STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305057	A. Building B. Wing	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Courville at Manchester	44 West Webster Street Manchester, NH 03104

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview, record review, and policy review, it was determined that the facility failed to implement the facility's abuse policy for 1 out of 1 residents reviewed for abuse in a final sample of 19 residents. (Resident Identifier is #21). Review on 1/17/25 of Resident #21's medical record revealed a progress note, dated 12/6/24, stating that Resident asked to use the bathroom this evening around 4:40 p.m. Resident appeared to still have the bed pan underneath of [pronoun omitted] bottom from the morning shift as LNA's [Licensed Nursing Assistant] stated. Resident appeared to have a red bottom . Interview on 1/17/25 at approximately 9:30 a.m. with Staff I (Licensed Practical Nurse) revealed that he/she had reported to Staff J (Nursing Supervisor (3-11 Shift)) on 12/6/24 that they found Resident #21 on a bedpan for an undetermined amount of time and that their bottom was red. Interview on 1/17/25 at approximately 9:30 a.m. with Staff I (Licensed Practical Nurse) revealed that he/she had reported to Staff J (Nursing Supervisor (3-11 Shift)) on 12/6/24 that they found Resident #21 on a bedpan for an undetermined amount of time and that their bottom was red. Interview on 1/17/25 at approximately 9:30 a.m. with Staff J revealed that he/she had not notified the Administrator or the Director of Nursing that Resident #21 had potentially been left on the bedpan since the morning. Review on 1/17/25 of facility policy titled Resident Abuse Prevention and Investigation Policy, reviewed on 8/28/24, revealed . If staff or resident makes an allegation of abuse, mistreatment, neglect .the administrator or DON [Director of Nursing] will be notified by the supervisor immediately and follow their recommendations .

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, it was determined that the facility failed to report an allegation of neglect to the administrator for 1 of 1 resident reviewed for abuse in a final sample of 19 (Resident Identifier is #21). Review on 1/17/25 of Resident #21's medical record revealed a progress note, dated 12/6/24, stating that Resident asked to use the bathroom this evening around 4:40 p.m. Resident appeared to still have the bed pan underneath of [pronoun omitted] bottom from the morning shift as LNA's [Licensed Nursing Assistant] stated. Resident appeared to have a red bottom . Interview on 1/17/25 at approximately 9:30 a.m. with Staff I (Licensed Practical Nurse) revealed that he/she had reported to Staff J (Nursing Supervisor (3-11 Shift)) on 12/6/24 that they found Resident #21 on a bedpan for an undetermined amount of time and that their bottom was red. Interview on 1/17/25 at approximately 9:30 a.m. with Staff J revealed that he/she had not reported the incident to the Administrator or the Director of Nursing that Resident #21 had potentially been left on the bedpan since the morning.

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the facility failed to ensure that the Minimum Data Set (MDS) assessment accurately reflected the residents' status for 4 of 19 residents in a final sample of 19 residents (Resident Identifiers are #18, #68, #72, and #73). Findings include: Resident #18 Review on 1/16/25 of Resident #18's social service note, dated 12/27/24, revealed that Resident #18 had an unplanned transfer to the hospital and was anticipated to return to the facility. Review on 1/16/25 of Resident #18's MDS, with Assessment Reference Date (ARD) of 12/27/24, revealed under section A0310: Type of Assessment: 10: Discharge assessment - return not anticipated was coded indicating that Resident #18 was not anticipated to return to the facility. Interview on 1/16/25 at 12:29 p.m. with Staff L (Director of Social Services) confirmed that Resident #18 had planned to return to the facility after being transferred to the hospital on [DATE]. Resident #72 Review on 1/17/25 of Resident #72's Discharge - return not anticipated MDS, with an ARD of 11/22/24, revealed under section A0301G: Type of discharge: Unplanned was coded. Review on 1/17/25 of Resident #72's social service note, dated 11/22/24, revealed that Resident #72 was a planned discharge to home. Interview on 1/17/25 at 8:31 a.m. with Staff L confirmed that Resident #72 was a planned discharge to home on [DATE]. Resident #73 Review on 1/16/25 of Resident #73's progress note, dated 11/7/24, revealed that Resident #73 was being discharged to home. Review on 1/16/15 of Resident #73's Discharge - return not anticipated MDS, with an ARD date of 11/7/24, revealed under section A2105: Identification Information: Discharge Status: 04: Short-Term General Hospital was coded indicating that Resident #73 was discharged to the hospital. Interview on 1/17/25 at 8:46 a.m. with Staff K (MDS Coordinator) confirmed that Resident #73 was discharged to home and not to the hospital. Interview further revealed that the MDS was coded incorrectly for Resident #18, #72 and Resident #73.Resident #68 Review on 1/17/25 of Resident #68's Entry Record, dated 8/30/24, and the admission Assessment, dated 9/3/24, revealed that Resident #68's name in Section A-Identification Information of the MDS was spelled incorretly. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Review on 1/17/25 of final validation report for Resident #68's IPA assessment, dated 9/17/24, Submission ID: 32647423 and dated 9/20/24, revealed: Message Number: -1027 Message Type: Warning Message: A new resident record was created in the iQIES System with the information submitted in this MDS record. Verify that the new information is correct. Interview on 1/17/25 at approximately 2:00 p.m. with Staff K confirmed the above findings and that because Resident #68's name had been entered incorrectly, it created a seperate record.

