STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225569	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Nashoba Valley	191 Foster Street Littleton, MA 01460

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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. 36431 Based on observation, record review, and interview the facility failed to ensure that dignity was maintained for residents during dining on one unit, (designated as a Dementia Special Care Unit), out of three resident care units. Findings include: Review of the Health Care Reporting System indicated the facility submitted a Dementia Special Care Unit disclosure form dated 2/13/24. Review of the facility's policy dated reviewed: 09/25/2023, indicated, each resident has the right to be treated with dignity and respect. Interactions and activities with residents, staff, temporary agency staff, or volunteers must focus on maintaining and enhancing the resident's self-esteem, self-worth, and incorporating the resident's goals preferences, and choices. Staff must respect the resident's individuality as well as, honor and value their input. Procedure. 1. All residents will be treated with dignity and respect. 2. Promoting resident independence and dignity while dining, such as avoiding c. Staff standing over residents while assisting them to eat; d. Staff interacting/conversing only with each other rather than residents while assisting with meals; g Staff should not discuss residents in settings where others can overhear private or protected information or document in charts/electronic records where others can see a resident's information. On 7/30/24 at 9:22 A.M., the surveyor made the following observations during the breakfast meal in the dining room: -Three staff members, with approximately 20 residents at tables eating or being assisted with eating their breakfast. The three staff were at different tables and were conversing with each other across the room about a resident (not identified by name) saying he/she's family does not see this and the resident needs PT (physical therapy). The staff continued to talk freely around the residents while they ate, about their concerns about another resident. -One Certified Nursing Assistant (CNA) was standing while assisting a resident to eat. The CNA was not at eye level with the resident who required the assistance. On 7/31/24 at the following observations were made in the dining room during the lunch: (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 12:56 P.M. a CNA was standing while feeding a resident to eat his/her lunch, then moved to another resident and while standing began to feed that resident. At 1:02 P.M., the CNA continued to feed a resident while standing above the eye level of the resident. During an interview on 7/31/24 at 2:30 P.M., CNA #1 said there are many residents on her assignment that require assistance with eating. CNA #1 said staff are supposed to be sitting on the same level as the resident. CNA #1 said she was helping two residents at different tables and that is why she did not sit on their level. During an interview on 7/31/24 at 3:48 P.M., Activities Assistant (AA) #1 said during meals staff who are feeding residents should be sitting with the resident. AA #1 said during meals conversations should be towards residents and not with other staff. AA #1 said they were talking about a resident who they were concerned about.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation, record review and interview the facility failed to ensure one Resident (#92), out of a total sample of 25 residents, was assessed for the use of a possible physical restraint. Specifically, Resident #92 wore a one- piece outfit adjacent to his/her body and zippered up the back. Findings include: Review of the facility's policy titled 'Physical Restraint Use' revised: 12/29/2023, indicated the following: Policy: the intent is for each resident to attain and maintain his/her highest practical well-being in an environment that prohibits the use of physical restraints for discipline or convenience, prohibits the use of physical restraints to unnecessarily inhibit a resident's freedom of movement or activity, and limits physical restraint use to circumstances in which the resident has medical symptoms that may warrant the use of restraints. Definitions Physical restraint -any manual method or physical or mechanical device, equipment, or material that meets all of the following criteria: a. Is attached or adjacent to the resident's body, b. cannot be removed easily (meaning it can be removed intentionally by the resident in the same manor it was applied by the staff); and c Restricts the resident's freedom of movement or normal access to his/her body. Procedure Assessment, 1. When alternatives to restraint use are not effective, the interdisciplinary team evaluates the least restrictive to promote safety and attain/maintain the highest practical physical, mental, and psychosocial function of the resident. 