

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 07/01/2024
NAME OF PROVIDER OR SUPPLIER Life Care Center of Leominster		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44337</p> <p>Based on observation, record review and interview, the facility failed to provide an environment that was free from physical restraints for one Resident (#56) out of a total sample of 23 residents.</p> <p>Specifically, the facility failed to assess and re-evaluate the need for physical restraints with the use of Resident #56's bed positioned flush against the wall on the left side of the bed that restricted the Resident from exiting the left side of the bed if needed.</p> <p>Findings include:</p> <p>Review of the facility policy titled Physical Restraint Use last revised 12/29/23 indicated the following:</p> <ul style="list-style-type: none"> -The intent is for each resident to attain and maintain his/her highest practicable well-being in an environment that: <ul style="list-style-type: none"> >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. -Physical restraint- any manual method or physical or mechanical device, equipment, or material that meets the following criteria: <ul style="list-style-type: none"> a. Is attached or adjacent to the resident's body b. Cannot be moved easily by the resident (meaning it can be removed intentionally by the resident in the same manner as it was applied by the staff); and c. Restricts the resident's movement or normal access to his/her body <p>(continued on next page)</p>

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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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The type of restraining device, frequency/duration and medical reasons for restraining device are documented on the Physical Restraint Informed Consent.</p> <p>-The resident or resident representative may request the use of a physical restraint; however, if there are no medical symptoms identified that require treatment, the use of a restraint is prohibited.</p> <p>-A Physician's order is required for the use of the specific restraints. The order should include the specific type of restraint, the condition and/or medical symptom that warrants restraint use, where and how the restraint is to be applied and used, and the time and frequency the restraint should be released.</p> <p>-The Physician's order alone, without supporting clinical documentation, is not sufficient to warrant the use of a restraint.</p> <p>-The need for the restraint is assessed quarterly and as indicated.</p> <p>Resident #56 was admitted to the facility in February 2018, with diagnoses including Dementia (a condition in which memory, social skills and thinking abilities are impaired), and Lack of normal physiological development in childhood (developmental delay in physical and mental development).</p> <p>Review of a Minimum Data Set Assessment (MDS) dated [DATE], indicated Resident #56 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) score of three out of a total score of 15.</p> <p>On 6/25/24 at 9:49 A.M., the surveyor observed Resident #56 lying in bed, with the bed positioned flush against the wall on the left side of the bed.</p> <p>On 6/26/24 at 8:22 A.M., the surveyor observed Resident #56 lying in bed, with the bed positioned flush against the wall on the left side of the bed.</p> <p>On 6/26/24 at 2:05 P.M., the surveyor observed Resident #56 lying in bed, with the bed positioned flush against the wall on the left side of the bed.</p> <p>Review of the current Physician's orders dated 6/27/24, did not indicate any evidence of an order for Resident #56 to have the bed positioned flush against the wall on the left side of the bed.</p> <p>Review of Resident #56's clinical record did not provide any evidence that assessment and re-evaluation had been completed relative to positioning Resident #56's bed flush against the wall on the left side of the bed as a physical restraint.</p> <p>Further review of Resident #56's clinical record did not provide any evidence documented in the progress notes relative to positioning Resident #56's bed flush against the wall on the left side of the bed.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/26/24 at 2:07 P.M., Certified Nurses Aide #1 (CNA #1) said she worked full-time on the Main Hall nursing unit and often provided care to Resident #56. CNA #1 said Resident #56's bed had been pushed flush against the wall on the left side of the bed for several months because it is safer for Resident #56 to get into and out of bed with the bed positioned against the wall. CNA #1 also said that she was not sure why or how it was decided that positioning the left side of the bed flush against the wall was safer for Resident #56.</p> <p>During an interview on 6/26/24 at 2:28 P.M., Unit Manager (UM) #1 said that she was not sure how Resident #56 had been assessed to require the left side of the bed be positioned flush against the wall. UM #1 said that with the bed positioned flush against the wall, the Resident is not able to exit the bed on the left side. UM #1 also said that restricting Resident #56 from exiting the left side of the bed could potentially be a restraint.