STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305005	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nashua Post Acute Care	55 Harris Road Nashua, NH 03062

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, it was determined that the facility failed to provide a safe and clean environment for 3 of 5 units observed and 1 of 5 kitchenettes observed.Findings include:Unit #6 Observation on 11/18/25 at approximately 9:11 a.m. in room [ROOM NUMBER] revealed there was black tape adhered to floor threshold over uneven surface where the floor was lifting. Observation on 11/18/25 at approximately 9:18 a.m. in room [ROOM NUMBER] revealed the oxygen concentrator had a layer of dust on the concentrator near the controls. Observation on 11/18/25 at approximately 9:23 a.m. in room [ROOM NUMBER] revealed the wall between the bathroom and the resident's bed had a two by four foot area with exposed drywall. Further observation revealed a brown substance on the bed rail. The side table surface top was peeling along 25 percent of the table. Observation on 11/18/25 at approximately 9:50 a.m. in room [ROOM NUMBER] revealed the privacy curtain had a brown substance in the midsection of the curtain facing away from the resident's bed. The wall between the bathroom and the resident's bed had multiple scraps, dings, and discoloration in an area approximately six by three feet wide. Observation on 11/18/25 at approximately 10:01 a.m. in room [ROOM NUMBER] revealed a long continuous crack that resembled stairs in an area on the wall approximately six by twelve inches. Observation on 11/18/25 at approximately 1:17 p.m. in room [ROOM NUMBER] revealed that the floor at the entrance was lifting. Observation on 11/18/25 at approximately 2:15 p.m. in room [ROOM NUMBER] revealed a brown substance on the outside mid-area of the privacy curtain. The bed rail had a brown substance smeared along the bed rail. The bedside table was visually soiled with crumbs, dried brown and reddish color substance on the top surface of the table. Interview on 11/18/25 at approximately 2:18 p.m. with Staff D (Unit Manager) confirmed all the findings from Unit #6. Unit #5 Observation on 11/18/2025 at approximately 1:21 p.m. in room [ROOM NUMBER] revealed that there was floor tile on the side of the bed where he/she exits that were curled on the edges and lifted. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 11/19/2025 at approximately 8:38 a.m in room [ROOM NUMBER] revealed that the above floor tile was loose and could be moved completely out of place with light pressure. Interview on 11/19/2025 at approximately 8:44 a.m. with Staff Y(Licensed Practical Nurse) confirmed that the floor was damaged and that the tile moved. Observation on 11/18/2025 at approximately 12:57 p.m. in room [ROOM NUMBER] revealed that there were floor tiles on the side of the bed where the resident exits their bed that were loose and curled. There was also missing trim to his/her bedside table. Interview on 11/20/2025 at approximately 9:59 a.m. with Staff W (Unit Manager) confirmed the above findings of missing trim and loose/curled flooring. Unit 1# West Observation on 11/18/2025 at approximately 10:00 a.m. of Unit #1 [NAME] kitchenette revealed missing tiles resulting in uneven flooring. The edges of the tiles remaining where covered with black tape. Interview on 11/18/2025 at approximately 12:30 p.m. with Staff Q (Activities Aide) confirmed the missing tiles on the kitchenette floor. Observation on 11/18/2025 at approximately 12:30 p.m. revealed a resident walking over the uneven flooring to get to the kitchenette fridge.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, and policy review, it was determined that the facility failed to ensure that food was stored in accordance with professional standards for food service safety for main kitchen and 3 of 5 kitchenettes observed. Findings Include:Review of the facilities Food Receiving and Storage Policy , undated, on 11/18/25 revealed . Refrigerated/Frozen Storage 1. All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date).7. Refrigerated foods are labeled, dated and monitored so they are used by their use-by date, frozen, or discarded.Foods and Snacks Kept on Nursing Units.2. All foods belonging to residents are labeled with the resident's name, the item and the use by date. 3. Refrigerators must have a working thermometers and are monitored for temperature according to specific guidelines.Main KitchenObservation on 11/18/25 at approximately 8:25 a.m. with Staff R (Food Services Director), of the