

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 305037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2024
NAME OF PROVIDER OR SUPPLIER Courville at Nashua		STREET ADDRESS, CITY, STATE, ZIP CODE 22 Hunt Street Nashua, NH 03060	

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 0553</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>43408</p> <p>Based on interview and record review, it was determined that the facility failed to notify the resident and/or residents representative of care plan meetings for 2 residents reviewed for care plans in a sample of 19 residents (Resident Identifiers #16 and #40).</p> <p>Findings include:</p> <p>Resident #16</p> <p>Interview on 5/13/24 at approximately 11:50 a.m. with Resident #16's activated Durable Power of Attorney (DPOA) revealed he/she has not been invited to any care plan meetings for over 6 months. The DPOA would like to be in attendance to share thoughts about the care of Resident #16.</p> <p>Review on 5/14/24 of Resident #16's Medical Record revealed no documentation of care plan meeting notifications to Resident #16's DPOA.</p> <p>Interview on 5/14/24 at approximately 9:20 a.m. with Staff J (Social Worker) confirmed that their was no documentation that could be provided showing Resident #16 and/or their DPOA were invited to or attended a care plan meeting for the time period of December 2023 through May 2024.</p> <p>Resident #40</p> <p>Interview on 5/13/24 at approximately 12:00 p.m. with Resident #40's activated DPOA revealed he/she did not get invited to care plan meetings. The DPOA revealed that he/she did not know what a care plan meeting was or when they had been scheduled. The DPOA would be able to attend as he/she is at the facility almost every day visiting Resident #40. The DPOA would like to be in attendance to share thoughts about the care of Resident #40.</p> <p>Review on 5/14/24 of Resident #40's Medical Record revealed no documentation of care plan meeting notifications to Resident #40's DPOA.</p> <p>Interview on 5/14/24 at approximately 9:21 a.m. with Staff J confirmed that their was no documentation that could be provided showing Resident #40 and/or their DPOA were invited to or attended a care plan meeting.</p> <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 0553</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Review on 5/14/24 of the facility policy titled Care Planning- Interdisciplinary Team, revised on March 2022, revealed: .4. The resident, and the family and/or the residents's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. 5. Care plan meetings are scheduled at the best time of the day for the resident and family when possible. 6. If it is determined that participation of the resident or representative is not practicable for development of the care plan, an explanation is documented in the medical record .</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>43408</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to provide the necessary care to ensure that a resident's ability to communicate was maintained with a communication device for 1 of 1 resident reviewed for communication in a final sample of 19 residents (Resident Identifier is #40).</p> <p>Findings include:</p> <p>Interview on 5/13/24 at approximately 12:10 p.m. with Resident #40's Durable Power of Attorney (DPOA) revealed that Resident #40 has difficulty with communication due to his/her advanced Parkinson's Disease and was admitted in March 2024 with a communication board that he/she used to allow for easier communication. Resident #40's DPOA stated that he/she has not seen the communication board since shortly after admission.</p> <p>Interview on 5/14/24 at approximately 8:30 a.m. with Staff M (Registered Nurse) revealed that he/she did recall Resident #40 being admitted with a communication device that he/she used at home. Staff M confirmed that it could not be located at the time of the interview.</p> <p>Interview on 5/14/24 at approximately 8:35 a.m. with Staff K (Licensed Nursing Assistant (LNA)) and Staff F (LNA) revealed they were unaware of Resident #40 using a communication board. Staff K stated that Resident #40 can answer simple yes or no questions when asked if you give him/her enough time to respond.</p> <p>Interview on 5/14/24 at approximately 8:45 a.m. with Staff M revealed that the communication board was located in a drawer in Resident #40's room.</p> <p>Interview on 5/14/24 at approximately 11:50 a.m. with Resident #40 revealed that communication with the staff has been difficult without his/her communication board.</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>48515</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to ensure that residents receive appropriate treatment to maintain mobility for 1 resident reviewed for limited range of motion in a final sample of 19 (Resident Identifier is #28).