STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305041	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elm Wood Center at Claremont	290 Hanover Street Claremont, NH 03743

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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 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 47129 Based on interview and record review, it was determined that the facility failed to ensure that the resident and/or resident representative was informed timely of the Skilled Nursing Facility (SNF) Notice of Medicare Non-Coverage (NOMNC) or Advance Beneficiary Notice (ABN) for 2 out of 3 residents reviewed for beneficiary notices (Resident Identifiers are #33 and #217). Findings include: Resident #33 Review on 6/11/24 of the Beneficiary Notice - Residents discharged Within the Last Six Months form, completed by the facility, revealed that Resident #33 was discharged from Medicare Services on 2/28/24 and remained in the facility. Review on 6/11/24 of Resident #33's SNF Beneficiary Notification Review form, completed by the facility, revealed that Resident #33's last covered day of Medicare Part A Skilled Services was 2/28/24 and that the facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted. Further reviewed of this form under Question 1 Was SNF ABN, Form CMS-10055 provided to resident? was checked No. Interview on 6/11/24 at 1:16 p.m. with Staff J (Business Officer) confirmed the above findings. Staff J stated that they had not filled out the the SNF ABN, Form CMS-10055 with Resident #33. Resident #217 Review on 6/11/24 of the Beneficiary Notice - Residents discharged Within the Last Six Months form, completed by the facility, revealed that Resident #217 was discharged from Medicare Services on 2/12/24 and discharged home. Review on 6/11/24 of Resident #217's SNF Beneficiary Notification Review form, completed by the facility, revealed that Resident #217's last covered day of Medicare Part A Skilled Services was 2/12/24 and that the facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted. Further reviewed of this form under Question 2 Was a NOMNC, form CMS-10123 provided to the resident? was checked No. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Interview on 6/11/24 at 1:55 p.m. with Staff J confirmed that above findings. Staff J stated that Resident #217 was not provided the NOMNC form or notice of non-coverage prior to Resident #217's last covered day of Medicare services. Review on 5/7/24 of Form Instructions for the NOMNC CMS-10123, retrieved from https://www.cms.gov/medicare/medicare-general-information/bni/downloads/instructions-for-notice-of-medicare-non-coverage-nomnc.pdf revealed: . The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily .

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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 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** 43002 Based on interview and record review, it was determined that the facility failed to follow physician's orders for 3 residents in a final sample of 17 residents (Resident Identifiers are #22, #25, and #64). Findings include: Standards: [NAME], [NAME] A., and [NAME] [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 . Resident #25 Review on 6/12/24 of Resident #25's June Medication Administration Record (MAR) revealed a physician's order for Metoprolol Tartrate 25 milligrams (mg) twice daily for blood pressure. Hold for systolic blood pressure (SBP) less than 100. Further review revealed the following: -On 6/2/24 at 8:00 a.m. a SBP of 99 and was documented as being administered. -On 6/5/24 at 8:00 p.m. a SBP of 90 and was documented as being administered. -On 6/11/24 at 8:00 a.m. a SBP of 99 and was documented as being administered. Review on 6/12/24 of Resident #25's May MAR revealed a physician's order for Metoprolol Tartrate 25 mg twice daily for blood pressure. Hold for systolic blood pressure (SBP) less than 100. Further review revealed the following: -On 5/27/24 at 8:00 a.m. a SBP of 94 and was documented as being administered. -On 5/27/24 at 8:00 p.m. a SBP of 92 and was documented as being administered. -On 5/31/24 at 8:00 a.m. a SBP of 97 and was documented as being administered. Interview on 6/13/24 at 12:36 p.m. with Staff E (Unit Manager) confirmed the above findings. Staff E stated that the blood pressure medication should not have been administered to Resident #25 on the above mentioned dates per the physician's orders. Interview on 6/13/24 at 12:36 p.m. with Staff A (Licensed Practical Nurse) confirmed that on 5/31/24, 6/2/24 and 6/11/24 he/she documented that the blood pressure medication was administered. Staff A stated that the blood pressure medication should have been held per physician's orders. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	38218 Resident #22 Review on 6/12/24 of Resident #22's May and June 2024 Medication Administration Records revealed the following order: Metoprolol Tartrate Tablet, Give 12.5 mg by mouth two times a day for blood pressure control, hold for BP (blood pressure) less than 100/60 or pulse less than 50, Start Date 3/22/24. May 2024 On 5/9/24 at 8:00 p.m. BP was 84/55 and Metoprolol was documented as being administered to Resident #22 June 2024 On 6/3/24 at 8:00 a.m. BP was 93/56 and Metoprolol was documented as being administered to Resident #22. Resident #64 Review on 6/12/24 of Resident #64's May and June 2024 Medication Administration Records revealed the following order: Metoprolol Tartrate Tablet, Give 12.5 mg by mouth two times a day for HTN (Hypertension), Hold for SBP less than 100. May 2024 For the 8:00 a.m. dose, no documented blood pressure was obtained prior to administration on 5/26/24 and 5/30/24. June 2024 For the 8:00 p.m. dose, no documented blood pressure was obtained prior to administration on 6/3/24 and 6/4/24. Interview on 6/12/24 at approximately 1:30 p.m. with Staff B (Unit Manager) confirmed the above findings for Resident #22 and #64.