STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225655	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Raynham	546 South Street East Raynham, MA 02767

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 46562 Based on interview and record review, the facility failed to develop and implement an individualized, person-centered care plan to meet the physical, psychosocial, and functional needs for one Resident (#73), out of 29 sampled residents. Specifically, the facility failed to ensure a comprehensive care plan was developed for the use of an anticoagulant medication. Findings include: Review of the facility's policy titled Comprehensive Care Plans and Revisions, dated as revised 9/11/24, indicated but was not limited to: -the facility will ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that all comprehensive care plans are reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs Resident #73 was admitted to the facility in November 2020 with diagnoses which included a history of venous thrombosis and embolism (blood clot). Review of the Minimum Data Set (MDS) assessment, dated 10/9/24, indicated Resident #73 had received an anticoagulant medication. Review of Resident #73's Physician's Orders indicated but was not limited to: -Apixaban (anticoagulant) 2.5 milligrams (mg) two times a day, dated 5/9/24 Review of the November 2024, December 2024, and January 2025 Medication Administration Records (MAR) indicated he/she had received Apixaban as ordered. Review of Resident #73's care plan failed to indicate a care plan for the use of anticoagulant medication had been developed. During an interview on 1/7/25 at 12:15 P.M., Nurse #2 said residents on high-risk medications including an anticoagulant should have a care plan for it. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/7/25 at 12:42 P.M., Unit Manager #2 said Resident #73 was on an anticoagulant. Unit Manager #2 reviewed Resident #73's medical record and said there was no care plan for the anticoagulant medication but there should have been. During an interview on 1/7/25 at 1:50 P.M., the Director of Nurses (DON) said any resident on an anticoagulant should have a care plan for the use of the anticoagulant.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49428 Based on observation, interview, and record review, the facility failed to meet professional standards of practice for two Residents (#5 and #35), out of a sample of 29 residents. Specifically, the facility failed: 1. For Resident #5, to ensure a physician's order was in place for the use of compression stockings for bilateral lower extremity edema, swelling caused due to excess fluid accumulation in the body tissues; and 2. For Resident #35, to ensure a physician's order was in place for the use of an air mattress for pain. Findings include: Review of [NAME], Manual of Nursing Practice 11th edition, dated 2019, indicated the following: -The professional nurse's scope of practice is defined and outlined by the State Board of Nursing that governs practice. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling on Nursing Practice dated as revised April 11, 2018, indicated but was not limited to: Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers that are received by a variety of methods (i.e., written, verbal/telephone, standing orders/protocols, pre-printed order sets, electronic) in emergent and non-emergent situations. Licensed nurses in a management role must ensure an infrastructure is in place, consistent with current standards of care, to minimize error. 1. Resident #5 was admitted to the facility in December 2022 with diagnoses which included chronic diastolic heart failure, a cardiovascular condition that can cause swelling in the feet, ankles, or legs. Review of Resident #5's Minimum Data Set (MDS) assessment, dated 12/2/24, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the Resident was cognitively intact. During an observation with an interview on 1/7/25 at 9:30 A.M., the surveyor observed Resident #5 wearing white compression stockings that covered both legs. Resident #5 said he/she wears the leg stockings due to leg edema. Resident #5 said he/she wears the stockings during the day and they are removed at night. Review of Resident #5's active care plan indicated but was not limited to the following: -Resident is at increased risk for break in skin integrity due to decreased mobility, bilateral lower extremity edema, and incontinence; revised 11/21/23. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additionally, review of Resident #5's care plan failed to indicate a care plan for the use of compression stockings. Review of Resident #5's Physician's Orders failed to indicate an order for compression stockings. During an interview on 1/7/25 at 10:30 A.M., Nurse #1 said Resident #5 wears compression stockings daily due to edema. Nurse #1 reviewed the Resident's current physician's orders and could not find a treatment order to apply compression stockings to the Resident's legs. Nurse #1 said there should be a physician's order and a care plan for Resident #5's compression stockings. During an interview on 1/7/25 at 10:40 A.M., the Director of Nursing (DON) said if a resident is wearing compression stockings on a daily basis as a treatment, there should be a physician's order for the stockings and the use of the compression stockings should be included in the resident's care plan. The DON said Resident #5 should have a physician's order and care plan pertaining to the use of compression stockings for the Resident's bilateral lower extremity edema. 