STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305022	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewood Centre (the)	928 South Street Portsmouth, NH 03801

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47129 Based on interview and record review it was determined that the facility failed to make a Level II Pre-Admission Screening and Resident Review (PASARR) referral for a resident with a newly evident mental disorder for 1 of 3 residents reviewed for PASARR in a final survey sample of 27 residents (Resident Identifier is #26). Findings include: Review on 3/13/24 of Resident #26's medical record revealed that resident was admitted to the facility on , d+[DATE] without having a diagnosis of a serious mental illness. Review on 3/13/24 of Resident #26's Level I PASARR form (completed on 11/22/23) revealed: Section 2: Screening for Mental Illness (MI), No was checked. Section 3: Screening for Intellectual Disability/Developmental Disability (ID/DD), No was checked. Section 4: Screening for Related Condition (RC), No was checked. Section 5: Undiagnosed Condition, No was checked. Review on 3/13/24 of Resident #26's Psychiatric Evaluation and Consultation dated 12/6/23 revealed a new diagnosis of Post-Traumatic Stress Disorder (PTSD) and that Resident #26 was started on a new medication for tremors/anxiety/PTSD. Interview on 3/13/24 at 1:35 p.m. with Staff R (Director of Social Services) confirmed the above findings. Interview further revealed that the facility should have submitted a new Level 1 PASARR indicating a diagnosis of PTSD and anxiety. Review on 3/13/24 of facility policy titled PASRR, dated 8/22, revealed .7. If a resident currently at Edgewood received a newly acquired diagnosis of MI/MD per MDS nurse, a new Level 1 PASRR form will be submitted to OMS for determination .

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47129 Based on record review and interview, it was determined that the facility failed to ensure that a Preadmission Screening and Resident Review (PASARR) screening was done for 1 of 3 residents reviewed for PASARR in a final sample of 27 residents (Resident Identifier is #111). Findings include: Review on 3/13/24 of Resident #111's medical record revealed that Resident #111 was admitted to the facility on ,d+[DATE] with a known diagnosis of bipolar disorder. Review of Resident #111s initial PASARR dated 2/15/24 revealed that in Section II titled PASRR Level I Screening for Mental Illness (MI) was answered NO to indicate that Resident #111 did not have a diagnosis of severe mental illness. Therefore, the facility failed to refer the resident to the appropriate state-designated authority for evaluation and determination. Interview on 3/13/24 at 1:35 p.m. with Staff R (Director of Social Services) confirmed that Resident #111 had a diagnosis of bipolar disorder upon admission and the facility did not refer the resident to the appropriate state-designated authority for evaluation and determination. Review on 3/13/24 of facility policy titled PASRR, dated 8/22, revealed .1. The Edgewood Admissions Laison [sic] reviews potential admission for a diagnosis or for probability of MI/ID. For confirmed or probable MI/ID, The Admissions Laison [sic] or representative will provide Level 1 for to the Office of Medical Services (OMS) .

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 38218 Based on observation, interview, and policy review, it was determined that the facility failed to ensure adequate staffing to provide assistance with breakfast on 1 of 3 units observed (South Unit). Findings include: Interview on 3/12/24 at approximately 9:20 a.m. with Staff K (Licensed Nursing Assistant (LNA)) revealed that the breakfast meal arrives to the unit at approximately 8:15 a.m. Staff K revealed that there are 14 residents on the unit that require total assistance with meals and other residents require cues at meals. Further interview revealed that there are usually 4 LNA's on the unit to assist residents with breakfast. Observation on 3/12/24 at approximately 9:20 a.m. during breakfast dining on the unit revealed 7 resident meal trays remained on the meal truck and had not been given to the residents. Interview on 3/12/24 at approximately 9:35 a.m. with Staff M (LNA) revealed that there are not enough staff on the South Unit to assist all the residents that require assistance with breakfast timely and it was not uncommon for residents to be receiving breakfast after 10:00 a.m. Staff M confirmed that lunch starts around 12:00 p.m. on the South Unit. Observation on 3/12/24 at approximately 10:00 a.m. to 10:30 a.m. revealed 3 residents on the Sunroom Porch being assisted with breakfast. Interview on 3/12/24 at approximately 12:00 p.m. with Staff D (Medication Nursing Assistant) revealed that staff on the South Unit are unable to assist residents with breakfast timely and perform Activities of Daily Living (ADLs) at the same time. Observation on 3/13/24 at approximately 8:15 a.m. revealed that the 1st meal truck arrived on the South Unit. At approximately 8:38 a.m. the 2nd meal truck arrived on South Unit. Further observation of the South Unit revealed that there were approximately 24 residents that remained in bed at this time. At approximately 8:50 a.m. 3 resident meal trays remained on the 1st meal truck and 8 trays remained untouched from the 2nd meal truck. At approximately 8:50 a.m. a utility cart arrived to the South Unit with 5 additional trays. At 9:15 a.m., 7 trays remained untouched in the meal truck. Interview on 3/13/24 at approximately 9:30 a.m. with Staff N (LNA) revealed that it is not uncommon for residents to be served breakfast after 10:00 a.m. Review on 3/14/24 of the facility policy titled, Timely Meal Service Policy, undated revealed: .Meals will be delivered promptly with supervision as needed by nursing staff Review on 3/14/24 of the facility policy titled, Dining Experience Policy, undated revealed: .14.a. Individuals will be assisted promptly and in a timely manner after the meal arrives .

