STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225732	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Stoneham	25 Woodland Road Stoneham, MA 02180

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 49880 Based on observations and interviews the facility failed to ensure a dignified existence was maintained for residents who require assistance with meals. Findings Include: Review of facility policy titled Dignity, dated as reviewed 9/25/23, indicated the following: -Each resident has the right to be treated with dignity and respect. -Examples of treating residents with dignity and respect include, but are not limited to: -e. Addressing residents by the name or pronoun of the resident's choice, avoiding the use of labels for residents such as feeders or walkers. On 9/19/24 at 8:03 A.M., the surveyor overheard a staff member in a resident's room yell out into the hallway to another staff member to go downstairs and help with breakfast because they have more feeders on that unit. The Staff member yelling into the hallway was sitting in a resident room, assisting a resident with his/her meal. During an interview on 9/19/24 at 10:32 A.M., the Director of Nurses (DON) said staff should not refer to residents as feeders as it is not dignified to refer to someone that way.

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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(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. 41105 Based on observations, record review and interviews, the facility failed to develop and implement a comprehensive person centered care plan for three Residents (#43, #31 and #16) out of a total sample of 20 residents. Specifically, 1. For Resident #43, the facility failed to develop a care plan regarding a new skin tear and treatment applied. 2. For Resident #31, the facility failed to develop a care plan for Resident #31's resident specific Activities of Daily Living needs. 3. For Resident #16, the facility failed to implement the plan of care for completing weekly skin checks. Findings include: 1. Resident #43 was admitted to the facility in September 2019 and has diagnoses that include dementia, anxiety disorder and history of falling. Review of the most recent Minimum Data Set (MDS) assessment, dated 6/20/24, indicated that on the Brief Interview for Mental Status exam Resident #43 scored a 2 out of a possible 15, indicating severe cognitive impairment. The MDS further indicated Resident #43 was dependent on staff for activities of daily living. On 9/17/24 at 8:34 A.M., Resident #43 was observed in bed. There was a bandage on his/her left hand, not labeled or dated with approximately a nickel size red area on the bandage. Resident #43 said some woman came in two days ago and said what happened here, its bleeding and put on the bandage. On 9/17/24 at 12:37 P.M., Resident #43 was observed in bed with the same unlabeled and undated bandage on the left hand. On 9/18/24 at 7:35 A.M., Resident #43 was observed in bed with the same unlabeled and undated bandage on the left hand, as evidenced by the curling of all sides of the bandage. Review of Resident #43's current care plan failed to indicate a plan of care for a left-hand skin tear or for a left-hand skin treatment. During an interview on 9/18/24 at 7:31 A.M., the Director of Nursing said that when the skin tear was discovered staff should have developed a care plan specific to the skin tear and the treatment applied. 2. Resident #31 was admitted to the facility in July 2024 and has diagnoses that include an unstageable pressure ulcer of the right heel and Type II Diabetes. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the most recent Minimum Data Set (MDS) assessment, dated 7/22/24, indicated that on the Brief Interview for Mental Status exam Resident #31 scored a 6 out of a possible 15, indicating severe cognitive impairment. The MDS further indicated Resident #31 requires substantial/maximal assistance with lower body care, including putting on/taking off footwear. Review of Resident #43's care plan failed to indicate a plan of care had been developed regarding Resident #31's Activities of Daily Living needs. During an interview on 9/19/24 at 8:05 A.M., the Director of Nursing said that it was the expectation that a care plan be developed by nursing for every resident's Activities of Daily Living needs. 49880 3. Review of facility policy titled Skin Integrity & Pressure Ulcer/Injury Prevention and Management, dated as reviewed 7/9/24, indicated the following: -A skin assessment/ inspection should be performed weekly by a licensed nurse. Resident #16 was admitted to the facility in August 2024 with diagnoses that included acute on chronic diastolic congestive heart failure and lymphedema. Review of Resident #16's most recent Minimum Data Set (MDS) assessment, dated 8/19/24, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15, indicating that Resident #16 is cognitively intact. The MDS further indicated that the Resident has no pressure areas but is at risk for developing pressure ulcers/ injuries. Review of Resident #16's active plan of care for skin integrity, dated 8/14/24, indicated interventions for weekly skin checks. Review of Resident #16's medical record indicated the only skin check was completed on 8/23/24, and no further skin checks were completed after this date. Review of nursing progress notes since the Residents' admission failed to indicate that Resident #16 refused any weekly skin checks. During an interview on 9/19/24 at 9:18 A.M., Nurse #4 said that every resident has a skin check weekly that triggers automatically in the electronic health record (EHR). During an interview on 9/19/24 at 10:25 A.M., the Director of Nurses (DON) said the plan of care should be followed for weekly skin checks, and that they are assigned automatically on the computer in the EHR (Electronic Health Record). The Director of Nursing said If a skin check is refused by a resident, it should be documented in a nurses note.

