| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 305037 | A. Building<br>B. Wing | 07/02/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Courville at Nashua | 22 Hunt Street<br>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 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure as needed (PRN) orders for psychotropic drugs were limited to 14 days for 1 of 5 residents reviewed for Unnecessary medications in a final sample of 16 residents. (Resident identifier is #5.)Findings include:Review on 7/1/26 of Resident #5's Medication Administration Record (MAR) revealed a current order for Lorazepam Oral Tablet 0.5 MG (milligram) give 1 tablet by mouth every 4 hours as needed for agitation, with a start date of 6/12/26. Interview on 7/2/26 at approximately 8:24 a.m. with Staff C (Director of Nursing) confirmed that the Lorazepam order for Resident #5 was greater than 14 days. Interview on 7/2/26 at approximately 10:47 a.m. with Staff G (Physician's Assistant) revealed that they did not document a rationale for the Lorazepam. Review on 7/2/26 of the facility's policy The [NAME] at Nashua Psychotropic Medication Use, with no review date, revealed, 2. Psychotropic medications are not prescribed or given on a PRN basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. a. PRN orders for psychotropic medications are limited to 14 days. |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observation, interview, and record review, the facility failed to implement their policies for hand hygiene and enhanced barrier precautions (EBP) for 1 of 4 residents observed for medication administration and for 1 of 3 residents reviewed for EBP. (Resident identifiers are #34 and #42.) Findings include:<br><br>Resident #34<br><br>Review on 6/30/26 of Resident #34's physician's orders revealed an order for IV Cefazolin (antibiotic) 2 grams every 8 hours for left knee infection and orders to maintain a PICC line.<br><br>Observation on 06/30/2026 at approximately 1:56 p.m. with Staff B (Licensed Practical Nurse) during Resident #34's medication administration revealed Staff B entered the room wearing a gown and no gloves, Staff B was holding a pair of clean gloves, an IV antibiotic bag, saline flushes, alcohol wipes, and a pack of IV tubing. Staff B placed these items on a dresser, the saline flush fell onto the floor. Staff B picked it up with an ungloved hand and placed it on top of the dresser, Staff B moved Resident #34's belongings from the bedside table onto the dresser. Staff B donned clean gloves without performing hand hygiene and began cleaning and disinfecting the bedside table with bleach wipes. Afterward, Staff B doffed the gloves, discarded them, and donned a new pair of gloves without performing hand hygiene. After flushing Resident #34's Peripherally Inserted Central Catheter (PICC) line, attaching the IV antibiotic to the IV tubing, priming the IV tubing, and threading the IV tubing to the IV pump to start the IV antibiotic infusion, Staff B doffed gloves and donned a new pair of gloves without performing hand hygiene then labeled the IV tubing with a date.<br><br>Interview on 6/30/26 at approximately 2:12 p.m. with Staff B confirmed that they did not perform hand hygiene after changing gloves as mentioned during the above observation.<br><br>Review on 7/1/26 of the facility's policy titled, Handwashing/Hand Hygiene, revision date of October 2023, revealed, .Hand hygiene is indicated: .after touching the resident's environment .immediately after glove removal .<br><br>Review on 7/1/26 of the facility's policy titled, Personal Protective Equipment - Using Gloves, revision date of September 2010, revealed, .wash hands after removing gloves. (Note: Gloves do not replace handwashing.)<br><br>Review on 7/2/26 of the Centers for Disease Control and Prevention (CDC) website titled, Clinical Safety: Hand Hygiene for Healthcare Workers, dated 2/27/24, retrieved from: https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html, revealed, .Gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene before donning gloves and touching the patient or the patient's surroundings. Always clean your hands after removing gloves .<br><br>Resident #42<br><br>Observation on 7/2/26 at approximately 8:55 a.m. outside Resident #42's room revealed a posted sign for EBP. Observation further revealed that the sign was specific to Bed A, belonging to Resident #42. The EBP signage at Resident #42's door revealed, Providers and staff must also: Wear gloves and gown for the following high-contact resident care activities Transferring .changing linens .<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation on 7/2/26 at approximately 8:56 a.m. revealed Resident #42 transfering from their bed to wheelchair by Staff E (Licensed Nursing Assistant (LNA)) wearing gloves and no gown. Further observation revealed that Staff E then removed the linens from Resident #42's bed wearing gloves and no gown.<br><br>Interview on 7/2/26 at approximately 9:07 a.m. with Staff E confirmed the above findings.<br><br>Review on 7/2/26 of Resident #42's care plan revealed an intervention for Right and Left Stage 3 pressure ulcers of Enhanced barrier Precautions.<br><br>Review on 7/2/26 of Resident #42's physician orders revealed and order dated 11/3/25 for Enhanced barrier precautions r/t (related to) wounds.<br><br>Review on 7/2/26 of the facility's Infection Prevention Control Program reviewed on 1/7/26 revealed, Enhanced Barrier Precautions: Used for care of . chronic wounds . Precautions Enhanced Barrier Precautions . Applies to Any Resident with any of the following . wounds.PPE use for these situations .during high contact care activities .transferring .changing linens .<br><br>Interview on 7/2/26 at approximately 9:34 a.m. with Staff F (Infection Preventionist) confirmed that staff should wear gowns and gloves for residents on EBP during high contact activities such as transferring a resident and changing linens. |

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| F 0628<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide residents with written bed-hold notice at the time of transfer for 2 of 2 residents reviewed for hospitalizations. (Resident identifiers are #4 and #23.) Findings include:<br><br>Resident #4<br><br>Review on 7/2/26 of Resident #4's progress notes from March 2026 to June 2026 revealed that Resident #4 was admitted to the facility on [DATE] for skilled services. Further review revealed that Resident #4 was transferred to the hospital on 3/9/26, 4/28/26, and 6/25/26. There was no documentation indicating that a written bedˆhold notice was provided to Resident #4 at the time of transfer to the hospital.<br><br>Interview on 7/2/26 at approximately 11:13 a.m. with Resident #4 confirmed that they did not receive a written bedˆhold notice in regards to the above mentioned hospital transfers.<br><br>Resident #23<br><br>Review on 7/2/26 of Resident # 23's provider note, dated 6/9/26, revealed that Resident #23 was sent to the hospital for evaluation. There was no documentation indicating that a written bed-hold notice was provided to Resident #23 at the time of the hospital transfer.<br><br>Interview on 7/2/26 at approximately 11:00 a.m. with Staff A confirmed that Resident #23 was not provided a written bed-hold notice at the time of the 6/9/26 hospital transfer.<br><br>Interview on 7/2/26 at approximately 11:20 a.m. with Staff A (admission Coordinator) confirmed that Resident #4 and Resident #23 were not provided a written bed-hold notice at the time of the above mentioned hospital transfers. Staff A revealed that they do not provide written bed-hold notice for residents who are transferred to the hospital. |