

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225376	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/08/2024
NAME OF PROVIDER OR SUPPLIER Penacook Place, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 150 Water Street Haverhill, MA 01830	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41456</p> <p>Based on observations, interview and record review, the facility failed to follow the plan of care for one Resident (#100) by not following a doctor's order to offload heels, out of a total sample of 24 residents.</p> <p>Findings include:</p> <p>Resident #100 was admitted to the facility in August 2023 with diagnoses including dementia and pain in both feet.</p> <p>Review of Resident #100's most recent Minimum Data Set (MDS) assessment, dated 5/2/24, indicated the Resident had a Brief Interview for Mental Status exam score of 3 out of a possible 15, which indicated he/she had severe cognitive impairment. The MDS also indicated Resident #100 is dependent on staff for all bed mobility tasks.</p> <p>On 5/06/24 at 8:37 A.M., Resident #100 was observed lying in bed with both heels directly on the bed. There was no pillow present in the bed or in the room to offload pressure from Resident #100's heels.</p> <p>On 05/07/24 at 7:36 A.M., 8:37 A.M., and 1:47 P.M., Resident #100 was observed lying in bed with both heels directly on the bed. There was no pillow present in the bed or in the room to offload pressure from Resident #100's heels.</p> <p>On 5/08/24 at 7:38 A.M., Resident #100 was observed lying in bed with both heels directly on the bed. There was no pillow present in the bed or in the room to offload pressure from Resident #100's heels.</p> <p>Review of the nursing note dated 5/02/24 indicated the following:</p> <p>Bruising noted on R (right) lateral foot. yellowish/blue in color. NP (nurse practitioner) made aware and assessed. NP informed that this resident is on 2 different blood thinners. NP looking into these medications as it may be the cause of resident easily bruising. HCP (health care proxy) updated.</p> <p>Review of the skin assessment dated [DATE] indicated Resident #100 had redness on his/her left heel and bruising to his/her right foot.</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 225376	If continuation sheet Page 1 of 10

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #100's physician orders indicated the following order:</p> <p>Offload heels every shift when in bed, initiated on 4/24/24.</p> <p>During an interview on 5/08/24 at 7:39 A.M., Nurse (#2) said Resident #100's heels should be offloaded.</p> <p>During an interview on 5/08/24 at 10:02 A.M., the Director of Nursing said she expects all orders to be followed as ordered.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>41019</p> <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on observation, record review, and interview, the facility staff failed to provide supervision with meals for one Resident (#37) out of a total sample of 24 residents.</p> <p>Findings include:</p> <p>Resident #37 was admitted to the facility in October 2021 with diagnoses including dementia.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 4/25/24, indicated that Resident #37 could not participate in the Brief Interview for Mental Status exam and was assessed by staff to have severely impaired cognition. The MDS further indicated that Resident #37 requires supervision with eating.</p> <p>Review of Resident #37's current activities of daily living care plan indicated that Resident #37 requires supervision after setup with eating.</p> <p>Review of the most recent Functional Abilities and Goals Assessment, dated 4/26/24, indicated that Resident #37 requires supervision or touching assistance with meals.</p> <p>Review of the task performance documentation for the last 30 days indicated that Resident #37 required varying assistance levels between independence and dependence with meals.</p> <p>During an observation on 5/06/24 at 9:29 A.M., Resident #37 was observed in his/her room, in bed eating breakfast. There were no staff present to provide supervision. Resident #37 was struggling to eat toast with a spoon.</p> <p>During an observation on 5/07/24 at 8:03 A.M., Resident #37 was observed in his/her room, in bed eating breakfast. There were no staff present to provide supervision.</p> <p>During an observation on 5/08/24 at 8:28 A.M., Resident #37 was observed in his/her room, in bed eating breakfast. There were no staff present to provide supervision.</p> <p>During an interview on 5/08/24 at 8:51, Nurse (#2) said that Resident #37 requires supervision with meals and sometimes assistance.