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 47129 Based on observation and record review, it was determined that the facility failed to post the daily nurse staffing data for 1 of 2 days observed (3/13/24). Interview on 3/14/24 at 7:37 a.m. with Staff G (Staff Development Coordinator) revealed that the daily nurse staffing data was posted in 2 places in the facility, on the bulletin board in the hallway leading into the [NAME] Unit and in the window in the entrance way of the facility. Observation on 3/14/24 at 7:40 a.m. of the bulletin board in the hallway leading into the [NAME] Unit revealed the facility nurse staffing data dated 3/12/24. Interview on 3/14/24 at 7:41 a.m. with Staff G confirmed the above. Observation on 3/14/24 at 7:42 a.m. of the entrance way to the facility revealed the daily nurse staffing data was taped to the window. Observation further revealed that the daily nurse staffing data was dated 3/11/24. Interview on 3/14/24 at 7:43 a.m. with Staff G confirmed the above.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28881 Based on record review, interview, and policy review, it was determined that the facility failed to establish a system of records of receipt and disposition of controlled drugs in sufficient detail to enable an accurate reconciliation; and determine that drug records were in order and that an account of all controlled drugs was maintained for 2 of 2 narcotic books reviewed. Findings Include: East Unit Medication Cart Observation on 3/12/24 at approximately 9:30 a.m. of the East Unit Narcotic/Controlled Substance Log - Shift Count revealed missing staff signatures for the following dates: 1/8/24 (day nurse coming on duty), 1/24/24 (night nurse coming on duty), 1/28/24 (day nurse coming on duty & night nurse coming off duty), 2/14/24 (night nurse going off duty), 2/27/24 (night nurse coming on duty), 2/28/24 (night nurse going off duty), 3/3/24 (night nurse going off duty), 3/7/24 (night nurse going off duty), and 3/12/24 (night nurse coming on duty). Interview on 3/12/24 at approximately 9:30 a.m. with Staff P (Licensed Practical Nurse) confirmed the above findings. West Unit Medication Cart Observation on 3/12/24 at approximately 12:30 p.m. of the [NAME] Unit Narcotic/Controlled Substance Log - Shift Count revealed missing staff signatures for the following dates: 1/13/24 (day nurse coming on duty), 1/14/24 (day nurse coming on duty), 2/11/24 (night nurse going off duty), 3/1/24 (day nurse coming on duty & night nurse going off duty), and 3/9/24 (night nurse coming on duty). Interview on 3/12/24 at approximately 9:30 a.m. with Staff Q (LPN) confirmed the finding. Review on 3/14/24 of the facility policy titled, Change of Shift Counts Policy, dated 07/23, revealed: Purpose - To maintain compliance with regulations, prevent the diversion of drugs, prevent medication errors and maintain accountability .2. Licensed staff are responsible for completing the following information .d. Nurse Coming On Duty .e. Nurse Going Off Duty. Review on 3/14/24 of Standard in [NAME] A. [NAME] and [NAME] [NAME] Fundamentals of Nursing 7th edition page 688 revealed: .Medication Regulation and Nursing Practice .The nurse is responsible for following legal provisions when administering controlled substances or narcotics which are carefully controlled through federal and state guidelines

