STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225038	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Leominster	370 West Street Leominster, MA 01453

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (continued on next page)

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one Resident (#104) was assessed for and free from restraints out of a total sample of 25 residents. Specifically, the facility failed to ensure Resident #104 was free from a restraint in the form of pillows being stuffed under his/her fitted sheets to keep the Resident in bed.Findings include:Review of the facility policy titled Physical Restraint Use, dated and revised 8/16/22, indicated the following:- The intent is for each resident to attain and maintain his/her highest practicable well-being in an environment that prohibits the use of physical restraints for discipline or convenience, prohibits the use of physical restraints to unnecessary inhibit a resident's freedom of movement.- When a physical restraint is used, the facility must use the least restrictive restraint for the least amount of time and provide on-going re-evaluation of the need for physical restraint.- The type of restraining device, frequency/duration, and medical reason for restraining device are documented on the Physical Restraint Informed Consent.- A physician's order is required for the use of the specific type of restraint.- The physician's order alone, without supporting clinical documentation, is not sufficient to warrant the use of a restraint. - The resident and/or resident representative must sign the Physical Restraint Informed Consent prior to restraint use.Resident #104 was admitted to the facility in April 2025 with diagnoses including concussion, edema of the cervical spinal cord and protein calorie malnutrition. Review of Resident #104's most recent Minimum Data Set Assessment (MDS) dated [DATE], indicated the Resident was unable to complete the Brief Interview for Mental Status exam indicating severe cognitive impairment. Further review of the MDS indicated that the Resident was dependent on staff for all activities of daily living. On 8/20/25 at 6:42 A.M., Resident #104 was observed awake laying in his/her bed, the Resident was twisting and turning while in bed. On the left side of Resident #104's bed was large mound that was higher than the Resident, the surveyor observed multiple pillows stuffed under the fitted sheet from the top to the bottom of Resident #104's bed.On 8/20/25 at 6:48 A.M., Certified Nursing Assistant (CNA) #1 was observed to adjust the pillows tucked under Resident #104's fitted sheet. CNA #1 said she is the overnight CNA and Resident #104 moves around in bed a lot, so we use the pillows to keep him/her in the bed.During an observation 8/20/25 at 7:28 A. M., CNA # 2 and CNA #3 were boosting (a term used to describe moving a patient up towards the head of the bed after they have slid down) Resident #104 in his/her bed, they proceeded to remove the pillows from under the Resident's fitted sheet. As this was happening, Unit Manager #1 approached Resident #104's room, Unit Manager #1 told CNA #2 and CNA #3 to remove the pillows as they cannot be tucked under the fitted sheet. The surveyor then asked Unit Manager #1 about the pillows and Unit Manager #1 said pillows should not be under the fitted sheets. Unit Manager #1 said Resident #104 likes to wiggle around in bed and throw his/her legs over the mattress. Unit Manager #1 said a restraint assessment needs to be done if a potential restraint is being used. Unit Manager #1 then said pillows stuffed under Resident #104's sheets are considered a restraint.During an interview on 8/19/25 at 10:46 A.M., Resident #104's Outside Caretaker said she was his/her caretaker from his/her outside group home. She continued to say that she comes in at 9:00 A.M. and usually stays until nighttime so she can provide supervision and assistance. Resident #104's Outside Caretaker said Resident #104 tries to get out of bed often, so she needs to constantly adjust him/her back into bed.Review of Resident #104's electronic medical record or paper medical record failed to indicate a restraint assessment was completed.Review of Resident #104's physician's orders failed to indicate an order for the use of a restraint.Review of Resident #104's falls care plan indicated the following interventions:- Dated 7/11/25: Increase supervision when restlessReview of Resident #104's incident reports indicated that the Resident fell out of bed on 7/11/25 and on 8/21/25.During an interview on 8/21/25 at 8:42 A. M., the Director of Nursing (DON) said Resident #104 likes to wiggle around and move a lot in bed and he/she has squirmed out of bed a lot. The DON said frequent checks should be completed for Resident #104. The DON said no restraints are used in the facility, when the surveyor shared the observations of pillows being stuffed under Resident #104's fitted sheet, the DON said pillows should not be under the sheets as it is a restraint. The DON was unsure if restraint assessments need to be done as she has never encountered a restraint in the facility and she is fairly new in the role as DON.