STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305018	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dover Center for Health & Rehabilitation	307 Plaza Drive Dover, NH 03820

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 38218 Based on observation, interview, and record review, it was determined that the facility failed to determine if self-administration of medications was clinically appropriate for 1 of 4 residents reviewed for choices in a final sample of 20 residents. (Resident identifier is #68.) Findings include: Observation on 4/30/25 at approximately 8:35 a.m. of Resident #68's bedside table revealed a bottle of Refresh tears and Fluticasone nasal spray. Interview on 4/30/25 at approximately 8:35 a.m. with Resident #68 revealed that the medication has been on his/her bedside table since he/she was admitted about a month ago. Further interview revealed that he/she self-administers the medications 1-2 times a day. Observation on 4/30/25 at approximately 11:15 a.m. of Resident #68's bedside table revealed a bottle of Refresh tears and Fluticasone nasal spray. Review on 5/1/25 of Resident #68's medical record revealed that there was no assessment completed to determine if self-administration of medications is clinically appropriate for Resident #68. There was no physician orders for Refresh tears or Fluticasone nasal spray Interview on 5/1/25 at approximately 10:15 a.m. with Staff D (Licensed Practical Nurse) confirmed the above findings. Review on 5/1/25 of the facility policy titled Clinical Services, revision Date 10/2024 revealed: To maintain the residents' right to maintain a high level of independence, residents who request to self-administer medications are permitted to do so if the center's self-evaluation has determined that the practice would be safe for the resident and there is a health care provider's order to self-administer medication(s)/treatments. Procedure, 1. If the resident requests to self-administer medications, a Self-Administration Evaluation is completed by the licensed nurse to evaluate the resident's safety and understanding of their medication/treatments. 3. Upon obtaining the order for the medication/treatment the licensed nurse will instruct the resident in the process of storing the medications safely which should include a locked box .

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. 47129 Based on interview and record review, it was determined that the facility failed to develop and implement a comphrensive care plan for 1 of of 3 residents reviewed for accidents in a final sample of 20 residents (Resident Identifier is #6). Findings include: Review on 5/1/25 of Resident #6's progress notes revealed the following notes: On 3/19/25 at 11:34 a.m., Resident noted to have scissors in [pronoun omitted] room. Resident states [pronoun omitted] got them from [pronoun] niece. [Name omitted] and ADON [Assistant Director of Nursing] attempted to retrieve scissors from resident but [pronoun omitted] refused multiple times. On 3/19/25 at 12:14 a.m., Scissors and stapler obtained from Resident's room and kept in UM [unit manager] office for safety . On 4/12/25 at 10:58 a.m., This writer was notified by MNA [Medication Nursing Assistant] that resident took [pronoun omitted] scissors and an ensure from med cart when [pronoun omitted] stepped away. Scissors were found hiding inside resident's pillowcase. When staff removed scissors from resident's room, [pronoun omitted] began to threaten the staff. On 4/24/25 at 10:16 a.m., Resident found attempting to get into staff offices and locked cabinets and room . Interview on 4/30/25 at 8:45 a.m. with Staff J (Licensed Nursing Assistant) that Resident #6 wanders in and out of resident's room and takes things from other residents. Interview further revieaed that Resident #6 had a history of being physically threatening to residents and staff. Staff J stated that he/she was not assigned to care for Resident #6 anymore because Resident #6 threatened to stab him/her. Observation on 5/2/25 between 9:00 a.m. and 9:10 a.m. of the medication cart #4 on the TCU unit revealed that there were scissors left unattended on the medication cart while Staff K (Registered Nurse) was in a resident's room administering medication. Interview on 5/2/25 at 9:11 a.m. with Staff K confirmed that he/she left the scissors on top of medication cart #4 and the scissors were not secured. Review on 5/2/25 of Resident #6's comprehensive care plan revealed that there was no focus, goals, or interventions in place for Resident #6's behaviors of taking items that can pose a safety risk to themself or others or physically threatening residents and staff. Interciew on 5/2/25 at approximately 11:00 a.m. with Staff E (Director of Nursing) confirmed the above findings.