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assist a resident in gaining access to vision and hearing services. 43002 Based on observation, interview and record review, it was determined that the facility failed to ensure that a resident received proper treatment to maintain hearing abilities by ensuring audiology appointments were made for 1 of 1 residents reviewed for Communication-Sensory in a final sample of 17 residents (Resident identifier is #36). Findings include: Interview on 6/11/24 at 10:38 a.m. with Resident #36 revealed that he/she was very hard of hearing and that his/her hearing aids were not working well. Resident #36 stated that he/she had been waiting a long time to see the hearing doctor and was not sure the status of the referral. Review on 6/11/24 of Resident #36's care plan revealed that the resident had impaired communication related to impaired hearing in both ears. Further review revealed an intervention initiated on 6/8/22 to obtain audiology exams as indicated. Review on 6/11/24 of Resident #36's Clinical Documentation Supporting Medical and/or Surgical Need for Audiology Services revealed that Complaints of vertigo and/or dizziness was checked. This form was signed on 10/27/23 by the practitioner and 11/8/23 by Staff E (Unit Manager). Review on 6/11/24 of Resident #36's medical record revealed no completed Audiology consult. Interview on 6/12/24 at 1:38 p.m. with Staff F (Customer Service Representative for the Audiology Company) confirmed that Resident #36 had not yet been seen by the audiologist. Staff F revealed that multiple audiology clinics had been set up for the facility in November and December of 2023; and in February, March and April of 2024, but were all canceled due to the facility sending incomplete orders and/or paperwork needed for the visits. Staff F revealed that emails had been sent to the facility regarding the incomplete orders/paperwork prior to each visit, including to Staff E; however, no response was received for any of these emails and therefore the clinics were canceled. Staff F revealed that there were approximately 22 residents from the facility waiting to be seen by the Audiologist, including Resident #36. Interview on 6/13/24 at 8:22 a.m. with Staff E revealed that he/she had faxed requests to be seen for multiple residents, including Resident #36, to the audiology company on 4/6/24, but the audiologist did not show up. Interview on 6/13/24 at 9:48 a.m. and 10:41 a.m. with Staff E confirmed the above findings.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38218 Based on interview and record review, it was determined that the facility failed to ensure that a resident received effective pain management for 1 out 1 resident reviewed for pain in a final sample of 17 residents (Resident Identifier is #118). Findings include: Interview on 6/11/24 at approximately 11:00 a.m. with Resident #118 revealed that he/she was admitted to the facility on [DATE] around lunch time. Further interview revealed that Resident #118 was in pain at the time of admission and the pain continued until about 5:00 a.m. this morning when he/she received their pain medications. Resident # 118 stated I guess they were unable to get my pain medication and I was in pain all night, I barely slept. Review on 6/12/24 of Resident #118's Clinical Admission, dated 6/10/24 at 12:45 p.m. revealed resident #36's pain level was a 7 out of 10. Review on 6/12/24 of Resident #118's June 2024's Medication Administration Record revealed the following physician's order: Oxycodone Hydrochloric Acid (HCL) Tablet 5 milligrams (mg), Give 1 tablet by mouth every 4 hours as needed for moderate to severe pain, Start Date 6/10/24. Further review revealed that the 1st dose administered to Resident #118 was on 6/11/24 at 5:52 a.m. Interview on 6/12/24 at approximately 12:45 a.m. with Staff B (Unit Manager) revealed that Staff B was aware of Resident #118's pain when he/she was admitted . Further interview revealed that Resident #118 came from the hospital without a written prescription for the Schedule II narcotic and the facility was having a hard time reaching an on call provider that would be willing to write a prescription, which took approximately 3-4 hours. Staff B also revealed that the nurse should have notified the pharmacy once the prescription was obtained so that the Emergency Medication Kit in the facility could've been accessed to obtain Resident #118's Oxycodone. Review on 6/13/24 of the facility policy titled, 4.2 New Orders for Schedule II Controlled Substances, revision Date 1/1/22 revealed: .2. Physicians/Prescribers should provide Pharmacy with verbal authorization for Schedule II controlled substances in cases of an Emergency Situation. An Emergency Situation is one in which the prescribing practitioner determines that: 2.1 Immediate administration of the Schedule II controlled substance is necessary for proper treatment of the intended user; . Review on 6/13/14 of the facility policy titled, NSG227 Pain Management, revision Date 11/1/23 revealed: .Purpose, To maintain the highest possible level of comfort for patients by providing a system to identify, assess, treat, and evaluate pain .