2. Resident #35 was admitted to the facility in April 2023 with diagnoses which included spinal stenosis, restless leg syndrome, and pain in both shoulders. Review of Resident #35's MDS assessment, dated 10/29/24, indicated but was not limited to the following: -no unhealed pressure ulcers; -no venous and arterial ulcers; -no other ulcers, wounds, and skin problems; -skin and Ulcer treatments included a pressure reducing device for bed; -the Resident had been on a scheduled pain medication regimen; -a pain assessment interview was conducted and the Resident reported frequent pain that frequently affected sleep and a pain intensity rating of 8 (on a 00 to 10 rating scale, with 10 being the highest level). -weight of 150 pounds; -a BIMS score of 15 out of 15, indicating the Resident was cognitively intact. On 1/2/25 at 10:15 A.M., the surveyor observed Resident #35's air mattress set to 250 pounds, normal pressure. During an interview on 1/6/25 at 10:10 A.M., the surveyor observed Resident #35 sitting in a chair near the foot of his/her bed. Resident #35 said he/she has an air mattress for pain. The Resident said staff manages the air mattress setting and the Resident was unsure of what the setting should be. The surveyor observed the air mattress setting to be around 240 pounds, normal pressure. The Resident said the air mattress was okay but he/she preferred it to be firmer. (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 #35's active care plan indicated but was not limited to the following: -At risk for break in skin integrity related to decreased mobility, incontinence and polyneuropathy; -Pressure reducing mattress; -Resident #35 expresses right hip/sciatica pain due to spinal stenosis and decreased mobility; -Educate Resident and family regarding pain management; -Evaluate the effectiveness of pain interventions; -Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain; -Observe and report to nurse Resident complaints of pain or requests for pain treatment; -Pain medications as ordered. Review of Resident #35's current Physician's Orders failed to indicate orders for an air mattress. During an interview on 1/6/25 at 4:30 P.M., Nurse #7 said Resident #35's skin was intact and the Resident used an air mattress to help with pain. Nurse #7 could not find a physician's order for an air mattress. During an interview on 1/6/25 at 4:35 P.M., Unit Manager #3 said if Resident #35 used an air mattress for pain, there should be an order and a care plan to reflect that. During an interview on 1/7/25 at 1:50 P.M., the DON said if Resident #35 has an air mattress as a treatment for pain, there should be a physician's order and the air mattress should be included in the Resident's care plan for pain.

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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. 46562 Based on observations, interviews, and records reviewed, for one Resident (#14), out of five residents with pressure ulcers investigated and 29 total sampled residents, the facility failed to ensure Resident #14 received necessary treatment and services, consistent with professional standards of practice to promote healing and prevent infection. Specifically, the facility failed to ensure the pressure ulcer was assessed by the Wound team as soon as it was identified, resulting in a delay in treatment, and to conduct daily assessments of the Resident's wound to monitor changes in the wound status between 5/21/24 and 5/30/24. Findings include: Review of the facility's policy titled Documentation and Assessment of Wounds, dated as revised 8/23/21, indicated but was not limited to: -A wound assessment/documentation is required to occur at a minimum 'weekly'. Nurses performing the treatment would perform an as needed assessment/documentation if noted change has occurred i.e., wound has healed/resolved, appears infected, or appears to have declined. Review of the facility's policy titled Skin Integrity and Pressure Ulcer/Injury Prevention and Management, dated as revised 7/9/24, indicated but was not limited to: -a skin assessment/inspection should be performed weekly by a licensed nurse. Any changes or open areas are reported to the Nurse. Nurse will complete further inspection/assessment and provide treatment if needed. -measures to maintain and improve the residents' tissue tolerance to pressure are implemented in the plan of care -when skin breakdown occurs, it requires attention and a change in the plan of care may be indicated to treat the resident Review of the facility's policy titled Incident and Reportable Event Management, dated as revised 8/15/23, indicated but was not limited to: -Event Management includes but is not limited to, the following types of events: Pressure Ulcer/Injury (in house acquired) greater than stage 1 -To help reduce the risk of an event, all residents receive assistance and supervision as addressed in their care plan. If an event occurs, the facility will follow the 5 I's in an effort to minimize the potential for recurrence. 1. Incident (what happened or was reported as happening) 2. Injury (provide care and document the injury) (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Interview (who saw the resident last or at the time of the event) 4. Investigate (why did it happen) 5. Intervention (what mitigation effort are we using) Resident #14 was admitted to the facility in November 2022 with diagnoses which included dementia and paraplegia (paralysis of the legs and lower body). Review of the Minimum Data Set (MDS) assessment, dated 12/4/24, indicated Resident #14 had a facility acquired pressure ulcer (localized damage to the skin and/or underlying soft tissue usually over a bony prominence). Review of Resident #14's care plans indicated he/she had a pressure ulcer to coccyx (base of the spine, near the top of the buttocks), initiated on 5/30/24. Review of Resident #14's Weekly Skin Integrity Data Collection Tool, dated 5/15/24, indicated his/her skin was intact. Review of Resident #14's Progress Note, dated 5/21/24, completed by Nurse #3, indicated an open area was noted on his/her coccyx and measured approximately 1.05 centimeters (cm) x 1.01 cm with no drainage. Further review of the progress note indicated there was a new order for normal saline wash followed by triad (a zinc-oxide based sterile coating designed to manage low to moderate levels of drainage, while promoting a moist wound healing environment) to the area. During a telephonic interview on 1/7/25 at 1:17 P.M., Nurse #3 said when a wound is discovered a risk assessment should be initiated, the provider should be notified and new orders should be obtained. Nurse #3 said the facility wound team should be notified when a wound