</p> <p>During an interview on 6/27/24 at 1:13 P.M., the Director of Nursing (DON) said that having the bed positioned flush against the wall prevented Resident #56 from exiting the bed on the left side. The DON said that Resident #56 had a history of falls and the left side of the bed being placed flush against the wall provided Resident #56 with more space that would prevent him/her from striking furniture or other objects if he/she fell again. The DON said that there should have been a restraint assessment completed, a Physician's order obtained, and progress note documented that reflected the positioning of Resident #56's left side of the bed flush against the wall. The DON further said that she could not provide any evidence that a restraint assessment had been completed, a Physician's order had been obtained, or a progress note that reflected positioning Resident 56's left side of the bed flush against the wall.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>45435</p> <p>Based on interview, observation, record and policy review, the facility failed to ensure that one Resident (#60) of four applicable residents, out of a total sample of 23 residents, received care and services for his/her pressure ulcer (a wound, usually over a bony prominence, that is caused by unrelieved pressure to the area) in accordance with professional standards of practice.</p> <p>Specifically, the facility failed to ensure a wound dressing was in place as ordered by the Physician, placing the Resident at risk for infection and worsening of his/her pressure ulcer.</p> <p>Findings include:</p> <p>Review of the facility policy titled Skin Integrity and Pressure Ulcer/Injury Prevention and Management, dated 3/31/23, indicated the following:</p> <p>-A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.</p> <p>Review of the facility policy titled Skin Integrity and Pressure Ulcer/Injury Prevention and Management, dated 3/31/23, indicated the following:</p> <p>-Procedure: this facility will utilize Lippincott procedures: Pressure Injury Prevention</p> <p>Review of the Lippincott Nursing Procedure Manual - 9th Edition (2023) indicated the following:</p> <p>-As the name implies, pressure injuries result when pressure - applied with great force for a short period or with less force over a long period - impairs circulation, depriving tissues of oxygen and other life-sustaining nutrients. This process damages skin and underlying structures. Untreated, resulting ischemic (reduced blood flow) lesions (a damaged area of tissue) can lead to serious infection.</p> <p>-If left untreated, pressure injuries can become infected or necrotic (dead tissue). Advancing infection or cellulitis (potentially serious bacterial infection of the skin) can lead to septicemia (a life threatening condition that occurs when bacteria enter the bloodstream).</p> <p>Review of the facility policy titled Treatment of Wounds, dated 3/31/23 indicated the following:</p> <p>-This facility will utilize the Lippincott procedures: Traumatic Wound Care: abrasion, laceration, and puncture wounds.</p> <p>Review of the Lippincott Nursing Procedure Manual - 9th Edition (2023) indicated the following:</p> <p>-Apply a dry, sterile dressing over the wound to absorb drainage and help prevent bacterial contamination.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #60 was admitted to the facility in May 2020, with diagnoses including cerebral infarction (also known as stroke, a condition that occurs when blood flow to the brain is disrupted, causing brain cells to die due to lack of oxygen) with hemiparesis (weakness on one side of the body) and hemiplegia (paralysis of one side of the body).</p> <p>Review of the Minimum Data Set (MDS) Assessment, dated 5/31/24, indicated the following:</p> <ul style="list-style-type: none"> -Resident #60 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 points. -Had range of motion impairments on one side affecting the upper and lower extremities. -Was dependent on staff for bathing, dressing, hygiene, and bed mobility. -Was at risk for pressure ulcers. -Had no pressure ulcers/injuries. <p>Review of the Wound Observation Tool, dated 6/25/24, indicated the following:</p> <ul style="list-style-type: none"> -Resident #60 acquired an unstageable deep tissue injury (a type of pressure injury when full-thickness skin and tissue are lost but the extent of the damage is covered by dead tissue) on the left lateral malleolus (bone on the outside of the left ankle). -The wound was acquired on 6/11/24, and was unchanged. -Wound measured 0.8 centimeters (cm) in length by (x) 1.1 cm in width, with no depth. -Wound was deep purple/red with redness surrounding the wound. -Current treatment plan was Allevyn (a foam dressing that absorbs drainage) dressing to be changed every five days and as needed (PRN). <p>Review of the Physician's orders, dated June 2024, indicated the following:</p> <ul style="list-style-type: none"> -small Allevyn dressing to the left lateral malleolus every five days, evening shift (3:00 P.M. - 11:00 P.M.), date initiated 6/11/24. <p>On 6/28/24 at 7:47 A.M., the surveyor and Nurse #1 observed the Resident's left lateral malleolus wound and found that there was no dressing in place over the wound. The wound was observed to have a dark dry center measuring approximately 0.75 cm in length x 0.75 cm in width. The wound was also noted to be opening at the top of the wound bed and a small amount of blood-tinged drainage was observed on the bed linen under the wound. Nurse #1 said that the Resident did not have an order for a dressing and that the wound team said to just monitor the wound.