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 47129 Based on interview and record review, it was determined that the facility failed to provide sufficient staff to meet residents' needs on Saturdays and Sundays in January 2024, February 2024, and March 2024. Findings include: Review of the facility's Payroll Based Journal (PBJ) Staffing Data Report for Fiscal Year Quarter 2 2024 (January 1 - March 31) revealed that the facility triggered for excessively low weekend staffing. Interview on 6/13/ 24 at 8:30 a.m. with Staff B (Unit Manager) revealed that during the winter months especially in January, February and March, short staffing was a real concern on the weekends. Review on 6/13/24 of the 2024 Facility Assessment revealed the following staffing levels for direct care staff: Licensed Nurses (Registered Nurse (RN), Licensed Practical Nurse (LPN), or Medication Nursing Assistant (MNA)) - 12-hour day shift was 3 and 12-hour night shift was 2; Nurse aides (Certified Nursing Assistant (CNA), Licensed Nursing Assistant (LNA)) - 7:00 a.m. to 3:00 p.m. (day)shift was 6, 3:00 p.m. to 11:00 p.m. (Evening) shift was 6, and 11:00 p.m. to 7:00 a.m. (night) shift was 3. Interview on 6/13/24 at 10:00 a.m. with Staff C (Staff Scheduler) revealed that staff would be scheduled to either the Long-Term Care (LTC) unit or the Medical Skilled Unit (MCU). Review on 6/13/24 of the Daily Staffing Sheets from January 2024 to March 2024 revealed that staffing levels for direct care staff were lower than what was defined in the facility assessment for licensed nurses and nurses aides on the following weekend shifts: January: 1/6/24 - Saturday - LTC Unit - Day shift - 2 LPN, 3 CNA - Evening shift - 2 LPN, 3 CNA - Unit census 48; 1/13/24 - Saturday - LTC Unit - Evening shift - 2 LPN, 3 CNA - Unit census 50; 1/14/24 - Sunday - LTC Unit - Evening shift - 2 LPN, 3 CNA - Unit census 50; 1/20/24 - Saturday - LTC Unit - Evening shift - 2 LPN/RN, 3.5 CNA - Unit census 51; 1/27/24 - Saturday - LTC Unit - Day shift - 2 LPN, 3 CNA - Evening shift - 2 LPN, 2 CNA - Unit census 48; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/28/24 - Sunday - LTC Unit - Day shift - 2 LPN, 3.5 CNA - Unit census 48. February: 2/3/24 - Saturday - LTC Unit - Day shift - 2 LPN/RN, 3.5 CNA - Evening shift - 3 LPN/RN, 2.5 CNA - Unit census 48; 2/4/24 - Sunday - LTC Unit - Day shift - 2 LPN, 3 CNA - Evening shift - 2 LPN/RN, 2.5 CNA - Night shift 1 RN, 1 CNA - Unit census 48; 2/10/24 - Saturday - LTC Unit - Day shift - 2 LNA, 3.5 CNA - Unit census 48; 2/11/24 - Sunday - LTC Unit - Day shift - 2 LPN, 3.5 CNA - Night shift - 1 LPN/RN, 1.5 CNA - Unit Census 49; 2/17//24 - Saturday - LTC Unit - Day shift - 2 LPN, 3 CNA - Evening shift - 2 LPN/MNA, 2.5 CNA - Unit Census 48; 2/18/24 - Sunday - LTC Unit - Day shift - 2 LPN, 2 CNA - Evening shift - 1.5 LPN, 1.5 CNA - Unit Census 48; 2/24/24 - Saturday - LTC Unit - Day shift - 2 LPN/RN, 3 CNA - Night shift - 1 LPN, 1.5 CNA - Unit Census 51; 2/25/24 - Sunday - LTC Unit - Day shift - 2 LPN, 3 CNA - Night shift - 1 LPN/RN, 1.0 CNA - Unit Census 51. March: 3/2/24 - Saturday - LTC Unit - Day shift - 2 LPN, 2 CNA - Evening shift - 2 LPN, 3 CNA - Night shift - 1 LPN, 1 CNA - Unit census 51; 3/3/24 - Sunday - LTC Unit - Day shift - 2 LPN, 3 CNA - Evening shift - 2 LPN/MNA, 2 CNA - Night shift 1 LPN, 1 CNA - Unit Census 51; 3/9/24 - Saturday - LTC Unit - Evening shift - 2 LPN, 3.5 CNA - Night shift - 1 LPN, 1.5 CNA - Unit census 50; 3/10/24 - Sunday - LTC Unit - Evening shift - 2 LPN, 3.5 CNA - Night shift - 1 LPN, 1.5 CNA - Unit census 50; 3/16/24 - Saturday - LTC Unit - Day shift - 2 LPN, 3 CNA - Evening shift - 2 LPN/MNA, 3 CNA - Unit census 51; 3/17/24 - Sunday - LTC Unit - Day shift - 2 LPN, 3 CNA - Evening shift - 2 LPN/MNA, 3 CNA - Unit census 51; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/23/24 - Saturday - LTC Unit -Evening shift - 2 LPN, 2 CNA - Night shift - 1 LPN, 1 CNA - Unit census 50; 3/24/24 - Sunday - LTC Unit - Night shift - 1 LPN, 1.5 CNA - Unit census 50; 3/30 24 - Saturday - LTC Unit - Day shift - 2 LPN, 3 CNA - Night shift - 1 LPN, 1 CNA - Unit census 49; 3/31/24 - Sunday - LTC Unit - Day shift - 2 LPN, 3.5 CNA - Unit census 49. Interview on 6/13/24 at 12:40 p.m. with Staff C confirmed the above findings. Interview on 6/13/24 at 8:16 a.m. with Staff H (LNA) revealed that he/she felt that the staffing levels had improvement over the last month. Interview on 6/13/24 at 8:22 a.m. with Staff G (LPN) revealed that over the winter he/she would be forced to work additional shifts due to call outs. Interview further revealed that Staff G felt that currently staffing was in a very good place. Interview on 6/13/24 12:50 p.m. with Staff D (Director of Nursing) revealed that a staffing action plan resulted from staffing concerns from nursing management.

