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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of the North Shore	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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations and interviews, the facility failed to ensure residents received food prepared by methods that conserve nutritive value, flavor, and appearance, and was palatable, attractive, and at a safe and appetizing temperature for three out of three test trays. Findings include:During the Resident Council meeting held on 3/18/26 at 10:02 A.M., 8 out of 10 residents in attendance said hot food served at the facility is often served cold and 10 out of 10 residents said meal trays usually take 20-30 minutes to pass out on the units, which they believe effects the temperatures. On 3/18/26 at 12:30 P.M., Surveyor #1 completed a test tray for the second-floor unit. The test tray left the kitchen at 12:20 P.M.; the last tray was served off the meal cart at 12:30 P.M., Surveyor #1 tested the tray and observed the following temperatures and palatability: -Hot dog in a roll, 118 degrees Fahrenheit (F), warm to taste, but hot dog roll was soggy and mushy from the baked bean and coleslaw liquid that filled the plate. -Coleslaw, 78 degrees F, lukewarm and unappetizing to taste. -Lemon pudding with whipped cream, 60 degrees F, cool to taste. -Whole milk, 58 degrees F, cool but not cold to taste. On 3/18/26 at 12:37 P.M., Surveyor #2 completed a mechanically altered test tray for the third-floor unit. The test tray left the kitchen at 12:28 P.M.; the last tray was served off the meal cart at 12:37 P.M. Surveyor #2 tested the tray and observed the following temperatures and palatability: -Pureed cabbage with carrots, 114 degrees, warm but not refreshing to taste. -Pureed bread, 108 degrees F, room temperature to taste. -Lemon pudding with whipped cream, 62 degrees F, slightly cool but not cold and not refreshing to taste. -Whole milk, 59 degrees F, slightly cool but not cold and not refreshing to taste. On 3/18/26 at 12:51 P.M., Surveyor #3 completed a mechanically altered test tray for the fourth-floor unit. The test tray left the kitchen at 12:38 P.M.; the last tray was served off the meal cart at 12:51 P.M. Surveyor #3 tested the tray and observed the following temperatures and palatability: -Pureed hot dog, 104 degrees F, lukewarm to taste. -Pureed baked beans, 114 degrees F, lukewarm to taste. -Pureed cabbage with carrots, 110 degrees F, lukewarm to taste with a thick, gummy texture and bland flavor. -Pureed bread, 98 degrees F, cool to taste with a gritty, lumpy texture and bland flavor. -Lemon pudding with whipped cream, 56 degrees F, slightly cool but not cold to taste. -Whole milk, 60 degrees F, slightly cool but not cold and not refreshing to taste. The results of the test trays validated residents' complaints of cold food. During an interview on 3/18/26 at 2:28 P.M., the Food Service Director (FSD) said all hot foods should be 120 degrees F or higher when served and all cold foods should be 39-45 degrees F for palatability. The FSD said she would expect hot food temperatures to be higher than what they were served, and cold food temperatures to be colder than what they were served for palatability.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interview, the facility failed to store and handle food in accordance with professional standards of practice for food service safety, potentially putting the residents at risk for foodborne illness. Specifically, the facility failed to: Ensure that beverages and nutritional supplements were dated in three out three nourishment kitchens.Ensure staff did not handle ready-to-eat food with bare hands or contaminated gloves. Findings include:1. Review of the facility policy titled Food Safety, dated April 2023, indicated but was not limited to the following:-The facility must store, prepare, distribute, and serve food in accordance with professional standards for food service safety.-Although almost any food can be contaminated, certain foods are considered more hazardous than others and are called Potentially Hazardous Foods (PHF) or Time/Temperature Controlled for Safety (TCS) food. Examples of PHF/TCS foods include ground beef, poultry, chicken, seafood (fish or shellfish), cut melon, unpasteurized eggs, milk, yogurt, and cottage cheese.-Food is labeled with the date received if not already indicated on the item.-Leftovers are dated properly and discarded after 72 hours unless otherwise indicated. During an observation on 3/17/26 at 9:18 A.M., the fourth-floor nourishment kitchen refrigerator contained the following:-A 32-ounce carton of honey-thick milk, opened and dated 3/10/26, with the manufacturer label indicating to use within four days of opening.-Two 32-ounce cartons of half-and-half creamer, opened but undated, with the manufacturer label indicating to use within seven days of opening.-A 32-ounce carton of a nutritionally fortified supplemental drink, opened but undated, with the manufacturer label indicating to use within four days of opening.-A 32-ounce carton of lactose-free milk, opened but undated, with the manufacturer label indicating to use within 14 days of opening.