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	225732	A. Building B. Wing	09/19/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 49880 Based on observations, record review and interviews the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good grooming and hygiene. Specifically, the facility failed to provide nail care for one Resident (#54) out of a total sample of 20 residents. Findings Include: Review of facility policy titled Nail Care. dated as reviewed 9/10/24, indicated but was not limited to the following: - For general fingernail care for most residents, the following procedure will be followed: - 1. Ensure fingernails are clean and trimmed to avoid injury and infection. Resident #54 was admitted to the facility in August 2024 with diagnoses that included fracture of the right femur and muscle weakness. Review of Resident #54's most recent Minimum Data Set (MDS) assessment, dated 9/2/24, indicated a Brief Interview for Mental Status score of 14 out of 15, indicating that the Resident is cognitively intact. The MDS further indicated that the Resident is dependent on staff for activities of daily living (ADLs). Further review of the MDS indicated that rejection of care is not a behavior exhibited by Resident #54. On 9/17/24 at 8:32 A.M., the surveyor observed Resident #54 sitting up dressed in his/her wheelchair eating breakfast. His/her right arm was in a sling and his/her left hand had a dark black substance under all of his/her fingernails. On 9/18/24 at 7:26 A.M., the surveyor observed Resident #54 laying in bed. The Resident's fingernails on his/her left hand were observed to have had a dark black substance under them. On 9/19/24 at 8:14 A.M., the surveyor observed Resident #54 in bed eating breakfast. His/her fingernails on the left hand were observed to have had a dark black substance under them. Resident #54 said that the staff assist him/her with activities of daily living and hygiene tasks because of his/her current condition. When asked if anyone has offered to help clean under his/her nails, Resident #54 said no. Resident #54 said he/she would like help cleaning their nails because this isn't typically how they keep them. Review of Resident #54's nursing progress notes since the Residents' admission failed to indicate any refusal of care. Review of Certified Nurses Aid (CNA) documentation failed to indicate any behaviors for refusal of care for Resident #54. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #54's Activities of Daily Living (ADLs) care plan, dated 9/3/24, indicated that for personal hygiene and oral care, Resident #54 requires extensive assistance. During an interview on 9/19/24 at 10:12 A.M., Certified Nurses Aid (CNA) #2 said that Resident #54 requires extensive assistance with ADLs. CNA #2 said nail care should be part of the ADL process each day and CNAs should be checking resident's nails ensure they are not too long and are not dirty. The surveyor and CNA #2 observed Resident #54's nails and CNA #2 said they are dirty and need to be cleaned. CNA #2 said Resident #54 does not refuse care. During an interview on 9/19/24 at 10:20 A.M., Nurse #5 said that CNAs should be performing nail care as part of daily ADL care. Nurse #5 said that if a resident refuses, the CNA would tell the nurse and the nurse would document it in a nurses note. During an interview on 9/19/24 at 10:23 A.M., the Director of Nurses (DON) said that if nails are long or dirty, nail care should be performed as part of ADLs and hygiene care.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 41105 Based on observation, record review and interview the facility failed to ensure standards of quality care were implemented for one Resident (#43) out of a total sample of 20 residents. Specifically, the facility failed to a.) notify the physician or responsible party of a new skin tear, b.) failed to obtain an order for a treatment applied to a new skin tear and c.) failed to document an assessment of the new skin tear. Findings include: The facility policy titled area of Focus: Basic Skin Management, dated 11/29/23, indicated the following: -All residents have a head-to-toe inspection upon admission/readmission, then completed weekly, and as needed by nursing. It is documented in PCC: NRSG: Weekly Skin. -If any new skin alteration/wound is identified, it is the responsibility of the nurse to perform and document an assessment/observation, obtain treatment orders, and notify the MD and responsible party. -Orders are required for skin and wound care. There are wound care protocol orders in PCC under Orders-TX (treatment) Template. Resident #43 was admitted to the facility in September 2019 and has diagnoses that include dementia, anxiety disorder and history of falling. Review of the most recent Minimum Data Set (MDS) assessment, dated 6/20/24, indicated that