</p> <p>During an interview on 5/08/24 at 8:39 A.M., the Director of Nursing said that residents that require supervision should be in the hallway or dining room when eating to be supervised and if a resident does not want to leave their room, then a staff member should be sitting in the resident's room while the Resident eats.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>48990</p> <p>Based on observation, interview, record review, and policy review, the facility failed to ensure that one Resident (#57), out of 24 total sampled residents, received treatment and care in accordance with professional standards of practice. Specifically, the facility failed to obtain weekly wound measurements and failed to obtain recommendations for wound treatments from a follow-up physician appointment for Resident #57.</p> <p>Findings include:</p> <p>The facility policy titled Skin Tears - Abrasions and Minor Breaks, Care of, revised September 2013, indicated, but was not limited to:</p> <ul style="list-style-type: none"> -Obtain a physician's order as needed. Document physician notification in medical record. -Review the resident's care plan, current orders, and diagnoses to determine resident's needs. -Generate a Non-Pressure form and complete. <p>Resident #57 was admitted to the facility in October 2022 with diagnoses including peripheral vascular disease and diabetes.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 3/07/24, indicated that Resident #57 was cognitively intact as evidenced by a Brief Interview for Mental Status exam score of 15 out of 15.</p> <p>During an interview on 5/06/24 at 8:40 A.M., Resident #57 said he/she has a wound that never healed on his/her right amputation incision. The surveyor observed a dressing on his/her right amputated residual limb.</p> <p>Review of the active physician's order indicated the following order:</p> <ul style="list-style-type: none"> -Residual limb wound care: Cleanse wound w/NS (normal saline), pat dry. Pack wound with one sterile 4x4 gauze (DRY DRESSING). May secure with another 4x4 gauze and tape. When changing dressing, DO NOT dampen dressing. <p>Review of the plan of care related to the wound on the suture line of the right below the knee amputation, dated 1/04/24, indicated:</p> <ul style="list-style-type: none"> -Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations, initiated 10/20/22. <p>Review of Resident #57's medical record failed to indicate any weekly wound assessments were completed for his/her non-healing surgical wound.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #57's medical record on 5/07/24 indicated the last time the non-healing surgical wound had measurements documented was on 2/22/24, over 10 weeks prior.</p> <p>During an interview on 5/07/24 at 8:39 A.M., Nurse (#4) said Resident #57 should have weekly measurements done in the facility for his/her non-healing surgical wound. Nurse #4 said Resident #57 is followed by a vascular physician in the community for his/her non-healing surgical wound but is unable to locate documentation from recent visits or any weekly wound assessments or measurements completed since he/she was seen by the in-house wound provider in on 1/02/24.</p> <p>During an interview on 5/07/24 at 8:52 A.M., the Assistant Director of Nursing (ADON) said she had told the Unit Manager multiple times that weekly wound measurements and assessments were needed for Resident #57, as they were not being done. As well, the ADON said she told the unit manager multiple times that documentation from the vascular physician needed to be obtained because the facility didn't have it. The ADON said Resident #57's non-healing surgical wound should have been assessed with measurements weekly but was not.</p> <p>During a follow-up interview on 5/07/24 at 9:39 A.M., Nurse #4 provided the surveyor with paperwork from Resident #57's two most recent vascular physician progress notes dated 3/06/24 and 4/03/24. Nurse #4 said this documentation was obtained on that day. Nurse #4 said she would expect notes from a doctor's appointment to be sent back with the Resident and be reviewed for any order changes needed and that if the documentation did not return with the resident, that a nurse should have reached out to the doctors office and attempted to get it faxed over the same day.</p> <p>Review of the vascular physician progress note, dated 4/03/24, indicated:</p> <p>-We placed bacitracin in the wound and put a dressing back on.</p> <p>-He/she should continue with bacitracin dressings and [sic] a daily basis. I will see her back in 4 weeks for a wound check.