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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. 28881 Based on interview and record review, it was determined that the facility failed to ensure that residents on antipsychotic medications were monitored for side effects for 2 of 5 residents reviewed for unnecessary medications in a final sample of 27 residents (Resident Identifiers are #12 and #42). Findings include: Resident #12 Review on 3/13/24 of Resident #12's March 2024's Medication Administration Record (MAR) revealed the following physician's order: Seroquel Oral Tablet 25 mg [milligrams] [Quetiapine Fumarate] Give 12.5 mg by mouth two times a day for Major Depressive Disorder delusional/agitation, Start Date 9/21/23. Review on 3/14/24 of Resident #12's Abnormal Involuntary Movement Scale (AIMS) revealed that the last one completed with Resident #12 was dated 8/21/23. Interview on 3/14/24 at approximately 10:45 a.m. with Staff C (Assistant Director of Nursing) revealed that the AIMS test should be completed every 6 months when residents are on antipsychotic medications. Further interview revealed that the facility does not have a policy for when AIMS testing should be done. Resident #42 Review on 3/13/24 at approximately 7:00 a.m. of Resident #42's medical record revealed an order for Abilify (Antipsychotic) 5 mg with an order date of 9/13/23. Further review of Resident #42's medical record revealed an AIMS test on 3/26/23. Interview on 3/14/24 at approximately 12:50 p.m. with Staff E (Director of Nursing) confirmed the finding. Review on 3/14/24 of the National Institute of Health AIMS Screening for Tardive Dyskinesthia (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10292174/), dated 5/2023 revealed: The Abnormal Involuntary Movement Scale (AIMS) is used not only to detect tardive dyskinesia but also to follow the severity of a patient's TD over time. It is a valuable tool for clinicians who are monitoring the effects of long-term treatment with neuroleptic medications and for researchers studying the effects of these drugs. The AIMS is administered every three to six months to monitor the patient for the development of TD.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 48515 Based on observation, interview, and record review, it was determined that the facility failed to ensure controlled medications were stored in a separately locked, permanently affixed storage compartment in 2 of 2 medication rooms observed, and that the facility failed to ensure that medications were appropriately disposed of in 2 of 3 medication administrations observed. Findings include: Observation on 3/12/24 of [NAME] 1 cart at approximately 8:15 a.m. revealed Staff I (Registered Nurse) dropped one capsule of Colace (Bowel Medication) on the medication cart, then picked it up and threw it in the trash barrel attached to the medication cart. Interview on 3/12/24 at approximately 8:15 a.m. with Staff I confirmed above findings. Observation on 3/12/24 of [NAME] 2 cart at approximately 8:20 a.m. revealed Staff J (Registered Nurse) dropped one tablet (Multivitamin) on the medication cart and then disposed of it in the open trash barrel on the side of the medication cart. Interview on 3/125/24 at approximately 8:20 a.m. with Staff J confirmed the above findings. Interview on 3/14/24 at approximately 1:35 p.m. with Staff C (Assistant Director of Nursing) revealed that the expectation would be to dispose of medications in the Drug Buster (drug disposal system). Review on 3/14/24 of facility policy titled Disposal of Medications and Medication-Related Supplies, dated 7/1/23 revealed .D. Authorized personnel who have access to medications should deposit pharmaceutical waste in the appropriately labeled container .M The facility must train all employees who handle pharmaceuticals on the appropriate management and disposal of pharmaceutical waste and emergency procedures upon hire and then at least once yearly . 28881 West Unit Medication Room Observation on 3/12/24 at approximately 9:00 a.m. of the [NAME] Unit Medication Room revealed an unlocked medication refrigerator with 1 bottle of a controlled substance, Lorazepam Intensol Oral Concentrate 2 milligrams/milliliter (mg/ml), stored on the refrigerator door shelf. Interview on 3/12/24 at approximately 9:00 a.m. at the time of observation with Staff J confirmed the findings. East Unit Medication Room (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 3/12/24 at approximately 9:15 a.m. of the East Unit Medication Room revealed an unlocked medication refrigerator with 2 bottles of controlled substances, Lorazepam Intensol Oral Concentrate 2mg/ml, stored on the refrigerator door shelf. Interview on 3/12/24 at approximately 9:15 a.m. at the time of observation with Staff P (Licensed Practical Nurse) confirmed the finding. West Unit Medication Cart Observation on 3/14/24 from 7:45 a.m. to 7:55 a.m. revealed the [NAME] Unit Medication Cart was left unlocked and unattended for 10 minutes in the resident hallway with residents present. Interview on on 3/14/24 at 7:55 a.m. with Staff I (Registered Nurse) confirmed the finding. Review on 3/14/24 of the facility policy titled, Medication Storage Policy, dated 08/22, revealed: Purpose - To ensure proper storage of medication and biologicals for safety and security .6. Controlled medications are stored separately from other medications in a locked drawer or compartment designated for that purpose.