on the Brief Interview for Mental Status exam Resident #43 scored a 2 out of a possible 15, indicating severe cognitive impairment. The MDS further indicated Resident #43 was dependent on staff for activities of daily living. On 9/17/24 at 8:34 A.M., Resident #43 was observed in bed. There was a bandage on his/her left hand, not labeled or dated with approximately a nickel size red area on the bandage. Resident #43 said some woman came in two days ago and said what happened here, its bleeding and put on the bandage. On 9/17/24 at 12:37 P.M., Resident #43 was observed in bed with the same unlabeled and undated bandage on the left hand. On 9/18/24 at 7:35 A.M., Resident #43 was observed in bed with the same unlabeled and undated bandage on the left hand, as evidenced by the curling of all sides of the bandage. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 9/18/24 at 7:23 A.M., with Resident #43's Nurse (#1) the surveyor and Nurse #1 observed Resident #43's hand with an unlabeled and undated bandage on the left hand. Nurse #1 said the bandage should be labeled and dated and that she would expect there is an order for the treatment. Nurse #1 reviewed the record and said that there was not a Physician's order for the treatment. Following review of the record Nurse #1, the Director of Nursing and the surveyor observed Resident #43's hand and Nurse #1 removed the bandage, exposing an approximately 1-inch-long skin tear. Review of the most recent Skin Integrity update assessment, dated 9/9/24, indicated Resident #43 had no skin tears. The option to indicate Resident #43 had any skin tears was blank. Review of the Physician/PA/NP visit note, dated 9/16/24, indicates Resident #43 was assessed by the NP and there was no documented skin tear or treatment to the left hand indicated. Review of the current Physician orders for Resident #43 failed to indicate an order for a treatment to the left hand. Review of the record failed to indicate that the Physician or Activated Health Care Proxy for Resident #43 were notified of a skin tear to the left hand. Review of the record failed to indicate that when the new skin alteration/wound was identified that the nurse documented an assessment/observation of the area. Review of Resident #43's current care plan failed to indicate a care plan for a left-hand skin tear or for a left-hand skin treatment. During an interview on 9/18/24 at 7:31 A.M., the Director of Nursing said that when the skin tear was discovered staff should have done the following: -Created a risk report, which would include getting statements from staff and attempting to determine the cause of the skin tear; -notify the Physician and obtain an order for a treatment to the skin tear; -notify Resident #43's responsible party of the incident; -develop a care plan specific to the skin tear; and, -document all the above in the electronic medical record. In this case the Director of Nursing said that none of those things occurred.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 41105 Based on observation, record review and interview, the facility failed to ensure a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent new ulcers from developing for one Resident (#31) out of a total sample of 20 residents. Specifically, the facility failed to ensure Resident #31 wore Prevalon boots while in bed, as ordered by the Physician. Findings include: The facility policy titled Skin Integrity & Pressure Ulcer/Injury Prevention and Management, dated as revised 7/9/24, indicated the following: 5. Measures to protect the resident against the adverse effects of external mechanical forces, such as pressure, friction and shear are implemented in the plan of care: d. heel protection/suspension if indicated. Resident #31 was admitted to the facility in July 2024 and has diagnoses that include an unstageable pressure ulcer of the right heel and Type II Diabetes. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/22/24, indicated that on the Brief Interview for Mental Status exam Resident #31 scored a 6 out of a possible 15, indicating severe cognitive impairment. The MDS further indicated Resident #31 substantial/maximal assistance with lower body care, including putting on/taking off footwear. Review of the current Physician orders indicated Resident #31 had the following order: -Wear Prevalon Boot when in bed or not walking, Do not walk or transfer while wearing the Prevalon boot, start date 7/16/24. (sic) Review of Resident #31's care plans indicated the following: -A care plan that indicated Resident #31 has an unstageable pressure ulcer right heel. Interventions on the care plan include: Treatment as ordered. -A care plan that indicated Resident #31 has a Skin Tear of the left hand (back) and DTI to right heel. Interventions on the care plan include: Prevalon boots to bilateral lower extremities as tolerated -A behavior care plan, indicating Resident #31 was resistive to care, however the care plan failed to indicate Resident #31 refused to wear the Prevalon boots. Review of the clinical progress note dated 9/17/24 that Resident #31 has area to right heel which requires treatment and Prevalon boot daily. (continued on next page)

