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	08/14/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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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. Based on observation, record review and interview the facility failed to ensure a comprehensive person-centered care plan with individualized interventions was developed for one Resident (#79), out of three residents reviewed for Activities of Daily Living (ADLS), out of a total sample of 23 residents. Findings include:Resident #79 was admitted to the facility in November 2024 with diagnoses that include but are not limited to Alzheimer's disease, chronic obstructive pulmonary disease, and type 2 diabetes mellitus. Review of the Minimum Data Set (MDS) assessment, dated 6/30/25, indicated Resident #79 scored a 6 out of 15 on the Brief Interview for Mental Status exam indicating he/she as having severe cognitive impairment. Further, the MDS indicated Resident #79 required partial to moderate assistance for oral hygiene, required set-up for eating, required substantial/maximal assistance for toileting, upper and lower body dressing, putting on/off footwear, personal hygiene and he/she was dependent for bathing/showers. On 8/12/25 at 12:30 P.M., the surveyor observed Resident #79 in his/her bed with staff assisting to cut up his/her meal and then exited the room.A review of the established ADL care plan of care and Kardex (a document used to guide Certified Nurse's Assistants (CNA), dated current on 8/12/25, failed to indicate what level of care Resident #79 required for eating.During an interview on 8/13/25 at 4:19 P.M., CNA #1 said a Kardex is used to inform a CNA of a resident's needs. CNA #1 said she cares for Resident #79 and that he/she can eat after he/she is set up, uses a stand lift for transfers, is incontinent and is dependent on staff for bathing and dressing. Review of Resident #79's clinical record included the following care plan related to ADL performance:Focus: Resident has an ADL self-care performance deficit related to Confusion, Dementia, Fatigue, Impaired balance, date initiated 3/31/25.Goal: The resident will maintain current level of function in Assist of 2 through review date. (SIC) Revision date 6/23/25. Interventions:*Resident uses size L (large) protective underwear during the day hours and size L brief at night, date initiated 6/30/25. *AM ROUTINE: The residents preferred dressing/grooming, date initiated 3/31/25 The Care Plan failed to include specific person-centered interventions for all of Resident #79's ADL needs.During an interview on 8/13/25 at 3:54 P.M., Unit Manager #1 said after a resident is admitted each department develops their care plan for the resident. Unit Manager #1 said the care plans should reflect a resident's specific needs and the care plans are reviewed by the team quarterly.During an interview on 8/14/25 at 1:09 P.M., the MDS Nurse said Resident #79's ADL care plan lacks his/her specific ADL needs and should include all his/her specific ADL needs so staff would know how to care for the Resident.

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure for 1 Resident (#3), out of a total sample of 23 residents, that the care plans were revised to reflect a resident's status. Specifically, -For Resident #3 the care plan for anticoagulant medication (a medication used to prevent blood clots from forming in the bloodstream) was not revised to reflect the current anticoagulation treatment. Findings include: Review of the facility's policy titled, Area of Focus: Care Planning-Baseline, Comprehensive, and Routine Updates dated as reviewed 11/25/24, included but not limited to the following: Comprehensive Care Plan. 2. The Comprehensive Care Plan must be updated with each MDS (Minimum Data Set) assessment and periodically.Resident #3 was admitted to the facility in April 2023 and has diagnoses that include but are not limited to hypertension and unspecified atrial fibrillation.Review of the most recent MDS assessment dated [DATE] indicated Resident #3 scored a 15 out of 15 on the Brief Interview for Mental Status exam, indicating he/she as having intact cognition. Further the MDS indicated Resident #3 was administered a high-risk drug class of anticoagulant medication.Review of Resident #3's physician's orders indicated the following:-Eliquis (anticoagulant medication) 2.5 mg (milligrams) (Apixaban), give 1 tablet by mouth two times a day for a-fib (Atrial Fibrillation) order date 2/27/25. Review of Resident #3's care plans indicated the following:-Resident is on anticoagulant therapy Coumadin (a type of anticoagulant medication), as ordered secondary to DX (diagnosis) A-Fib, cardiac pacemaker, date initiated 5/3/2023. Goal INR (International Normalized Ration, a standard measure used to assess blood coagulation) and/or Protime (a blood test which measures how quickly the blood clots) within specific limits through next review, date initiated 5/3/23, revision on 5/13/25 and a target date of 10/9/25.Review of the order listing report indicated Resident #3's Coumadin Tablet 4 mg was discontinued on 1/9/25. Review of the Care Plan indicates it conflicts with the current order for Eliquis dated 2/27/25.Review of the MDS assessments indicated Resident #3 had a comprehensive MDS dated [DATE] and a quarterly MDS 7/23/25 which indicates 2 MDS assessments were completed since Resident #3 anticoagulant medication changed from Coumadin to Eliquis.During an interview on 8/14/25 at 12:48 P.M. , Unit Manager #1 reviewed Resident #3's care plan and said if the Resident is off coumadin it should not be on the care plan. Unit Manager #1 reviewed the orders and said the coumadin was discontinued in January 2025 and that the care plan should have been reviewed and revised during the quarterly care plan reviews. During an interview on 8/14/25 at 1:00 P.M. the MDS nurse said care plans are reviewed every 90 days and that nursing staff are to make updates or changes on care plans in between MDS assessments. The MDS nurse said the coumadin should have been resolved on the anticoagulant care plan.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure for 2 Residents (#19 and #79), out of 5 applicable residents, out of a total sample of 23 residents, that the consulting pharmacist's monthly medication regimen review recommendations were conveyed to the provider (physician/nurse practitioner) and acted upon timely. Findings include: Review of the facility's policy entitled, Pharmacy Services and Medication Regimen Review (MRR), dated reviewed 9/16/24, included but was not limited to the following: -The facility maintains the resident's highest practicable level of physical, mental and psychosocial well-being and prevents or minimizes adverse consequences related to medication therapy to the extent possible, by providing oversight by a licensed pharmacist, attending physician, medical director, and the director of nursing (DON). Procedure: 8. The consulting pharmacist will provide the resident's MRRs to the facility identified personnel who will ensure that the attending physician, medical director, director of nursing and other necessary facility staff receive the recommendations. 1. Resident #19 was admitted to the facility in May 2024 and has diagnoses that include but are not limited to Parkinson's disease, monoplegia of lower limb following cerebral infarction affecting right dominant side, and dementia.Review of the most recent Minimum Data Set assessment dated [DATE] indicated Resident #19 scored a 4 out of 15 on the Brief Interview for Mental Status exam indicating he/she has severe cognitive impairment.Review of Resident #19's clinical record indicated the following monthly medication reviews identified as having consultation reports:10/29/24, 11/30/25, 1/27/25, 4/25/25, 5/27/25 and 6/23/25.Further review of the clinical record including the EHR (electronic health record) and paper chart failed to reveal the reports and what the consulting pharmacist's recommendations entailed.On 8/13/25 at 3:30 P.M., Unit Manager #1 provided the surveyor with Resident #19's the consulting pharmacist reports. Review of the reports with Unit Manager #1 indicated the following:a. A Consultation report dated as issued on 10/29/24, indicated the following:-Please evaluate the continued risk versus benefit for metformin hydrochloride (an antidiabetic agent that lowers blood sugar). The area for the DON comments and signature was blank. Unit Manger #1 said the recommendation was not done. b. A Consultation report dated as issued on 11/30/24, indicated the following:-Please consider adding periodic (e.g., weekly) orthostatic BP (blood pressure measurements as suggested in the guidelines. The area for the DON comments and signature was blank. Unit Manger #1 said the recommendation was not reviewed or implemented. c. Consultation reports dated as issued 1/27/25, 4/25/25, and on 7/25/25, indicated the following: -Resident receives two or more medications that are contraindicated due to increased risk of serotonin syndrome (a condition caused by excessive serotonin: Rasagiline mesylate (medication used for symptoms of Parkinson's disease) and Buspirone Hydrochloride (medication