dated 2/1/24, indicated: -Nurse taking care of this resident reported that he/she had an open area on his/her coccyx/buttock area. Upon inspection there are 2 areas that are open, base of wounds are beefy red. The left buttock has a 2 cm by 1.9 cm area that is a stage 2. No apparent drainage from site; surrounding skin is pinkish red in color and blanchable. The coccyx crack has an open area that is 2 cm by 0.5 cm; no apparent drainage from wound, stage 2. Both were cleaned and triad cream applied. Resident is positioned in bed slightly to the right side. Will be monitored on Tuesday by the Wound team. Review of Resident #91's skin care plan indicated that Resident has stage 3 pressure ulcer to the coccyx r/t (related to) immobility, incontinence-facility acquired. Stage 2 pressure ulcer to right heel-facility acquired-healed x 1 week. Stage 3 pressure ulcer on midback/spine-facility acquired, Revised 3/26/24. Interventions on the care plan included: -Wound care to coccyx normal saline wash, pat dry apply medihoney (Wound gel) to wound bed and apply antifungal cream to peri wound and cover with mepilex dressing daily. And as needed soilage/removal. Dated 2/2/24. -Weekly treatment documentation to include measurement of each area of skin breakdown's width, depth, type of tissue and exudate. Dated 2/2/24. -The resident needs assistance to turn/reposition /weight shift in chair at least every 2-3 hours. Dated 2/2/24. -Set air mattress as ordered, dated 2/28/24. -Pillows to float heels while in bed as tolerated. Dated 3/1/24. -Air mattress to bed- setting to patient weight -check function every shift. Revised 3/18/24. -To mid back (left side) nsw (normal saline wash), pat dry (dry) apply medihoney to wound bed, apply triad to peri wound and mepilex dressing three times a week. Revised 4/1/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225529	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER Life Care Center of the North Shore		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Birch Street Lynn, MA 01902	

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/17/24 at 9:44 A.M., with the facility's Wound Nurse she said, Resident #91 should have had treatments put in place at the time of admission due to the skin issues that were identified at that time. The Wound Nurse said that at minimum preventative interventions should have included skin prep, floating his/her heels, an air mattress, and triad cream should have been applied to the coccyx. The Wound Nurse said she first became aware of the skin issues on 2/6/24 when open area developed on the coccyx. During an interview on 4/17/24 at 9:47 A.M., the Director of Nursing Services (DON) said wound rounds are scheduled weekly and documented by the Wound Nurse. The DON said that nursing should have implemented preventative measures upon Resident #91's admission and reviewed weekly to prevent worsening of the wounds, not after a wound developed on 2/1/24. 46339 2. Resident #97 was admitted to the facility in March 2024 with diagnoses including muscle weakness, drug induced polyneuropathy and difficulty in walking. Review of Resident #97's most recent Minimum Data Set (MDS) assessment, dated 3/14/24, indicated Resident #97 scored a 12 out of a possible 15 on the Brief Interview for Mental Status exam, indicating moderate cognitive impairment. The MDS further indicated that the Resident was at risk for developing pressure ulcers. Review of Resident #97's physician's orders dated 4/11/24, indicated the following order: -Prevalon boots to bilateral lower extremities while in bed every shift. Review of the Nurse Practitioner progress note dated 4/12/24 indicated the following: -Deep tissue injury-bilateral heels due to spending most of his/her time in bed with his/her heels digging in a mattress. Prevalon boots have been added for his/her protection and staff also use skin prep. Review of the Treatment Administration Record for April 2024 indicated that staff had documented that the Resident had the Prevalon heel boots on during the time of the surveyors' observations: On 4/16/24 at 8:35 A.M., the surveyor observed Resident #97 lying in bed and he/she did not have Prevalon heel boots on. On 4/17/24 at 7:32 A.M., the surveyor observed Resident #97 lying in bed and his/her heels were directly placed on the mattress. Resident #97 did not have the Prevalon heel boots on. On 4/17/24 at 11:43 A.M., the surveyor observed Resident #97 lying in bed with his/her heels directly placed on the mattress. Resident #97 said his/her heels were in pain. the surveyor observed the heels which were reddened and non-blanchable (discoloration of the skin that does not turn white when pressed). On 4/17/24 at 2:56 P.M., the surveyor observed Resident #97 lying in bed and he/she did not have the Prevalon heel boots on. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/18/24 at 9:37 A.M., Nurse (#3) said if a Resident had an order for Prevalon boots then the boots should be on as ordered. During an interview on 4/18/24 at 9:43 A.M., the Director of Nursing said physician orders should be followed as ordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225529	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024

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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. 36797 Based on observation, policy review and interview the facility failed to ensure medications were labeled properly and failed to ensure treatment items were not stored with oral medications in one of three medication carts observed. Findings include: The facility policy titled Storage and Expiration Dating of Medications, Biological's, dated as revised 8/7/23, indicated the following: -External use medications and biological's are stored separately from internal use medications and biological's. -Once any medication or biological package is opened, the facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container when the medication has a shortened expiration date once opened. On 4/17/24, at 3:14 P.M., the surveyor observed the following in the Hillview medication cart: -1 Arnuity inhaler (used to treat asthma) open and without a date. Review of the manufacturer's directions indicated to discard the inhaler 6 weeks after opening. -1 bottle of Calamine topical lotion -1 box of Tucks hemorrhoidal pads -1 tube of Preparation H hemorrhoidal cream During an interview on 4/17/24, at 3:14 P.M., Nurse #5 said she was not able to locate a date of when the inhaler was opened.