2. The type of restraining device, frequency/duration, and medical reason(s) for restraining device are documented on the Physical restraint Informed Consent. 3. The resident or resident representative may request the use of a physical restraint, however, if there is no medical symptoms identified that require treatment, Resident #92 was admitted to the facility in November 2023 with diagnoses that include but not limited to Alzheimer's Disease, depression unspecified, and dementia. Review of the most recent Minimum Data Set assessment dated [DATE] indicated Resident #92 was assessed by staff as having severely impaired cognition and requiring substantial/maximum assistance with toileting and upper body and lower body dressing. During the survey the following observations were made: -On 7/30/24 at 7:46 A.M., Resident #92 was standing at the nursing desk and made eye contact with the surveyor but did not respond to the surveyor's verbal greeting. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 7/30/24 at approximately 4:30 P.M., Resident #92 was observed wearing a snug fitting one-piece outfit with a zipper on the back that extended from the bottom of the back up to the neck, walking down the hall with a Certified Nursing Assistant (CNA). -On 7/31/24 at 7:39 A.M., 9:01 A.M., and 1:06 P.M., Resident #92 was wearing a one-piece outfit with a snug fit and zipper up the back, while sitting in the dining room. -On 7/31/24 at 4:48 P.M., Resident #92 was walking down the hall with a CNA, wearing a one-piece outfit with a zipper up the back. -On 8/1/24 at 8:29 A.M., Resident #92 was wearing a one-piece outfit with a zipper up the back while sitting in the dining room. Review of the care plan dated 11/24/24 indicated: Resident is at risk of injury/poisoning due to wandering on the secure memory unit. I have been observed putting inedible objects and feces/liquids in my mouth with an intervention dated 11/24/23 utilize adaptive clothing as able per HCP (health care proxy) request. Review of Resident #92's medical record failed to indicate a restraint assessment was completed to assess whether the one-piece outfit was a restraint. During an interview on 7/31/24 at 4:53 P.M., CNA #2 said the Resident has several one-piece suits and wears them to prevent him/her from getting into his/her poop. CNA #2 said the Resident cannot open or remove the clothing because the zipper is on the back. CNA #2 said the Resident's family provided the one-piece suit and that he/she has been wearing them for a few months. During an interview on 8/1/24 at 8:21 A.M., Activity Assistant (AA) #2 said Resident #92 does not have behaviors but does have PICA (a condition where a person eats things that are not food and don't have nutritional value or purpose) and that he/she wears a one-piece outfit to prevent his/her from reaching into his/her incontinence brief. During an interview on 8/1/24 at 8:54 A.M., Nurse #4 said they (staff) use a 'onesie' with a zip up back to keep Resident #92 from putting things in his/her mouth that he/she should not eat. Nurse #4 said Resident #92 is provided incontinence care every few hours and would have access to his/her body during that time. Nurse #4 said Resident #92 would not be able to remove the 'onesie' him/herself. Nurse #4 said she could not recall when the one-piece outfit was implemented. During an interview on 8/1/24 at 9:04 A.M. Unit Manager (UM) #3 said Resident #92 wears a one-piece outfit to prevent him/her from digging in his/her incontinent brief. UM #3 said she is not sure if it could be easily removed by the Resident. UM #3 reviewed Resident #92's medical record and said she did not see any assessment for the use of the one-piece outfit as a possible restraint. During an interview on 8/1/24 at 10:12 A.M., the Director of Nursing said the one-piece outfit is adjacent to the Resident's body and that was looked at as a behavior intervention and not looked at in the way of a potential restraint.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on record review and interview the facility failed for one Resident (#75), out of a sample of 25 residents, to convey to the receiving provider the necessary information to care for the resident. Review of the facility's policy titled 'Transfers and Discharges' dated as revised 6/28/2024 indicates Policy: the facility will follow limited conditions under which CMS (Centers of Medicare and Medicaid) has outlined how the facility may initiate transfer or discharge of a resident, the documentation that must be included in the medical record, and who is responsible for making he documentation. Additionally, the facility will ensure the information that must be conveyed to the receiving provider for residents being transferred or discharged to another health care setting is provided in accordance to federal guidance. Resident #75 was admitted to the facility in January 2021 with diagnoses that include depression, unspecified dementia, delusional disorder transient ischemic attack and cerebral infarction. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #75 has severely impaired cognition and requires substantial/maximum assistance for daily care including toileting, bathing and dressing. Further review of the MDSs completed indicated Resident #75 had a discharge with a return expected on 7/24/24 and an entry MDS on 7/29/24, which indicated Resident #75 went to the hospital. Review of Resident #75's medical record indicated a 'behavior note' dated 7/24/24; MD (medical doctor) recommended to send resident out for assessment, family made aware. Resident was taken finally to the hospital around 5 pm (sic). Further review of the medical record failed to indicate the written conveyance of information to care for Resident #75 was sent to the receiving provider. During an interview on 7/31/24 at 12:52 P.M., Nurse #5 said when a resident is sent to the hospital an MD order is obtained, and the face sheet, medication orders and advanced directive information is sent with the resident, and that a referral is also sent called an e-interact which includes information for the Resident's care. During an interview on 7/31/24 at 2:38 P.M. Unit Manger #3 said a e-interact is used to provided information to the hospital when a resident is transferred. Unit Manager #3 said she could not find an e-interact or any supporting information that was sent with Resident #75 when he/she was transferred to the hospital on 7/24/24. During an interview on 8/1/24 9:54 A.M., the Director of Nursing said the MD called the emergency room directly to give a history and report on Resident #75. The DON reviewed the medical record and said the only nursing documentation was the behavior note on 7/24/24. The DON said the nursing staff should have completed and sent the e-interact form to the hospital.

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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** 46339 Based on observation, record review and interviews, the facility failed to ensure professional standards of practice were followed for one Resident (#19) out of a total sample of 25 residents. Specifically, the facility failed to ensure nurses were not leaving medications with the Resident without proper assessment, and ensuring a physician order was in place for medication administration. Findings include: Review of the facility policy titled 'Administration of Medications' revised August 2023, indicated the following but not limited to: -Medication administration is the responsibility of those individuals who through certification and licensure are authorized in their state to administer medications in a skilled nursing facility. -A physician order that includes dosage, route, frequency, duration, and other required considerations including the purpose, diagnosis or indication for use is required for administration of medication. Resident #19 was admitted to the facility in October 2022 with diagnoses including unspecified glaucoma and polyneuropathy. Review of Resident #19's Minimum Data Set (MDS), dated [DATE], indicated the Resident scored a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact. The MDS further revealed the Resident did not have behaviors. On 7/31/24 at 9:38 A.M., the surveyor observed Nurse #3 prepare medications for Resident #19 for administration. Nurse #3 prepared all morning medications to be administered. He took a bottle of Flonase nasal spray from the medication cart and said the Resident receives it every morning but could not see the order. Nurse #3 said maybe the order dropped off. Nurse #3 and the surveyor proceeded into Resident #19's room for medication administration. Resident #19 said he/she was not pleased with how the medication administration was occurring as his/her spouse normally administers his/her medications when the nurses bring them to the room. Resident #19 was yelling out loud in frustration. On 7/31/24 at 9:50 A.M., Resident #19 started yelling and raising his/her voice and said that he/she should not be subjected to a change happening because the surveyor was present. He/she further said he/she has been receiving the Flonase nasal spray every day until this morning. Resident #19's spouse said that she has been administering the medications and the eye drops once the nurses brought them into the room. She further said since there are three eye drops it takes about 15 minutes of the nurses' time, and she understands they are busy. When asked if an assessment had been done for the Resident to self-administer medication, Resident #19's spouse said he/she was not aware. Review of Resident #19's medical record failed to indicate an assessment for self-administration of medication had been completed. The records also failed to indicate an order to administer Flonase nasal spray. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/31/24 at 10:04 A.M., Nurse #3 said nurses are not supposed to leave medications with the residents until administration is completed, a self-administration assessment should be completed, and physician order is required for all medication administration. Nurse #3 said that Resident #19 is particular with how he/she receives his/her medications. During an interview on 7/31/24 at 10:33 A.M. Unit Manager #1 said she was not aware that Resident #19's spouse was administering the eye drops and medications once the nurses brought them into the room. Unit Manager #1 said the Resident had not been assessed for self-administration and nurses are to stay with the residents until the administration is completed. During an interview on 8/1/24 at 8:25 A.M., the Director of Nursing said nurses are to stay with the residents during medication administration unless they have been assessed for self-administration. She further said all medications administered should have a physician order.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observations, record review and interview the facility failed to ensure for one Resident (#55) that care was provided in accordance to the plan of care. Specifically, Resident #55 was not provided supervision by staff during his/her breakfast meals. Findings include: Review of the facility's policy, titled 'Activities of Daily Living' revised 2/12/2024 indicated, the resident will receive assistance as needed to complete activities of daily living (ADLS). Resident #55 was admitted to the facility in December 2022 with diagnoses that include chronic kidney disease, chronic obstructive pulmonary disease, adjustment disorder with depressed mood, and unspecified dementia. Review of the Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #55 scored 3 out of 15 on the Brief Interview for Mental Status exam indicating a severe cognitive impairment and for eating requires supervision/or touching assistance, helper provides verbal cues/or touching steadying assistance as resident completes activity. On 7/30/24 at 9:14 A.M., Resident #55 was observed sitting up in bed, with his/her breakfast tray in front of him/her. The breakfast consisted of barely consumed cut up pancakes, coffee, hot cereal, and milk. Resident #55 was using his/her left hand, which was shaky, and had difficulty placing the cup down on the tray. There was no staff in the room or nearby. At 9:29 A.M., staff entered the room, verbally encouraged the resident to eat and promptly left. Review of Resident #55's medical record indicated the following: -A physician's order for regular diet, regular texture, 12/1/2022. -A Kardex Report (a document used to inform staff of a resident's care needs) Eating: Resident is able to: eat with supervision and set-up help. Assist if needed. -A care plan, 'Resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) confusion, decreased awareness of his/her needs' Interventions: Eating Resident is able to: eat with supervision and set-up help. Assist if needed. 12/12/2022. Review of the Documentation Survey Report v2 for ADL- eating indicated Resident #55 was documented on 7/30/34 and 7/31/24 at 0800 (8:00 A.M.) as eating self-performance as limited assistance and set-up help only. On 7/31/24 at 8:41 A.M., Resident #55 was sitting up in bed at approximately 60-70 degrees with his/her breakfast tray in front of him/her. The breakfast tray was set-up and Resident #55 was eating bread with jelly on it then placed it on the front of him/her and not on the tray. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-8:44 A.M., Resident #55 had his/her cup of milk in his/her hand was not actively drinking and no staff was present or nearby. -At 8:54 A.M., the toast was partially consumed, the eggs were barely eaten, and the coffee was untouched. Resident #55 was staring off and not actively eating. There were no staff in the room or nearby. - At 9:05 A.M., Resident #55 was staring at his/her food. Not actively eating and no staff were in the room or nearby. -At 9:11 A.M., Resident #55 was staring at his/her untouched breakfast, was not actively eating and no staff were present in the room nor nearby. -At 9:18 A.M., Certified Nursing Assistant (CNA) #4 entered the room, provided brief encouragement, exited the room and Resident picked up his/her spoon to eat but did not actively eat. - At 9:24 A.M., forty-three minutes after the observation began, a CNA entered and encouraged Resident #55 to eat. -At 9:27 A.M., Resident #55's breakfast