is identified and the wound should be assessed by the wound team as soon as possible. Nurse #3 said Resident #14 had a wound on his/her coccyx but did not recall if she was the one who discovered it or not. Review of Resident #14's Weekly Skin Integrity Data Collection (his/her weekly skin inspection), dated 5/22/24, completed by Nurse #4, failed to indicate any alterations in his/her skin integrity. During a telephonic interview on 1/7/25 at 2:19 P.M., Nurse #4 said a weekly head to toe assessment was completed weekly and any skin abnormalities should be documented. Nurse #4 said the facility wound team should be notified of any new findings. Nurse #4 said when skin status changed, the provider should be made aware and if a wound was not improving it should be documented. Nurse #4 said she did not remember Resident #14's skin status in May 2024. During an interview on 1/7/25 at 3:52 P.M., the Director of Nurses (DON) said when impaired skin integrity is noted the wound should be observed by the wound team as soon as possible and then weekly, on Tuesdays, during wound rounds. Review of the medical record failed to indicate the Wound team assessed Resident #14's new open area on his/her coccyx identified on 5/21/24 prior to or during wound rounds on Tuesday (5/28/24). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #14's Weekly Skin Integrity Data collection, dated 5/29/24, completed by Nurse #5, failed to indicate any alterations in his/her skin integrity. During a telephonic interview on 1/7/25 at 2:23 P.M., Nurse #5 said weekly head to toe assessments were completed and if impaired skin was observed the wound team should be notified. Nurse #5 said she did not recall Resident #14's skin status in May 2024. Review of Resident #14's Skin/Wound Note, dated 5/30/24, completed by Nurse #8, indicated during care the Resident was noted to have a wound over his/her coccyx with no drainage. The surrounding skin was reddened with irritation and the wound bed was tacky with dark discoloration. The Resident denied pain or discomfort, the provider was made aware and new orders were obtained. Review of the Wound Observation Tool, dated 5/30/24, completed by the Assistant Director of Nurses (ADON)/Wound Champion, indicated but was not limited to: -Location: Coccyx -Type: Pressure -Stage: Unstageable -Specify: Slough (non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture)/Eschar (dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like) -Visible Tissue: Overall Impression: first observation, no reference -Visible Tissue: Slough tissue present (yellow, tan, white, stringy) in 50% of the wound bed -Drainage: Small amount of serous (watery, clear, or slightly yellow/tan/pink fluid that has separated from the blood and presents as drainage) drainage -Wound measurements: length 2.5 cm, width 3 cm, depth 0.1 cm -Additional comments: patient noted with open wound to coccyx, wound bed contains slough to center, edges slightly rolled and with minor maceration (the softening of tissue by soaking. Macerated skin has a white appearance and a very soft, sometimes soggy texture) -Treatment Plan: Santyl and Silvercel (a nonadherent dressing used to help manage wound fluid and protect from infection) Review of Resident #14's May 2024 Treatment Administration Record (TAR) indicated but was not limited to: -Triad to coccyx every shift, dated 3/13/24 -Normal saline wash to coccyx followed by triad daily in the evening, initiated 5/21/24 and discontinued 5/30/24 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Treatment to coccyx: Normal saline wash, apply Santyl ointment to base, cover with Silvercel dressing as secondary dressing (cut small piece to fit wound bed) then apply foam dressing, every evening shift, dated 5/30/24 Review of Resident #14's medical record failed to include evidence that the wound worsened between 5/21/24 and 5/29/24. During an interview on 1/7/25 at 12:42 P.M., Unit Manager #2 said Resident #14 had a facility acquired wound in his/her coccyx and was followed by the facility wound team and the wound clinic. Unit Manager #2 said when a wound was discovered the wound team should be notified and an assessment should be completed. Unit Manager #2 and the surveyor reviewed the medical record and Unit Manager #2 said the wound was discovered on 5/21/24 and there was no further documentation of the wound status until 5/30/24. During an interview on 1/7/25 at 12:53 P.M., the ADON/ Wound Champion said Resident #14 had a facility acquired wound on his/her coccyx. The Wound Champion said she was notified of the wound on 5/30/24 and completed both the risk assessment and wound observation tool on that date. The Wound Champion and the surveyor reviewed the medical record, and the Wound Champion said she was not aware that the wound was first identified on 5/21/24 and no risk assessment or wound observation tool had been initiated at that time. The Wound Champion said the expectation was for the wound team to see a new wound as soon as possible. Review of the Hospital Discharge Summary, dated 6/23/24, indicated but was not limited to: -He/she was sent to the hospital for concern of worsening infection due to abnormal labs and admitted due to an infected sacral ulcer -CT scan of the abdomen and pelvic showed a sacral decubitus with associated gas, without concern for osteomyelitis or abscess formation. -He/she was started on multiple antibiotics and an infectious disease consult was initiated -He/she required surgical intervention for debridement, and he/she underwent I&D for debridement on 6/19/24 which resulted in copious amounts of dark purulent fluid draining from his/her necrotic ulcer. -Wound measurements, post debridement, were 7 cm, x 3.5 cm x 2.5 cm with undermining all around with 2 cm at 2 o'clock, wound bed was 75% yellow/necrotic tissue an 25% red/moist, mild odor, moderate yellow serosanguinous (type of wound discharge that consists of a mix of clear and blood-tinged fluid. It is common after surgery or during wound healing, and may appear as a thin, pale red or pink fluid) drainage.