

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  04/03/2025
NAME OF PROVIDER OR SUPPLIER  Life Care Center of the North Shore		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50338</b></p> <p>Based on observation, record review and interview, the facility failed to notify the physician of a change in condition for three Residents, (#35, #40, and #100), out of a total of 29 sampled residents. Specifically, the facility failed to notify the physician of a change in condition related to a Gastrointestinal (GI) Outbreak.</p> <p>Findings include:</p> <p>Review of the facility's Acute Gastrointestinal Surveillance Line List, dated 4/1/25, identified 19 residents as having signs and symptoms that included abdominal pain, diarrhea, and/or vomiting. The earliest recorded onset was 3/19/25 and 15 out of 19 had resolved by 4/1/25.</p> <p>Review of the facility policy titled Change in a Resident's Condition or Status, dated as reviewed September 2024, indicated that the facility shall promptly notify the resident, his or her attending physician and representative of changes in the resident's medical/mental condition and or status.</p> <p>1a. Resident #35 was admitted to the facility in April 2022 with diagnoses including dementia, stroke, and diabetes.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 1/8/25, indicated that Resident #35 was rarely/never understood and was assessed by staff as having severe cognitive impairment. The MDS also indicated that he/she was dependent for all aspects of care.</p> <p>Review of facility's Gastroenteritis Surveillance Line List, dated 4/1/25, indicated that Resident #35 began to exhibit GI symptoms which included diarrhea on 3/29/25, with symptom resolution on 3/31/25.</p> <p>Review of Resident #35's nursing progress note, dated 3/30/25, indicated had a large vomit following [his/her] transfer with aide of mechanical lift on to the recliner. Tolerated sitting in the recliner until the beginning of the evening shift when [he/she] transferred on to the bed and discovered [he/she] had a large loose stool. [sic]. Further review of the nursing progress notes 3/28/25 through 4/3/25 failed to indicate physician had been notified of Resident #35's change in condition.</p> <p>1b. Resident #40 was admitted to the facility in November 2023 with diagnoses including Parkinson's Disease.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the most recent MDS, dated [DATE], indicated that Resident #40 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15. The MDS also indicated he/she was dependent for all aspects of care.</p> <p>Review of facility's Gastrointestinal Surveillance Line List, dated 4/1/25, indicated Resident #40 began to exhibit GI symptoms which included vomiting and diarrhea on 3/30/25, with symptom resolution on 4/1/25.</p> <p>Review of Resident #40's nursing progress notes, dated 3/26/25 and 4/1/25, indicated that Resident #40 received Pepto-Bismol Oral Suspension for complaints of loose stools/ diarrhea. Further review of nursing progress notes 3/26/25 through 4/3/25 failed to indicate that a physician had been notified of Resident #40's change in condition.</p> <p>1c. Resident #100 was admitted to the facility in May 2024 with diagnoses including a stroke.</p> <p>Review of the most recent MDS, dated [DATE], indicated that Resident #100 was cognitively intact as evidenced by a BIMS score of 13 out of a possible 15. The MDS also indicated that he/she required moderate assist for activities of daily living and supervision for mobility.</p> <p>Review of facility's Gastrointestinal Surveillance Line List, dated 4/1/25, indicated that Resident #100 began to exhibit GI symptoms that included vomiting and diarrhea on 3/27/25, with resolution of symptoms on 3/30/25.</p> <p>Review of Resident #100's weights and vitals summary, dated 4/3/25, indicated the following weights:</p> <p>3/31/25 147.5 pounds (lbs.).</p> <p>4/1/25 140.5 lbs.</p> <p>Review of Resident #100's Medication Administration Record (MAR), dated 4/2/25, indicated that Resident #100's weight was 140.5 lbs.</p> <p>Review of Resident #100's registered dietician progress note, dated 4/2/25, indicated that Resident #100 had a seven-pound weight loss from 3/31/25 until 4/1/25. Action: no new changes at this time monitor weights/protocol [sic].</p> <p>Review of Resident #100's nursing progress notes, dated 3/27/25 through 4/3/25, failed to indicate that the physician had been notified of Resident #100's change in condition in regard to GI symptoms and weight loss.</p> <p>During a phone interview on 4/2/25 at 1:13 P.M., the Medical Director said that she had not been notified of any Gastrointestinal (GI) Outbreak at the facility, but it is her Nurse Practitioner (NP) that usually takes calls over the weekend so she would check with her to see if the NP had received any calls. The surveyor read Resident #35 and Resident #40's names to her, and she said she did not have any notes on either of those Residents.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a follow-up phone interview on 4/2/25 at 1:19 P.M., the Medical Director said that she checked with her NP and confirmed that they did not receive any calls from the facility over the weekend about any signs and symptoms of vomiting and diarrhea.