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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** 38218 Based on observation, interview, and record review, it was determined that the facility failed to follow professional standards for medication storage and administration for 1 of 3 medication carts observed. (Resident identifier is #69.) Findings include: [NAME], [NAME] A., and [NAME] [NAME]. Fundamentals of Nursing. 10th edition St. Louis, Missouri: Elsevier, 2021. Page 608 . Right Medication . Because the nurse who administers the medication is responsible for any errors related to it, nurses administer only the medications they prepare. You cannot delegate preperation of medication to another person and then administer the medication to a patient . Observation on 4/30/25 at approximately 7:30 a.m. of the medication cart TCU #4 with Staff B (Registered Nurse) revealed an unlabeled medication cup with pills in the top drawer. Further observation revealed that the medication cup was tipped on it's side and 3 unidentifiable pills were on the side of the medication cup on the bottom of the medication cart drawer. Interview on 4/30/25 at approximately 7:30 a.m. with Staff B confirmed the above findings and that the unlabeled medication cup with pills were for Resident #69. Review on 4/30/25 of Resident #69's April 2025's MAR (Medication Administration Record) revealed the following 6:00 a.m. medications signed as administered on 4/30/25: Bactrim DS (Double Strength) tablet 800-160 mg (milligrams) Cholecalciferol Tablet 50 mcg (micrograms) Ferrous Sulfate Tablet 325 mg Furosemide Tablet 20 mg Loratidine Tablet 10 mg Multivitamin Tablet Omeprazole Capsule Delayed Release 40 mg Oxycodone Tablet 5 mg Prednisone Tablet 20 mg Reglan Tablet 5 mg (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/30/25 at approximately 12:00 p.m. with Staff B confirmed the medication in the medicine cup was for Resident #69 and that Staff B was not the nurse who prepared the medications. Further interview with Staff B revealed that the night nurse prepared the medications for Resident #69 and asked him/her to administer the medications to the resident. Staff B administered them to Resident #69. Interview on 4/30/25 at approximately 1:45 p.m. with Staff C (Licensed Practical Nurse) night nurse confirmed that they had prepared Resident #69's morning medications and left them in the top drawer of the medication cart to be administered by Staff B on day shift. Further interview with Staff C confirmed that Resident #69's Oxycodone was in the medication cup and was not double locked. Review on 4/30/25 of the facility policy titled, Clinical Services, revision date 9/23/24, revealed the following . Do not pre-pour medications: administer them as they are prepared. Administration of medications must be documented at the time of the medication pass .

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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. 47129 Based on observation, interview, and record review, it was determined that the facility failed to maintain an environment free of accident hazards by not securing scissors when not in use for 1 of 3 residents reviewed for accidents in a final sample of 20 residents (Resident Identifier is #6). Findings include: Observation on 4/30/25 at 9:30 a.m. on the Transitional Care Unit (TCU) revealed that Resident #6 was ambulating with a rolling walker around the TCU unit going in and out of other resident's rooms. Review on 5/1/25 of Resident #6's progress notes revealed the following notes: On 3/19/25 at 11:34 a.m., Resident noted to have scissors in [pronoun omitted] room. Resident states [pronoun omitted] got them from [pronoun] niece. [Name omitted] and ADON [Assistant Director of Nursing] attempted to retrieve scissors from resident but [pronoun omitted] refused multiple times. On 3/19/25 at 12:14 a.m., Scissors and stapler obtained from Resident's room and kept in UM [unit manager] office for safety . On 4/12/25 at 10:58 a.m., This writer was notified by MNA [Medication Nursing Assistant] that resident took [pronoun omitted] scissors and an ensure from med cart when [pronoun omitted] stepped away. Scissors were found hiding inside resident's pillowcase. When staff removed scissors from resident's room, [pronoun omitted] began to threaten the staff. On 4/24/25 at 10:16 a.m., Resident found attempting to get into staff offices and locked cabinets and room. Resident redirected and educated on staying in resident areas. Resident states I don't care, I'll find the code. Interview on 4/30/25 at 8:45 a.m. with Staff J (Licensed Nursing Assistant) that Resident #6 wanders in and out of resident's room and takes things from other residents. Interview further revieaed that Resident #6 had a history of being physically threatening to residents and staff. Staff J stated that he/she was not assigned to care for Resident #6 anymore because Resident #6 threatened to stab him/her. Observation on 5/2/25 between 9:00 a.m. and 9:10 a.m. of the medication cart #4 on the TCU unit revealed that there were scissors left unattended on the medication cart while Staff K (Registered Nurse) was in a resident's room administering medication. Interview on 5/2/25 at 9:11 a.m. with Staff K confirmed that he/she left the scissors on top of medication cart #4 and the scissors were not secured.