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	225732	A. Building B. Wing	09/19/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/17/24 at 7:58 A.M., Resident #31 was observed in bed with his/her feet flat on the mattress. Resident #31 was not wearing Prevalon boots and none were observed in the room. On 9/17/24 at 8:40 A.M., Resident #31 was observed in bed with his/her feet flat on the mattress. Resident #31 was not wearing Prevalon boots and none were observed in the room. On 9/17/24 at 12:40 P.M., Resident #31 was observed in bed with his/her feet flat on the mattress. Resident #31 was not wearing Prevalon boots, and none were observed in the room. On 9/18/24 at 2:35 P.M., Resident #31 was observed in bed with his/her feet flat on the mattress. Resident #31 was not wearing Prevalon boots. On 9/19/24 at 7:29 A.M., Resident #31 was observed in bed with his/her feet flat on the mattress. Resident #31 was not wearing Prevalon boots. During an interview on 9/19/24 at 7:49 A.M., Resident #31's Certified Nursing Assistant (CNA) #1 said that Resident #31 fluctuates and requires one person assist to total care by 2 staff. He said that the nurses are responsible to put the Prevalon boots on Resident #31. During an interview and observation on 9/19/24 at 7:55 A.M., Resident #31's Nurse (#3) said that Resident #31 has an area on his/her heel and that nurses are responsible to put the Prevalon boots on when Resident #31 is in bed. The surveyor and Nurse #3 observed Resident #31 in bed without the Prevalon boots on. Nurse #3 searched the room but could not locate the boots. During an interview on 9/19/24 at 8:05 A.M., the Director of Nursing said that she would expect that staff follow MD orders and ensure Resident #31 had his/her Prevalon boots applied when in bed. The DON said that if Resident #31 refused the boots it should be documented in the Treatment Administration Record.

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	225732	A. Building B. Wing	09/19/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 36431 Based on observation, record review and interview the facility failed to ensure professional standards of practice for food service safety by failing to perform proper hand hygiene. Findings include: Review of the facility's policy, titled Chapter 1: Food Safety and Infection Control, Washing Hands Properly, not dated, indicated the following: -Training objective: Participants will know when they should wash their hands and will demonstrate the proper way to do so. Discussion, as food service workers, our hands come into contact with many unsanitary things during the day. Some of these contacts are part of our job tasks and some are not. Harmful bacteria can pass from an infected person to a well person from objects such as food, dishes, eating, utensils, glasses etc. These bacteria, in turn can make a person very ill. We can reduce the risk of becoming contaminated by washing out hands properly. When you should wash your hands: included but not limited to: -When they become soiled, -After completing a task and before beginning a new one. -Before handling food, clean dishes, or flatware. 1. During observation of the breakfast tray line in the kitchen on 9/19/24 at 7:35 A.M., the surveyor made the following observations. -Diet Aid #1, wearing gloves on both hands, was rolling flatware into napkins. Diet Aide #1 then removed his gloves, and without hand washing, touched the food truck, the door handle and left the kitchen with the food truck. Diet Aide #1 then returned to the kitchen, went to the hand washing sink, washed his hands and used his clean hands to turn off the water, thus contaminating his hands. Diet Aide #1 then proceeded to place on gloves and returned to rolling flatware into napkins. -Diet Aide #1 left the kitchen with the food truck two additional times after removing gloves and failing to perform hand hygiene after glove removal. Both additional times, Diet Aide #1 returned to the hand washing sink, washed his hands, turned off the water using his clean hands and in doing so contaminated his hands. After each of the two times he proceeded to put on gloves and returned to task including putting away clean items from the dish room. During an interview on 9/19/24 at 9:40 A.M., the Food Service Director (FSD) said staff are to wash hands when removing gloves and use proper hand washing techniques which would include using a paper towel to turn off the water to prevent contamination of clean hands.

