

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 305077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2026
NAME OF PROVIDER OR SUPPLIER Lafayette Center		STREET ADDRESS, CITY, STATE, ZIP CODE 93 Main Street Franconia, NH 03580	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow Centers for Disease Control and Prevention (CDC) guidelines for laundry services, failed to update their water management program to include information identified during a recent water infection control risk assessment, and failed to identify other potential risk areas in an effort to minimize the risk of Legionella that had the potential to effect the facility census of 58 residents. Findings include: Review on 6/24/26 of the CDC website titled Healthcare-Associated Infections (HAIs) Appendix D-Linen and Laundry management, retrieved from : https://www.cdc.gov/hai/prevent/resource-limited/laundry.html, revised on 3/27/20, revealed, .Best practice for linen (and Laundry) handling: .Always launder soiled linens from patient care areas in a designated area, which should: be a dedicated space for performing laundering of soiled linen .have a separation between the soiled linen and clean linen storage areas .Best practices for management for clean linen: Sort, package, transport, and store clean linens in a manner that prevents risk of contamination by dust, debris, soiled linens or other soiled items .Observation on 6/24/26 at approximately 11:30 a.m. on the dirty side of the facility laundry room with Staff H (Infection Preventionist) revealed 2 cardboard boxes of clean linen stored on the floor just inside the doorway, 2 cardboard boxes of clean linen stored on the floor behind the washing machine, and 3 cardboard boxes of clean linen to be stored on the floor next to the rinse sink. Interview on 6/24/26 at approximately 11:30 a.m. with Staff H confirmed clean linen was being stored in cardboard boxes on the dirty side of the laundry room. Review on 6/24/26 of the facility water management plan, revised 3/9/26, revealed that the plan identified one dead leg/capped pipe in the Director of Nursing's (DON) office, and the 2 ice machines would be cleaned on a bi-annual basis. The water management plan did not include the 2 water bubblers as a potential risk area with control measures, did not identify that the hot water boiler/heaters needed to be maintained at or above 140 degrees Fahrenheit, and failed to have monitoring and control measures in place in the event that the degrees fell below 140 degrees Fahrenheit. Review on 6/24/26 of the facility water Infection Control Risk Assessment, dated 6/4/26, accepted and reviewed by the Quality Assurance and Performance Improvement team on 6/16/26, revealed the assessment identified 2 water bubblers that are used within the facility, no dead legs in the facility, and stated that the facility's 2 ice machines would be cleaned by vender on a quarterly basis. Review on 6/24/26 of the facility policy titled Legionella Surveillance revised 6/2025, revealed, .d. Temperature controls: .ii. Hot water shall be stored above 140 [degrees] F [Fahrenheit] and circulated at a minimum return temperature of 124 [degrees] F [Fahrenheit]. Interview on 6/25/26 at approximately 9:30 a.m. with Staff A (Administrator) confirmed that the 3/9/26 water management plan was not updated after the 6/4/26 Infection Control Risk Assessment. Staff A confirmed that water temperatures were not taken at the hot water boiler/heaters.		

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to implement their system for monitoring antibiotic use for 5 of 7 resident reviewed for antibiotic stewardship. (Resident identifiers are #6, #7, #35, #45 and #60.) Findings include: Review on 6/24/26 of the facility policy titled Antibiotic Stewardship Program, revised on 6/2025, revealed .iii. The facility uses .updated McGeer criteria.to define infections.Nursing will monitor the initiation of antibiotics on residents and conduct an antibiotic time out within 48-72 [hours] of antibiotic therapy to monitor the response to the antibiotic and review laboratory results and will consult with the practitioner to determine if the antibiotic is to continue or if adjustments need to be made based on the findings.Review on 6/24/26 of LOEB AND REVISED MCGEER CRITERIA, found at https://infectioncontrolma.org/docs/Loeb-and-Revised-McGeer-Criteria.pdf , updated September 2023, revealed .Revised McGeer criteria for urinary tract infection.UTI [Urinary Tract Infection] without indwelling catheter criteria.At least one of the following microbiologic criteria: ^ 10,000 cfu [colony forming unit]/mL[milliliter] of no more than 2 species of organisms in a voided urine sample ^ 1,000 cfu/mL of any organism(s) in a specimen collected by an in-and-out catheter.Review on 6/24/26 of the antibiotic use line listing for April 2026 through June 2026 revealed the following residents were prescribed an antibiotic for a diagnosis of Urinary Tract Infection (UTI) but did not have a Culture and Sensitivity to review during an antibiotic time out:Resident #7 was prescribed an antibiotic on 4/14/26; Resident #6 was prescribed an antibiotic on 5/10/26; Resident #35 was prescribed an antibiotic on 5/24/26; Resident #45 was prescribed an antibiotic on 6/2/26; and Resident #60 was prescribed an antibiotic on 6/5/26. Interview on 6/24/26 at approximately 10:00 a.m. with Staff H (Infection Preventionist) confirmed a culture and sensitivity was not available to review during the antibiotic time out for the above residents.		

