

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 305045	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2025
NAME OF PROVIDER OR SUPPLIER Pleasant View Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>26364</p> <p>Based on interview and record review, it was determined that the facility failed to ensure that an alleged violation of abuse was reported immediately to the State Survey Agency (SSA) for 1 of 1 resident reviewed for an alleged violation of Abuse or Neglect. (Resident Identifier is #5.)</p> <p>Findings include:</p> <p>Review on 2/26/25 of Resident #5's medical record revealed the following nursing note written by Staff E (Registered Nurse), dated 2/23/25 at 4:17 p.m.: During morning medication round I inadvertently administered the incorrect medication to the patient. While verifying the medication administration record (MAR) I recognized that the following medications were given.</p> <p>Ativan oral tab [tablet] 0.5 mg [milligrams]</p> <p>Zyprexa oral tab 7.5 mg</p> <p>Tramadol HCL [hydrochloric acid] 50 mg half tab</p> <p>Amantadine 100 mg tab</p> <p>Amlodipine 10 mg tab</p> <p>Cymbalta oral cap [capsule] delayed release particles 20 mg</p> <p>Gabapentin 300 mg capsule</p> <p>Protonix oral tab delayed release 40 mg tab</p> <p>Instead of the following prescribed medication</p> <p>Atenolol oral tab 25 mg</p> <p>Lactobacillus capsule</p> <p>Omeprazole oral capsule delayed release 20 mg</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
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>RN [Registered Nurse] assessed patient immediately and notified attending physician. RN continued to assess the patient. Family notified. No allergic reaction noted. MD [Physician] states to call back if any changes and ordered PRN [as needed] Naloxone spray.</p> <p>Interview on 2/26/25 at approximately 10:00 a.m. with Staff E confirmed that they administered another resident's medications to Resident #5 a little before noon on 2/23/25.</p> <p>Review on 2/26/25 of Resident #5's medical record revealed the following nursing note, dated 2/23/25 10:46 p.m.: Resident lethargic at beginning of shift. Previous staff reported a med [medication] error. [Telehealth name omitted] provider contacted. Provider asked this nurse to monitor vitals and report back. This nurse contacted provider with vitals, which were trending down. Provider ordered Narcan. Narcan administered. Resident still lethargic. Resident sent out 911 [Emergency Medical Services] per facility police [sic]. Family contact 1 notified. DON [Director of Nursing] also notified</p> <p>Interview on 2/26/25 at approximately 11:30 a.m. with Staff A (Director of Nursing) confirmed that Resident #5 had been admitted to the hospital on 2/23/25.</p> <p>Interview on 2/26/25 at approximately 11:00 a.m. with Staff B (Administrator) confirmed the above findings and that he/she had began the investigation into the incident on 2/24/25. Staff B reported the incident to the SSA on 2/26/25.</p> <p>Review on 2/26/25 of the facility policy titled, Abuse, Neglect and Exploitation, Revision Date 1/24, revealed . VII. Reporting/Response, . 1. Reporting of all alleged violations to the Administrator, state agency, . within specified timeframe's: a. Immediately, but no later than 2 hours after the 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 events that cause the allegation do not involve abuse and do not result in serious bodily injury .</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38218</p> <p>Based on interview, observation, and record review, it was determined that the facility failed to provide medications timely for 2 of 4 residents reviewed. (Resident identifiers are #1 and #4.)</p> <p>Findings include:</p> <p>Review on 2/26/25 of [NAME], [NAME] Griffin; [NAME], [NAME] A.; [NAME], Wendy; and [NAME], [NAME]. Clinical Nursing Skills & Techniques. 10th ed. [NAME], Pennsylvania: Elsevier, 2022, Page 597 , Safe Medication Preparation: Right Time revealed the following: With time-critical medications (e.g., antibiotics, anticoagulants, insulin, immunosuppressives), early or delayed administration of the maintenance doses of more than 30 minutes before or after the scheduled dose will most likely cause harm or result in subtherapeutic responses in a patient.</p> <p>Resident #4</p> <p>Observation on 2/26/25 at approximately 8:35 a.m. of Staff H (Registered Nurse) during medication administration revealed on his/her computer screen that Resident #4's name was in red.</p> <p>Interview on 2/26/25 at approximately 8:35 a.m. with Staff H revealed that Resident #4's name was in red because Staff H was late in administering their medications. Interview further revealed that Resident #4 had not received their schedule insulin, that their blood sugar had been 177 when checked that morning and that Resident #4 had finished breakfast.</p> <p>Review on 2/26/25 of Resident #4's February 2025 Medication Administration Report revealed the following physician's order: Insulin Aspart Subcutaneous Solution Pen-injector 100 unit/ml (milliliters) (Insulin Aspart), Inject as per sliding scale: if 151-200 = 2; . subcutaneously before meals. Review revealed that the insulin scheduled at 7:00 a.m. and was not administered until 8:51 a.m. on 2/26/25.