STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305045	A. Building B. Wing	09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant View Center	239 Pleasant Street Concord, NH 03301

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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 43408 Based on record review and interview, it was determined that the facility failed to notify the resident's activated Durable Power of Attorney for Healthcare (DPOA-H) of a change in condition or needs to alter treatment for 1 of 3 residents reviewed for death (Resident Identifier #8). Findings include: Review on 9/24/24 of Resident #'8's medical record revealed the following: Provider note on 7/8 at 9:42 a.m.- Resident was seen due to reports of hypoxia and nasal congestion. Chest x-ray and Flonase was ordered. Nursing note on 7/9/24 at 1:30 a.m.- Resident complained of difficulty breathing and increased congestion. Resident refused chest x-ray. Provider note on 7/9/24 at 9:45 a.m.- Resident was seen for follow up and consider gradual dose reduction of morphine. Resident reports chest congestion, cough and shortness of breath. Resident refused chest x-ray. Resident was started on 250 mg [milligram] Azithromycin once daily for 5 days, discontinued 0.75ml [milliliter] of Morphine 10 mg/ 5 ml 4x [times] daily and started on 5 mg Oxycodone 3x daily. Nursing note on 7/9/24 at 1:07 p.m.- Resident refused all medications. Nursing note on 7/10/23 at 7:55 a.m.- Resident consumed 25% of meal. Provider note on 7/11/24 at 10:53 a.m.- Resident was seen for follow up and progressive symptoms. Resident was to start on Ceftriaxone 1 gram IM [Intramuscularly] daily for 5 days in addition to the Azithromycin started on 7/9/24. Nursing note on 7/11/24 at 12:52 p.m.- Resident declined Ceftriaxone 2 times. Resident was not feeling well. Nursing note on 7/12/24 at 6:40 p.m.- DPOA-H called and requested Oxycodone be held due to Residents reaction to the medications in the past. He/she states that he/she was not made aware of the oxycodone being started. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305045	A. Building B. Wing	09/24/2024

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review on 9/24/24 of Resident #8's current physician's orders revealed an order dated 5/24/24 to activate Resident #8's DPOA-H. Interview on 9/24/24 at approximately 10:00 a.m. with Staff C (Assistant Director of Nursing) confirmed the above findings and that there was no documentation found that Resident #8's DPOA-H was notified of Resident #8's change in condition or of the medication changes. Review on 9/24/24 of the facility's policy, Notification of Changes, revised 1/24, revealed: .The facility must inform the resident, consult with the resident's physician and/ or notify the resident's family member or legal representative when there is a change requiring such notifications .Circumstances requiring notification include: .2. Significant change in the resident physical, mental or psychosocial condition such as deterioration in health .3. Circumstances that require a need to alter treatment. This may include: a. New treatment. b. Discontinuation of current treatment due to: i. Adverse consequences. ii. Acute condition. iii. Exacerbation of a chronic condition .

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43408 Based on observation, interview and record review, it was determined the facility failed to ensure that allegations involving neglect were reported to the State Survey Agency for 1 of 3 residents reviewed for elopement (Resident Identifier #3). Findings include: Review on 9/23/24 of Resident #3's progress note, dated 7/28/24, revealed that around 5:40 p.m. the nurse could not locate the resident inside or outside the facility. The resident had not signed out of the check out book on the unit floor or at the reception desk. Administration was notified and a statement was given to the police. The resident was found and reported back on the floor around 9:00 p.m. Interview on 9/23/24 at approximately 2:35 p.m. with Staff C (Assistant Director of Nursing) revealed Resident #3 had left the faciity on [DATE], without the facilities knowledge, and walked down the road. Resident #3 got a ride to the Holiday Inn where they went inside and proceeded to drink alcohol at the bar. The police located Resident #3 and notified the facility of their location. Review on 9/23/24 of Resident #3's medical record revealed the following diagnosis: unspecified dementia, unspecified severity, with psychotic disturbance. Further review of Resident #3's medical record revealed they had been taking the following medications at the time of the above incident: Clorazepate Dipotassium (benzodiazapine) 30 milligrams (mg) once a day; Gabapentin (anticonvulsant) 300 mg twice a day; Depakote sprinkles (anticonvulsant) 125 mg twice a day; Venlafaxine (antidepressant) 37.5 mg once a day. Interview on 9/24/24 at approximately 1:00 p.m. with Staff A (Administrator) confirmed that Resident #3 had left the facility with out staff knowledge and the police were notified. Staff A revealed that no report was made to the State Survey Agency regarding the elopement of Resident #3. Review on 9/24/24 of the facility policy titled, Abuse, Neglect and Exploitation, dated 1/24, revealed: . Reporting/Response .A. The facility will have a written procedure that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agency (e.g. law enforcement if applicable) within specified timeframes: a. Immediately, but no later than 2 hours after allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the event that cause the allegation do not involve abuse and do not result in serious bodily injury .