Deli 2 refrigerator revealed the following items without and open or use by date: a pastry bag of whipped cream with decorative tip attached without coverage of the open tip and an opened container of Thicken Easy Nectar. Observation on 11/18/25 at approximately 8:38 a.m. with Staff R of the Deli 1 refrigerator revealed that following: a partial block of mozzarella cheese wrapped in [NAME] wrap with date of 10/9 with brown liquid on the edges. Further observation revealed 4 sandwiches sliced in half with a side of pasta salad wrapped in [NAME] wrap without a use by date.Observation on 11/18/25 at approximately 8:45 a.m. with Staff R of the Cooler 3 refrigerator revealed the following items without and open or use by date: a block of butter partially unwrapped.Observation on 11/18/25 at approximately 8:50 a.m. with Staff R of the walk- in refrigerator revealed the following items without open or use by dates:1 package of American cheese slices, shredded orange cheese in an unmarked bag, and shredded white cheese in an unmarked bag. Further observation revealed three 1-pound packages of fresh strawberries with visible fuzzy grey growth, 1-pint container of blueberries with visible fuzzy grey growth and 1-package of whole grain rolls with a torn bag.Observation on 11/18/25 at approximately 8:55 a.m. in the main kitchen revealed a covered bulk container of granulated sugar that contained black particles with a prep date of 9/1/25 and no use by date.KitchenettesObservation on 11/18/25 at approximately 9:10 a.m. of the 1 [NAME] kitchenette with Staff R (Food Services Director) revealed that 3 of 4 draws located to the right of the sink contained brownish-green fuzzy growth covering greater than one third of the inside of the draw base.Observation on 11/18/25 at approximately 9:10 a.m. of the 1 [NAME] kitchenette revealed that the external refrigerator thermometer was showing an error code and there was no thermometer inside the refrigerator to assess the temperature. Observation on 11/18/25 at approximately 9:15 a.m. with Staff R of the unit 3/4 kitchenette revealed three clothes resembling washable mop heads approximately 4 inches by 18 inches in the base of the cabinet under the work sink that had black fuzzy residue on them. Further observation revealed two plates covered in [NAME] wrap that contained a sandwich cut in half with a side of pasta closed into the top of the deli prep station. Interview on 11/18/25 at approximately 9:15 a.m. with Staff R confirmed the above findings for Unit 1 [NAME] and Unit 3/4. Observation on 11/18/25 at approximately 9:05 a.m. with Staff R of the Unit 5 kitchenette revealed that there was a paper towel with brown spots located in the unit microwave.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, it was determined that the facility failed to ensure proper processing of resident's clothing and failed to implement policies and procedures for Enhanced Barrier Precautions (EBP) for 1 of 3 residents reviewed for EBP.Findings include:Observation on 11/20/25 between at approximately 11:00 a.m. in the laundry room with Staff P (Infection Preventionist) and Staff O (Director of Housekeeping) revealed two residential washing machines were running on the normal mode and the warm water setting. Interview on 11/20/25 at approximately 11:00 a.m. with Staff O revealed the residential washing machines had been used for over a year for cleaning the resident's personal clothes. They use a household detergent on all personal clothes. Interview on 11/20/25 at approximately 2:30 pm with Staff V (laundry aide) revealed that the residential washers were used on the Normal Mode using the warm water setting and that the only detergent that was used was a household detergent. Staff V did not know the water temperature used when the warm water setting was selected. Review on 11/20/25 of the facility policy titled Departmental (Environmental Services)- Laundry and Linen, revision date January 2014, revealed . Washing Linen and other Soiled Items 1. Laundry may be processed in either low-temperature or high-temperature cycles. A. For High-temperature processing, wash linen in water that is at least 160 degrees Fahrenheit, for a minimum of twenty-five (25) minutes. B. For low-temperature processing, wash linen in water that is at least 71-77 degrees Fahrenheit and use a 125-parts-per-million (ppm) chlorine bleach rinse if the materials being washed can withstand bleach and remain intact. C. Ozone cleaning systems are also acceptable means of processing laundry. Review on 11/20/25 of the residential