STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305068	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Elms Center	71 Elm Street Milford, NH 03055

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, it was determined that the facility failed to ensure that a resident is fully informed of their care and treatment in a language that he/she understands for 1 of 2 residents reviewed for communication in a final sample of 16 residents. (Resident identifier is #44.) Findings include: Interview on 1/8/25 at approximately 10:20 a.m. with Resident #44 revealed his/her primary language was Spanish. Interview on 1/8/25 at approximately 10:25 a.m. with Staff A (Social Services) revealed he/she utilize their personal translator application on their phone to communicate with Resident #44. Interview on 1/9/25 at approximately 12:00 p.m. with Staff B (Licensed Nursing Assistant (LNA)) revealed Resident #44 understands most English. The resident will initiate communication using his/her personal translator application on their phone. Review on 1/10/25 of Resident #44's admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 5/17/24 revealed Section A coded Spanish as primary language and he/she wants an interpreter. Review on 1/10/25 of Resident #44's medical record revealed that there were no signed consents for treatments in Resident #44's language. Interview on 1/10/25 at approximately 1:00 p.m. with Staff C (Director of Nursing) confirmed that the facility has no language interpreter services available for communicating in a language that Resident #44 understands.

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and medical record review, it was determined that the facility failed to ensure the resident's right to formulate advance directives for 1 out of 2 residents reviewed for advance directives (Resident Identifier is #35). Findings include: Review on 1/10/25 of Resident #35's medical record revealed a physician's order dated 1/8/25 for Do Not Recusitate (DNR). Further review revealed that their care plan reflected Full Code status. Interview on 1/10/25 at approximately 9:20 a.m. with Staff N (Advanced Practice Nurse) revealed that he/she had not given an order to change Resident #35's code status to DNR. Interview on 1/10/25 at approximately 10:15 a.m. with Staff C (Director of Nursing) revealed that code status had been changed without discussion with Resident #35, Resident #35's representative or the Nurse Practioner.

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F 0637 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident when there is a significant change in condition Based on record review and interview, it was determined that the facility failed to conduct a comprehensive Minimum Data Set (MDS) assessment within 14 days after a significant change was determined for 1 of 1 resident reviewed for hospice and 1 of 2 residents closed records reviewed in a final sample of 16 residents (Resident identifiers are #47 and #24). Findings include: Resident #47 Review on 1/10/25 of Resident #47's medical record revealed that Resident #47 was admitted to hospice on 11/1/24. Review on 1/10/25 of Resident #47's MDS assessments revealed no completed significant change MDS for Resident #47's admission to hospice. Interview on 1/10/25 at approximately 11:00 a.m. with Staff D (Regional MDS) confirmed the above findings. Resident #24 Review on 1/9/25 of Resident #24's hospice certification revealed that Resident #24 was admitted to hospice on 4/18/24. Review on 1/9/25 of Resident #24's Significant Change MDS Assessment with Assessment Reference Date (ARD) 4/23/24 revealed the completion date 5/7/24 (5 days late). Interview on 1/10/25 at approximately 11:00 a.m. with Staff D confirmed the MDS Resident Assessment Instrument Manual requires completion within 14 days of identification of significant change and the above assessments were not completed timely.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview, it was determined that the facility failed to hold routine interdisciplinary care plan meetings for 2 of 16 residents reviewed for care planning in a final sample of 16 residents (Resident identifiers are #24 and #44). Findings include: Resident #24 Interview on 1/8/25 at approximately 12:00 p.m. with Resident #24's Representative (Durable Power of Attorney) revealed they did not think there had been a care plan meetings for about a year. Review on 1/9/25 of Resident #24's medical record revealed the most recent interdisciplinary care plan meeting minutes were on 5/1/24. Interview on 1/9/25 at approximately 1:30 p.m. with Staff C (Director of Nursing) confirmed the above findings. Resident #44 Review on 1/9/25 of Resident #44's medical record revealed that he/she had been admitted in May 2024. Review on 1/9/25 of Resident #44's medical record revealed no interdisciplinary care plan meetings between May and November 2024. Interview on 1/9/25 at approximately 1:30 p.m. with Staff C confirmed the only care plan meeting conducted for Resident #44 since admission was on 11/27/24. Review on 1/10/25 of facility policy titled Care Planning - Resident reviewed/revised 12/1/24 revealed .Policy Explanation and Compliance Guidelines: .10. The facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences .initially, at routine intervals, and after significant change .