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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 interview, and record review, the facility failed to implement a care plan for Psychotropic Medications for 1 of 5 residents reviewed for unnecessary medications in a final sample of 17 residents. (Resident identifier is #3). Findings include: Review on 6/24/26 of Resident #3's care plan for risk for complications related to the use of psychotropic medications, dated 2/20/26, revealed an intervention, AIMS testing per protocol. Review on 6/24/26 of the facility's policy Use of Psychotropic Medication(s), dated 6/26, revealed, .13. Residents who receive an antipsychotic medication will have an Abnormal Involuntary Movement Scale (AIMS) test performed on admission, quarterly, with a significant change in condition, change in antipsychotic medication, PRN, or as per facility policy .Review on 6/24/26 of Resident #3's medical record revealed a physician's order for Quetiapine Fumarate for Dementia with psychosis since admission. Review on 6/24/26 of Resident #3's medical record revealed an admission Screening Assessment, dated 2/20/26, under Section M. Antipsychotics/AIMS, 2. AIMS Assessment, it was documented that Resident #3 was not assessed due to impaired cognition. Section M. Antipsychotics/AIMS, 3. Facial and Oral Movements, 4. Extremity Movements, 5. Trunk Movements, 6. Global Judgements, 8. Movements in Sleep and 9. Scoring were not completed. Review on 6/24/26 of Resident #3's medical record revealed an admission Screening Assessment, dated 5/27/26, Section M. Antipsychotics/AIMS, 2. AIMS Assessment, 3. Facial and Oral Movements, 4. Extremity Movements, 5. Trunk Movements, 6. Global Judgements, 8. Movements in Sleep and 9. Scoring were not completed. Interview on 06/24/2026 at approximately 11:30 with Staff L (Unit Manager) confirmed that Resident #3 has been taking an antipsychotic medication since Resident #3 was admitted in February 2026 and that no AIMS testing was completed at admission or quarterly as per facility policy.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, interview and record review, the facility failed to provide assistance with eating during meals for 1 of 2 residents reviewed for nutrition in a final sample of 17 residents. (Resident identifier is #47.) Findings include: Review on 6/22/26 of Resident #47's Activities of Daily Living (ADL) care plan, initiated on 5/1/26, revealed the following interventions: Provide setup to partial assistance for eating, dated 6/5/26; Monitor conditions that may contribute to ADL decline, including poor nutrition, dated 5/7/26; and Provide cuing for safety and sequencing to maximize current level of function, dated 5/7/26. Review on 6/22/26 of Resident #47's Nutrition care plan, initiated 5/4/26, revealed the following interventions: Resident does need assistance with eating at times. Assist as needed, dated 5/7/26; Monitor for changes in nutritional status (changes in intake, ability to feed self, unplanned weight loss/gain, abnormal labs) and report to food and nutrition/physician as indicated, dated 5/4/26; and Monitor intake at all meals, offer alternate choices as needed, alert dietitian and physician to any decline in intake, dated 5/4/26. Observation on 6/22/26 at approximately 12:15 p.m. of Resident #47 while eating lunch revealed Resident #47 trying to pick up a piece of their hamburger for several minutes. All the ground meat fell out of the bun. Observation on 6/23/26 at approximately 8:15 a.m. of Resident #47 while eating breakfast revealed Resident #47 using their fingers to eat the scrambled egg that was on the plate. There was scrambled egg on their lap and on their tray as well. Observation on 6/23/26 at approximately 12:00 p.m. of Resident #47 while eating lunch revealed attempting to scoop up ground chicken with their spoon. Several empty spoonfuls were placed in their mouth. Approximately a quarter of the ground chicken was off the plate on the tray. Resident #47 attempted to scoop the broccoli with their spoon, but it fell off the plate on to the tray. Resident # 47 was able to eat approximately 25 % (percent) of the ground chicken that he/she was provided), half of a dinner roll that was cut in half, none of the broccoli, none of the macaroni, and all of the dessert. Interview on 6/23/26 at approximately 12:30 p.m. with Staff E (Licensed Practical Nurse) and Staff F (Licensed Nursing Assistant) revealed that the staff do not offer Resident #47 assistance at meals other than to set up the tray. Interview on 6/23/26 at approximately 12:30 p.m. with Staff G (Dietitian) confirmed that Resident #47 did require some assistance with meals.