STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225282	A. Building B. Wing	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of the South Shore	309 Driftway Box 830 Scituate, MA 02066

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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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 41106 Based on interviews, the facility failed to employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service. Specifically, the facility failed to designate a person who met the minimum qualifications to serve as the Director of Food and Nutrition Services. Findings include: During an interview with the Dietitian and the Food Service Manager (FSM) on 1/29/24 at 10:40 A.M., the Dietitian said she is employed 32 hours per week and is in the building four days a week. The FSM said he has been employed since September 2023 and currently is not certified as a Food Service Director. He said he is enrolled in an online class starting in February. During an interview on 1/31/24 at 1:00 P.M., the Dietitian said most of the time when she is in the building, she is in meetings. She said she has tried to help in the kitchen and provide some education and support to the Food Service Manager, but it has been tough. During an interview on 1/31/24 at 2:15 P.M., the Administrator said he understands the FSM does not currently meet the qualifications to be the Food Service Director and the Dietitian needs to work 35 hours (full-time) and she is working only 32 hours.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 41106 Based on observation, policy review, and interview, the facility failed to follow their policy and 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 milk cartons stored in the milk chest and served to the residents were not expired; 2. Handle ready-to-eat food (food which does not require cooking or further preparation prior to consumption) utilizing proper hand hygiene to prevent cross contamination. In addition, ensure the use of gloves was limited to a single use task; 3. Ensure the floor in front of the food service line was maintained in a sanitary condition when food service operation was occurring; 4. Service the main kitchen ice machine per the facility policy; 5. Ensure food items designated as emergency supply were stored in a clean environment and were not expired; and 6. Ensure the clean side of the dishwasher in the dish room was maintained in a clean, sanitary condition to prevent cross contamination to the clean dishes exiting the dish machine. Findings include: Review of the facility's policy titled Resident Dining Services, dated [DATE], indicated but was not limited to the following: -Store, prepare, distribute, and serve food in accordance with professional standards for food service safety. -Flatware will be wrapped, and food, desserts, salads, and beverages will be covered before being transported throughout the facility. Review of the facility's policy titled Food Safety, dated [DATE], indicated but was not limited to the following: -Cross-contamination- means the transfer of harmful substances or disease-causing microorganisms to food by hands, food contact surfaces, sponges, cloth towels, or utensils which are not cleaned after touching raw food, and then touch ready-to-eat foods. -Food will not be stored in the locker room, bathroom, dressing room, garbage room, mechanical room, under sewer lines, sprinkler heads, or water lines under which water has condensed, and under open stairwells. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The first in, first out (FIFO) method is used in food storage or according to state regulation. -Foods are prepared and served with clean tongs, scoops, forks, spoons spatulas, or other suitable implements so as to avoid manual contact with prepared foods. -Tongs must be used when serving rolls, pickles, etc., cakes and pies must be placed on a plate with a spatula. Review of the 2022 Food Code by the U.S. Food and Drug Administration (FDA) indicated but was not limited to: -,d+[DATE].11 Equipment Food-Contact Surfaces and Utensils. (E)(4) In EQUIPMENT such as ice bins and BEVERAGE dispensing nozzles and enclosed components of EQUIPMENT such as ice makers, cooking oil storage tanks and distribution lines, BEVERAGE and syrup dispensing lines or tubes, coffee bean grinders, and water vending EQUIPMENT: (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold. -,d+[DATE].15 Gloves, Use Limitation. (A) If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. 1. On [DATE] at 8:25 A.M., the surveyor observed the main kitchen's milk chest and there were two crates filled with a mixture of whole milk and 1% milk cartons, all with various dates. In both crates, there were observed numerous 1% milk cartons dated [DATE]. The surveyor then observed the breakfast tray line ice bath of milk cartons and observed numerous cartons of milk dated [DATE]. During an interview on [DATE] at 8:30 A.M., the Food Service Director (FSD) said the milk dated [DATE] should not have been in the milk chest or on the tray line for morning's breakfast service. He said after a meal service the dietary staff has been putting the cartons of milk back into the crates in the milk chest and they should not be doing that. On [DATE] at 9:00 A.M., the surveyor observed milk cartons, dated [DATE], on residents' breakfast trays in the following rooms: -room [ROOM NUMBER] -room [ROOM NUMBER] -room [ROOM NUMBER] -room [ROOM NUMBER] -room [ROOM NUMBER] -room [ROOM NUMBER] (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 9:18 A.M., the Director of Nurses (DON) and the surveyor observed a milk carton on a breakfast tray in room [ROOM NUMBER], dated [DATE]. The DON said the milk cartons dated [DATE] should not have been served during breakfast service today. During an interview on [DATE] at 11:50 A.M., the Administrator said he was made aware of the milk served during this mornings breakfast service was dated [DATE]. He said there should have been an immediate action plan to correct the problem. 