</p> <p>During a phone interview on 4/3/25 at 8:22 A.M., the Medical Director said she would have ordered stool sample testing for Norovirus if she had been aware of the amount of residents that were affected. She said that the results of the testing would not change the treatment as it is essentially supportive care, but would be helpful to determine if results should be escalated to the Medical Director, etc. She said she had spoken with her NP again yesterday to educate her about the communication that was necessary to monitor for trends in conditions of residents. She said the NP was also unaware of the number of residents that had been affected by the GI symptoms.</p> <p>During an interview on 4/3/25 at 8:10 A.M., the MDS Coordinator said there were residents with symptoms on Wednesday (3/26/25), Thursday (3/27/25), and Friday (3/28/25), but that over the weekend (3/29/25-3/30/25) the number of cases blew up. She said there were no stools sent to check for Norovirus. She said in general it was more vomiting than loose stools. She said that from what she understood, somebody should notify the MD (physician) or Medical Director in the case of any type of outbreak. She was not sure if anyone notified the Medical Director. She said nurses should write a note about what was happening throughout their shift and notify the MD or NP of symptoms or changes in condition. She said she would consider this a change in condition where notification should be sent to MD or NP. She would expect that the NP or MD would be called over the weekend as these symptoms started. She would expect that nurses are assessing and documenting assessment on hydration.</p> <p>During an interview on 4/3/25 at 08:21 A.M., the Infection Preventionist said nurses should be documenting their symptoms and with persistent symptoms should notify MD, NP, and family. She said she reviewed documentation and there is no documentation in progress notes. She was not notified when the number of cases blew up over the weekend. She said that the NP or MD should have been notified. She said over the weekend the Medical Director should have been notified, and they were not. She said nurses should be assessing hydration status, should have orders for monitoring, assessing, and encouraging oral intakes. She did not see any Norovirus testing asked about, discussed, or ordered.</p> <p>During an interview on 4/3/25 at 9:39 A.M., the Director of Nursing (DON) said there should be documentation in the nursing progress notes about the residents having GI signs and symptoms. She would consider these symptoms to be a change in condition and would expect the NP or MD to be notified. The notification should be documented in the medical record even if the NP or MD was notified in person. She said nurses should have a daily note for ongoing assessment to monitor for hydration status. She said when GI symptoms increased over the weekend, the NP or call service should have been notified. She said the process during an outbreak is to notify the Medical Director. The DON was unaware that only three of the 19 Residents included on the GI line listing had any documentation in their medical record. She was also unaware that Resident #100 had a seven-pound weight loss from 3/31/25 to 4/1/25 and was one of the Residents affected by the GI outbreak. She said that NP or MD should have been notified but they were not.</p> <p>Refer to F842</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>45763</p> <p>Based on observation and interviews, the facility failed to serve food that was palatable, and at a safe and appetizing temperature, on three out of three units.</p> <p>Findings include:</p> <p>Review of a blank Test Tray Audit form indicated that the meal cart should be served within 15-20 minutes, that the temperature for cold foods should be less than 50 degrees Fahrenheit and the temperature for hot food should be greater than 120 degrees Fahrenheit.</p> <p>During the initial tour of the facility on 4/1/25 the surveyors met with residents; eleven residents voiced dissatisfaction with the temperature and/or taste of the food served at the facility.</p> <p>During the resident group meeting on 4/2/25 at 10:32 A.M. the surveyors met with residents; five out of five residents said the food was often cold when delivered.</p> <p>On 4/2/25 at 8:00 A.M. the surveyor observed staff calibrating the thermometers to be used for test trays.</p> <p>On 4/2/25 at 8:24 A.M., the Oceanview unit food truck arrived at the resident care unit. After all resident trays were served the surveyor received the test tray at 8:50 A.M., 26 minutes after the truck had arrived. The following was recorded and observed:</p> <ul style="list-style-type: none"> <li>- Cream of wheat was 100 degrees Fahrenheit, tasted cold, not hot, and bland.</li> <li>- Scrambled eggs were 108 degrees Fahrenheit and tasted cool not hot.</li> <li>- Toast was 90 degrees Fahrenheit, was soggy and tasted cold.</li> <li>- Cheesy hashbrowns were 110 degrees Fahrenheit, had good flavor but tasted lukewarm, not hot.</li> <li>- Milk was 58 degrees Fahrenheit and tasted warm, not cold.</li> <li>- Orange juice was 60 degrees Fahrenheit and tasted warm, not cold.