STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225564	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Attleboro	969 Park Street Attleboro, MA 02703

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 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. Based on interview and record review, the facility failed to ensure residents were provided care in accordance with professional standards of practice for three Residents (#7, #32, and #104), out of a total sample of 24 residents.Specifically, the facility failed:1. For Resident #7, to ensure Metoprolol Tartrate (a medication used to lower blood pressure and/or heart rate) was not administered when the Resident's systolic blood pressure (SBP) was below 110 millimeters of mercury (mmHg) or the Resident's heart rate (HR) was below 65 beats per minute as instructed in the physician's order; and 2. For Residents #32 and #104, to ensure that the nurse observed the Residents taking the medications and not leave the medications at the Residents' bedside. Findings include:Review of the facility's policy titled Administration of Medications, reviewed 9/9/25, indicated, but was not limited to, the following:-The facility will ensure medications are administered safely and appropriately per physician order to address residents' diagnoses and signs and symptoms.-Medication error – This means the observed or identified preparation or administration of medications or biologicals which is not in accordance with:1. The prescriber's order2. Manufacturer's specifications regarding the preparation and administration of the medication or biological; or3. Accepted professional standards and principles which apply to professionals providing services.-Staff who are responsible for medications administration will adhere to the 10 Rights of Medication Administration*Right Assessment. Note the resident's history and any parameters around drug administration. Review of the facility's policy titled Physician Orders, reviewed 2/27/25, indicated, but was not limited to, the following: -The facility is obligated to follow and carry out the orders of the prescriber in accordance with all applicable state and federal guidelines. Standard of Practice Reference: Pursuant to Massachusetts General Law (M.G.L.), chapter 112, individuals are given the designation of registered nurse and practical nurse which includes the responsibility to provide nursing care. Pursuant to the Code of Massachusetts Regulation (CMR) 244, Rules and Regulations 3.02 and 3.04 define the responsibilities and functions of a Registered nurse and Practical nurse respectively. The regulations stipulate that both the registered nurse and practical nurse bear full responsibility for systematically assessing health status and recording the related health data. They also stipulate that both the registered nurse and practical nurse incorporate into the plan of care, and implement prescribed medical regimens. A nurse licensed by the Board shall not administer any prescription drug or non-prescription drug to any person in the course of nursing practice except as directed by an authorized prescriber. A nurse licensed by the Board shall document the handling, administration, and destruction of controlled substances in accordance with all federal and state laws and regulations and in a manner consistent with accepted standards of practice. Resident #7 was admitted to the facility in April 2025 with diagnoses including atrial fibrillation, heart failure, and end stage renal disease on renal dialysis. Review of Resident #7's Minimum Data Set (MDS) assessment, dated 8/5/25, indicated he/she was (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. Review of Resident #7's Physician's Orders indicated, but was not limited to, the following:-Metoprolol Tartrate Tablet Give 12.5 milligram (mg) by mouth two times a day for atrial fibrillation **Hold for SBP less than 110 or HR less than 65** (order date 8/1/25) Review of Resident #7's Medication Administration Record (MAR) for the month of August 2025 indicated, but was not limited to, the following:- Metoprolol Tartrate was administered 17 times when the Resident's SBP was less than 110 mmHg or HR was less than 65 as documented on the MAR Review of Resident #7's MAR for the month of September 2025 indicated, but was not limited to, the following:- Metoprolol Tartrate was administered 7 times when the Resident's SBP was less than 110 mmHg or HR was less than 65 as documented on the MAR Further review of Resident #7's medical record failed to indicate nursing documentation related to the reason for medication administration or that the physician was contacted and ordered the medication to be given when the Resident's vital signs were noted to be outside of the order's parameters. During an interview on 9/22/25 at 2:19 P.M., Nurse #1 reviewed Resident #7's August 2025 MAR with the surveyor, who identified the dates which indicated the Resident's vital signs were outside of the physician's ordered parameters for Metoprolol. Nurse #1 confirmed the MAR indicated the medication had been administered despite the Resident's vital signs being documented outside of the parameters ordered. Nurse #1 said when the Resident's vital signs were out of parameters ordered, the medication should have been held and not administered. During an interview on 9/22/25 at 3:50 P.M., the Director of Nursing said she had reviewed the Resident's MAR and noticed the medication was administered numerous times when the Resident's vital signs were outside of the ordered parameters. The Director of Nursing said it was her expectation that the physician's orders would be followed when nurses administer medications. 2. During an observation with interview on 9/17/25 at 9:09 A.M., the surveyor entered the room of Resident #104 and observed a plastic medication cup with a large, pink tablet inside it on the Resident's bedside table. The Resident said that he/she thought the medication was for his/her stomach. The Resident said that Nurse #3 left the medication at the bedside for him/her to take on their own. Resident #104 said that often, Nurse #3 would leave medication at the bedside and leave the room before he/she took them. During an observation with interview on 9/17/25 at 9:50 A.M., the surveyor entered Resident #32's room and observed a medication cup containing applesauce and a crushed white substance which the Resident was spooning it into his/her mouth. Resident #32 said that Nurse #3 had placed the medication at the bedside, instructed him/her to take it, and left the room before he/she took the medication. The Resident said the medication crushed and mixed in the applesauce was Tylenol. During an interview on 9/17/25 at 10:00 A.M., Nurse #3 said that he left medications at the bedsides of Residents #32 and #104. Nurse #3 said that he left a Tums at Resident #104's bedside and did not wait until the Resident took it before leaving the Resident. Nurse #3 said that he left Tylenol crushed in applesauce at Resident #32's bedside and did not wait with the Resident to ensure that he/she took all the medication. Nurse #3 said that he knows he is supposed to stay with residents and observe that they take all the prescribed medication before leaving them. He said that's the facility (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	policy and he didn't follow it. During an interview on 9/18/25 at 10:06 A.M., the surveyor informed the DON of their observations of Nurse #3's failure to observe Residents #32 and #104 consume their prescribed medications before leaving the Resident as per standards of practice for medication administration. The DON said that Nurse #3 failed to follow the facility policy for medication administration. She said that it is not safe or appropriate to leave medications at a resident's bedside. She said the nurse is responsible for staying with the resident until the resident is finished taking all the prescribed medication. The DON said that it is a safety concern if the nurse fails to ensure that a resident takes all the medication as ordered by the physician.