</p> <p>During an interview on 5/07/24 at 1:21 P.M., Nurse #4 said paperwork should be reviewed as soon as possible after a resident returns from an appointment for any recommendations. Nurse #4 said the facility's Nurse Practitioner (NP) defers to the vascular physician for treatment orders for Resident #57 because the in-house wound team no longer follows him/her, but that since the paperwork from the 4/03/24 appointment was never obtained the recommendation was missed. Nurse #4 said the Nurse Practitioner would like to observe the wound change today before approving the order, since it had been over a month since it was recommended. Nurse #4 said the follow-up appointment was not scheduled in time because they didn't have the paperwork.</p> <p>Review of nursing progress note, dated 5/07/24, indicated:</p> <p>-Spoke with NP (nurse practitioner) regarding delay in care for her wound, ordered from vascular surgery. Resident has been followed by Vascular surgery outpatient. Resident's wound will be evaluated by the NP at the time of the dressing change that will be scheduled for this afternoon, to assess and decide if the treatment which has been suggested by vascular is appropriate and will then be added to the plan of care if so. Resident will have a follow up on 5/15/24 at 12 PM.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/7/24 at 2:20 P.M., the surveyor observed the wound dressing change with Nurse #3 and the Nurse Practitioner. The Nurse Practitioner said she would have approved the wound recommendation from the vascular physician and will change the order at this time.</p> <p>During an interview on 5/07/24 at 1:50 P.M., the Director of Nursing (DON) said Resident #57 should have had weekly wound assessments including measurements completed. The DON said the nurses on the floor are responsible for obtaining paperwork after an appointment and ensuring all recommendations are reviewed with the physician. The DON said if paperwork is not sent back from the appointment, then the nurse, or a delegate, should call that day to attempt to obtain the paperwork.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>46339</p> <p>Based on observations, record reviews and interviews, the facility failed to provide respiratory care services in accordance with professional standards of practice. Specifically, the facility failed to ensure oxygen administration was in accordance with the medical plan of care for one Resident (#5) out of a total sample of 24 residents.</p> <p>Findings include:</p> <p>The facility policy titled Oxygen Administration, undated, indicated the following but not limited to:</p> <ul style="list-style-type: none"> -The purpose of this procedure is to provide guidelines for safe oxygen administration. -Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. <p>Resident #5 was admitted to the facility in June 2023 with diagnoses including chronic obstructive pulmonary disorder, neoplasm of bronchus or lung, chronic respiratory failure and dependent on supplemental oxygen.</p> <p>Review of Resident #5's most recent Minimum Data Set (MDS) assessment, dated 4/18/24, indicated Resident #5 scored a 10 out of 15 on the Brief Interview for Mental Status exam indicating that he/she had moderately impaired cognition. The MDS further indicated Resident #5 is dependent on oxygen.</p> <p>On 5/06/24 at 8:43 A.M., Resident #5 was observed lying in bed wearing oxygen via a nasal cannula at 3.5 liters/ minute. The oxygen concentrator filters were covered with a thick layer of dust.</p> <p>On 5/07/24 at 9:00 A.M., Resident #5 was observed lying in bed wearing oxygen via nasal cannula at 3.5 liters/ minute. The oxygen concentrator filters were covered with a thick layer of dust.</p> <p>On 5/07/24 at 10:46 A.M., Resident #5 was observed lying in bed wearing oxygen via nasal cannula at 3.5 liters/ minute. The oxygen concentrator filters were covered with a thick layer of dust.</p> <p>Review of the current physicians' orders indicated the following orders:</p> <ul style="list-style-type: none"> -Oxygen continuous at 4 liters/minute via nasal cannula every shift for shortness of breath care and comfort. -Change tubing and clean air filter weekly every night shift every Sunday. -Change oxygen/nebulizer tubing and clean filter every evening shift every Monday. <p>Review of the Treatment Administration Record for May 2024 indicated that the oxygen tube and filter was changed on Sunday 5/05/24 and that nursing staff was monitoring for oxygen administration at 4 liters/minute via nasal cannula every shift.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #5's emphysema/COPD, chronic respiratory failure with dependent oxygen continuous use care plan, last revised 8/30/23, indicated the following intervention:</p> <p>-Oxygen settings per physician orders.</p> <p>During an interview on 5/07/24 at 10:53 A.M., Nurse #1 said the oxygen should be set at 4 liters/minute and that the filters should not have a thick coat of dust if they were changed two days ago. Nurse #1 further said physicians orders should be followed as ordered.