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview, it was determined that the facility failed to post daily the nurse staffing information. Findings include: Observation on 1/9/25 at approximately 9:45 a.m. of all facility entrances revealed that there was no nurse staffing information posted. Interview on 1/9/25 at approximately 9:45 a.m. of Staff G (Unit Manager) confirmed above findings. Interview on 1/9/25 at approximately 2:00 p.m. with Staff H (Nursing Scheduler) revealed that he/she has not been posting daily the nurse staffing information since he/she took over the position in October 2024.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, it was determined that the facility failed to ensure that multidose medications were labeled with opened/expiration dates appropriately in 1of 1 medication cart reviewed and expired medications were removed from use in 1 out of 1 medication room observed. Findings include: Observation on 1/8/25 at approximately 8:20 a.m. of the medication room refrigerator revealed an Aplisol TB (Tuberculin Purified Protein Derivative, Diluted [Stabilized Solution]) vial, with an open date of 11/22/24 (to expire on 12/22/24, 30 days from opening). Review on 1/8/25 of manufacturers instructions for Aplisol TB revealed .Vials in use more than 30 days should be discarded due to possible oxidation and degridation which may affect potency . Interview on 1/8/25 at approximatley 8:20 a.m. with Staff G (Unit Manager) confirmed the above findings. Staff G confirmed that the Aplisol TB would expire 30 days from opening. Observation on 1/8/25 at approximately 8:40 a.m. of the [NAME] Medication Cart revealed 1 bottle of Timolol Maleate Opthalmic Solution 0.5% with no open date indicated. Review on 1/8/25 of manufacturers instructions for Timolol Maleate Opthalmic Solution revealed: .Opened bottles containing preservatives should be discarded after 28 days . Interview on 1/8/25 at approximately 8:40 a.m. with Staff I (Registered Nurse) confirmed that the Timolol Maleate was an active medication that was in use.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and policy review, it was determined that the facility failed to ensure that food was labeled and failed to maintain a clean environment in the food preparation area for the main kitchen observed. Findings include: Observation on 1/8/25 at approximately 8:30 a.m. in the main kitchen revealed individual plastic containers containing white liquid with no labeled identifiers and dates in the milk refrigerator. Interview on 1/8/25 at approximately 8:30 a.m. Staff F (Food Service Director) confirmed the above findings. Staff F stated that the white liquid was coffee creamer that they individually poured in the plastic containers. Review on 1/10/25 of the facility policy titled Food Storage: Cold foods, created date of 2017, revealed .5. All foods will be .labeled and dated . Observation on 1/8/25 at approximately 8:30 a.m. in the main kitchen revealed a fan with accumulation of dust on the blades and cage of the circulation fans which was pointing directly towards the food preparation area. Interview on 1/8/25 at approximately 8:30 a.m. with Staff K (cook) confirmed the above finding related to the fan. Staff K stated that they utilized the fan during meal preparation in the food preparation area. Review on 1/10/25 of facility policy titled, Environment, revised date of 9/2017, revealed .1. The Dining services Director will ensure that the kitchen is maintained in a clean and sanitary manner including floors, walls, ceilings, lighting, and ventilation .

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **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 facility assessment included specific staffing needs for each shift such as day, evening, and night. Findings include: Review on 1/9/25 of the Facility assessment dated [DATE] revealed that the facility assessment did not include information on the staffing levels needed for specific shifts such as day, evening, and night. Interview on 1/9/25 at approximately 8:15 a.m. with Staff E (Administrator) confirmed the above findings.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, it was determined that the facility failed to ensure that the required committee members attended Quality Assurance Performance Improvement (QAPI) meetings at least quarterly for 2 of the 4 quarterly meetings reviewed for 2024. Findings include: Review on 1/10/25 of the second quarter QAPI meeting attendance sheet, dated July 2024, revealed that the Infection Preventionist (required member) was not in attendance. Review on 1/10/25 of the third quarter QAPI meeting attendance sheet, dated October 2024, revealed that the Infection Preventionist (required member) was not in attendance. Interview on 1/10/25 at approximately 2:30 p.m. with Staff C (Director of Nursing) confirmed the above findings. Staff C (Director of Nursing) further indicated that there was an Infection Preventionist in October but he/she did not attend the QAPI meeting.

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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 interview and record review, it was determined that the facility failed to implement and review, at least annually, the facility's water management plan that has the potential to effect the facility census of 46 residents who resided at the facility. Findings include: Review on 1/8/25 of the facility's water management plan revealed the following: 1. The last review date was dated June 2023, which is 18 months of when the plan was last reviewed. 2. The water management plan committee consisted of the Maintenance Supervisor, Director of Nursing, and the Administrator. There was no Infection Preventionist included in the committee. Further review of the water management plan revealed that the water management committee was responsible for the oversight and implementation of the water management plan, which included but not limited to, development, annual reviews, management, and maintenance activities where needed. 3. The water management plan revealed control measures and monitoring of the following: - dead legs (a section of potable water pipe which contains water that has no flow or does not circulate) and to flush dead legs. The water management plan does not mentioned a frequency to flush dead legs. -less frequently used areas which include soiled linen rooms, medications rooms, shower stalls, private rooms showers, and empty resident rooms- run both hot and cold water for 8 minutes weekly. Interview on 1/9/25 at approximately 12:30 p.m. with Staff J (Maintenance Director) confirmed the above findings. Staff J stated that he/she flushed dead legs monthly. Staff J also stated that he/she ran the water in infrequently used areas monthly and not weekly as mentioned in the above water management plan. Staff J was unable to provide documentation of an updated water management plan reviewed in 2024. Interview on 1/9/25 at approximately 3:00 p.m. with Staff L (Infection Preventionist) revealed that he/she started working at the facility in November of 2024 and had not reviewed the facility's water management plan. Interview on 1/10/25 at approximately 8:20 a.m. with Staff J revealed that he/she developed that water management plan and that he/she does not recall what nationally recognized standards he/she used to develop the water management plan. Interview on 1/10/25 at approximately 8:48 a.m. with Staff C (Director of Nursing) revealed that he/she does not remember reviewing the water management plan and is not familiar with the facility's water management plan. Review on 1/10/25 of the facility's water management plan, review date of June 2023, revealed that the facility utilized the Center for Disease Control and Prevention (CDC) to established protocols for acceptable ranges for control measures. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review on 1/10/25 of the CDC website titled, Controlling Legionella in Potable Water Systems, dated 1/3/25, retrieved from: https://www.cdc.gov/control-legionella/php/toolkit/potable-water-systems-module.html, revealed .Operation, maintenance, and control limits Guidance .Flushing: Flush low-flow piping runs and dead legs at least weekly. Flush infrequently used fixtures (e.g., eye wash stations, emergency showers) regularly as needed to maintain water quality parameters within control limits .