</p> <p>Resident #1</p> <p>Review on 2/26/25 of Resident #1's medical record revealed the following physician's note, dated 2/22/25 at 7:34 p.m.: .Summary: Pt [patient] is on IV [Intravenous] Cefazolin Q8H [every 8 hours], a.m. dose was given late-at 2:30 p.m. Nurse is requesting orders going forward with how to schedule the antibiotics vs. (versus) skip a dose .</p> <p>Review on 2/26/25 of Resident #1's February 2025's Medication Administration Audit Report revealed a physician order : Cefazolin Sodium Solution Reconstituted 1 GM (gram), Use 2 gram intravenously every 8 hours for Staph aureus septicemia for 6 weeks Review further revealed the following late antibiotic administrations:</p> <p>Scheduled Date and Time Administration Time</p> <p>2/23/25 12:00 a.m. 2/23/25 1:23 a.m.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2/23/25 8:00 a.m. 2/23/25 4:26 p.m.</p> <p>2/23/25 4:00 p.m. 2/23/25 5:37 p.m.</p> <p>2/24/25 8:00 a.m. 2/24/25 9:37 a.m.</p> <p>2/25/25 8:00 a.m. 2/25/25 10:14 a.m.</p> <p>2/26/25 8:00 a.m. 2/26/25 9:21 a.m.</p> <p>Interview on 2/26/25 at approximately 12:30 p.m. with Staff A (Director of Nursing) confirmed the above medications were administered late.</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>38218</p> <p>Based on interview, the facility failed to ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents needs for 1 of 2 staff reviewed for competencies. (Staff identifier is E.)</p> <p>Findings include:</p> <p>Interview on 2/26/25 at approximately 10:00 a.m. with Staff E (Registered Nurse) revealed that on 2/23/25, he/she entered the facility for a shift that he/she had picked up through an agency. Staff E did not receive an orientation prior to the assignment or upon arrival. Staff E was assigned to do medication administration. Staff E had never used the electronic medical record that the facility used. Staff E stated that one resident required antibiotics and Staff E did not know where the medication room was located and did not know how to use the intravenous pump that was needed for administration.</p> <p>Interview on 2/26/25 at approximately 10:30 a.m. with Staff G (Night Supervisor) revealed that on the morning of 2/23/25, Staff E (Registered Nurse) arrived for their shift. Staff G revealed that Staff E voiced some concerns to Staff G that they did not know the electronic medical record that the facility used for medication administration. Staff G stated that they stayed after their shift to show Staff E the basics in the medical record before going home.</p> <p>Interview on 2/26/25 at approximately 11:45 a.m. with Staff B (Administrator) revealed that there is no orientation or skills assessment for agency staff that are only there for a shift. Staff B confirmed that Staff E did not have an orientation prior to starting their shift.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>38218</p> <p>Based on record review, interview, and policy review, it was determined that the facility failed to establish and maintain a system of records of receipt and disposition of controlled drugs in sufficient detail to enable an accurate reconciliation for 1 of 1 residents reviewed for controlled drugs. (Resident Identifier is #2.)</p> <p>Findings include:</p> <p>Interview on 2/26/25 at approximately 10:00 a.m. with Staff E (Registered Nurse) revealed that on 2/23/25 they reconciled the narcotic count with the night shift nurse and discovered that the amount of narcotics for one resident did not match the documented count in the narcotic book. Staff E told Staff G (Night Supervisor) who changed the count in the narcotic book to match the physical count.</p> <p>Interview on 2/26/25 at approximately 10:30 a.m. with Staff G confirmed that there was a discrepancy with the narcotic count and revealed that Staff G counted the number of the actual pills and changed the narcotic book to match that number with no investigation.</p> <p>Interview on 2/26/25 at approximately 11:00 a.m. with Staff A revealed Staff A denied knowledge of the narcotic count discrepancy on 2/23/25 and confirmed there was no investigation into the missing narcotics.</p> <p>Review on 2/26/25 of the Narcotic Book for Resident #2's Dilaudid 2 mg (milligrams) tablets and Resident #2's February 2025 Medication Administration Record revealed the following discrepancies in the number of tablets documented as administered:</p> <p>Date MAR Narcotic Book</p> <p>(tablets) (tablets)</p> <p>2/1 21 24</p> <p>2/3 13 22</p> <p>2/4 15 25</p> <p>2/5 18 25</p> <p>2/8 16 22</p> <p>2/9 16 24</p> <p>2/10 22 19</p> <p>2/12 10 20</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2/13 19 23</p> <p>2/14 11 48</p> <p>2/15 17 21</p> <p>2/16 21 30</p> <p>2/18 20 23</p> <p>2/19 18 24</p> <p>2/20 19 23</p> <p>2/21 17 27</p> <p>2/22 17 13</p> <p>2/23 20 19</p> <p>2/24 21 27</p> <p>Further review of the narcotic book for Resident #2's Dilaudid (2mg) revealed four entries of medication administration on 2/21/25 that were illegible. Resident #2's Dilaudid was received from the pharmacy on 2/21/25 and the amount received was illegible.</p> <p>Review on 2/26/25 of the facility policy titled, Preparation and General Guidelines, IIA7: Controlled Substances, Dated May 2018, revealed . E. Accurate accountability of the inventory of all controlled medicines is maintained at all times .