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to follow professional standards of nursing practice for one Resident (#50) out of a total sample of 25 residents. Specifically, the facility failed to date and initial a bandage on Resident #50's left lower extremity.Findings include: Resident #50 was admitted to the facility in July 2025 with diagnoses including type 2 Diabetes Mellitus, hemiplegia and hemiparesis following cerebral infarction. Review of Resident #50's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 99 indicating severe cognitive impairment and requires staff assistance with activities of daily living. The surveyor made the following observations:- On 8/19/25 at 9:06 A.M., Resident #50 was sitting in his/her wheelchair in the hallway. There was a white bandage on his/her left shin with some seepage starting to saturate the bandage. There were no date or initials on the bandage.- On 8/20/25 at 6:53 A.M., and 8:11 A.M., Resident #50 was sitting in his/her wheelchair in the day room, There was a white bandage on his/her left shin with some seepage starting to saturate the bandage. There were no date or initials on the bandage. At 1:07 P.M., Resident #50 was sitting in the hallway, there were no date or initials on the bandage.Review of Resident #50's Weekly Skin Check dated 8/14/25 indicated the following:- Select any alteration in skin: scattered to bilat (bilateral) arms and lower legs from self-inflicted scratching.Review of Resident #50's physician's orders failed to indicate a treatment order for his/her lower extremities due to self-inflicted scratching.During an interview on 8/21/25 at 7:49 A.M., Unit Manager #2 said Resident #50 scratches his/her legs and has edema causing some seepage from his/her skin so we put bandages on as needed. Unit Manager #2 said anytime a nurse puts on a bandage they need to date and initial them, so we know who and when the treatment was provided. During an interview on 8/21/25 at 8:53 A.M., the Director of Nursing (DON) said staff should always be dating and signing bandages as it is a nursing professional standard, and her expectation for her staff to be doing so the treatment can be effectively monitored.During an interview on 8/21/25 at 10:39 A.M., Nurse #1 said any time a resident requires a bandage or covering, staff need to be dating and initialing the treatment so we can monitor the treatment and so we know who provided it and when.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to provide respiratory care services consistent with professional standards of practice for one Resident (#26) out of a total sample of 25 residents. Specifically, the facility failed to develop and maintain a plan for the care of the nebulizer machine, (a small machine that turns liquid medicine into a mist that can be easily inhaled), mask and tubing.Findings include:Review of the facility policy titled 'Oxygen Administration (Infection Control, Safety, and Storage), dated 6/24/25, indicated the following but not limited to:-Store oxygen and respiratory supplies in bag labeled when not in use.-Change oxygen supplies (example cannula, tubing, humidifier) weekly and when visibly soiled. Equipment should be labeled with resident name and dated when setup or changed out.Resident #26 was admitted to the facility in November 2024 with diagnoses including chronic obstructive pulmonary disease (COPD).Review of the Minimum Data Set (MDS), dated [DATE], indicated the Resident scored a 15 out of a total possible 15 on the Brief Interview for Mental Status assessment, indicating intact cognition. The MDS further indicated that the Resident has asthma (COPD) or chronic lung disease.The surveyors made the following observations:On 8/19/25 at 9:03 A.M., an uncovered nebulizer mask was resting on top of the contents on the bedside table, the tubing was dated 8/1/25. The Resident said he/she uses the nebulizer twice a day and as needed. On 8/20/25 at 8:30 A.M., the nebulizer mask was observed uncovered on top of the nebulizer machine and the tubing was dated 8/1/25.On 8/20/25 at 4:18 P.M., the nebulizer mask was hanging from the Resident's bed railing. Review of Resident #26's medical record indicated the following:-A physician's order dated 6/10/25, brovana inhalation nebulization solution 15 microgram (mcg)/2 milliliter (ml) (arformoterol tartrate)15 microgram inhale orally two times a day for shortness of breath.-A physician's order dated 7/7/25, budesonide suspension 0.5 milligram/2 ml inhale orally every 12 hours for chronic asthmatic bronchitis.