washing machine manufacturer's instructions revealed the following .Water temperature by cycle Sanitize: up to 150 degrees Fahrenheit, Extra Hot: Around 141 degrees Fahrenheit, Hot: 110 degrees Fahrenheit and above, Warm: Approximately 90 degrees Fahrenheit, Cold: Approximately 60 degrees Fahrenheit. Interview on 11/20/25 at approximately 1:40 p.m. with Staff S (Regional Plant Operations) did not know what water temperature the clothes in the residential machines were being washed at or temperature personal clothing needed to be washed at using the residential washing machine and the household detergent. Resident #183 Observation on 11/19/25 at approximately 11:00 a.m. outside of Resident #183's room revealed an EBP signage, indicating that Resident #183 was on EBP. Observation on 11/19/25 at approximately 11:00 a.m. in Resident #183's bedroom revealed Staff F (Hospice Licensed Nursing Assistant) was leaning over Resident #183's bed and shaving him/her with gloves on and no protective gown for Personal Protective Equipment (PPE). Interview on 11/19/25 at approximately 11:00 a.m. with Staff F revealed that he/she was providing hygiene to Resident #183 and confirmed that Staff F had gloves on and no protective gown for PPE. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review on 11/19/25 of Resident #183 physician's orders revealed an order for .Enhanced Barrier Precautions: R/T [related to] Wound: open wound every shift for Supportive Documentation, Start Date 10/9/24. Interview on 11/19/25 at approximately 11:05 a.m. with Staff D (Unit Manager) revealed that Resident #183 was on EBP for a Stage IV pressure ulcer. Review on 11/19/25 of the facility's policy titled, Enhanced Barrier Precautions, dated 2001 revealed: .Enhanced barrier precautions (EBPs) refer to infection prevention and control interventions designed to reduce the transmission of multi-drug-resistant organisms (MDRO) during high contact resident care activities .Enhanced barrier precautions apply when .b. A resident is NOT known to be infected or colonized with any MDRO, has a wound or indwelling medical devices, and does not have secretions or excretions that are unable to be covered or contained .8. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: .c. providing hygiene or grooming .

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on interview and record review, it was determined that the facility failed to ensure residents who chose and were scheduled to have a weekly showers received showers for 3 of 8 residents reviewed for activities of daily living (ADL) in a final sample of 35 residents (Resident Identifiers are #36, #107 and #176).Findings include:Resident #176Interview on 11/18/25 at 11:55 a.m. with Resident #176 revealed that he/she gets a shower once a month and they would like one weekly. Review on 11/21/25 of Resident #176's Care Plan, dated 8/6/25, revealed that the he/she required one staff assistance with bathing. Review on 11/21/25 of the Unit 1 Licensed Nursing Assistants (LNA) Assignment Sheet revealed that Resident #176 was scheduled for showers weekly on the 3-11 p.m. shift every Thursday.Review on 11/21/25 of LNA Task Documentation for Resident #176's during the past 30 days revealed that under Shower Thursday 3-11 there was no documentation that a shower had been completed. Interview on 11/21/25 at 10:35 a.m. with Staff K (LNA) revealed that he/she had worked 11/20/25 (Thursday) on the 3-11 p.m. shift and Resident #176 had not received a shower. Interview on 11/21/2025 at 10:40 a.m. with Staff L (Unit Manager) confirmed that there was no documentation that Resident #176 had a shower in the past 30 days.Resident #36Interview on 11/18/25 at approximately 11:45 a.m. with Resident #36 revealed that he/she did not always get a weekly shower. Resident #36 stated that sometimes he/she will go 2-3 weeks without a shower. Review on 11/20/25 of Resident #36's LNA task documentation for 10/20/25 through 11/20/25 revealed that no showers were marked as completed.Review on 11/20/25 of the LNA Assignment sheet revealed that Resident #36 was scheduled for a weekly shower on Tuesday during the 3-11 p.m. shift.Review on 11/21/25 of Resident #36's Quarterly Minimum Data Set with an Assessment Reference Date of 9/9/25 revealed the resident needed substantial to maximum assistance with bathing. Interview on 11/20/25 at approximately 8:45 a.m. with Staff M (unit manager) confirmed that there was no documentation that a shower had been given or offered to Resident #36 for the above time frame.Resident #107Interview