-A 64-ounce carton of almond milk, opened but undated, with the manufacturer label indicating to use within 7-10 days of opening. During an observation on 3/17/26 at 2:05 P.M., the third-floor nourishment kitchen refrigerator contained the following:-A 32-ounce carton of honey-thick milk, opened and dated 3/10/26, with the manufacturer label indicating to use within four days of opening.-A 32-ounce carton of half-and-half creamer, opened but undated, with the manufacturer label indicating to use within seven days of opening. During an observation on 3/17/26 at 2:15 P.M., the second-floor nourishment kitchen refrigerator contained the following:-A 32-ounce carton of lactose-free milk, opened but undated, with the manufacturer label indicating to use within 14 days of opening. During an interview on 3/18/26 at 2:07 P.M., the Food Service Director (FSD) said all food and beverage items should be labeled with a received date and opened date, and all opened food and beverage items should be discarded after three days due to the risk of foodborne illness. The FSD said dietary staff check the nourishment kitchens daily for proper labeling and dating; additionally, she checks the nourishment kitchens at least weekly for proper labeling and dating. The FSD said the nursing department is responsible for labeling and dating oral nutrition supplements, thickened milk, applesauce, and any resident-provided foods, and the dietary department is responsible for labeling and dating all other food and beverage items. During an interview on 3/19/26 at 7:18 A.M., the Director of Nursing (DON) said most food and beverage items are labeled and dated by the kitchen, but if any items are unopened and undated, nursing is responsible for dating the item. The DON said the overnight nursing shift is typically responsible for discarding any opened food or beverage items that exceed the three-day policy due to risk of foodborne illness. 2. Review of the facility policy titled Food from Outside Sources, dated June 2024, indicated but was not limited to the following:-General guidelines on keeping food safe for residents: gloves should be worn when handling any ready-to-eat foods. Review of the facility policy titled Food Safety, dated April 2023, indicated but was not limited to the following:-Foods are prepared and served with clean tongs, scoops, forks, spoons, spatulas, or other suitable implements so as to avoid manual contact with prepared foods.-Tongs must be used when serving rolls, pickles, etc., cakes and pies must be placed on a plate with a spatula. Review of the facility policy titled Safe (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Food Handling, dated October 2019, indicated but was not limited to the following:-The facility must store, prepare, distribute and serve food in accordance with professional standards for food service safety.-Associates shall wash their hands in accordance with the Hand Hygiene Policy and current Food Code Guidelines before handling or consuming food including with clean equipment and utensils, and:>After using the bathroom and touching bare human body parts.>After engaging in any other activities that contaminate the hands.-Local, state and federal guidelines are followed when handling food. On 3/18/26 at 8:13 A.M., the surveyor observed the breakfast service in the fourth floor dining room and made the following observations:-At 8:40 A.M., Certified Nursing Assistant (CNA) #1 brought a resident his/her breakfast tray which consisted of hard-boiled eggs in-shell. CNA #1 proceeded to hold the eggs with her bare hands, deshell them, and put them back on the resident's plate for consumption.-At 8:41 A.M., Nurse #3 approached a resident, picked up- an English muffin off his/her plate with her bare hands, split open the English muffin, and used a knife to spread butter on both sides of the English muffin, touching both sides of the English muffin with her bare hands, then returning the English muffin to the resident's plate for consumption.-At 8:46 A.M., Nurse #3 approached another resident, picked up an English muffin off his/her plate with her bare hands, split open the English muffin, and used a knife to spread butter on both sides of the English muffin, touching both sides of the English muffin with her bare hands, then returning the English muffin back to the resident's plate for consumption. During an interview on 3/18/26 at 9:02 A.M., Nurse #3 said it is an acceptable practice to handle ready-to-eat foods, such as English muffins, with bare hands if they are sanitized and the staff member has the residents' permission. During an interview on 3/18/26 at 9:06 A.M., CNA #1 said it is an acceptable practice to handle ready-to-eat foods with bare hands if they are sanitized. CNA #1 said she does not wear gloves when handling hard-boiled eggs because they are hard to de-shell. During an interview on 3/19/26 at 7:18 A.M., the Director of Nursing (DON) said staff are expected to wear gloves when handling ready-to-eat foods, such as hard-boiled eggs and English muffins. The DON said there should be no bare hand contact when handling resident food due to the risk of foodborne illness. On 3/18/26 at 11:54 A.M., the surveyor observed the lunch line in the main kitchen and made the following observations:-At 12:00 P.M., the cook touched the handle of the dish cart with his left gloved hand, potentially contaminating his left glove, and started assembling a resident's meal plate. The cook wiped the front of his shirt with his right gloved hand, potentially contaminating his right glove, and then used his right gloved hand to remove excess puree on the resident's plate. With the same potentially contaminated gloves, the cook handled a hot dog roll with both hands, grabbed a hot dog from the steamtable with tongs to initially place in the roll, and then used his right hand to push the hot dog inside the roll. -At 12:02 P.M., without changing his gloves, the cook wiped his face with his right gloved hand and removed excess liquid from baked beans off a resident's meal plate with the same hand; he proceeded to handle a hot dog roll with both hands, placed a hot dog inside the roll with tongs, and touched his face again.