STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Leominster	370 West Street Leominster, MA 01453

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on records reviewed and interviews, for one of three sampled residents (Resident #1), who had severe cognitive impairment, and was found with new areas of bruising on his/her left upper arm, the Facility failed to ensure that Resident #1 and other residents on his/her unit were protected from potential further abuse by a staff member, when on 04/07/26, although the Assistant Director of Nurses (ADON) was aware that Resident #1 had alleged that staff were rough with him/her during care, the Facility failed to ensure they conducted a thorough investigation into his/her bruising of unknown origin. The Facility's Report did not include an investigation into Resident #1's allegation of rough handling as potential for abuse and they did not obtain and maintain copies of witness statements, therefore placing residents at risk for the potential abuse.Findings include:Review of the Facility's Policy titled, Incident and Reportable Event Management, dated as revised 09/23/25, indicated that in response to allegations of abuse, neglect, exploitation, or mistreatment, the Facility must:-have evidence that all alleged violations are thoroughly investigated, and-prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in process.Resident #1 was admitted to the Facility in December 2022, diagnoses included dementia, depression, and anxiety.Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 03/19/26, indicated he/she had severe cognitive impairment, and was dependent on staff to meet his/her care needs.Review of Resident #1's Skin Assessment, dated 04/07/26, indicated he/she had a new area of bruising on his/her left inner and outer forearm.Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated as submitted 04/07/26, indicated that on 04/07/26, small bruises were noted on Resident #1's inner and outer left forearm.Review of the Facility's Internal Investigation Report, undated, indicated that the Activity Director had noticed bruises on Resident #1's left forearm and reported this to the nurse. The Report indicated that the Nurse noted a small cluster of bruises on Resident #1's left inner and outer forearm, and that he/she (Resident #) had no recollection of what caused the bruising. The Report indicated that Resident #1's left forearm bruising might have been caused by wheelchair self-propulsion with both arms. The Report indicated that the Facility could not substantiate abuse.During an interview on 04/29/26 at 10:30 A.M., (which included review of her written witness statement, dated 04/09/26), the Activity Director said that on 04/07/26, during lunch, she noticed bruises on Resident #1's left forearm. The Activity Director said she asked Resident #1 how he/she got the bruises and Resident #1 told her that, they were rough with me. The Activity Director said Resident #1 told her that he/she did not want to get anyone in trouble, so when she asked him/her (Resident #1) which staff member was rough with him/her, he/she would not tell her. The Activity Director said she immediately told the Unit Manager and the Assistant Director of Nurses (ADON).Further review of the Facility's Internal Investigation indicated that there was no documentation to support that staff members had been interviewed or asked to provide a written witness statement specific to an allegation of rough care that could have potentially determined if any staff member had witnessed or had provided rough care to Resident #1.Although Resident #1 had alleged rough care from staff when asked what happened to his/her arm, the Facility investigated the bruising as an injury of unknown origin and not as an allegation of potential abuse, and therefore no attempts were made to identify an accused staff (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	member and therefore protect Resident #1 or other residents from further potential abuse. During an interview on 04/29/26 at 12:44 P.M., the Unit Manager said that on 04/07/26, the Activity Director told her that she noticed bruising on Resident #1's left forearm, and that he/she (Resident #1) had told her (Activity Director) that someone had been rough with him/her. The Unit Manager said she immediately told the ADON and they both went to assess Resident #1. The Unit Manager said Resident #1 was unable to tell them what happened. The Unit Manager said she and the ADON thought the bruising might have been from Resident #1 self-propelling his/her wheelchair, but the Unit Manager also said he/she had been self-propelling his/her wheelchair for a long time and had not had similar bruising.During an interview on 4/29/26 at 1:05 P.M., the Assistant Director of Nurses (ADON), said she went into assess Resident #1 with the Unit Manager and said she saw a small cluster of bruises on his/her left forearm, and said when she asked Resident #1 what had caused the bruises, he/she (Resident #1) could not answer. The ADON said that on 04/07/26, she was aware that Resident #1 had alleged that staff had been rough with him/her and that rough care could have caused his/her bruising. During an interview on 04/29/26 at 2:28 P.M., the Director of Nurses (DON) said the Unit Manager had notified her that Resident #1 had new bruising on his/her left forearm. The DON said that she, the ADON, and the Unit Manager investigated the bruises and determined that the bruise was caused by Resident #1 self-propelling his/her wheelchair. The DON said she could not recall when she was made aware that Resident #1 had alleged that staff were rough with care and was the cause of the bruising on his/her left forearm. The DON said she did not investigate the bruises as an allegation of abuse by staff but should have.During a telephone interview on 05/13/26 at 12:05 P.M., the Administrator said that she had not been made aware that Resident #1 made an allegation of rough care by staff on 04/07/26 until the day of survey (04/29/26). The Administrator said that immediately after staff noticed new bruising on Resident #1's forearm and he/she alleged rough care by staff, the incident should have been reported and investigated as an abuse allegation and not just an injury of unknown origin. The Administrator said that because a thorough abuse investigation had not been completed, staff on all shifts from 48-72 hours prior to the allegation being made had not been interviewed or asked to write a witness statement specific to the abuse allegation, other residents on the unit had not been interviewed, and efforts to identify an accused staff member had not been made, but should have been. The Administrator said that once she was made aware that Resident #1 had made an allegation of abuse by staff, a thorough abuse investigation had been completed, and she had not been able to substantiate abuse.