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/28/24 at 8:16 A.M., the surveyor and Nurse #1 reviewed the Physician's orders for Resident #60. Nurse #1 said that she did not see the order for the dressing because the dressing change was scheduled for the evening shift. Nurse #1 said that she had not checked to see if a dressing was in place the previous day (6/27/24), because she did not know the Resident was ordered for a wound a dressing. Nurse #1 said usually the Treatment Administration Record (TAR) would show that the Resident had a dressing that needed to be checked every shift, but this Resident's TAR did not indicate that. Nurse #1 said that she had not looked at the Resident's legs or feet the previous day.</p> <p>During an interview on 6/28/24 at 8:43 A.M., Resident #60 said he/she never had a dressing on his/her left ankle.</p> <p>On 6/28/24 at 8:43 A.M., the surveyor and the Director of Nursing (DON) observed the Resident's left lateral malleolus wound and found that there was no dressing in place. The surveyor observed that the wound was unchanged from the previous observation with Nurse #1, and there was a small amount of blood-tinged drainage on the bed linen under the wound. The DON said there should be a dressing in place as ordered by the Physician.</p> <p>During an interview on 6/28/24 at 12:42 A.M., the Assistant Director of Nursing (ADON) said the wound team consisted of the DON, ADON, Unit Manager (UM) and a Physical Therapist (PT). The ADON said the wound team completed rounds on each resident's wound in the facility weekly, then met to discuss treatment orders. The ADON said that someone from the wound team would obtain the new orders from the Physician and enter them into the electronic medical record (EMR). The ADON said generally the Physician's orders included orders to wash and dry the wound, apply a dressing, and to monitor the wound each shift for signs and symptoms of change.</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>45435</p> <p>Based on interview, record and policy review, the facility failed to ensure that recommendations made by the Consultant Pharmacist during a monthly Medication Regimen Review (MRR) were acted upon as required for two Residents (#60 and #79), of five applicable residents reviewed for unnecessary medications, out of a total sample of 23 residents.</p> <p>Specifically, the facility staff failed to:</p> <ol style="list-style-type: none"> For Resident #60, ensure that MRR recommendations for discontinuation of an antihistamine medication and an acetylcholinesterase inhibitor medication were reviewed by the Physician and responded to as required. For Resident #79, ensure that MRR recommendations for medication administration changes of a mild pain reliever, a NMDA receptor antagonist, an anti-seizure medication and discontinuation of a probiotic and multivitamin medication were reviewed by the Physician and responded to as required. <p>Findings include:</p> <p>Review of the facility policy titled Pharmacy Recommendations, dated 11/29/23 indicated the following:</p> <ul style="list-style-type: none"> -The MRR includes review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication error, or other irregularities. -The pharmacist must report any irregularities to the Attending Physician and the facility's Medical Director and Director of Nursing, and these reports must be acted upon. -The Attending Physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any action has been taken to address it. -If there is to be no change in the medication, the Attending Physician should document his or her rationale in resident's medical record. <p>1. Resident #60 was admitted to the facility in May 2020, with diagnoses including cerebral infarction (also known as stroke, a condition that occurs when blood flow to the brain is disrupted, causing brain cells to die due to lack of oxygen) with hemiparesis (weakness on one side of the body) and hemiplegia (paralysis of one side of the body).</p> <p>Review of the Consultant Pharmacist Report, dated 1/15/24, indicated the following:</p> <ul style="list-style-type: none"> -The Resident is receiving Hospice, comfort or palliative care services. <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Please re-evaluate the current medication regimen to assure the benefits of each medication outweighs the potential risks, perhaps giving consideration to discontinuing use of Loratadine (antihistamine medication used to treat symptoms of allergies), Donepezil (acetylcholinesterase inhibitor medication used to improve mental function).</p> <p>Review of Resident #60's Physician's orders, dated June 2024, indicated the following:</p> <p>-Donepezil 5 milligrams (mg), give one tablet by mouth one time a day for Dementia, date initiated 3/23/23.</p> <p>-Loratadine 10 mg, give one tablet by mouth in the morning for allergy, date initiated 3/23/23.</p> <p>Review of the Medication Administration Record (MAR), dated 6/1/24 through 6/27/24, indicated that the Resident was administered Donepezil 5 mg and Loratadine 10 mg daily as ordered.