-The Medication Administration Record (MAR) indicated the Resident was receiving the oral inhalation medication via nebulizer twice daily.Review of Resident #26's medical record failed to indicate a physician's order or care plan for the care of the nebulizer machine, including tubing or mask, was developed or implemented.During an interview on 8/21/25 at 10:40 A.M., Nurse #2 said nebulizer mask and tubing are changed every Sunday night, the tubing should be dated and labeled. The masks are stored in a respiratory bag when not in use.During an interview on 8/21/25 at 10:42 A.M., Unit Manager #1 said nebulizer masks and tubing are changed weekly on Sunday night. The masks are stored in resident's bag with name and date. During an interview on 8/21/25 at 10:46 A.M., the Director of Nursing said nebulizer tubing and masks are changed weekly unless they are soiled and should be stored in a plastic bag by Resident's bed and must be dated.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure a current hospice plan of care was present in the medical record and coordinated with facility staff for one Resident (#11) out of a total sample of 25 residents. Findings include:Review of the facility policy titled 'Hospice Coordination of Care', last reviewed 9/6/24, indicated the following but not limited to:-The facility provides hospice care under a written agreement and must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the long-term care facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.Resident #11 was admitted to the facility in January 2025 with diagnoses including malignant carcinoid tumor of the bronchus and lungs.Review of Resident's #11 Minimum Data Set (MDS) assessment dated [DATE], indicated the Resident scored a 13 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively intact. The MDS further indicated that the Resident was receiving hospice services.Review of Resident #11's medical record indicated the following:-A physician's order dated 6/11/25, admit to (contracted) hospice services.-A facility care plan: Resident has a terminal prognosis and has signed onto (contracted) hospice, date initiated 6/12/25.Review of the medical record failed to indicate the hospice agency's plan of care was available to the staff at the facility.During an interview on 8/21/25 at 7:51 A.M., Unit Manager #1 said hospice plan of care should be in the hospice binder, she was unable to locate the hospice plan of care.During an interview on 8/21/25 at 7:53 A.M., Social Worker (SW) #1 said the hospice care plan should be in the hospice binder as the information from the hospice plan of care is integrated into the facility's hospice care plan. SW #1 could not locate the hospice plan of care. She said she was going to contact hospice agency and have the plan of care sent to the facility.On 8/21/25 at 8:25 A.M., SW #1 approached the surveyor and handed over a copy of the hospice plan of care. She said she called hospice agency who emailed it to her, and she updated the facility's hospice care plan. The SW #1 said hospice plan of care should be available to the staff at the facility. During an interview on 8/21/25 at 10:13 A.M., the Director of Nursing said no specific person is assigned to coordinate hospice care in the facility and that hospice plan of care should be available in the facility.During an interview on 8/21/25 at 10:32 A.M., SW #2 said the social services is responsible for making hospice referrals, coordinating care, and ensuring that hospice plan of care is available in the facility.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to implement their policies and procedures to ensure residents/residents' representatives were educated on benefits and potential side effects of immunizations, ensure the medical record contained documented consent or refusal of the pneumococcal immunization for four Residents out of five sampled residents. Findings include: A review of the facility policy titled 'Pneumococcal Vaccine Policy for Residents' dated 7/8/25 indicated the following:-Education is provided to the resident and/or representative regarding benefits and side effects or risks and a consent is signed. -Each resident should be offered pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized. There should be documentation in the medical record if there is reason to believe that pneumococcal vaccine(s) was given previously, but the date cannot be verified, and this had an impact upon the decision regarding administration of the vaccine(s). -Consents and declinations should be documented using the Med-Pass form (CP-1800P-25) and placed in the medical record. The facility should re-address the refusal with the resident and/or resident representative each year to ensure they have not changed their decision. These conversations should be captured in the medical record. A review of the facility's informed consent for pneumococcal vaccine indicated the following:-You are being offered the pneumococcal vaccine because it is recommended by the Advisory Committee on immunization Practices for your age group to prevent pneumococcal disease. It is recommended that adult's aged >[AGE] years old (and those at increased risk of pneumococcal disease) who have not previously