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 15214 Based on observation, record review, and staff interview, the facility failed to ensure that appropriate care and services were implemented to prevent the development of urinary tract infections (UTI) for one Resident (#58), of a total sample of 29 residents. Findings include: Review of the facility's policy titled Indwelling Urinary Catheter (Foley) Management issued 4/1/22 and Reviewed 9/10/24, indicated but was not limited to the following: Policy: The facility will ensure that residents admitted with a urinary catheter, or determined to need a urinary catheter for a medical indication will have the following areas addressed; -Insertion, ongoing care and catheter removal protocols that adhere to professional standards of practice and infection prevention and control procedures. General Urinary Catheter Maintenance Guidelines 2. -Maintain unobstructed urine flow b. Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor. Resident #58 was admitted in September 2024 with diagnoses which included a history of UTIs and a chronic urinary catheter. Record review indicated that the Resident had been started on Augmentin (antibiotic), every 12 hours x 7 days for a urinary tract infection (UTI) on 1/3/25. The Resident had a past medical history of UTIs. On 1/3/25 at 8:34 A.M., the surveyor observed Resident #58 lying in bed with her/his eyes closed. The Resident's continuous drainage bag from the Foley catheter was observed to be attached to the bed frame and resting directly on the floor without being placed in a privacy bag. During an interview on 1/7/25 at 11:17 A.M., Unit Manager (UM) #2 said that the Resident's continuous drainage bag from the urinary catheter should not be resting on the floor and should always be contained in a privacy bag. UM #2 said that there is a risk for contamination and the policy is to make sure the catheter bag is always positioned so it does not touch the floor to reduce the risk of infection. During an interview on 1/7/25 at 3:48 P.M., the Director of Nurses said that the Resident's catheter bag should not have been resting on the floor.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 46562 Based on interview and record review, the facility failed to act upon recommendations made by the Consultant Pharmacist during the monthly Medication Regimen Reviews (MRR) for one Resident (#14), out of a total sample of 29 residents. Specifically, the facility failed to act on the Consultant Pharmacist's recommendation to consider an antidepressant medication dose reduction. Findings include: Review of the facility's policy titled Medication Regimen Review, dated as revised 8/17/23, indicated but was not limited to: -Facility should encourage Physician/Prescriber or other Responsible Parties receiving MRR and the Director of Nursing to act upon the recommendations contained in the MRR -For those issues that require Physician/Prescriber intervention, facility should encourage Physician/Prescriber to either accept and act upon the recommendations contained within the MRR and provide an explanation as to why the recommendation was rejected -The attending physician should document in the residents' health record that the identified irregularity has been reviewed and what, if any, action has been taken to address it -If the attending physician has decided to make no changes in the medication, the attending physician should document the rationale in the residents' health record -The attending physician should address the consultant pharmacist's recommendation no later than their next scheduled visit to the facility to assess the resident either 30 or 60 days per applicable regulation Resident #14 was admitted to the facility in November 2022 with diagnoses which included dementia and depression. Review of Resident #14's medical record indicated he/she was seen by the Consultant Pharmacist in August 2024 and recommendations were made. The surveyor was unable to locate the August 2024 Consultant Pharmacist's recommendation in Resident #14's record. After inquiry, the facility provided Resident #14's August 2024 Consultant Pharmacist's Consultation Report. The document indicated but was not limited to: -Resident #14 was receiving two antidepressants for depression, Trazodone (antidepressant) 150 milligrams (mg) every hour of sleep and Venlafaxine Hydrochloride (antidepressant) 75 mg daily and they were due for a dose reduction (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The pharmacist recommended the physician consider reducing Trazodone to 125 mg every hour of sleep or Venlafaxine to 50 mg daily -The physician response section was blank Further review of the September through December 2024 MRRs failed to indicate the pharmacist followed up and readdressed the GDR recommended in the August 2024 MRR. During an interview on 1/7/25 at 12:42 P.M., Unit Manager #2 said the process was for the Consultant Pharmacist's Consultation Reports to be provided to the provider for review. Unit Manager #2 said once the physician reviews the recommendation, and provides a response, any new orders are implemented. Unit Manager #2 said the complete Consultation Report forms are filed in the medical record and with the Director of Nurses (DON). During an interview on 1/7/25 at 10:31 A.M., the DON said she had reviewed Resident #14's medical record and the August 2024 Consultant Pharmacist's Consultation Report had not been addressed by the physician.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49428 Based on observation and interview, the facility failed to follow professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to: 1. Ensure food items were properly dated and stored in the main kitchen and kitchenettes; and 2. Ensure two of three ice machines were maintained in a clean and sanitary condition. Findings include: 1. Review of the 2022 Food Code by the Food and Drug Administration (FDA), revised 1/2023, indicated but was not limited to the following: 3-305.11 (A) Except as specified in paragraphs (B) and (C) of this section, food shall be protected from contamination by storing the food (1) in a clean, dry location. 