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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, interview, and record review, it was determined that the facility failed to follow physicians orders for 1 out of 1 residents reviewed for bowel/bladder incontinence in a final sample of 19 residents. (Resident identifier is #31). Findings include: Standards: [NAME], [NAME] A., and [NAME]. Fundamentals of Nursing. 7th ed. St. Louis, Missouri: Mosby Elsevier, 2009. Page 336 - Physicians' Orders .The physician is responsible for directing medical treatment. Nurses follow physician's orders unless they believe the orders are in error or harm clients. Therefore you need to assess all orders, and if you find one to be erroneous or harmful, further clarification from the physician is necessary . Review on 1/16/25 of Resident #31's physician's orders revealed the following orders: Offer 120 ml (milliliters) of prune juice by mouth for 3 days without a bowel movement on 7-3 shift. As needed for no bowel movement for 3 day, Start Date 12/5/24; M.O.M. (Milk of Magnesia Concentrate Suspension) (Magnesium Hydroxide) Give 30 ml by mouth as needed for constipation for a day 3 without a bowel movement on 3-11 shift, Start Date 12/5/24. Review on 1/15/25 of Resident #31's Bowel Continence Record for December 2024 and January 2025 revealed that Resident #31 had no bowel movement recorded for the following consecutive time frames: December 15-17 (3 days); December 20-22 (3 days): January 5-7 (3 days): January 9-11(3 days). Review on 1/16/25 of Resident #31's December 2024 and January 2025's MAR (Medication Administration Record) revealed that Resident #31 did not receive as needed Prune Juice or M.O.M. per physicians orders for the above listed time periods. Interview on 1/16/25 at approximately 12:30 p.m. with Staff D (Unit Manager) confirmed the above findings. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review on 1/17/25 of the facility policy titled, Bowel Management, Effective Date 6/05, revealed: .if there is no BM [bowel movement] by the second night, give the ordered laxative or a glass of prune juice. If there is no BM by the third day, give a rectal suppository or enema (with MD [Doctor of Medicine]) orders

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, it was determined that the facility failed to provide supervision at meals for 1 of 1 resident reviewed for ADL's (Activities of Daily Living) in a final survey sample of 19 residents. (Resident identifier is #60). Findings include: Observation on 1/15/25 at approximately 9:40 a.m. revealed a sign posted above Resident #60's bed: ASPIRATION PRECAUTIONS 1:1 [One on One] ASSIST W/FEEDING [with feeding] (SLOWLY ALTERNATE BITES/SIPS). Observation on 1/15/25 at approximately 12:10 p.m. to 12:15 p.m. revealed that Resident #60 was sitting on his/her bed eating lunch with no staff present. Observation on 1/16/25 at approximately 12:10 p.m. to 12:15 p.m. revealed that Resident #60 was sitting on his/her bed eating lunch with no staff present. Review on 1/16/25 of Resident #60's Nutritional Care Plan, dated 12/30/24, revealed: . Interventions . Resident to eat all meals in supervised area. Encourage small bites; encourage frequent small sips of fluid between bites Interview on 1/16/25 at approximately 12:15 p.m. with Staff F (Licensed Practical Nurse) revealed that they were unaware that Resident #60 needed to eat in a supervised area. Review on 1/17/25 of Resident #60's Health Status Notes, dated 10/12/24 at 12:32 p.m., revealed: .Resident found choking at lunch by another resident .New order to place resident on aspiration precautions . Review on 1/17/25 of Physician order, dated 10/12/24, revealed . Resident to eat all meals in supervised area