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 48515 Based on interview and record review, it was determined that the facility failed to ensure that the provider reviewed irregularities identified by the pharmacist during the monthly Pharmacy Medication Regimen Review (MRR) timely for 3 of 5 residents reviewed for unnecessary medications (Resident Identifiers are #1, #51, and #55). Findings include: Resident #1 Review on 5/2/25 of Resident # 1's Pharmacy MRR, dated 3/4/25, revealed the following recommendation: Resident has an order for Gabapentin 200 mg (milligrams), twice daily for, 'post herpetic neuralgia'. This order was initiated 9-16-2024. Please review if this scheduled medication for pain remains necessary for the resident. Further review of the MRR revealed that the physician did not address the recommendation until 5/1/25. Resident #51 Review on 5/2/25 of Resident #51's Pharmacy MRR, dated 3/4/2025, revealed the following recommendation: Resident is receiving Lipitor 40 mg. Please consider lipid panel with next resident lab draw and at least annually thereafter. Further review revealed that the physician did not address the recommendation until 5/1/25. Interview on 5/2/25 at approximately 10:30 a.m. with Staff E (Director of Nursing) confirmed the above findings for Resident #1 and #51. 40522 Resident #55 Review on 5/1/25 of Resident #55's monthly Medication Regimen Review, dated 1/6/25, revealed that Resident #55 was receiving Protonix since 8/2023 and a pharmacist recommendation to consider tapering to discontinue the Protonix medication or if no change to the Protonix medication to indicate medical necessity of current therapy and potential risk versus current therapeutic benefit in the progress note. Further review of the MRR revealed that there was no documentation that the provider reviewed and/or addressed this recommendation. Review on 5/1/25 of Resident #55's active physician's orders revealed an order for Protonix delayed release 40 milligrams by mouth once a day for acid reflux with a start date of 8/19/23. Review on 5/1/25 of Resident #55's progress notes revealed no documentation from the provider of the medical necessity and potential risk versus current therapeutic benefit for the continued use of the Protonix medication. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/1/25 at approximately 2:13 p.m. with Staff E (Director of Nursing) confirmed that Resident #55's MRR, dated 1/6/25, was not reviewed or addressed by the provider. Review on 5/2/25 of the facility policy titled, Documentation and Communication of Consultant Pharmacist Recommendations, revision date of 12/2019, revealed .Comments and recommendations concerning medication therapy are communicated in a timely fashion. The timing of these recommendations should enable a response prior to the next medication regimen review .Recommendations are acted upon and documented by the facility staff and/or the prescriber. If the prescriber does not respond to recommendations directed to him/her [within 30 days], the Director of Nursing and/or the consultant pharmacist may contact the Medical Director .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48515 Based on interview and record review, it was determined that the facility failed to ensure that a resident receiving antipsychotic medication had an adequate indication for use for 1 of 5 residents reviewed for unnecessary medications in a final sample of 20 residents (Resident identifier is #1). Findings include: Review on 5/2/25 of Resident #1's physician orders revealed the following order: Seroquel (Antipsychotic Medication) Oral Tablet 25 mg (milligrams) Give 25 mg by mouth one time a day for confusion, agitation with a start date of 9/16/24. Review on 5/2/25 of Resident #1's medical record revealed that he/she was admitted to the facility on [DATE]. Review on 5/2/25 of Resident #1's diagnosis list revealed a diagnosis of Vascular Dementia, mild, with anxiety. Review on 5/2/25 of Resident #1's medical record for monitoring behavior symptoms revealed that Resident #1 did not exhibit any behaviors from 4/3/25 thru 5/2/25. Review on 5/2/25 of Resident #1's Psychiatric Evaluation and Consultation note, dated 1/24/25, revealed the following: [Name omitted] is a [AGE] year old [pronoun omitted] with no significant past psychiatric history. [Pronoun removed] he was hospitalized on [DATE] for UTI [urinary tract infection], and was started on Seroquel same day per chart review . Family refused GDR [gradual dose reduction]. Review on 5/2/25 of Resident #1's most recent Psychiatric Evaluation and Consultation note. dated 3/7/25. revealed the following: [Name omitted] is a [AGE] year old [gender removed] with no significant past psychiatric history. Further review revealed a diagnosis of Unspecified Dementia without behavioral disturbance- Severity: Low. Interview on 5/2/25 with Staff G (Nurse Practitioner/Psychiatric Provider) revealed that Resident #1 has no significant psychiatric diagnosis. Review on 5/2/25 of facility policy titled Clinical Services Subject: Psychotropic Medications, dated 5/2023, revealed the following: .Guidelines: 2. When the psychoactive medications are prescribed, a specific condition or targeted behavior that warrants the use of psychoactive medications shall be documented in the clinical record .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 47129 Based on interview and record review, it was determined that the facility failed to ensure residents remained free from significant medication errors for 1 of 3 residents reviewed for accidents and hazards in a final sample of 20 residents. (Resident identifiers is #9.) Findings include: Review on 5/1/25 of Resident #9's medical record revealed a nursing note, written by Staff L (Registered Nurse), dated 4/23/25, at 7:51 p.m.: Med error reported to on call physician and DPOA (Durable Power of Attorney). Resident given 30 units of Lantus, 75 mg (milligrams) of Lyrica. 