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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. 47129 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 are in order; and that an account of all controlled drugs was maintained in 2 of 3 narcotic books reviewed. Findings include: Review on 6/11/24 of the facility's policy titled Controlled Substance Management, dated April 1, 2022, revealed: .Two licensed nurses must perform a shift count .Ongoing inventory: A complete count of all Schedule II-IV controlled substances is required at the change of shifts per state regulation or at any time when narcotic keys are surrendered from one licensed nursing staff to another. The count must be performed by two licensed nurses and/or authorized nursing personnel . Review on 6/11/24 at 8:55 p.m. of the Medication Cart #1 (200's) Shift Change Controlled Substance Inventory Count for May 2024 and June 2024 revealed the following days with only one of two required nurse signatures for narcotic shift count: 5/9/24, 5/10/24, 5/30/24, 6/8/24, and 6/11/24. Interview on 6/11/24 at 9:00 a.m. with Staff A (Licensed Practical Nurse) confirmed the above finding for Medication cart #1. Staff A stated that he/she forgot to sign his/her name this morning when he/she did the controlled inventory count. Review on 6/11/24 at 9:40 a.m. of the Medication Cart #2 (300's) Shift Change Controlled Substance Inventory Count Sheets for May 2024 and June 2024 revealed the following days with only one of two required nurse signatures for narcotic shift count: 5/9, 5/13, 5/30, 6/8 and 6/10. Interview on 6/11/24 at 9:45 a.m. with Staff K (Licensed Practice Nurse) confirmed the above findings for Medication cart #2. Interview on 6/11/24 at 2:30 p.m. with Staff D (Director of Nursing) revealed that Controlled Substance Inventory Count Sheets should be signed and dated by the nursing staff when the actual counts are done, and that nursing staff should document all information required on the form.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 38218 Based on observation, interview, and record review, it was determined that the facility failed to ensure a medication error rate less than 5 percent (%) for medication administration for 2 of 25 medications observed (8% error rate) (Resident Identifier is #33). Findings include: Observation on 6/10/24 at approximately 9:45 a.m. of medication administration with Resident #33 revealed Staff A (Licensed Practical Nurse) prepared the following medications: Sacchromyces Boulardii (probiotic), 1 capsule; Folic Acid 400 mcg (micrograms) 1 tablet. Review on 6/11/24 of Resident #33's June 2024's Medication Administration Record (MAR) revealed the following physician's orders: Folic Acid Oral Tablet, 1 milligram (mg) (Folic Acid) Give 1 mg by mouth one time a day for supplement, Start Date 1/19/24. Lactobacillus Oral Capsule, (Lactobacillus) Give 1 capsule by mouth one time a day of supplement, Start Date 1/19/24. Interview on 6/11/24 at approximately 9:45 a.m. with Staff A (Licensed Practical Nurse) confirmed that the he/she was going to administer the wrong dose of Folic Acid and the wrong probiotic. Review on 6/10/24 of the facility policy titled, 6.0 General Dose Preparation and Medication Administration, revision date or 4/30/24 revealed: .3. Prior to administration of medication, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: 3.1 Verify each time a medication is administered that is the correct medication, at the correct dose . There were 2 medication errors out of a total of 25 medication administration opportunities resulting in a 8% error rate.