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ staff that are licensed, certified, or registered in accordance with state laws. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49880 Based on record review and interview, the facility failed to ensure professional staff are licensed, certified, or registered in accordance with applicable State laws. Specifically, when the facility indicated they had one nurse employed under a nursing waiver, they failed to ensure that the nurse had graduated from a board approved nursing program. Findings Include: Review of The Department of Public Health (DPH) Circular Letter, issued on June 3, 2024, regarding Guidance for Nursing Practice by Graduates and Students in Their Last Semester of Nursing Education Programs, indicated, but was not limited to: -An individual who graduated from a registered nursing or practical nursing program approved by the board or who is a senior nursing student attending the last semester of a registered nursing or practical nursing program approved by the board may practice nursing; provided that: -(iii) the employing licensed health care facility or licensed health care provider has verified that the individual is a graduate of a registered nurse or practical nursing program approved by the board or that the individual is a senior nursing student attending the last semester of a registered nursing or practical nursing program approved by the board. -In order to practice under the authorization of Chapter 88 of the Acts of 2023, a graduate or student in their last semester: 1. Must have graduated from a board approved nursing education program within one year of the hire date or be a student currently enrolled in their last semester of a board approved nursing education program. -Responsibilities of Licensed Healthcare Facilities and Licensed Healthcare Providers -In order to allow a graduate or student in their last semester to practice under the authorization of Chapter 88 of the Acts of 2023, a licensed healthcare facility or licensed healthcare provider shall: -1. Verify the individual is a graduate from a board approved registered nursing program or practical nursing program or is a student in their last semester of a board approved registered nursing or practical program. The licensed healthcare facility or licensed healthcare provider must obtain independent verification and/or official documentation from the nursing education program. It is not sufficient for a licensed healthcare facility or licensed healthcare provider to rely on an individual's representation of their education status. Review of the board approved nursing education programs included programs that were located only in Massachusetts. (continued on next page)

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	225732	A. Building B. Wing	09/19/2024

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the entrance conference on 9/17/24 at 8:54 A.M., the Director of Nurses (DON) and Administrator they said they have one nurse (Nurse #2) working in the facility under a state waiver who has graduated from nursing school and is waiting to take her boards exam in November. Review of Nurse #2's personnel file included a resume indicating a graduation from Nova Southwestern University in [NAME], Florida in May 2020 and an application for employment indicating she had completed a nursing program. Nurse #2's personnel file failed to include independent verification and/or official documentation from the nursing education program to confirm completion. Review of the License verification site for the Office of Health and Human Services for Massachusetts, failed to indicate an active nursing license for Nurse #2. Review of Nurse #2 worked hours and punch log indicated that Nurse #2 worked 670.02 hours as a nurse from 5/22/24 through 9/18/24. During an interview on 9/18/24 at 1:51 P.M., the DON said she was aware that Nurse #2 went to school in Florida, graduated from the program and moved to this area not too long ago. The Surveyor and the DON reviewed the personnel file together and the DON said that with the information in the file there was no evidence that the employee completed the nursing program and that the statement on the resume is not enough to confirm. The surveyor and DON also reviewed the State Circular Letter with respect to board approved nursing programs, and the DON said she had not reviewed the list of schools. During a follow up interview on 9/18/24 at 3:03 P.M., the DON said that the nurse should not be working in the facility. During an interview on 9/18/24 at 1:59 P.M., the Corporate Recruiter said the facility should have confirmation that the employee completed and graduated from an accredited nursing program, and they do not. He was not able to confirm if Nurse #2 completed a nursing program. He said the nurse should not be employed at the facility at this time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225732	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Stoneham	25 Woodland Road Stoneham, MA 02180