</p> <p>Review of the Resident's clinical record indicated no documented evidence that the Consultant Pharmacist recommendations dated 1/15/24, was reviewed or responded to by the Physician or facility staff, as required.</p> <p>During an interview on 6/28/24 at 11:41 A.M., the Consultant Pharmacist said her recommendations are based on recent guidelines and it is up to the Physician and facility staff to follow through with the recommendations. The Consultant Pharmacist said she did make the recommendations for Resident #60 on 1/15/24, but would not repeat the recommendations the following month. The Consultant Pharmacist said the facility receives her recommendations by monthly email to the DON. The Consultant Pharmacist said she keeps a calendar of her recommendations and would do a repeat request six months after the initial recommendation. The Consultant Pharmacist further said she had marked Resident #60's recommendation on her calendar to see if there was a need to place another recommendation request.</p> <p>2. Resident #79 was admitted to the facility in August of 2023, with the diagnoses including unspecified Dementia (a mental disorder that occurs when someone has dementia but does not have a specific diagnosis).</p> <p>Review of the Consultant Pharmacist Report, dated 2/9/24, indicated the following:</p> <p>-The Resident has been routinely refusing to take the medications below on a consistent basis .</p> <p>-Acetaminophen (mild pain reliever). Consider making afternoon dose PRN (as needed).</p> <p>-Please consider switching Memantine ER (NMDA receptor antagonists used to treat Dementia) once daily capsule which can be opened and sprinkled on applesauce.</p> <p>-Lamotrigine ER (used to treat seizures) tablets cannot be crushed but could be considered if patient can swallow whole.</p> <p>-Please consider discontinuation of Probiotic (supplement to improve the good bacteria in the body) and multivitamin.</p> <p>Review of the Physician's orders, dated June 2024, indicated the following:</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Acetaminophen 1000 mg scheduled three times a day, date initiated 2/6/24.</p> <p>-Memantine 10 mg twice a day, date initiated 2/6/24</p> <p>-Lamotrigine 100 mg twice a day, date initiated 2/6/24</p> <p>-Probiotic oral capsule give one daily, date initiated 8/1/23</p> <p>-Multivitamin give one tablet daily, date initiated 8/11/23</p> <p>Review of the Resident's clinical record indicated no documented evidence that the Consultant Pharmacist recommendations dated 2/9/24 were reviewed or responded to by the Physician or facility staff, as required.</p> <p>During an interview on 6/28/24 at 10:22 A.M., the Director of Nursing (DON) said after the Consultant Pharmacist reviews the medical records, the DON and the Assistant Director of Nursing (ADON) will receive the recommendations. The DON said that they will print the recommendations and bring them to the Unit Manager (UM), who will ensure that the recommendations have been addressed by the Physician. The DON said that the process for follow-up to see if the Consultant Pharmacist recommendations had been addressed, has been hit or miss. The DON further said that she had to call the Pharmacy today to request the 2/9/24 Consultant Pharmacist recommendations because the facility did not have the report when the surveyor requested to 'see report' as indicated in the Pharmacist note.</p> <p>During an interview on 6/28/24 at 2:30 P.M., the ADON said she could provide no documented evidence that the Pharmacy Consultation report for Resident #60, dated 1/15/24, had been reviewed or responded to by the Physician or facility staff as required.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>45435</p> <p>Based on interview, record and policy review, the facility failed to ensure that the medication regimen was free from unnecessary medication for one Resident (#60), of five applicable residents reviewed for unnecessary medication review, out of a total sample of 23 residents.</p> <p>Specifically, the facility failed to ensure Resident #60 was free from administration of an excessive duration for an antibiotic eye ointment medication that was ordered by the Physician for a duration of seven days and was administered to the Resident for a duration of ten days.</p> <p>Findings include:</p> <p>Review of the facility policy titled Administration of Medications, dated 8/24/23, indicated the following:</p> <ul style="list-style-type: none"> -The facility will ensure medications are administered safely and appropriately per Physician order to address resident's diagnoses and signs and symptoms. -A Physician's 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. -Check the order for when it would be given and when was the last time it was given. <p>Resident #60 was admitted to the facility in May 2020, with diagnoses of cerebral infarction (also known as stroke, a condition that occurs when blood flow to the brain is disrupted, causing brain cells to die due to lack of oxygen) with hemiparesis (weakness on one side of the body) and hemiplegia (paralysis of one side of the body).