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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. 48515 Based on observation, interview, and record review, the facility failed to adhere to facility established infection prevention procedures for 1 of 4 residents reviewed with catheters and for transmission based precautions for 2 of 6 residents reviewed for infection control in a final sample of 27 residents (Resident Identifiers are #75, #172, and #174). Findings include: 28881 Resident #174 Record review on 3/12/24 of Resident #174's medical record revealed the resident had a Foley catheter. Observation on 3/12/24 at 12:38 p.m. of Resident #174 revealed them in their room seated in a chair with an uncovered catheter bag and tubing resting on the floor. Observation on 3/13/24 at approximately 12:30 p.m. revealed Resident #174 in their room seated in a chair with an uncovered catheter bag hanging from the heating unit. Interview on 3/13/24 at approximately 12:35 p.m. with Staff S (Licensed Practical Nurse) confirmed the finding. Review on 3/18/24 of the facility policy titled, Emptying Foley Catheter Drainage Bag, revealed: Never allow the drainage tube to touch the floor .Bacteria can very easily travel back up the tubing into the bladder. Resident #172 Record review on 3/12/24 of Resident #172's medical record revealed a diagnosis of clostridioides difficile. Observation on 3/13/24 at approximately 9:30 a.m. revealed Staff T (Licensed Nurse Assistant (LNA)) exited Resident #172's room with a hoyer lift and proceed to the clean the lifts handles with EcoLab 6000261 disinfectant wipes. Interview 3/13/24 at approximately 9:30 a.m. with Staff T revealed the hoyer lift was used for multiple residents and that EcoLab 6000261 disinfectant wipes were the product used to clean the hoyer lift. Review on 3/13/24 of the EcoLab 6000261 bottle and EcoLab Disinfectant Wipe Product Specification Document revealed the product does not kill clostridioides difficile, thus posing a cross-contamination risk to other residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 3/13/24 at 11:50 a.m. with Staff E (Director of Nursing) confirmed the finding. Review on 3/18/24 of the facility policy titled, Clostridium Difficile, revealed: Equipment must be thoroughly disinfected prior to use elsewhere. 38218 Resident #75 Review on 3/12/24 of Resident #75's March 2024's Medication Administration Record (MAR) revealed the following physician's order: Linezolid Oral Tablet 600 mg [milligrams], Give 600 mg by mouth two times a day for UTI [Urinary Tract Infection] VRE [Vancomycin-resistant enterococci] for 7 days, Start Date 3/11/24. Observation on 3/12/24 at approximately 1:15 p.m. of Resident #75's room revealed that Resident #75 was not on Transmission Based Precautions (TBP) for VRE. Interview on 3/12/24 at approximately 1:25 p.m. with Staff A (LNA) confirmed that Resident #75 was not on TBP and he/she did not know why Resident #75 would be on precautions. Interview on 3/12/24 at approximately 1:30 p.m. with Staff B (Nurse Practitioner) revealed that Resident #75 should be on TBP while being treated for VRE. Interview on 3/12/24 at approximately 1:35 p.m. with Staff C (Infection Preventionist) revealed that Resident #75 should be on TBP while being treated for VRE. Review on 3/13/24 of the facility policy titled, VRE Infection/Colonization, undated revealed: Procedure: .C. Extended Precautions: refers to the transmission-based precautions (i.e., contact, droplet, airborne) that are used in addition to Standard Precautions to prevent the transmission of VRE when the rout of transmission cannot be totally controlled by the use of Standard Precautions 1.b Use of gowns and gloves by healthcare workers and visitors for interactions that involve contact with affected areas

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **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 a resident was offered and/or provided education on the risks and benefits of the Pneumococcal or Influenza vaccination for 2 of 5 residents reviewed for vaccinations (Resident identifiers are #29 and #107). Findings include: Resident #29 Review on 3/13/24 of Resident #29's medical record revealed that Resident #29 was admitted to the facility on [DATE]. Further review revealed that Resident #29 had not received an influenza vaccination and had received Pneumovax 23 prior to admission. Interview on 3/14/24 at approximately 11 a.m. with Staff C (Infection Preventionist) revealed that Resident #29 had not been offered or educated on the risks/benefits of the Influenza vaccine or any other additional pneumonia vaccines. Resident #107 Review on 3/13/24 of Resident #107's medical record revealed that Resident #107 was admitted to the facility on [DATE]. Further review revealed that Resident #107 had not received a pneumonia vaccine. Interview on 3/14/24 at approximately 11 a.m. with Staff C revealed that Resident #107 had not been offered or educated on the risks/benefits of additional pneumonia vaccines. Review on 3/14/24 of facility policy titled Immunization Of The Residents, revealed .all new residents must be assessed for pneumococcal, influenza, and COVID-19 vaccine status .B. Permission must be obtained from the resident (or representative) to administer pnuemococcal vaccine (one time), influenza vaccine annually in the fall .F .Because long term care residents are prone to developing serious complications when they contract the flu and COVID-19, all residents must receive a flu and COVID-19 vaccines unless otherwise ordered by the physician or the resident refuses. Review on 3/14/24 of the CDC's Pneumococcal Vaccine Timing for Adults revealed PPSV23 only at any age; Option A > 1 year PCV 20 or option B >1 year PCV 15.