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 41105 Based on observation, record review and interview the facility failed to maintain an accurate medical record for two Residents (#31 and #43) out of a total sample of 20 residents. Specifically, 1. Nurses documented in the Treatment Administration Record (TAR) that Resident #31 wore Prevalon boots while in bed, contrary to direct observation of the boots not being worn. 2. A nurse inaccurately documented on a Skin Assessment that Resident #43 did not have a skin tear, when he/she had a skin tear to the left hand. Findings include: The facility policy titled Nursing Documentation, dated as reviewed 9/5/24, indicated the following: -The medical record must contain an accurate representation of the actual experience of the resident and include enough information to provide a picture of the resident's progress, including his/her response to treatment and /or services, and changes in his/her condition, plan of care goals, objectives and/or interventions. 1. Resident #31 was admitted to the facility in July 2024 and has diagnoses that include an unstageable pressure ulcer of the right heel and type II diabetes. Review of the most recent Minimum Data Set (MDS) assessment, dated 7/22/24, indicated that on the Brief Interview for Mental Status exam Resident #31 scored a 6 out of a possible 15, indicating severe cognitive impairment. The MDS further indicated Resident #31 substantial/maximal assistance with lower body care, including putting on/taking off footwear. Review of the current Physician orders indicated Resident #31 had the following order: -Wear Prevalon Boot when in bed or not walking, Do not walk or transfer while wearing the Prevalon boot, start date 7/16/24. (sic) On 9/17/24 at 7:58 A.M., Resident #31 was observed in bed with his/her feet flat on the mattress. Resident #31 was not wearing Prevalon boots, and none were observed in the room. On 9/17/24 at 8:40 A.M., Resident #31 was observed in bed with his/her feet flat on the mattress. Resident #31 was not wearing Prevalon boots, and none were observed in the room. On 9/17/24 at 12:40 P.M., Resident #31 was observed in bed with his/her feet flat on the mattress. Resident #31 was not wearing Prevalon boots, and none were observed in the room. On 09/18/24 at 2:35 P.M., Resident #31 was observed in bed with his/her feet flat on the mattress. Resident #31 was not wearing Prevalon boots. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/19/24 at 7:29 A.M., Resident #31 was observed in bed with his/her feet flat on the mattress. Resident #31 was not wearing Prevalon boots. Review of the September 2024 TAR indicated the following: -On 9/17/24, day shift, Nursing documented Resident #31 wore Prevalon boots while in bed, contrary to observations at 7:58 A.M., 8:40 A.M., and 12:40 P.M., of the Resident #31 in bed with his/her feet flat on the mattress. -On 9/18/24, day shift, Nursing documented Resident #31 wore Prevalon boots while in bed, contrary to the observation at 2:35 P.M., of Resident #31 in bed with his/her feet flat on the mattress. During an interview on 9/19/24 at 7:55 A. M., with Resident #31's Nurse (#3) she said that Resident #31 has an area on his/her heel and has an order for Prevalon boots to be worn when in bed. The surveyor and Nurse #3 observed Resident #31 in bed without the Prevalon boots on and upon searching the room Nurse #3 could not locate the boots. Nurse #3 said that she had not yet been in to see Resident #3 that morning, but because the night nurse had documented that the boots were on overnight, she would have expected the boots to be on when she went into the patient that morning. During an interview on 9/19/24 at 8:05 A.M., with the Director of Nursing (DON) she said that she would expect that the documentation in the TAR to be accurate. The DON said that if the boot were not applied as ordered this should be documented and a note written explaining the reason. 2. Resident #43 was admitted to the facility in September 2019 and has diagnoses that include dementia, anxiety disorder and history of falling. Review of the most recent Minimum Data Set (MDS) assessment, dated 6/20/24, indicated that on the Brief Interview for Mental Status exam Resident #43 scored a 2 out of a possible 15, indicating severe cognitive impairment. The MDS further indicated Resident #43 was dependent on staff for activities of daily living. On 9/17/24 at 8:34 A.M., Resident #43 was observed in bed. There was a bandage on his/her left hand, not labeled or dated with approximately a nickel size red area under the bandage. Resident #43 said some woman came in two days ago and said what happened here, its bleeding and put on the bandage. On 9/17/24 at 12:37 P.M., Resident #43 was observed in bed with the same unlabeled and undated bandage on the left hand. Review of the most recent Skin Assessment, dated 9/17/24 at 23:01 P.M., indicated Resident #43 had Scattered bruises all over the body especially the arms and hands. Skin is very fragile, however the assessment failed to indicate Resident #43 had a skin tear to the left hand. The option to indicate Resident #43 had any skin tears was blank. During an observation and interview on 9/18/24 at 7:23 A.M., the surveyor and Resident #43's Nurse (#1) observed Resident #43's hand with an unlabeled and undated bandage on the left hand. Nurse #1 removed the bandage, exposing an approximately 1-inch-long skin tear. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/18/24 at 7:31 A.M., the Director of Nursing said that the Skin Assessment completed 9/17/24 at 23:01 P.M., should have been completed accurately and noted the skin tear on the left hand.