</p> <p>Findings include:</p> <p>Review on 5/14/24 of Resident #28's care plan revealed: Interventions for Preventing Pressure Injury, dated 3/19/24, Place face cloth rolled into R [right] hand, change with care and re-apply should resident remove.</p> <p>Observation on 5/13/24 at approximately 10:00 a.m. revealed Resident #28 was asleep in bed with his/her right hand clenched. There was no rolled face cloth in his/her right hand.</p> <p>Observation on 5/13/24 at approximately 12:15 p.m. revealed Resident #28 was up in his/her chair in the dining room. His/Her right hand was clenched. There was no rolled face cloth in his/her right hand.</p> <p>Observation on 5/14/24 at approximately 11:00 a.m. revealed Resident #28 was up in his/her chair in the hallway. His/her right hand was tightly clenched with no rolled face cloth in his/her right hand.</p> <p>Interview on 5/14/24 at approximately 11:30 a.m. with Staff I (Licensed Nursing Assistant) revealed that Staff I did not know that Resident #28 should have a rolled face cloth to hold in his/her right hand.</p> <p>Review on 5/14/2024 or Resident #28's Physical Therapy Discharge Summary, dated 2/20/23, revealed: discharge goal met if Pt [patient] tolerates folded/rolled wash cloth in right hand between palm and thumb >/= [less than or equal to] 8 hours without evidence of skin integrity issues or new/worsening pain.</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>43408</p> <p>Based on interview and record review, it was determined that the facility failed to ensure that an ongoing collaboration and communication process was established between the nursing home and the hospice company for 1 out of 1 hospice residents reviewed in a final sample of 19 residents (Resident Identifier is #6).</p> <p>Findings include:</p> <p>Review on 5/13/24 of Resident #6's Medical Record revealed they had been admitted to hospice services as of 4/26/24.</p> <p>Review on 5/14/24 of Resident #6's Hospice Team Care Plan as of 5/3/24 revealed the visit frequency for aide to be 3 x [times] week x [for] 9 weeks.</p> <p>Review on 5/14/24 of Resident #6's Hospice Aide Weekly Visit Record revealed the following:</p> <p>Week of 4/29/24-5/3/24 had one aide visit that was documented on 5/2/24;</p> <p>Week of 5/6/24-5/10/24 had one aide visit that was documented on 5/9/24.</p> <p>Interview on 5/14/24 at approximately 10:00 a.m. with Staff N (Unit Manager) confirmed the above finding. Staff N stated that there was no actual schedule for the facility staff to know when the Hospice Aide is coming in to see Resident #6.</p> <p>Interview on 5/14/24 at approximately 11:30 a.m. with Staff O (Hospice Aide) confirmed that he/she had only documented one visit for each of the above two weeks for Resident #6. Staff O stated he/she came only once the week of 4/29/24-5/3/24, as he/she was new to their case load and that was normal. Staff O stated that they did come three times the week of 5/6/24-5/10/24, but had only documented one visit. Staff O confirmed that there is no schedule for the days or times that they come to see Resident #6.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49819</p> <p>Based on observation, interview and record review, it was determined that the facility failed to follow facility policy on contact precautions to reduce transmission of communicable diseases in 1 of 1 residents reviewed for Transmission Based Precautions in a final sample of 19 residents.</p> <p>Findings include:</p> <p>Standards: Per Centers for Disease Control (CDC) Follow specific recommendations when treating a patient with confirmed or suspected C. Difficile infection .When entering the room of a patient with C. difficile, the priority should be to ensure glove use (in addition to a gown) and proper technique when removing gloves to minimize the risk of self-contamination. (Accessed at https://www.cdc.gov/clean-hands/hcp/clinical-safety/ on 5/16/24).</p> <p>Observation on 5/13/24 at approximately 8:30 a.m. of Staff H (Licensed Practical Nurse (LPN)) revealed them entering a Transmission Based Precaution (TBP) room [ROOM NUMBER]-1 without donning a gown and/or gloves. Further observation revealed that Staff H was administering resident's medications without a gown and gloves.</p> <p>Interview on 5/13/24 at approximately 8:30 a.m. with Staff H revealed that the resident was on contact precautions for Clostridium Difficile (CDiff). Staff H stated when he/she is not providing direct care he/she does not put on PPE.</p> <p>Interview on 5/13/24 at approximately 2:10 p.m. with Staff G (Unit Manager/Infection Preventionist) revealed it is the facility's policy for the staff to wear a gown and gloves before entering a room with transmission based precautions for CDiff.</p> <p>Review on 5/13/24 of Facility Infection Prevention and Control Program, on page 5 revealed: .C-Difficile gastroenteritis, contact precautions .</p>