</p> <p>During an interview on 5/08/24 at 8:35 A.M., the Director of Nursing said the expectation is for nurses to follow physician's order for oxygen setting and changing tubing and filters.</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46339</p> <p>Based on record reviews, policy reviews and interviews, the facility failed to provide care and services consistent with professional standards for two Residents (#103 and #57) who required renal dialysis (a life sustaining treatment that helps the body remove extra fluid and waste products from the blood when the kidneys are not able to) out of a total sample of 24 residents. Specifically, the facility failed to ensure that clamps and pressure dressings were kept with the Resident's #103 and #57 in case of an emergency related to a tunneled hemodialysis catheter (a plastic tube used for exchanging blood between a patient and a hemodialysis machine).</p> <p>Findings include:</p> <p>The facility policy titled End-Stage Renal Disease, Care of a Resident with (sic), dated as revised September 2023, indicated the following but not limited to:</p> <ul style="list-style-type: none"> -Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care. -Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents. -How to recognize and intervene in medical emergencies such as hemorrhages and septic infections. <p>1.) Resident #103 was admitted to the facility in September 2023 with diagnoses including end stage renal disease, dependent on renal dialysis.</p> <p>Review of Resident #103's most recent Minimum Data Set (MDS) dated [DATE], indicated the Resident scored a 3 out of a possible 15 on the Brief Interview for Mental Status (BIMS) indicating he/she was cognitively impaired. The MDS further indicated the Resident was dependent on dialysis.</p> <p>Review of Resident #103's medical record indicated the following orders:</p> <ul style="list-style-type: none"> -Check dialysis right upper chest tunneled catheter dressing every shift for bleeding or signs/symptoms of infection, notify practitioner if present every shift for monitoring. -If dialysis tunneled catheter of right upper chest dressing becomes dislodged, apply dry clear dressing and call practitioner as needed for maintenance check every shift. <p>On 5/07/24 at 7:56 A.M., Resident #103 was observed lying in his/bed. The surveyor did not locate emergency clamps or pressure dressing with the Resident or in the Resident's room.</p> <p>During an interview on 5/07/24 at 10:55 A.M., Nurse #1 said the emergency clamp and pressure dressing should be taped to the wall in the Resident's room at all times.</p> <p>48990</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2.) Resident #57 was admitted to the facility in October 2022 with diagnoses including end-stage renal disease, peripheral vascular disease and diabetes.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 3/07/24, indicated that Resident #57 was cognitively intact as evidenced by a Brief Interview for Mental Status exam score of 15 out of 15. The MDS further indicated Resident #57 received dialysis.</p> <p>Review of the active physician's order, dated 7/28/23, indicated Resident #57 had dialysis every Monday, Wednesday, and Friday.</p> <p>Review of the active physician's order, dated 3/4/23, indicated:</p> <p>-Left IJ (internal jugular vein) tunneled HD (hemodialysis) catheter. For care, please F/U (follow up) with directed Tx (treatment) orders from the primary surgeon.</p> <p>Review of the plan of care related to dialysis, dated 10/02/2023, indicated:</p> <p>- Monitor/document/report PRN for s/sx of the following: Bleeding, Hemorrhage, Bacteremia, septic shock.</p> <p>During observation and interview on 5/06/24 at 8:40 AM, Resident #57 said he/she receives dialysis through tunneled hemodialysis catheter in his/her left chest. Resident #57 said there is not a dialysis emergency kit in his/her room with clamps and pressure dressings. The surveyor did not observe an emergency kit in Resident #57's room.</p> <p>During an interview on 5/07/24 at 8:26 A.M., Nurse (#3) said he doesn't know where dialysis emergency kits are located or where he would obtain emergency supplies if Resident #57 had unexpected bleeding from his/her tunneled hemodialysis catheter</p> <p>During an interview on 5/07/24 at 8:39 A.M., Nurse (#4) observed Resident #57's room with the surveyor and said there should be a dialysis emergency kit with a clamp available in Resident #57's room for use if unexpected bleeding occurred from the tunneled hemodialysis catheter, but that there was not.</p> <p>During an interview on 5/0/24 at 1:50 P.M., the Director of Nursing said there should be a dialysis emergency kit located in the room of every resident who receives dialysis which contains clamps and pressure dressings in case of an emergency.</p>		