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review, it was determined that the facility failed to complete a performance review at least once every 12 months for 1 of 1 Licensed Nurse Assistant (LNA) reviewed. Findings include: Review on 1/17/25 of the facility assessment, dated 8/2024, revealed: .Staff training/education and competencies: 3.4 . Required in-service training for nurse aides, In-service training must: Be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year . Address areas of weakness as determined in nurse aides' performance reviews and facility assessment and may address the special needs of residents as determined by the facility staff . Review on 1/17/25 of Staff M's (LNA) employee records revealed an employment start date of November 2022. Further review revealed there has been no evidence of a performance evaluation completed for 2023 and 2024. Interview on 1/17/25 at 2:47 p.m. with Staff C (Administrator) confirmed that the facility had not been doing performance reviews every 12 months for LNA's.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. Based on record review, it was determined that the facility failed to ensure that residents do not receive PRN (as needed) orders for psychotropic drugs that are limited to 14 days unless the physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days and indicate the duration for the PRN order for 1 of 4 residents reviewed for unnecessary medications (Resident Identifier is #71). Findings include: Review on 1/17/25 of Resident #71's medical record revealed an order, dated 12/26/24, for Lorazepam (anti-anxiety) Oral Tablet 0.5 mg (milligram) Give 1 tablet by mouth every 4 hours as needed for moderate anxiety and 2 tablets by mouth every 4 hours as needed for severe anxiety with no duration indicated. Further review of Resident #71's medical record revealed an order, dated 12/26/24, for Haloperidol lactate (anti-psychotic) Oral Concentrate 2 mg/ml (milliliter) Give 0.25 ml by mouth ever 4 hours as needed for moderate agitation, nausea, vomiting and give 0.5 ml by mouth every 4 hours as needed for severe agitation, nausea and vomiting with no duration indicated. Review on 1/17/25 or Resident #71's Medication Administration Record (MAR) for January 2025 revealed that Resident #71 received 7 doses of as needed Lorazepam and 5 doses of as needed Haloperidol after 1/8/25 (14 days after start date of 12/26/24). Review on 1/17/24 of Pharmacy Consultation report, dated 12/27/24, revealed that Resident #71 .has a PRN order for an antipsychotic without a stop date: haloperidol . A recommendation to .add a stop date that does not exceed 14 days from initiation . Recommendation was reviewed by provider and declined with the following written statement Pt [patient] is hospice-respite stable on current regime. Review on 1/17/25 of Pharmacy Consultation report dated 12/27/24 revealed that Resident #71 .has PRN orders without a stop date: lorazepam . A recommendation was present to .add a stop date that is less than 14 days from initiation . Recommendation was reviewed by provider and declined with the following written statement Pt [patient] is hospice-respite stable on current regime. Review on 1/17/25 of facility policy titled Psychotropic Medication Use, revision date 9/15/24, revealed .6. PRN order for psychotropic medications should be limited to no more than 14 days .6.1 If the physician/prescriber believes that it is appropriate for a PRN psychotropic order (excluding antipsychotics) to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration of use .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to implement policies and procedures for Transmission Based Precautions (TBP) to prevent the potential spread of infection for 1 of 1 residents on TBP in a final sample of 19 residents. (Resident identifier is #31). Findings include: Resident #31 Observation on 1/15/25 at approximately 9:30 a.m. revealed that Resident #31 had a sign posted on the wall, in their room stating Contact Precautions and what to wear for PPE (staff and visitors to wear gown and glove prior to entering the room). Review on 1/15/25 of Resident #31's medical record revealed that Resident #31 had a urinalysis culture with VRE (Vancomyocin-Resistant Enterococci) identified on 1/11/25. Observation on 1/15/25 at approximately 9:40 a.m. revealed Staff F (Licensed Practical Nurse) entered Resident #31's room without donning PPE. Interview on 1/15/25 at approximately 9:40 a.m. with Staff F revealed Staff F was not aware that Resident #31 was on contact precautions. Review on 1/17/25 of the facility policy, Isolation-Categories of Transmission-Based Precautions, Revision Date September 2022, revealed: .Contact Precautions .7. Staff and visitors wear gloves (clean, non-sterile) when entering the room [ROOM NUMBER]. Staff and visitors wear a disposable gown upon entering the room .

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, it was determined that the facility failed to ensure that required in-service training was conducted and maintained, including the required annual minimum 12 hours for nurse's aides and addressed areas of weakness as determined in nurse aides' performance reviews and the facility assessment for 1 of 1 Licensed Nursing Assistant (LNA) reviewed. Findings include: Review on 1/17/25 of the facility assessment, dated 8/2024, revealed: .Staff training/education and competencies: 3.4 . Required in-service training for nurse aides, In-service training must: Be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year .Address areas of weakness as determined in nurse aides' performance reviews and facility assessment and may address the special needs of residents as determined by the facility staff . Review on 1/17/25 of Staff M's (LNA) personnel and in-service training records for revealed that Staff M had started at the facility in 2022 and had approximately 8 hours of in-service training for dementia, abuse, and facility policies on infection control practices for 2024. Interview on 1/17/25 at 11:33 a.m. with Staff G (Staff Development) confirmed the above findings. Interview on 1/17/25 at 2:47 p.m. with Staff C (Administrator) revealed that they had not been doing performance reviews for LNA's every 12 months and therefore areas for weakness determined in performance reviews were not addressed. Review on 1/17/24 of facility policy titled, Education, revised 5/2019, revealed: .Nur 403.02 Continuing Education Requirements for LNA. Each applicant for renewal, reinstatement, or endorsement of an LNA license shall complete at least 12 contact hours per year of workshops, conferences, lectures, or in-service education offerings that are designed to enhance nursing assistant knowledge, judgment, and skills. Successful completion of a state nursing assistant examination may be used to fulfill such continuing education requirements .