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (B) Except as specified in (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the FDA Food Code 2022 Chapter 3. Food Chapter 3 - 29 PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. (D) A date marking system that meets the criteria stated in (A) and (B) of this section may include: (1) Using a method approved by the regulatory authority for refrigerated, ready-to-eat time/temperature control for safety food that is frequently rewrapped, such as lunchmeat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; (2) Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (A) of this section; (3) Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (B) of this section; or (4) Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the REGULATORY AUTHORITY upon request. 4-602.11 (D) Equipment is used for storage of packaged or unpackaged food such as a reach-in refrigerator and the equipment is cleaned at a frequency necessary to preclude accumulation of soil residues. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled Food Safety, revised 4/26/23, indicated but was not limited to: Policy: Food is stored and maintained in a clean, safe and sanitary manner following federal, state and local guidelines to minimize contamination and bacterial growth. Federal Regulation: 483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Review of the facility's policy titled Safe Food Handling, revised 4/26/23, indicated but was not limited to: Policy: All food purchased, stored, and distributed is handled with accepted food-handling practices, and per federal, state and local requirements. Procedure: -Snacks and other food items sent from the food service department will be handled safely in regard to temperature, labeling and storage. Review of the facility's Use by Date Guide, revised 3/18/20, indicated but was not limited to: -The following guide can be used to determine a use by date when labeling opened or unopened food that must be used within a certain time frame. -Please note that this information is used when there are no guidelines on the containers of food. -In some cases, {Facility} may require a shorter timeframe on a food item to reduce the number of items under refrigeration. For example, the food code indicates that leftovers may be kept up to 7 days, however, {Facility} guidelines are for 3 days (72 hours). -All opened containers of food in the dry storage area should be placed in an enclosed container, labeled, and dated with the open date and the use by date. Any unopened cans/packs should be marked with the date received. After opening, then the above guideline is followed regarding opened containers of food. On 1/2/25 at 8:10 A.M., the surveyor observed the following during the initial kitchen tour in the main kitchen: -one bag of sliced pepperoni re-packaged in a freezer bag, no date; -one bag of mozzarella cheese, opened, no date; -one bag of breadsticks, out of original box, no date; -one bag of French fries, out of original box, no date; -one container of cottage cheese about 1/4 full, no date; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-sliced cheese in plastic wrap, no date. On 1/2/25 at 11:21 A.M., the surveyor observed the following in the [NAME] Unit Kitchenette: -one bottle of vegetable juice, opened, no date; -two containers of prune juice, opened, no date; -20 nutritional shakes, thawed, no thaw date with manufacturer label stating use within 14 days of thawing. On 1/7/25 at 8:06 A.M., the surveyor observed the following in the [NAME] Kitchenette: -two containers of thickened water, opened, no date with manufacturer label stating After opening, may be kept up to 7 days under refrigeration; -two cartons of milk, opened, no date; -20 nutritional shakes, thawed, no thaw date with manufacturer label stating use within 14 days of thawing; -one carton prune juice, opened, no date. During an interview on 1/7/25 at 8:25 A.M., Dietary Staff #1 said they typically stocked and maintained the Unit Kitchenettes. Dietary Staff #1 said they were responsible for the refrigerator, freezer, cabinets, and microwave. Dietary Staff #1 and the surveyor observed the [NAME] Kitchenette together. Dietary Staff #1 said the nutritional shakes are not dated and could not confirm if any of the nutritional shakes in the Unit refrigerator were past the use within 14 days of thawing per manufacturer's instructions. During an interview on 1/7/25 at 8:30 A.M., the Food Service Director (FSD) and the surveyor observed the [NAME] Kitchenette. The FSD said any opened food or drink items stored in the unit kitchenettes should be labeled and dated with the date it was opened. The FSD said dietary staff maintained the Kitchenettes daily which included monitoring the labeling and dating of food and beverage items when they stocked the Kitchenettes. Dietary Staff #1 had already left the Kitchenette. The FSD and surveyor observed the refrigerator which still contained undated, opened containers of thickened water, milk, prune juice, and 20 thawed nutritional shakes. The FSD said all of the items should have a date when they were opened and the nutritional shakes should be labeled with a thaw date to ensure they are used within the 14 days stated by the manufacturer. On 1/7/25 at 9:06 A.M., the surveyor observed the following in the main kitchen: -one opened bag of cake mix, no date; -prune juice and thickened dairy, both opened with no date; -one container cottage cheese, opened and dated 12/19. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/7/25 at 9:06 A.M., the FSD said the cottage cheese was received on 12/19/24 and opened sometime that week. The FSD said any food or drink item that is opened should be labeled and dated with the date it was opened. On 1/7/25 at 10:10 A.M., the surveyor observed the following in the [NAME] Unit Kitchenette: -Lactaid milk, opened, no date with manufacturer label stating use within 14 days of opening; -12 nutritional shakes, thawed, no thaw date with manufacturer label stating use within 14 days of thawing. During an interview on 1/7/25 at 1:46 P.M., the Administrator said she expected the facility to comply with federal and state regulations when storing food, which included labeling and dating opened food/beverages and labeling and dating any undated items that are removed from the packaging. 