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review, the facility failed to implement interventions to reduce hazard(s) and risk(s) for 2 of 2 residents reviewed for elopement and for 1 of 1 resident reviewed for falls in a final sample of 17 residents. (Resident identifiers are #10, #49, and #56). Findings include: Resident #49 Interview on 6/22/26 at 11:27 a.m. with Resident #49 revealed that he/she fell in the bathroom shortly after she was admitted . There was one aide helping her in the bathroom when his/her knee gave out. Review on 6/23/26 of Resident #49's medical record revealed a care plan for assistance for ADL (Activities of Daily Living), with an intervention for two-person assist with a walker with a gait belt for all transfers, initiated on 6/1/26. Review on 6/23/26 of Resident #49's admission Minimum Data Set (MDS) with an assessment reference date of 6/1/26 revealed Resident #49 had a Basic Interview for Mental Status (BIMS) score of 15 out of 15, meaning cognitively intact. Further review revealed that under section GG &ndash; Functional Abilities, Resident #49 was coded as a substantia/maximal assistance for toilet transfer. Interview on 6/23/26 at approximately 11:00 a.m. with Staff M (Licensed Nursing Assistant (LNA)) revealed that he/she was assisting Resident #49 from the wheelchair to the toilet, Resident #49 slipped. Staff M stated that he/she was the only one assisting Resident #49 with the transfer to the toilet at the time of the fall. Interview on 6/23/26 at approximately 11:30 a.m. with Staff L (Unit Manager) confirmed that Resident #49 was a two-person assist with all transfers including transfers to the toilet. Interview on 6/23/26 at approximately 11:32 a.m. with Staff N (LNA) revealed that he/she was Resident #49's LNA on 6/23/26. Staff N stated they assisted Resident #49 to the bathroom and helped Resident #49 transfer to the toilet by themselves earlier today. Review on 6/23/26 of the facility's policy Fall Prevention Program, revised 6/26, revealed .8. Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. a. Interventions will be monitored for effectiveness. The plan of care will be revised as needed. 9. When any resident experiences a fall, the facility will: a. Assess the resident. b. Complete a post-fall assessment. c. Complete an incident report. d. Notify physician and family. e. Review the resident's care plan and update as indicated. f. Document all assessments and actions. g. Obtain witness statements in the case of injury. Resident #10 (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review on 6/23/26 of Resident #10's medical record revealed a physician's order for a wander guard elopement device due to poor safety awareness written on 4/22/26. Review on 6/23/26 of Resident #10's Wandering Assessment (Elopement) dated 4/22/26 Section 5. History of Wandering: 5a. is marked as Resident #10 has a history of wandering and that this behavior occurred daily. Section 9. At Risk: 9a. is marked yes for Resident #10 is believed to be at risk for elopement. Review on 6/23/26 of Resident #10's Elopement Risk Identification Form revealed that the wander guard is on Resident #10's right wrist. Observation on 6/23/26 at approximately 9:18 a.m. of Resident #10 sitting up eating breakfast with no wander guard on right or left wrist. Observation on 6/24/26 at approximately 9:12 a.m. of Resident # 10 sitting up eating breakfast with no wander guard on right or left wrist. Interview on 6/24/26 with Staff K (Licensed Practical Nurse) who confirmed that Resident #10 has an active order for a wander guard to be placed on right wrist and Resident #10 did not have one. Resident #56 Interview on 6/22/26 at approximately 9:30 a.m. with Staff B (LNA) revealed that Resident #56 wears a wander guard device to their left ankle but they are known to remove it. Review on 6/23/26 of Resident #56's wandering assessment, dated 4/22/26, that indicated the resident has wandered aimlessly within the home or off the grounds, they were at risk for elopement and a wander guard device was placed on their left ankle. Review on 6/23/26 pf Resident #56's Care plan for elopement revealed an intervention, dated 4/8/26, wander guard to left ankle. Observation on 6/22/26 at approximately 9:00 a.m. ,12:00 p.m. and 2:15 p.m. of Resident #56 and their bed room revealed a wander guard device sitting on the top of their nightstand. Resident #56 was not wearing a wander guard. Review on 6/23/26 of the facility policy titled Elopement and Wandering Residents, revised 7/2025, revealed .4. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering a. Residents will be assessed for risk of elopement or unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team. B. The interdisciplinary care team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan.e. Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly.		

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to provide the resident or the resident's representative with a bed hold notice that included the duration of the bed hold and reserve bed payment while hospitalized for 1 of 1 resident reviewed for hospitalizations in a final sample of 17 residents (Resident Identifier is #26). Findings include: Review on 6/24/26 of facility policy titled Bed Hold Notice, revised 6/2025, revealed .1. As part of the admission packet and at the time of a transfer to the hospital or therapeutic leave, the facility will provide the resident and/or resident representative written information that specifies a. The duration of the State bed-hold policy, if any, during which the resident is permitted to return and resume resident in the nursing facility b. The reserve bed payment policy in the state plan policy, if any. Review on 6/24/26 of Resident #26's medical record revealed that Resident #26 was transferred to the hospital on 2/10/26, 3/21/26, and 6/22/26. Further review revealed that Resident #26 received copies of the facility's policy titled Bed Hold Notice, dated June 2025 at the time of the hospital transfers. Interview on 06/24/26 at 9:22 a.m. with Staff A (Administrator) confirmed the Bed Hold Notice policy provided to Resident #26 did not include the duration of the bed hold and reserve bed payment for Resident #26's transfer to the hospital on 2/10/26, 3/21/26, and 6/22/26.		