-At 12:04 P.M., without changing his gloves, the cook opened the oven doors by the handles, retrieved a baked potato from the oven with tongs, and closed the oven doors by the handles; with the same potentially contaminated gloves, the cook used both hands to split open the potato on the resident's plate for service. During an interview on 3/18/26 at 12:22 P.M., the cook said he should change gloves when they are contaminated, such as when touching his face, his shirt, and oven door handles; he said he should have changed his gloves multiple times during lunch service and did not. The cook said the risk of handling food with potentially contaminated gloves is foodborne illness. During an interview on 3/18/26 at 2:28 P.M., the Food Service Director (FSD) said dietary staff should not be touching any food directly without utensils, and should be changing their gloves after touching their face, clothing, and oven door handles. The FSD said the cook should have used a utensil or changed gloves when potentially contaminated.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on interviews and record reviews, the facility failed to identify and implement nutritional interventions for one Resident (#124) with a significant weight loss out of a total sample of 25 residents. Findings include:Review of the facility policy titled, Weight Monitoring, long-term care, dated 9/2025, indicated the following:-Unplanned weight loss in residents is associated with increased mortality; a decrease in weight of 5% or more in a month or of more than 10% in 6 months should be reported to the practitioner for further evaluation. Resident #124 was admitted to the facility in December 2025 with diagnoses including stroke, diabetes and kidney disease. Review of Resident #124's most recent Minimum Data Set (MDS) assessment, dated 1/29/26, indicated the Resident scored a 15 out of a possible 15 on the Brief Interview for Mental Status exam, which indicated he/she had intact cognition. The MDS also indicated Resident #124 required assistance from staff for activities of daily living. On 12/29/25, Resident #124 weighed 188.9 lbs.(pounds) and on 1/26/26, Resident #124 weighed 178.9 lbs., which is a 5.29% significant weight loss in one month. Review of Resident #124's most current weight, taken on 3/18/26, indicated he/she weighs 174.7 lbs., a further loss of 4 pounds. Review of Resident #124's physician orders indicated the following nutritional order:-Consistent Carbohydrate (CCHO) diet Regular texture, thin consistency.-The orders failed to indicate Resident #124 was prescribed any nutritional supplements. Review of Resident #124's nutritional care plan, dated 12/29/25, indicated the following:-Focus: (the Resident) has potential nutritional problem r/t (related to) at risk for malnutrition, receiving a therapeutic diet.-Goal: (the Resident) will maintain weight free from unintentional changes >=5%, show no s/s (signs or symptoms) of malnutrition, tolerate current texture and consume >=50% at most meals upon next follow up. -Interventions: RD (Registered Dietitian) to evaluate and make diet change recommendations PRN (as needed) and provide and serve diet as ordered. Offer alternatives if PO<50% (oral intake is less than 50%). Review of Resident #124's admission Nutritional Assessment, dated 12/30/25, indicated the Resident was stable nutritionally at admission, however, the Dietitian would Continue to monitor and provide support as needed quarterly. Review of Resident #124's medical record indicated the following weight change note:- WEIGHT WARNING: Value: 174.0 (pounds) Vital Date: 2026-03-05 18:15:00.0 (obtained on 3.5.26 at 3:00 P.M.) -7.5% change (7.9% , 14.9). Action: Reports good appetite. No N/V/D/C (nausea/vomiting/diarrhea/constipation) or edema at this time. Shared that (he/she) does not always finish her meals d/t (due to) food preferences. Alternative choices and always menu reviewed. Personal menu updated accordingly. Response: (left blank). The medical record failed to indicate a new nutritional intervention was implemented after documentation the Registered Dietitian was aware of the significant loss. Review of the Nutritional Assessment, dated 3/11/26, was not complete with no fields filled out. During an interview on 3/18/26 at 8:13 A.M., the RD said she works at the facility full time and runs the weight report weekly to identify any significant weight change. The RD said the electronic medical record program also sends her alerts if a resident were to have a significant weight change. The RD said a significant weight change is 5% change in one month, 7.5% change in 60 days or 10% change in 6 months. The RD