

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  07/24/2025
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)		
F 0812  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation and interview, it was determined that the facility failed to ensure that equipment was clean and sanitary for 1 of 1 kitchen observed and handling of food for 1 of 2 kitchenettes observed. Findings include: Observation on 7/22/2025 at approximately 8:30 a.m. of the ice machine in the main kitchen with Staff B (Food Service Director) revealed a greenish brown film located in the interior of the ice machine below the ice cube metal grid. Interview on 7/22/25 at approximately 8:30 a.m with Staff B confirmed the above observation. Review on 7/24/25 of the manufacturer's instructions of the facility's ice machine revealed, .General : Clean and sanitize the ice machine every 6 months for efficient operation. If the ice machine requires more frequent cleaning and sanitizing, consult a qualified service company to test water quality and recommend water treatment .Observation on 7/22/25 at approximately 8:40 a.m. of the first floor satellite kitchenette refrigerator with Staff B revealed 5 supplemental shakes with a hand written date of 7/20/25. Interview on 7/22/25 at approximately 8:40 a.m. with Staff B confirmed the above finding. Staff B stated that the handwritten date on the above supplemental shakes was the use by date which was the 14th day from the thaw date. Review on 7/23/25 of the supplemental shake container revealed the following instructions: .Use thawed product within 14 days. Keep Refrigerated .</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
---	-------	-----------

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  07/24/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on interview and record review, it was determined that the facility failed to implement and review, at least annually, the facility's water management program, which had the potential to effect the facility census of 69 residents who resided at the facility. Findings include: Review on 7/24/25 of the facility's Water Management Program revealed that the facility had identified multiple at-risk areas in the facility, including water heaters, expansion tanks in the maintenance office; pipes, valves and fittings in the bathrooms, shower rooms and kitchen; faucets, aerators, faucet flow restrictors in the bathrooms/kitchen; shower heads and hoses in the first/second floor shower rooms; air washer and humidifiers in the second floor resident rooms; eyewash stations in the laundry, shower, chemical rooms, housekeeping closets and shower rooms; ice machines in the kitchen and 1st and 2nd floors; CPAP machines, bubblers for oxygen, nebulizers in the resident rooms; hydrotherapy equipment, heater-cooler units in the therapy office; water filters in the employee lounge and the [brand name omitted] coffee maker. Further review revealed the program did not describe what control measures would be applied and monitored to the at risk areas. Interview on 7/24/25 at 12:05 p.m. with Staff D (Maintenance Director) revealed that the facility identified the above areas where Legionella could grow and spread. Staff D was unable to provide additional documentation for control measures for the identified at-risk areas in the facility. Staff D did not know what nationally-recognized standard was used to developed their facility's water management program. Interview on 7/24/2025 at 12:18 p.m. with Staff F (Infection Preventionist) revealed that Staff D managed the Water Management Program. Staff F confirmed that they did not have documentation that Water Management Plan was discussed at a committee meeting and did not know which nationally-recognized standards the facility used to develop the facility's water management program. Review on 7/24/25 of the facility's policy titled Legionella Policy revealed it was last reviewed/updated on 11/20/2018. Interview on 7/24/2025 at 1:32 p.m. Staff E (Administrator) confirmed that there was no additional documentation to identify how control measures were applied and monitored and confirmed there was no documentation to show the policy had been reviewed since 2018.</p>		