</p> <p>Review of the June 2024 Physician's orders indicated the following:</p> <ul style="list-style-type: none"> -Erythromycin Ophthalmic Ointment (an antibiotic eye ointment used to treat infections of the eye) five milligrams (mg) per gram, instill one ribbon in left eye three times a day for infection for one week (7 days), date initiated 6/18/24. <p>Review of the June 2024 Medication Administration Record (MAR), indicated the Resident had received Erythromycin Ophthalmic Ointment at 8:00 A.M., 2:00 P.M., and 10:00 P.M., starting on 6/18/24 at 2:00 P.M., and continuing through 6/27/24 at 10:00 P.M., (10 days).</p> <p>During an interview on 6/28/24 at 9:33 A.M., Nurse #1 said the order for Erythromycin Ophthalmic Ointment should have ended after the 8:00 A.M. dose on 6/25/24 but that the order had continued and was an active order at this time. Nurse #1 said she was the Nurse who entered the order into the electronic medication record (EMR), and that she does not know why the order did not stop after seven days because she had put for seven days in the order.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/28/24 at 9:56 A.M., the Director of Nursing (DON) said the order for Resident #60's Erythromycin Ophthalmic Ointment should have been discontinued after seven days but had not been discontinued.</p>

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 07/01/2024
NAME OF PROVIDER OR SUPPLIER Life Care Center of Leominster		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48206</p> <p>Based on record and policy review, and interview, the facility failed to provide education, assess for eligibility, and offer COVID-19 vaccinations for one Resident (#24), of five applicable residents, out of a total sample of 23 residents.</p> <p>Specifically, the facility failed to offer Resident #24 an updated COVID-19 vaccination when medical record documentation indicated that he/she was eligible.</p> <p>Findings include:</p> <p>Review of the facility policy titled COVID-19 Vaccination Program Policy for Residents, last revised 3/19/24, indicated the following:</p> <ul style="list-style-type: none"> -The facility will ensure that residents are offered the COVID-19 vaccine unless the immunization is medically contraindicated, or the resident has already been immunized. -The resident's medical record should include documentation that indicates that the resident or resident representative was provided education regarding the benefits and potential side effects of the COVID-19 vaccine, -and that the resident (or representative) either accepted and received the COVID-19 vaccine or did not receive the vaccine due to medical contradictions, prior vaccination, or refusal. <p>Review of CDC guidance titled, Stay Up to Date with COVID-19 Vaccines, revised January 2024, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> -People aged [AGE] years and older who got COVID-19 vaccines before September 12, 2023, should get one updated Pfizer-BioNTech, Moderna, or Novavax COVID-19 vaccine. <p>Resident #24 admitted to the facility in November 2023, was over the age of 65, and had diagnoses including Spinal Stenosis (narrowing of the spinal column which puts pressure on the spinal cord and nerves and can cause pain), Cervicalgia (also referred to as neck pain, is pain in and around the spine beneath the head), and Osteoarthritis (a degenerative joint disease caused by an inflammatory reaction in bone and joint tissue, that worsens over time, often resulting in swelling, stiffness, chronic pain and loss of flexibility).</p> <p>Review of the MDS (Minimum Data Set) assessment dated [DATE], indicated that Resident #24 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of a total score of 15.</p> <p>Review of Resident #24's Massachusetts Immunization Information System (MIIS) indicated that he/she had received the COVID-19 Johnson & Johnson (J&J) vaccinations on 5/17/21 and 12/29/21.</p> <p>(continued on next page)</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #24's clinical record did not indicate that a COVID-19 vaccination was offered to the Resident since his/her admission to the facility in November 2023, or that there was a medical contraindication for COVID-19 vaccination.</p> <p>During an interview on 6/28/24 at 8:15 A.M., with the Director of Nursing (DON) and the Infection Preventionist (IP), the DON said when residents were admitted to the facility, the nursing staff would review the resident's records and discharge paperwork to determine the vaccination history if available. The DON said if the resident vaccination status was not known, nursing staff would review the vaccinations in the MIIS system, and record the information in the resident's clinical record. The DON further said that when vaccines were offered, staff would provide the Vaccine Information Statement (VIS) sheet to the resident or their responsible party, consent for the vaccine would be reviewed and then documented on a form to indicate if the resident or their responsible party consented or declined the vaccination.</p> <p>During a follow-up interview on 6/28/24 at 11:26 A.M., the IP said that she was unable to provide evidence that Resident #24 had been offered a COVID-19 vaccination. The IP further said that an updated COVID-19 vaccination should have been offered to Resident #24 but had not been offered.</p> <p>During an interview on 6/28/24 at 11:43 A.M., Resident #24 said that he/she had not been offered any COVID-19 vaccinations since he/she was admitted to the facility. Resident #24 said he/she would want a COVID-19 booster if it were offered.</p>