</li> </ul> <p>On 4/2/25 at 8:38 A.M. the Hillview unit food truck arrived at the resident care unit. After all resident trays were served the surveyor received the test tray at 8:58 A.M., 20 minutes after the truck had arrived. The following was recorded and observed:</p> <ul style="list-style-type: none"> <li>- Scrambled eggs were 120 degrees Fahrenheit, tasted warm, not hot and were not seasoned.</li> <li>- Cheesy hashbrowns were 122 degrees Fahrenheit and tasted warm, not hot.</li> <li>- Toast was 110 degrees Fahrenheit and tasted warm, the toast had a soggy texture.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45763</b></p> <p>Based on observation and interview, the facility failed to store food in accordance with professional standards for food service safety. Specifically, the facility failed to ensure that food was dated in the main kitchen and unit kitchenettes, and that raw chicken was not stored above ready-to-eat food.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Food Safety, revised [DATE], indicated, but was not limited to, the following:</p> <ul style="list-style-type: none"> <li>- Food is stored and maintained in a clean, safe and sanitary manner following federal, state and local guidelines to minimize contamination and bacterial growth.</li> <li>- Pre-packaged food is placed in a leak-proof, pest-proof, non-absorbent, sanitary (NSF) container with a tight-fitting lid. The container is labeled with the name of the contents and date (when the item is transferred to the new container). 'Use by date' is noted on the label or product when applicable.</li> <li>- All cooked and ready-to-eat food is stored above all raw food.</li> <li>- Leftovers are dated properly and discarded after 72 hours unless otherwise indicated.</li> <li>- Frozen, raw meat that is placed in a cooler is in a pan and labeled with pulled and use by dates.</li> </ul> <p>Review of the facility's policy titled Food from Outside Sources, reviewed [DATE], indicated, but was not limited to, the following:</p> <ul style="list-style-type: none"> <li>- Adhere to expiration date on prepackaged food items; Items should be discarded if past expiration date.</li> <li>- Foods that have been partially eaten (leftovers) should not be stored in the communal refrigerator but may be stored in a resident's personal refrigerator.</li> </ul> <p>On [DATE] at 7:08 A.M. the surveyor made the following observations during the initial walkthrough of the main kitchen:</p> <ul style="list-style-type: none"> <li>- Two bags of raw chicken stored on the top tray on a rack in the walk-in refrigerator. The bags of chicken were open, undated, and were above a tray of cooked pork and ready-to-eat deli-meat.</li> <li>- Two sandwiches wrapped but undated in the walk-in refrigerator.</li> <li>- A bag of shredded cheese open but undated in the walk-in refrigerator.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> <li>- A container of fried food, undated and unlabeled in the walk-in refrigerator.</li> <li>- A container of pasta salad open but undated in the walk-in refrigerator.</li> <li>- American cheese open but undated in the walk-in refrigerator.</li> <li>- Salami partially wrapped and undated in the walk-in refrigerator.</li> <li>- Deli turkey open and partially wrapped but undated in the walk-in refrigerator.</li> <li>- A container of thickened dairy drink open and dated ,d+[DATE] in the reach-in refrigerator.</li> <li>- A container of vegetable juice open with no use-by date in the reach-in refrigerator.</li> <li>- A container of cranberry juice open but undated in the reach-in refrigerator.</li> </ul> <p>On [DATE] at 7:38 A.M. the surveyor made the following observations in the Hillview kitchenette refrigerator:</p> <ul style="list-style-type: none"> <li>- An open apple juice dated ,d+[DATE].</li> <li>- An open orange juice dated ,d+[DATE].</li> <li>- An open cranberry juice, undated.</li> </ul> <p>On [DATE] at 7:43 A.M., the surveyor made the following observations in the 4th view kitchenette refrigerator:</p> <ul style="list-style-type: none"> <li>- Smoked cooked salami open and wrapped in a black plastic bag, undated.</li> <li>- An egg salad sandwich undated.</li> <li>- Two open containers of apple juice dated ,d+[DATE].</li> <li>- A brown paper bag containing leftover food dated ,d+[DATE].</li> <li>- A plastic cup containing leftover food, undated.</li> <li>- A brown paper bag with three containers of leftover food inside, labeled with a resident name but undated.</li> </ul> <p>On [DATE] at 8:12 A.M. the surveyor made the following observations in the Garden view kitchenette refrigerator:</p> <ul style="list-style-type: none"> <li>- A half-gallon of whole milk with an expiration date of [DATE]</li> <li>- A half-gallon of skim milk with an expiration date of [DATE].</li> </ul> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 8:13 A.M. Certified Nursing Aide #1 said the expired milk should not be in the fridge. She said the kitchen comes every day to check the dates and organize the kitchen and they should have removed it once it expired.</p> <p>During an interview on [DATE] at 7:19 A.M. the Assistant Food Service Director said the raw chicken should not have been stored above the cooked pork and that all prepared and open food should be wrapped and dated.</p> <p>During interviews on [DATE] at 7:25 A.M. and [DATE] at 7:37 A.M. the Food Service Director (FSD) said all open and prepared food items should be dated and discarded after three days, including in the kitchenette refrigerators; the FSD said undated and expired foods should be discarded.