2. On [DATE] at 7:30 A.M., the surveyor made the following observation during breakfast service tray line: -Cook #1 started the breakfast service tray line plating the French toast, English muffins, and toast with gloved hands. [NAME] #1 was observed wearing the same gloves during the observed breakfast service, leaving the tray line to obtain supplies, handling the plates, insulated dome covers and bottoms, which were received from the dietary staff not wearing gloves, and touching the oven doors. [NAME] #1 was not observed to change his gloves. -Dietary Staff #2 was observed handling the silverware with no gloves, touching the food-contact ends during breakfast tray line service. During tray line service, Dietary Staff #2 was observed preparing breakfast trays, reaching into ice baths for milk cartons, juice containers, and the silverware. On [DATE] at 12:30 P.M., the surveyor observed [NAME] #1 plating the dinner rolls with gloved hands. [NAME] #1 was observed wearing the same gloves during lunch service leaving the tray line to obtain supplies, handling the plates, insulated dome covers and bottoms which were received from the dietary staff not wearing gloves. [NAME] #1 was not observed to change his gloves. -Dietary Staff #2 was observed handling the flatware with no gloves, touching the food-contact ends during lunch tray line service. During tray line service, Dietary Staff #2 was observed preparing lunch trays, reaching into ice baths for milk cartons, juice containers, desserts, and the silverware. During an interview on [DATE] at 12:30 P.M., the Dietitian said [NAME] #1 should not be handling the rolls, French toast, English muffins, or toast with gloves that have touched other surfaces. She said Dietary Staff #2 should not be handling the food-contact ends of the silverware with no gloves. During an interview on [DATE] at 12:40 P.M., the Corporate Food Service Manager (FSM) said the silverware should be pre-rolled prior to meal service. 3. On [DATE] at 12:45 P.M., the surveyor observed a plastic mat in front of the tray line service area which had a saturated wet cardboard box underneath the plastic mat. The top of the perforated plastic mat was observed to be wet and dirty with a black substance. During an interview on [DATE] at 1:15 P.M., the Dietitian said there is a drainpipe broken underneath the floor by the tray service line and the facility had initiated the repair process. The Dietitian and the surveyor observed the mat, the standing black colored water, and a saturated wet cardboard box that had areas of a buildup of a black substance. The Dietitian said the kitchen staff should have been keeping this area clean until the pipe was repaired. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 2:15 P.M., the Administrator and the surveyor viewed the plastic mat in front of the tray service line, he said he does not know why there is a cardboard box under the mat or why it was wet and dirty. The Administrator said the kitchen staff should have maintained the area of the broken pipe and it should have been cleaned and sanitized using bleach until it could be fixed. 4. Review of the facility's policy titled Dietary Service Ice Making Machine, undated, indicated but was not limited to the following: -It is the policy of this facility that the ice machine will be maintained in a clean and sanitary manner. -Quarterly: every 90 days clean the evaporator and water filled tubes. An outside vendor may be called for this service. On [DATE] at 1:18 P.M., review of the main kitchen ice machine cleaning log indicated the last time the ice machine was cleaned was [DATE]. During an interview on [DATE] at 1:20 P.M., the Dietitian viewed the side of the ice machine and said the last time the ice machine was cleaned was [DATE]. She said the ice machine was due to be cleaned in [DATE] and was not. During an interview on [DATE] at 2:00 P.M., the Administrator said the ice machine should have been cleaned quarterly and it was not. He said maintenance does not have any documentation of the ice machine being serviced. 5. On [DATE] at 1:30 P.M., the Dietitian and the surveyor observed the facility's mechanical room for the emergency water and food supply and observed the following: -Four Boxes of pancake mix, dated [DATE]. -One case of B&M Baked beans, dated [DATE]. -Two bags of powdered milk, no date observed. During an interview on [DATE] at 2:00 P.M., the Administrator said there should be no food stored in the Mechanical room. He said the Food Service Manager was supposed to remove all the food stored in this room and he did not. 6. On [DATE] at 8:19 A.M., the surveyor observed the main kitchen dish room and made the following observations: -The right side of dish machine, where clean dishes exit the machine onto the metal countertop, had a buildup of food particles around the opening. -The top of the dish machine and the wall to the right of dish machine had a large amount of food particles dried to the surfaces. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The metal countertop to the right of the dish machine had visible food particles along the sides of the counter and at the end of the counter. During an interview on [DATE] at 1:00 P.M., the Dietitian said the dishwasher should be maintained clean and there should not be food particles on the side where the clean dishes exit the machine. During an interview on [DATE] at 2:20 P.M., the Administrator and the surveyor viewed the dish machine, the walls, and metal countertop to the right of the dish machine. He said the dishwasher, the walls, and the counter should be kept clean.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 34145 Based on observation, interview, and policy review, the facility failed to maintain and consistently implement an infection prevention and control program to provide a safe, sanitary, and comfortable environment and to help prevent the development and potential transmission of communicable diseases and infections for one Resident (#7), out of a total sample of 18 residents. Specifically, the facility failed to ensure Enhanced Barrier Precautions (EBP), including a gown, was consistently implemented during care. Findings include: Review of the facility's policy titled Enhanced Barrier Precautions, revised 6/12/23, included but was not limited to: -The facility may use Enhanced Barrier Precautions (EBP) as an additional MDRO (multi drug resistant organism) mitigation strategy for residents that meet the following criteria, during high-contact resident care activities. -Indwelling medical devices (e.g., central line, urinary catheter, feeding tube, trach, ventilator) regardless of MDRO colonization status. -Post clear signage on the door or wall outside of the resident room indicating Resident is on Enhanced Barrier Precautions, signage should also clearly indicate the high-contact resident care activities that require the use of a gown and gloves. Examples of high-contact resident care activities requiring gown and glove use include device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator. Resident #7 was admitted to the facility in March 2022 with diagnoses including dysphagia (swallowing difficulties) and presence of a gastrostomy tube (also called a G-tube- is a tube inserted through the belly that brings nutrition directly to the stomach). Review of the Physician's Orders for Resident #7 included but was not limited to: -Enteral Feed Order every shift Jevity 1.5 liters at 70 milliliters (ml)/hour for 16 hours via pump. Flush with 200 ml purified water every 4 hours (1/18/24) -Enhanced Barrier Precautions (7/10/24) -Morphine Sulfate (narcotic pain reliever) Concentrate Oral Solution 20 milligrams (mg)/ml two times a day (1/18/24) On 1/31/24 at 8:14 A.M., the surveyor observed a three-tiered plastic cart outside of Resident #7's room. Two of the three drawers contained disposable gowns. EBP signage was posted on the doorframe of Resident #7's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/31/24 at 8:16 A.M., the surveyor observed an enteral feeding pump (a medical device that is used to deliver nutrients directly into the gastrointestinal (GI) tract) with tubing connected to the pump at Resident #7's bedside. The pump was not in use and had unsecured tubing hanging down to the floor with the uncapped transition connector tip (end of the tubing that connects directly to the G-tube) lying directly on the floor. On 1/31/24 at 8:47 A.M., the surveyor observed Unit Manager #1 enter Resident #7's room and place a small syringe of medication and a cup on the overbed table, sanitize her hands, and put gloves on. Unit Manager #1 did not put a gown on. She poured water and liquid medication into an oral feeding syringe (used to deliver feeding or medication) connected to the G-tube and administered the medication. Upon completion of the medication administration, she took the feeding tube with the uncapped transition connector that was lying on the floor and told the surveyor she was going to attach the feeding tube to the port. Prior to the Unit Manager connecting the contaminated connector to the G-tube, the surveyor intervened and asked her to explain the process for G-tube tubing and uncapped connector that is lying on the floor. She inspected the connector and said she mistakenly thought it had a cap on it, and she needs to change the entire tubing set because it is contaminated. During an observation with interview on 1/31/24 at 9:00 A.M., the surveyor observed Unit Manager #1 enter Resident #7's room with a new tubing set, sanitize her hands, and put gloves on. Unit Manager #1 did not put a gown on. Unit Manager #1 then attached the new tubing to the pump and to Resident #7's G-tube port. Although the EBP sign was posted at Resident #7's doorway, Unit Manager #1 said she only needed to wear gloves to administer medications and feeding through a G-tube. During an interview on 1/31/24 at 11:03 A.M., Unit Manager #1 said she read the enhanced precautions sign posted at the Resident's door again and said she should have worn a gown when administering care to Resident #7's G-tube. During an interview on 1/31/24 at 2:00 P.M., the Staff Development Coordinator said Unit Manager #1 last completed training on infection control precautions, including EBP, on 5/7/23 and should have known to wear both a gown and gloves while providing care to Resident #7.