2. Review of the facility's policy titled Preventative Maintenance - Ice Machines, revised 1/11/23, indicated but was not limited to: Policy: It is policy that all ice machines in the facility will be inspected by the in-house maintenance department on a monthly basis and the coils will be cleaned every quarter. Procedure: Monthly -Any problems will be reported to the maintenance department via a work order; -The maintenance department or outside vendor will inspect each ice machine monthly; -All areas will be checked for cleanliness. Quarterly -All quarterly procedures will be completed by maintenance or outside vendor. On 1/2/25 at 11:21 A.M., the surveyor observed the [NAME] Unit ice machine with yellow and black residue on areas of the interior machine adjacent to where the ice was stored. On 1/7/25 at 8:06 A.M., the surveyor observed the [NAME] Unit ice machine with yellow and black residue on areas of the interior machine where ice was made. Specifically, there was a thick layer of yellow and black residue at the top of the evaporator plate, a metal piece that produces ice by freezing the water that streams down the plate. Additionally, there was milder yellow residue on other parts of the condenser plate. The surveyor observed water running over the residue, freezing, and forming ice. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/7/25 at 8:06 A.M., the surveyor observed Nurse #6 in the [NAME] Kitchenette scooping ice from the ice machine into a water pitcher. Nurse #6 said she was preparing water for medication pass. Nurse #6 and the surveyor observed the ice machine's interior. Nurse #6 said the ice machine looked as if it needed cleaning and she did not feel comfortable using the ice for medication pass to the residents. During an interview on 1/7/25 at 8:25 A.M., the Director of Maintenance (DOM) said the maintenance department is responsible for monitoring and maintaining the ice machines. The DOM said the ice machine maintenance schedule is produced by the facility's TELS system, a building management platform. The DOM said the maintenance included checking and cleaning the interior of the ice machine. Additionally, the DOM said the ice machines are cleaned every three months by a vendor. The DOM and the surveyor observed the [NAME] Kitchenette ice machine and the DOM said the machine needed to be cleaned. On 1/7/25 at 10:10 A.M., the surveyor observed the [NAME] Unit ice machine with yellow and black residue on the same areas of the interior machine adjacent to where the ice was stored. The DOM said he also observed the residue inside of the ice machine. Review of the TELS Logbook indicated maintenance of the ice machines on [NAME] and Life Care Plus units were performed on 12/6/24 and 9/6/24, which included: sanitize interior of ice machine per manufacturer's instructions and clean out and sanitize the ice bin. The Logbook indicated maintenance on 12/6/24 was marked done on time by the DOM. The Logbook indicated maintenance on 9/6/24 was marked done on time by the Administrator. During an interview on 1/7/25 at 1:46 P.M., the Administrator said she would expect the ice machines to be maintained and function in a clean and sanitary condition at all times.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 15214 Based on record review, observation, and staff interview, the facility failed to ensure that for four Residents (#28, #88, #78, and #143), of a total sample of 29 residents, infection control measures were implemented in order to prevent the potential development and spread of disease. Specifically, the facility failed: 1. For Residents #28 and #88, to ensure respiratory equipment was maintained in a clean and sanitary manner to decrease the risk of potential contamination and infection; 2. For Resident #78, to remove feces from hands prior to providing meals; and 3. For Resident #143, to ensure Contact Precaution measures were followed in a manner to prevent the potential spread of infection for a Resident with non-recurrent Clostridium difficile, a germ that causes diarrhea and colitis (an inflammation of the colon) and can be life-threatening. Findings include: 1. Review of the Policy titled Oxygen Administration, issued on 12/3/18 and revised on 10/1/24, included but was not limited to the following: Policy: -To assure that oxygen is administered and stored safely within the healthcare centers or in and outside storage area. Infection Control: -Change oxygen supplies weekly and when visibly soiled. Equipment should be labeled with patient name and dated when set up or changed out -Store oxygen and respiratory supplies in bag labeled with resident's name name when not in use. A. Resident #28 was admitted in December 2020 with diagnoses which included chronic obstructive pulmonary disease (COPD-chronic lung disorders resulting in blocked air flow in the lungs), chronic respiratory failure with hypoxia, and Alzheimer's dementia. Review of the most recent Brief Interview for Mental Status (BIMS) score of 12 out of 15 indicated the Resident had moderate cognitive impairment. Review of the current Physician's Order indicated: -Oxygen at 2 liters as needed, administer via an oxygen concentrator and nasal cannula. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/2/25 at 9:20 A.M., the surveyor observed Resident #28 seated in a wheelchair in his/her room. An oxygen concentrator was observed against the wall adjacent to the left upper side of the bed. The oxygen was not in use, however the the nasal cannula oxygen tubing was observed lying on the floor under the bed and not contained in a bag to protect it from environmental contaminants. The Resident utilized oxygen via the nasal cannula, as needed (PRN), and removed and replaced the nasal cannula adlib, without staff assistance or supervision. On 1/3/25 at 8:16 A.M., the surveyor observed Resident #28's oxygen tubing hanging on the left bed rail and was not contained in a bag to protect it from environmental contaminants. The oxygen tubing was dated 1/2/25. On 1/3/25 at 8:57 A.M., the surveyor observed Resident #28 lying in bed with the nasal cannula oxygen tubing that had been observed on the floor on 1/2/25 and hanging on the bed rail on 1/3/25 in the Resident's nose. On 1/3/25 at 11:54 A.M., the surveyor observed Resident #28's nasal cannula oxygen tubing lying on the floor at the left side of the Resident's bed. During an interview on 1/7/25 at 11:17 A.M., Unit Manager (UM) #2 said that the Resident's oxygen tubing should not be on the floor or hanging on the side rail. UM #2 said that the oxygen tubing should always be stored in a bag when not in use to prevent it from being contaminated and to prevent infection. During an interview on 1/7/25 at 3:54 P.M., the Director of Nursing (DON) said that the Resident's oxygen nasal cannula should not have been on the floor or hanging on the side rail. The DON said that respiratory equipment, such as nasal cannula oxygen tubing, should be stored in a bag when not in use, in order to maintain cleanliness and prevent contamination/infection. She said that due to the Resident's decreased cognition, he/she would not be capable of maintaining the respiratory equipment in a clean and safe manner to prevent contamination and/or the spread of infection. 50740 B. Resident #88 was admitted to the facility in December 2024 with diagnoses including chronic obstructive pulmonary disease (COPD- a disease caused by damage to the lungs), chronic respiratory failure, and dependence on supplemental oxygen. Review of the most recent Minimum Data Set (MDS) assessment, dated 12/12/24, indicated the Resident was cognitively intact, as evidenced by a BIMS score of 15 out of 15. Further review of the MDS assessment indicated the Resident received oxygen therapy. Review of Resident #88's Physician's Orders indicated but was not limited to the following: -Change oxygen tubing and nebulizer circuit every night shift every Sunday (12/15/24) -Oxygen at 2 liters/minute (l/min) continuously per nasal cannula. Document every shift (12/10/24) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the January 2025 Treatment Administration Record (TAR) indicated the Resident's oxygen tubing was due to be changed on the night shift on 1/5/25. The treatment was signed by Nurse #8 and a chart code of 6 was entered, indicating Absent from facility with meds. Review of the Resident's record indicated the Resident was not out of the facility on the night shift on 1/5/25. On 1/6/25 at 8:59 A.M., the surveyor observed Resident #88 utilizing Oxygen at 2 l/min via nasal cannula. The oxygen tubing was dated 12/30. On 1/7/25 at 7:14 A.M., the surveyor observed Resident #88 utilizing Oxygen at 2 l/min via nasal cannula. The oxygen tubing was dated 12/30. During an interview on 1/7/25 at 8:58 A.M., Unit Manager #1 said oxygen tubing should be changed on admission, every Sunday night, and as needed. Unit Manager #1 said Resident #88's tubing should have been changed on the night shift 1/5/25, but the Resident uses longer extension tubing that may not have been available on the unit during that time. During an interview on 1/7/25 at 9:19 A.M., the DON said Resident #88's oxygen tubing should have been changed on the night shift on Sunday 1/5/25 as scheduled. The DON said if the extension tubing was not available at that time, the nurse should have notified someone on the next shift for it to be changed. During an interview on 1/7/25 at 4:33 P.M., Nurse #8 said he prepared new tubing for Resident #88 on 1/5/25 and left the new tubing hanging in a respiratory bag in the Resident's room ready for use. 36542 2. Review of the facility's policy titled Hand Hygiene for Residents, Families and Visitors, dated as reviewed on 6/3/24 indicated the following: -the facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections -hand hygiene refers to a general term that applies to hand washing, antiseptic handwash, and alcohol-based hand rub -avoid touching eyes, nose or mouth with unwashed hands -the facility should assist either physically or through reminders to residents to perform hand hygiene after toileting and before meals Resident #78 was admitted to the facility in January 2021 with a diagnosis of dementia. Review of the MDS assessment, dated 12/10/24, indicated Resident #78 scored 3 out of 15 on the BIMS, indicating a severe cognitive impairment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plans for Resident #78 included a Focus for behaviors including but not limited to the potential to smear feces. Interventions included but were not limited to the following: two staff members when possible related to accusatory behavior, administering medications as ordered, anticipating the needs of the Resident, discuss behaviors and reinforce why not appropriate/acceptable, offer tasks to divert attention, praise progress/improvement in behavior, provide a program of activities of interest. On 1/2/25 at 9:40 A.M., the surveyor observed Resident #78 in bed with a strong smell of feces in the room. The surveyor observed Resident #78 with feces on, around, and underneath the fingernails, on tips of fingers, on the Styrofoam cup and a crumpled tissue on the bedside table. During an interview on 1/2/25 at 9:45 A.M., the surveyor informed Unit Manager #3 of Resident #78 having feces on their hands. The Unit Manager said Resident #78 had a behavior of touching his/her feces. On 1/2/25 at 9:50 A.M., the surveyor observed a Certified Nursing Assistant (CNA) go into the room of Resident #78 to provide care. On 1/2/25 at 11:30 A.M., the surveyor observed Resident #78 in bed. The Resident continued to have feces all around the fingernail bed and under the fingernail on multiple fingers; the fingertips were stained an orange/brown color. Resident #78 was observed to use the side of their index finger to rub their right eye. The surveyor observed the same Styrofoam cup with feces on it on the bedside table. On 1/2/25 at 12:45 P.M., the surveyor observed Resident #78 to continue to have feces on his/her hands and to be eating a tuna sandwich. On 1/3/25 at 8:15 A.M., the surveyor observed Resident #78 in bed having breakfast. The