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49880</p> <p>Based on record review and interview, the facility failed to maintain complete and accurate medical records. Specifically,</p> <ol style="list-style-type: none"> <li>1. During a gastrointestinal (GI) outbreak on the Garden View Unit, the facility failed to document symptoms exhibited by 16 out of 19 residents with a GI illness.</li> <li>2. For one Resident (#43) out of a total sample of 29 residents, nursing documented they obtained blood pressure from his/her left arm when they did not.</li> </ol> <p>Findings include:</p> <p>Review of the facility policy, titled Nursing Documentation, reviewed September 2024, indicated, but was not limited to, the following:</p> <ul style="list-style-type: none"> <li>- The medical record must also reflect the resident's condition, and the care and services provided across all disciplines to ensure information is available to facilitate communication among the interdisciplinary team.</li> </ul> <p>On 4/1/25 at 7:23 A.M., the Director of Nurses (DON) said that there was a current Norovirus outbreak in the facility that started over the weekend, but was not sure how many residents were affected.</p> <p>Review of the LTC (Long Term Care) Acute Gastroenteritis Surveillance Line List, dated 4/1/25, that was provided to the surveyor on 4/1/25 indicated that 19 residents were exhibiting a combination of symptoms that included nausea, vomiting and diarrhea. Further review of the line list indicated that the first resident began with symptoms on 3/19/25 and the most recent began on 3/30/25.</p> <p>Review of the medical records for all 19 residents indicated on the line list failed to indicate any documentation regarding GI symptoms for 16 out of 19 residents.</p> <p>During an interview on 4/3/25 at 7:59 A.M., Nurse #2 said if a resident was experiencing GI symptoms (nausea, vomiting and diarrhea) it should be documented in the nurses' notes, and if symptoms persisted then it should be reported to the physician and documented.</p> <p>During an interview on 4/3/25 at 8:10 A.M., the Minimum Data Set (MDS) Nurse said that residents began to experience symptoms last week, and that the GI illness really blew up over the weekend. She said that residents with symptoms were not tested for Norovirus. She said that residents were experiencing more vomiting than diarrhea. She said that the nurses on the floor should be documenting symptoms and interventions provided for the residents during this time and anything that happens on their shift in the medical record. She said she would consider the GI illness a change in condition where documentation would be necessary. She said she would expect that nurses are assessing and documenting hydration status of a resident with a GI illness.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/3/25 at 8:21 A.M., The Infection Control Nurse said that nursing staff should be documenting all symptoms of the GI illness in the medical record, but she said that she reviewed the documentation and there was no documentation regarding symptoms. She said that the GI illness Blew up over the weekend, but she was not called or notified of it until she returned to work on Monday. She said that nurses should be assessing and documenting hydration status for residents with GI symptoms, but they were not.</p> <p>During an interview on 4/3/25 at 9:41 A.M., the Director of Nurses said that residents who were exhibiting symptoms of GI illness were experiencing what she would consider a change in condition. She said that symptoms and assessments of the residents should have been documented in the medical records of the residents, but they were not.</p> <p>45763</p> <p>2. Resident #43 was admitted to the facility in June 2024 with a diagnosis of end stage renal disease.</p> <p>Review of the Minimum Data Set (MDS), dated [DATE], indicated Resident #43 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating the Resident was cognitively intact</p> <p>Review of Resident #43's active physician orders indicated the following order:</p> <p>- Dialysis patient: Receives dialysis at dialysis center Monday Wednesday Friday. Do not take BP (blood pressure) on LEFT arm with fistula/shunt.</p> <p>Review of Resident #43's blood pressure readings indicated nursing obtained his/her blood pressure on his/her left arm on the following dates: 2/1/25, 2/2/25, 2/8/25, 2/9/25, 2/15/25, 2/18/25, 2/22/25, 3/1/25, 3/3/25, 3/8/25, 3/9/25, 3/15/25, 3/16/25, 3/17/25, 3/22/25, 3/23/25, 3/29/25, 3/30/25.</p> <p>During an interview on 4/2/25 at 10:50 A.M. Resident #43 said staff only use his/her right arm to take blood pressure readings, never his/her left arm.</p> <p>During an interview on 4/2/25 at 10:57 A.M., Unit Manager #1 said Resident #43's left arm should not be used to take blood pressure readings as the Resident had a dialysis fistula on that arm. Unit Manager #1 Said the nurses had documented that the blood pressure was taken using Resident #43's left arm in error as they only use the Resident's right arm.</p> <p>During an interview on 4/2/25 at 3:06 P.M. the Director of Nursing (DON) said she would expect nurses to accurately document which arm was used for blood pressure readings.</p>		