on 11/18/25 at approximately 9:30 a.m. with Resident #107 revealed that they had not received a shower in over two weeks. Resident #107 stated that it is usually 2-3 weeks between his/her showers.Review on 11/20/25 of Resident #107's LNA task documentation for 10/20/25 through 11/20/25 revealed that the only shower that was documented as completed was on 11/2/25.Review on 11/20/25 of the Building 2 LNA Assignment revealed that Resident #107 is scheduled for a weekly shower on Tuesday during the 3-11 p.m. shift.Review on 11/21/25 of Resident #107's Quarterly Minimum Data Set, Assessment Reference Date of 8/13/25, Section GG, revealed the resident needed substantial to maximum assistance with bathing. Interview on 11/20/25 at approximately 8:45 a.m. with Staff M confirmed that there was one shower documented for Resident #107 between 10/20/25 through 11/20/25.Review on 11/20/2025 of the facility policy titled Activities of Daily Living (ADL), Supporting, revision date April 2025, revealed .Residents are provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADL).4. If a resident with cognitive impairment or dementia resists care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way, at a different time, or having another staff member speak with the resident may be appropriate. 5. Appropriate care and services are provided for residents who are unable to carry out ADL's independently, with the consent of the resident, and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing, dressing, grooming, and oral care).

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). Based on observation, record review, and interview, it was determined that the facility failed to keep a resident free from involuntary seclusion for 1 of 1 resident reviewed for restraints in a final sample of 35 residents (Resident identifier is #131).Findings include:Observation on 11/18/25 at 8:30 a.m. through approximately 9:30 a.m., 12:00 p.m. through approximately 2:00 p.m. revealed Resident #131 sitting in his/her room at the bedside table coloring. Staff G (Activity Aide) was sitting in a chair with a bedside table outside of Resident #131's room blocking Resident #131's exit. Interview on 11/18/25 at approximately 9:00 a.m. with Staff G revealed that he/she was sitting outside of Resident #131's door for the day because Resident #131 required 1:1 (constant) supervision. Further interview revealed that Resident #131 Had been on 1:1's for about a week due to wandering. Interview on 11/18/25 at approximately 9:10 a.m. with Resident #131 revealed that he/she was unable to answer simple questions requiring a yes and no response. Observation on 11/19/25 at approximately 8:30 through approximately 9:30 a.m. revealed Resident #131 sitting at the bedside table, inside his/her room, staring at the wall. Staff J (Licensed Nursing Assistant) was sitting outside the door with a bedside table blocking the exit of Resident #131's doorway. Observation on 11/19/25 at approximately 12:45 p.m. through 1:00 p.m. revealed Staff J was sitting outside the door with a bedside table blocking the exit of Resident #131's. Observation on 11/20/25 at approximately 9:10 a.m. through 9:30 a.m. revealed Staff I (Licensed Nursing Aide) was sitting at a table inside of Resident #131's room in the hallway of the exit blocking the doorway. Resident #131 was coloring. Interview on 11/20/25 at approximately 9:50 a.m. with Staff A (Physician) confirmed that Resident #131 had been assigned a staff member for 1:1 supervision for about a week due to Resident #131's behaviors. Observation on 11/21/25 at approximately 8:00 a.m. through 8:30 a.m. of Resident #131's room revealed a staff member blocking the doorway into Resident #131's room. Review on 11/21/25 of Resident #131's nursing notes revealed the following:11/16/25 7:43 a.m., Resident was kept on 1:1 supervision through the night, no issues noted. Got out of room once and escorted through the hallways and returned to bed until morning. 11/17/25 5:00 a.m., res [resident] continues on 1:1 supervision due to change in behaviors. 1:1 maintained, res stayed in [pronoun omitted] room most of the night, got out twice trying to open the clean laundry closet for [pronoun omitted] shoes. Redirected with ease, and stayed in [pronoun omitted] room. Able to hold simple conversations with assigned staff, no aggression noted or reported. Interview on 11/20/25 at approximately 12:25 p.m. with Staff H (Administrator) revealed that Resident #131 had been on 1:1 with staff since approximately 11/14/25 . Review on 11/20/25 of the facility policy titled, Identifying Involuntary Seclusion and Unauthorized Restraint, dated 2011, revealed: .1. Involuntary Seclusion is defined as a separation of a resident from other residents or from his or her room or confinement to his or her room . 