used for anxiety). Recommendation: As this combination is contraindicated, please discontinue one of the above medications, tapering when necessary, and consider alternate therapy. The reports dated 1/27/25 and 4/25/25 were blank in the areas for the DON to enter comments and signature. The report dated 7/25/25 had no written response or signature of the physician to accept, accept with modifications or decline the recommendation made by the consulting pharmacist. Unit Manager #1 said one of the medications was discontinued on 8/5/25, and that the same recommendation was made multiple times and was not addressed timely. d. A consultation report dated as issued on 5/27/25, indicated the following:-Resident receives midodrine for treatment for orthostatic hypotension at 8 am, 2 pm and 8 pm (sic). Please update the administration times to ensure this medication is not given after 6 pm or after the evening meal, or less than 4 hours before bedtime. The report failed to have the physician's response or signature. Unit Manager #1 said the recommendation was not implemented. e. A consultation report dated as issued 6/23/25, indicated the following:-Resident takes metformin for diabetes, levothyroxine for hypertension and atorvastatin for hyperlipidemia, if not recently done, consider A1C (a blood test to measure the sugar in your blood), TSH (a laboratory test to check thyroid stimulating hormone level), and lipids (a laboratory test to measure the level of fat in your blood). The report failed to have the signature or response to the recommendation. Unit Manager #1 said the recommendation was not implemented.Further interview at this time Unit Manager #1 said the pharmacist comes in monthly to review all residents' medications. Unit Manager #1 said pharmacist's recommendations were emailed to the Director of Nursing and when they were without a DON the recommendations got lost in transition and were not addressed timely. 2. Resident #79 was admitted to the facility in November 2024 with diagnoses that include but are not limited to Alzheimer's disease, chronic

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review and interview, the facility failed to ensure that medication was stored in accordance with professional standards of practice. Specifically, a medication used to treat hemorrhoids was left on a bureau in Resident #113's room and not secured over three days. Findings include: Review of the facility's policy titled, Storage and Expiration Dating of Medications and Biologicals, dated with a revision date 8/1/24, indicated:-Procedure: Facility should ensure external use medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or in a locked medication room that is inaccessible by residents or visitors. Resident #113 was admitted to the facility in January 2022 and has diagnoses that include but are not limited to unspecified dementia, mixed incontinence and type 2 diabetes mellitus. Review of the Minimum Data Set assessment, dated 7/16/25 indicated Resident #113 scored a 3 out of 15 on the Brief Interview of Mental Status, indicating Resident #113 as having severe cognitive impairment.On 8/12/25 at 4:46 P.M., the surveyor observed a large tube with long tip of hemorrhoid cream on top of the bureau across from the footboard in Resident #113's room. Resident #113 was in bed with his/her eyes closed. Review of Resident #113's physician's orders did not indicate an order for hemorrhoid treatment. On 8/13/25 at 7:43 A.M., and 11:15 A.M., the surveyor observed a large tube with a long tip of hemorrhoid cream on the bureau across from the Resident's foot of bed, out in the open. During an observation and interview on 8/14/25 at 12:33 P.M., Unit Manager #1 said the facility does have hemorrhoid cream as a facility product and the medicated cream is kept in the locked treatment cart. Unit Manager #1 and the surveyor went to Resident #113's room and observed the large tube of hemorrhoid cream on the Resident #113's bureau. Unit Manager #1 said any treatment including hemorrhoid cream should be kept in the locked medication cart. Unit Manager #1 said the tube was out in the open and staff should have seen it and removed it from the Resident's room. Unit Manager #1 said Resident #113 does not have an order for the hemorrhoid cream and she wondered if it was brought in by family. During an interview 8/14/2025 at 1:43 P.M., the Assistant Director of Nursing said all medications including treatments should not be stored in a resident's room regardless of whether it is house stock or if the resident has a physician's order and care plan for self-administration.