fingertips were cleaned and no longer had the orange/brown stain, the nail beds were cleaned and there were no longer feces around the nail beds. There continued to be feces under the fingernails on a couple of fingers. On 1/3/25 at 12:28 P.M., the surveyor observed the Staff Development Coordinator (SDC) setting up lunch for Resident #78 and assisting him/her with eating. The Resident's nails continued to look the same from four hours prior. At 12:39 P.M., the SDC provided the Resident with a clothing protector while the Resident fed him/herself a grilled cheese sandwich. During an interview on 1/3/25 at 12:44 P.M., the SDC said the process was for staff to use hand sanitizer wipes to clean residents' hands prior to eating. She said she had not cleaned Resident #78's hands because she had started off feeding the Resident. During an interview on 1/3/25 at 12:46 P.M., Nurse #1 said Resident #78 had behaviors which included disrobing and playing with feces with no particular frequency. During an interview on 1/3/25 at 12:48 P.M., CNA #1 said she had provided care to Resident #78 the day before when the Resident had a bowel movement. She said she was cleaning the hands of Resident #78 when the Resident pulled them away. She said the Resident can be resistant to having his/her nails cleaned and that she had done the best she could to get the feces off the nails. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/3/25 at 12:52 P.M., Unit Manager #3 said the process was for staff to clean the hands of residents with hand sanitizer wipes. On 1/7/25 at 8:01 A.M., the surveyor observed Resident #78 in bed with dried feces around the fingernail beds and under the fingernails. On 1/7/25 at 8:15 A.M., the surveyor observed Resident #78 in bed self-feeding a biscuit with his/her hand. During an interview with observation on 1/7/25 at 8:16 A.M., Unit Manager #3 said one hand on the Resident looked cleaner than the other and that there were feces on the nails. She said she knew the staff had worked on the Resident's fingernails over the weekend and the CNA had cleaned the Resident's hands prior to getting breakfast but there were still feces on the nails. 49428 3. Review of facility's policy titled Transmission-Based Precautions and Isolation Procedures, revised 9/24/24, indicated but was not limited to: Policy: The facility will implement and utilize transmission-based precautions to ensure the mitigation of infection spread and to ensure standards of infection prevention and control are followed. Categories of Transmission-based Precautions: -Contact Precautions are intended to prevent transmission of pathogens that are spread by direct (such as person-to-person) or indirect contact with the resident or environment, and require the use of appropriate personal protective equipment (PPE), including a gown and gloves before or upon entering (such as before making contact with the resident or resident's environment) the room or cubicle. Prior to leaving the resident's room or cubicle, the PPE is removed, and hand hygiene is performed. Procedure: -This facility will utilize the following Lippincott procedures: Contact Precautions Procedure Review of Lippincott Nursing Procedures- 9th edition, dated 2023, section titled Contact Precautions, indicated but was not limited to: -Equipment: gowns, gloves, plastic bags, contact precaution signs; -Perform hand hygiene; -Put on a gown and gloves before entering the patient's room to comply with contact precautions; -Handle all items that have come in contact with the patient as you would for a patient on standard precautions; -Remove and discard your gown and gloves before leaving the room; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225655	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Raynham	546 South Street East Raynham, MA 02767

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Perform hand hygiene before leaving the patient's room. Review of Resident #143's MDS assessment, dated 11/14/24, indicated the Resident had enterocolitis due to Clostridium difficile (C. diff), not specified as recurrent. Review of Resident #143's current Physician's Orders included but were not limited to: -12/31/24, Dificid (an antibiotic) oral tablet 200 milligrams (mg), give 1 tablet by mouth two times a day for C. diff until 1/10/25; -12/31/24, Contact plus precautions for C. diff, every shift. Review of Resident #143's active care plan included, but was not limited to: -The Resident has C. Difficile infection, dated 1/2/25; -Contact plus precautions, dated 1/2/25. On 1/2/25 at 10:30 A.M., the surveyor observed a Contact Precautions sign hung outside of Resident #143's door. The surveyor observed CNA #1 enter the Resident's room and don (put on) gloves without using hand sanitizer or washing hands with soap and water. CNA #1 did not don a gown. CNA #1 wheeled the Resident into their bathroom. The surveyor did not observe CNA #1 exiting the Resident's room. On 1/2/25 at 10:46 A.M., the surveyor observed CNA #1 enter Resident #143's room without sanitizing or washing hands with soap and water. CNA #1 donned gloves and entered the Resident's bathroom. CNA #1 was not wearing a gown. CNA #1 was observed without gloves or a gown when she exited the bathroom with the Resident and wheeled the Resident to their bed. The surveyor did not see any gowns discarded in the Resident's bathroom trash can. During an interview on 1/2/25 at 11:45 A.M., CNA #1 said she did not notice the Contact Precautions sign outside of Resident #143's room. During an interview on 1/7/25 at 10:15 A.M., Unit Manager (UM) #3 said staff caring for residents with C. diff should be gowned and gloved and should wash their hands with soap and water when entering and exiting the resident's room. UM #3 said CNA #1 should have donned a gown and gloves and practiced appropriate hand hygiene upon entering and exiting Resident #143's room. During an interview on 1/7/25 at 1:50 P.M., the DON said staff should utilize the appropriate PPE stated on Precaution signs. The DON said CNA #1 should have donned gloves and a gown and should have cleaned her hands before and after entering the room.