2. Examples of involuntary seclusion include: a. any attempt to keep a resident confined to a certain area by blocking the exit with furniture or a closed door; .d. confining a resident to his or her room as a form of punishment or for staff convenience .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, it was determined that the facility failed to ensure residents receive care in accordance with plan of care for 1 of 8 residents reviewed for choices in a final sample of 35 residents. (Resident identifier is #185.)Findings include:Interview on 11/18/25 at approximately 9:30 a.m. with Resident #185 revealed that he/she has been waiting to go to a follow up visit with the ENT (Ear, Nose, and Throat Specialist) for months. Further interview revealed that Resident #185 had been having an ongoing sore throat since September and had been asking nursing to make an appointment.Review on 11/21/25 of Resident #185's ENT office visit note, dated 7/1/25 revealed: . the following physician's order: nystatin (Mycostatin) 100,000 unit/ml suspension, Swish and swallow 5 ml (500,000 Units) four times daily for 10 days, Start Date 7/1/25, End Date 7/11/25, Indications: Chronic sore throat. Further review of the office visit note revealed, Follow up in about 8 weeks (around approximately 8/26/25).Review on 11/19/25 of Resident #185's medical record revealed that the following progress notes:On 9/24/25, a Health Status Note read: Resident complained sore throat, coughing covid test performed result negative.On 10/29/25, a Nurse Practitioner Note read: . who continues to complain of a sore throat. Saw ENT and was given nystatin. Was suppose to follow up in Sept. [September] but not done. Assessment/Plan . 15. Sore throat-completed nystatin treatment. Needs follow up with ENT.On 11/2/25, a Health Status Note read: Resident complained sore throat during this shift, Robitussin syrup 15 ml [milliliters] prn [as needed] po [by mouth] Adm. [administered] Review on 11/21/25 of Resident #185's physician's orders revealed the following order dated 11/3/25: Please send patient back to ENT for a 2 month follow up which should of been done in Sept. [September].Interview on 11/20/25 at approximately 2:45 p.m. with Staff D (Unit Manager) revealed that Resident #185 went to an ENT appointment in July 2025 and did not currently have a follow up appointment scheduled.

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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, interview and record review, it was determined that the facility failed to label medications with open expiration dates, monitor proper temperature controls, and permit only authorized personnel to have access to the keys for 2 of 6 medication carts observed and 2 of 3 medication room refrigerators observed. Findings Include:Observation on 11/18/25 at approximately 10:45 a.m. on Unit #6 revealed Staff E (Regional Registered Nurse) going through medications inside medication cart #5302 with no other facility staff present. Staff E appeared to be removing medications. Interview on 11/18/25 at approximately 10:45 a.m. with Staff E revealed that he/she was not assigned to the cart. Further interview revealed that Staff E works at another facility and was in the facility assisting during the survey. Interview on 11/18/25 at approximately 11:40 a.m. with Staff H (Administrator) confirmed that Staff E was not an employee of the facility. Staff E was employed by the corporation. Review on 11/18/25 of the facility policy titled, Medication Labeling and Storage, Dated 2001 revealed: . Only authorized personnel have access to keys. Resident #123 Observation on 11/19/25 at approximately 2:00 p.m. on Unit #6 medication cart #3501 revealed: Resident #123's one used Fluticasone 250 mg (milligrams)/ 50 mcg (micrograms) inhaler without a date of opening or open expiration date; and Resident #123's one used Incruse Ellipta 62.5 mcg inhaler without a date of opening or open expiration date. Review on 11/19/25 of Resident #123's November 2025's MAR (Medication Administration Record) revealed that Resident #123 received Fluticasone 250 mg / 50 mcg and the Incruse Ellipta 62.5 mcg inhaler on 11/19/25. Interview on 11/19/25 at approximately 2:00 p.m. with Staff X (Licensed Practical Nurse) confirmed the above findings. Further interview revealed that Resident #123 received both the inhalers listed above on 11/19/25. Review on 11/19/25 of the manufacturer's instructions for Incruse Ellipta, Revision Date December 2023, revealed: Safely throw away Incruse Ellipta in the trash 6 weeks after you open the tray or when the counter reads 0, whichever comes first. Write the date you open the tray on the label of the inhaler. Review on 11/19/25 of the manufacturer's instructions for Fluticasone Propionate and Salmeterol Diskus, Dated 2023, revealed: . Safely throw away Fluticasone Propionate/Salmeterol Diskus in the trash 1 month after you open the foil pouch or when the counter reads 0, whichever comes first. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review on 11/18/25 of the facility policy titled, Medication Labeling and Storage, Dated 2001 revealed: .Medication Labeling . 2. d. expiration date, when applicable; . Review on 11/19/25 of October 2025 medication refrigerator logs on Unit #5 revealed the following missing temperatures: 2-7, 9-16, 20-26 and 28, 29, and 31. Review on 11/19/25 of November 2025 medication refrigerator logs on Unit #5 revealed the following missing temperatures: 1-16. Review on 11/19/25 of facility policy titled MEDICATION STORAGE IN THE FACILITY dated November 2021 revealed .Procedures .L. All medications are maintained within the temperature ranges noted in the United States Pharmacopeia (USP) and by the Centers of Disease Control (CDC) .3) Refrigerated 36 [degrees] F [Fahrenheit] to 46 [degrees] F .Temperature .E. The Facility should maintain a temperature log in the storage area to record temperatures at least once a day . Interview on 11/19/25 at approximately 8:15 a.m. with Staff W (Unit Manager) confirmed the above findings. Review on 11/19/25 of October 2025 medication refrigerator logs on Unit #3 revealed the following missing temperatures: 5-8, 10-12, 18, 19, 23, 25-27, and 30 Review on 11/19/25 of November 2025 medication refrigerator logs on Unit #3 revealed the following missing temperatures: 1-7, 11, 12, 16, and 17. Interview on 11/19/25 at approximately 08:35 a.m. with Staff Z (Licensed Practical Nurse) confirmed the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305005	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nashua Post Acute Care	55 Harris Road Nashua, NH 03062

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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on interview, and record review, it was determined that the facility failed to ensure that a nourishing snacks was provided to residents consistent with the resident's plan of care for 1 of 1 residents reviewed for food and 1 of 6 residents reviewed for nutrition in a final sample of 35 residents. (Resident identifiers are #53 and #181).Findings include:Resident #53Interview on 11/18/25 at 11:23 a.m. with Resident #53 revealed that he/she was not offered snacks and the only snacks available when Resident #53 requests snacks were crackers and cookies.Review on 11/20/25 of Resident #53's care plan revealed that Resident #53 had potential for nutritional problems due to diabetes. Further review revealed an intervention initiated on 7/1/25 to offer a nourishing HS (Hour of Sleep) snack daily. Resident #181Interview on 11/18/25 at 9:54 a.m. with Resident #181 revealed that snacks offered in the evening were saltines or graham crackers and juice. He/she stated that he/she was a diabetic and he/she was not offered a snack with protein. Interview further revealed that staff had told her/him that there was no snacks with protein available in the evenings, they did not have the ability to get anything down in the main kitchen, and there wasn't anything in the kitchenette.Review on 11/20/25 of Resident #181 physician's orders revealed the following: Offer HS snack with protein/carb at bedtime for diabetes, dated 11/6/24.Interview on 11/20/25 at 12:30 a.m. with Resident #181 revealed that Resident #181 was not offered a snack on the evening of 11/19/25. Resident #181 stated that he/she had asked for an evening snack and was given 4 saltine crackers and water.Interview on 11/20/25 at 10:00 a.m. with Staff U (Dietician) revealed that he/she would consider a nourishing snack for a diabetic to consist of a half sandwich with a protein salad (egg, chicken, or tuna) or peanut butter, cottage cheese, peanut butter, cheese with fruit or crackers, or yogurt. Interview further revealed that he/she was told by residents and staff that residents with or without diabetes were receiving graham crackers or saltines, or cookies as a snack.