5 mg of oxy. Interview on 5/2/25 at approximately 1:00 p.m. with Staff E (Director of Nursing) confirmed that Resident #9 had received Resident #18's evening medications. Review on 5/2/25 of Resident #9's medical provider note dated 4/23/25 at 4:23 p.m. revealed that .Patient was given Lantus 30 units, Lyrica 75 mg, Oxycodone 5 mg with his usual nightly 4 ounces of scotch. Patient is a diabetic who takes 10 units of long acting typically . Review on 5/2/25 of Resident #9's active physician orders revealed the following: Lantus Solar Subcutaneous Solution 100 Unit/ML (milliliter) (Insulin Glargine), Inject 10 units subcutaneously one time a day for DM (Diabetes Mellitus), (Resident #9 received 30 units); No physician orders for Lyrica Oral Capsule 75 MG (Pregabalin); No physician orders Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl). Review on 5/2/25 of the facility's policy titled Medication Pass Policy dated 9/24 revealed, .Identify each resident PRIOR to administration of medication (picture, ID bracelet, ect.) .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38218 Based on observation, interview, and record review, it was determined that the facility failed to label and store medications in accordance with professional standards for 2 of 3 medication carts observed. Findings include: Observation on 4/30/25 at approximately 7:20 a.m. of the medication cart [NAME] Cart 2 and 4 with Staff A (Registered Nurse) revealed: Resident #59's Incruse Inhaler, opened without a date of opening; Resident #32's Fluticasone Propionate and Salemetrol inhaler opened with a labeled date of expiration of 4/24; Resident #29's Incruse inhaler opened, without a date of opening; Resident #5's Anoro inhaler opened, without a date of opening. Interview on 4/30/25 at approximately 7:20 a.m. with Staff A confirmed the above findings. Observation on 4/30/25 at approximately 7:30 a.m. of the medication cart TCU #4 with Staff B (Registered Nurse) revealed an unlabeled medication cup with pills in it in the top drawer for Resident #69. Resident #9's Lispro insulin opened labeled with a date of expiration of 4/28/25. Interview on 4/30/25 at approximately 7:30 a.m. with Staff B confirmed the above findings. Further interview revealed that Resident #9 received his/her a.m. dose of Lispro on 4/30/25. Review on 4/30/25 of Resident #9's April 2025's MAR (Medication Administration Record) revealed: On 4/30/25 at 6:00 a.m. Resident #9 received 8 units of Lispro. Review on 4/30/25 of Resident #69's April 2025's MAR (Medication Administration Record) revealed the following 6:00 a.m. medications signed as administered on 4/30/25: Bactrim DS (Double Strength) tablet 800-160 mg (milligrams) Cholecalciferol Tablet 50 mcg (micrograms) Ferrous Sulfate Tablet 325 mg (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Furosemide Tablet 20 mg Loratidine Tablet 10 mg Multivitamin Tablet Omeprazole Capsule Delayed Release 40 mg Oxycodone Tablet 5 mg Prednisone Tablet 20 mg Reglan Tablet 5 mg Interview on 4/30/25 at approximately 12:00 p.m. with Staff B confirmed the medication in the medicine cup was for Resident #69. Interview on 4/30/25 at approximately 1:45 p.m. with Staff C (Licensed Practical Nurse) night nurse confirmed that they had prepared Resident #69's morning medications and left them in the top drawer of the medication cart to be administered by Staff B on day shift. Further interview with Staff C confirmed that Resident #69's Oxycodone was in the medication cup and was not double locked. Review on 4/30/25 of the manufacturer's instructions for Insulin Lispro Cartridges and Pens, undated revealed: . Store opened cartridges and pens at room temperature. Throw away any part not used after 28 days Review on 4/30/25 of the manufacturer's instructions for Fluticasone and Salmetrol Inhalation Powder, undated revealed . Throw away the inhaler when the dose counter reaches 0', 1 month after opening foil pouch, or after the expiration date, whichever comes first . Review on 4/30/25 of the manufacturer's instructions for Umeclidinium and Vilanterol (Anoro Ellipta), undated revealed . Throw away the inhaler when the dose counter reaches 0', 6 weeks after opening foil pouch, or after the expiration date, whichever comes first . Review on 4/30/25 of the manufacturer's instructions for Umeclidinium (Incruse Ellipta), undated revealed . Throw away the inhaler when the dose counter reaches 0', 6 weeks after opening foil pouch, or after the expiration date, whichever comes first . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review on 4/30/25 of the facility policy titled, ID1: Storage of Medications, Revision Date December 2019, revealed . Procedures . C. All medications dispensed by the pharmacy are stored in the container with the pharmacy label H. Outdated, contaminated, or deteriorated medications . are immediately removed from inventory, . Expiration Dating .D. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. 1. The nurse shall place a date opened sticker on the medication and enter the date opened and the new date of expiration E. The nurse will check the expiration date of each medication before administering it ID2: Controlled Substances .B. Schedule [II-V] medications and other medications subject to abuse or diversion are stored in a permanently affixed, [double-locked] compartment separate from all other medications .