received a pneumococcal conjugate vaccine or whose previous vaccination history is unknown should receive a pneumococcal conjugate vaccine (either PCV-15, PCV-20, or PCV-21). If PCV-15 is used, this should be followed by a dose of PPSV-23 at least one year later. CDC (Center for Disease Control and Prevention) guidelines for Pneumococcal vaccines indicate the following:The CDC recommends that adults aged 65 years and older residing in nursing homes or long-term care facilities receive both a pneumococcal conjugate vaccine (PCV) and a pneumococcal polysaccharide vaccine (PPSV23). For those who have not previously received a PCV, the recommendation is to start with PCV15 or PCV20, followed by PPSV23 at least one year later. For adults who have received a previous PCV (like PCV13), shared clinical decision-making with a healthcare provider is recommended to determine the best vaccination approach. Review of the 4 residents' immunization record indicated the following:-4 out of the 5 resident's medical record failed to indicate education provided to the resident and/or representative regarding benefits and side effects or risks. -4 out of the 5 resident's medical record failed to indicate consents and declinations using the informed consent for pneumococcal vaccine. During an interview on 8/21/25 at 12:11 P.M., the Infection Preventionist said when residents are admitted , immunizations are reviewed in MIIS (Massachusetts Immunization Information System) and are documented in the resident's medical record. She further said, the resident and/or representative are educated regarding benefits and side effects/risks of immunizations. The facility uses consent forms for offering/ declination of immunizations to the residents, if a resident refuses immunization it would be documented in the medical record.During an interview on 8/21/25 at 12:57 P.M., the Director of Nursing said vaccines should be part of the admission assessment and it is her expectation for immunizations to be part of the information gathering on admission.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation and interview, the facility failed to maintain kitchen equipment in safe operating condition. Specifically, the facility failed to ensure the walk-in freezer door was functioning properly resulting in ice build-up on the freezer floor and frost covering food product inside the freezer.Findings includeDuring the initial kitchen walkthrough on 8/19/25 at 7:15 A.M., the surveyor opened the walk-in freezer door, the floor of the freezer near the door was covered in ice and was slippery. Next to the door, food products were covered in a thick layer of frost. The frost was piled up from the floor and reached the height of the door covering food product on the shelf next to it. The Food Service Director (FSD) said the warmer gasket which goes around the freezer door has been broken but he was waiting to have it fixed after the facility cookout which was the following day due to the door needing to be removed for a prolonged period of time. Next to the freezer, the metal hammer was observed on top of the ice machine, the FSD said it is used to break the ice in the freezer.Later in the day on 8/19/25, the facility Administrator brought in an order form of the parts needed to fix the freezer door. The parts arrived in the facility on 8/4/25, over two weeks ago since the surveyor's observation. Review of the tracking information from the order form indicated the parts were ordered on 7/25/25.During an interview on 8/21/25 at 9:02 A.M., the Maintenance Director said the freezer door has been broken for a little while now and he is not sure exactly how long it has been broken but it has been getting worse over time. The Maintenance Director then said the FSD asked him to wait to fix it because there is a lot of food product in the freezer.During a follow-up interview on 8/21/25 at 9:33 A.M., the Maintenance Director said he will install a heated wire and gasket that goes around the opening of the freezer to prevent frost build-up. He then said he can hang a plastic curtain on the opening of the freezer to keep the temperature cold, and it should only take him about a half hour to fix it. He then said he does not think the freezer needs to be emptied while he repairs it, he said there are plenty of options.During an interview on 8/21/25 at 9:40 A.M., the facility Administrator said she would expect all kitchen equipment to be working properly and that at one point, the FSD moved all product away from the freezer door so it would not be covered in frost.During an interview on 8/21/25 at 10:49 A.M., the FSD said he was unaware the parts to fix the freezer arrived on 8/4/25 and that it would not take long to fix the freezer. He said if he knew that information, he would have asked Maintenance to fix it already as the extra food product was not even ordered yet. The FSD said it was the worst he had ever seen the freezer when he observed it with the surveyor on 8/19/25.