tray with partially consumed eggs and untouched hot cereal was removed by the CNA. On 8/1/24 at 8:44 A.M., Resident #55 was observed sitting up in bed with his/her breakfast tray in front of him/her holding a cup of milk. No staff were present or nearby. -At 8:51 A.M., Resident #55 eyes were closed. There were no staff present to provide supervision or cueing. - At 9:01 A.M., Resident #55 eyes were opened but not actively eating his/her breakfast. No staff were in the room nor nearby. - At 9:07 A.M., Resident #55 remained with his/her breakfast tray in front of him/her not actively eating, and no staff present nor nearby. -At 9:14 A.M., Resident #55's had a spoon in his/her right hand, dropped the spoon and picked up the cut-p French toast with his/her fingers. The hot cereal, French toast, and coffee were barley eaten. -At 9:17 A.M., Resident #55's milk was partially consumed. He/she was not actively eating. Staff were not in the room or nearby. -At 9:21 A.M., Resident #55 was holding a cup and drinking milk. Observation of the clip board in Resident #55's room, indicated for eating Resident #55 requires set up and cues. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/01/24 at 9:22 A.M. thirty-eight minutes after the observation began, Certified Nursing Assistant (CNA) #3 said she just checked in on Resident #55 and that the Resident needs cueing to eat on his/her own. CNA #3 said the Resident likes to drink his/her beverages first. CNA said the supervision that is provided to the Resident when he/she eats in his/her room is staff going back to check on him/her to give him/her cues to eat. During an interview on 8/01/24 at 10:09 A.M., the Director of Nursing said Resident #55 should be provided with the supervision and assistance he/she requires.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36431 Based on observation, record review and interview for one Resident (#12), out of a total sample of 25 residents, the facility failed to ensure interventions were implemented in accordance with the medical plan of care. Specifically, the bed alarm for Resident #12, who was assessed by nursing as being a high risk for falls was not in use while Resident #12 was in bed. Findings include: Resident #12 was admitted to the facility in March 2021 with diagnoses that include osteoporosis, unspecified dementia and repeated falls. Review of the Minimum Data Set assessment dated [DATE] indicated Resident #12 scored a 3 out of 15 on the Brief Interview for Mental Status exam, indicating severe cognitive impairment, requires substantial/maximum assistance with bathing dressing and transfers and uses a bed alarm daily. Review of Resident #12's medical record indicated the following: -A physician's order dated 4/10/23 bed alarm at bedtime and monitor for function and placement. -A Kardex Report (a document which summarizes the plan of care, used by staff) bed and chair alarm for safety. - A care plan: Resident is at risk for falls with the intervention/task bed and chair alarm for safety 3/2/2021. - A Fall risk evaluation dated 5/15/24 post event score of 26, (a score of 10 or above is high fall risk.) On 7/30/24 at 4:26 P.M., and 5:03 P.M., Resident #12 was observed resting in his/her bed. The bed alarm cord was not plugged in to an alarm box. During an interview on 7/31/24 at 4:09 P.M., Nurse #6 said Resident #12 does have a risk for falls care plan and uses a bed and chair alarm. . On 7/31/24 at 4:17 P.M., Resident #12 was observed resting in his/her bed. The bed alarm cord was stuck in the bedside drawer and was not attached to the alarm box. During the observation Unit Manager #3 entered the room and observed the bed alarm cord not plugged into the alarm box. Unit Manager #3 found the alarm box in Resident #12's bedside drawer and said it should have been plugged in and in use.

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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 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. 41019 Based on observation and interview, the facility failed to appropriately use gloves in a sanitary manner during the lunch time meal service. Findings include: During an observation on 7/31/24 at 12:10 P.M., the cook was wearing gloves during the serving line and, with gloves, opened the oven door. With the same contaminated gloves, the cook proceeded to touch the fish that he was serving on a plate. With the same contaminated gloves, the cook touched meatloaf twice and then another plate with fish. The cook also grabbed a hot dog roll to serve with the same contaminated gloves. During an interview on 7/31/24 at 12:15 P.M., the Food Service Director was notified of the glove use and, she said that the cook should change his gloves after touching the oven door. The Food Service Director proceeded to educate the cooks on glove changing.