said if a resident in the facility has had a significant weight loss, the resident should be assessed within a week and interventions added as soon as possible. The RD said some interventions would include assessing food preferences and meal intake, and if both of those are good, the interventions would be nutritional supplements such as double portions, nutritional juice, nutritional shakes, or ice cream. The RD said she completes nutritional assessments on admission and then again quarterly and annually. The RD said Resident #124's last assessment, dated 3/11/26, was not complete and that was an error on her part. The RD said that Resident #124 can be selective with foods but has been educated regarding optional meals and has a good appetite. The RD reviewed Resident #124's medical record and weights with the surveyor and confirmed the Resident had a significant weight loss in January and has continued to lose weight. The RD reviewed the Resident's meal intake and said that Resident #124 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	has been eating well. The RD said she had not implemented a nutritional supplement for Resident #124 but a supplement would have been beneficial, especially since the Resident's meal intake and appetite have been good. During an interview on 3/18/26 at 8:52 A.M., Resident #124 said he/she would accept a nutritional supplement and that a supplement had not been offered.During an interview on 3/18/26 at 8:53 A.M., Nurse #1 said nurses are responsible for identifying weight loss when documenting weights and report this to the Dietitian. Nurse #1 said she was unaware of Resident #124's significant weight loss. Nurse #1 said Resident #124 has a lot of food in his/her room that has been brought in by his/her family and typically eats very well. During an interview on 3/18/26 at 9:46 A.M., the Director of Nursing said the Dietitian and nursing staff are both responsible for monitoring weights in the building, but it is the primary responsibility of the Dietitian. The Director of Nursing said if a significant weight loss were to be identified, the facility would obtain a reweight as soon as possible and would refer the resident with the weight loss to the Dietitian for assessment. The Director of Nursing said she would expect the Dietitian to implement an intervention within two weeks of the weight loss and waiting over a month to implement an intervention is too long. The Director of Nursing said she would have expected a supplement to be trialed for Resident #124 since her oral intake is high and it does not seem to be an appetite issue.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interviews, and record review, the facility failed to ensure that services were provided in accordance with professional standards of practice for one Resident (#147) with a gastrostomy tube (g-tube: a tube that is placed directly into the stomach through an abdominal incision for administration of nutrition) out of a total sample of 25 residents. Specifically, the facility failed to ensure nursing changed the water flush bag (a bag containing water that is connected to and delivers water for hydration through a gastrostomy tube), syringe, and enteral feed pump tubing every 24 hours as necessary to prevent infection and maintain the integrity of the feeding system. Findings include: Review of the facility policy titled Enteral Nutrition Therapy (Continuous), dated September 2024, indicated the following: -Proximal spike sets should be replaced once every 24 hours unless otherwise ordered. Resident #147 was admitted to the facility in March 2026 with diagnoses including dysphagia (difficulty swallowing), malignant neoplasm (a cancerous tumor that spreads) of skin of scalp and neck, and unspecified protein-calorie malnutrition. Review of Resident #147's rehab admission assessment, dated 3/10/26, indicated the Resident was cognitively intact as evidenced by a Brief Interview for Mental Status exam score of 13 out of a possible 15. Review of Resident #147's nursing admission assessment, dated 3/9/26, indicated the Resident is NPO (nothing by mouth), dependent on enteral nutrition, and requires assistance with activities of daily living. Review of Resident #147's Medication Administration Record indicated the following: -Enteral Feed Order: Jevity 1.5 at 90 mL/hr (milliliters per hour) x18 hours via pump. Flush with 100 mL purified water every 6 hours, up at 12 noon down at 6 A.M., start date 3/9/26. On 3/17/26 at 10:09 A.M., the surveyor observed Resident #147 awake and lying in bed. Next to the Resident was a pole consisting of a tube feeding pump, tube feeding formula in a bottle, and a water bag. A syringe was located on the Resident's overbed table. The tube feeding pump was off. The water flush bag was undated, and both the enteral feed pump tubing and syringe were dated 3/14/26, or three days prior to this observation. During an interview on 3/17/26 at 10:39 A.M., Nurse #2 said the date on the enteral feed pump tubing also applies to the water bag. Nurse #2 said Resident #147's enteral pump feed tubing, water bag, and syringe should have been changed daily. During an interview on 3/19/26 at 9:55 A.M., the Director of Nursing said enteral feed pump tubing should be changed every 24 hours and she would have expected Resident #147's enteral feed supplies to be changed daily.