</p> <p>Review on 2/26/25 of the facility policy titled, Medication Storage In The Facility, ID2: Controlled Substance Storage, Dated May 2018, revealed . Any discrepancy in controlled substance counts is reported to the director of nursing immediately. The director or designee investigates and makes every reasonable effort to reconcile all reported discrepancies. The director of nursing documents irreconcilable discrepancies in a report to the administrator. 1.) If a major discrepancy or a pattern of discrepancies occurs, or if there is apparent criminal activity, the director of nursing notifies the administrator and consultant pharmacist immediately. 2.) The administrator, consultant pharmacist, and/or director of nursing determine whether other action(s) are needed .3.) The medication regimen of residents using medications that have such discrepancies are reviewed to assure the resident has received all medications ordered and the goal of therapy is met .</p>

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38218</p> <p>Based on interview and record review, it was determined that the facility failed to ensure residents remained free from significant medication errors which resulted in a resident requiring interventions and hospitalization for multiple nights for 1 of 1 residents reviewed for medication errors. (Resident identifiers is #5.)</p> <p>Findings include:</p> <p>Review on 2/26/25 of Resident #5's medical record revealed the following nursing note written by Staff E (Registered Nurse), dated 2/23/25 at 4:17 p.m.: During morning medication round I inadvertently administered the incorrect medication to the patient. While verifying the medication administration record (MAR) I recognized that the following medications were given.</p> <p>Ativan oral tab [tablet] 0.5 mg [milligrams]</p> <p>Zyprexa oral tab 7.5 mg</p> <p>Tramadol HCL [hydrochloric acid] 50 mg half tab</p> <p>Amantadine 100 mg tab</p> <p>Amlodipine 10 mg tab</p> <p>Cymbalta oral cap [capsule] delayed release particles 20 mg</p> <p>Gabapentin 300 mg capsule</p> <p>Protonix oral tab delayed release 40 mg tab</p> <p>Instead of the following prescribed medication</p> <p>Atenolol oral tab 25 mg</p> <p>Lactobacillus capsule</p> <p>Omeprazole oral capsule delayed release 20 mg</p> <p>RN [Registered Nurse] assessed Patient immediately and notified attending physician. RN continued to assess the patient. Family notified. No allergic reaction noted. MD [Physician] states to call back if any changes and ordered PRN [as needed] Naloxone spray.</p> <p>Interview on 2/26/25 at approximately 10:00 a.m. with Staff E confirmed that they administered another resident's medications to Resident #5 a little before noon on 2/23/25.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review on 2/26/25 of Resident #5's medical record revealed the following physician's note dated 2/23/25 3:01 p.m.: Primary Chief Complaint: Clinical Concern: Medication Given in Error, . Vital Signs . BP [Blood Pressure] 98/57 .Orders: q [every] 15 min [minutes] vitals for 2 hrs [hours] after the 2 hrs q 1 hr vitals update me if any changes, but update me again in 2 hrs regardless .</p> <p>Review on 2/26/25 of Resident #5's medical record revealed the following nursing note, dated 2/23/25 10:46 p.m.: Resident lethargic at beginning of shift. Previous staff reported a med [medication] error. [Telehealth name omitted] provider contacted. Provider asked this nurse to monitor vitals and report back. This nurse contacted provider with vitals, which were trending down. Provider ordered Narcan. Narcan administered. Resident still lethargic. Resident sent out 911 [Emergency Medical Services] per facility police [sic]. Family contact 1 notified. DON [Director of Nursing] also notified</p> <p>Interview on 2/26/25 at approximately 11:30 a.m. with Staff A (Director of Nursing) confirmed that Resident #5 had been admitted to the hospital on 2/23/25. Staff A revealed that Resident #5 was currently an inpatient at the hospital.</p> <p>Review on 2/28/25 of Resident #5's Hospital's History and Physical, dated 2/23/25 at 7:01 p.m. revealed:</p> <p>Chief Complaint .given incorrect medication intended for other patient. now responsive to painful stimuli . History of Present Illness Patient is a [AGE] year-old female with past medical history including hypertension, hyperlipidemia, bladder cancer, chronic hypoxemic respiratory failure in the setting of interstitial lung disease requiring 3 L [liters] nasal canula at baseline and chronic kidney disease stage IV. [Pronoun omitted] presented via EMS [Emergency Medical Services] from nursing home after she accidentally received several medications in error . Patient's mental status was altered. [Pronoun Omitted] responded to stimulation but has required brief bag mask ventilation .Hospitalist team was asked to admit the patient for observation and medical management . Additional Information . blood pressure was 70s over 30s .</p> <p>Review on 2/28/25 of Patient's #5's hospital's progress note dated 2/24/25 at 1:50 p.m. revealed , Chief complaint accidental ingestion of medications. Patient still requires Levophed [used to treat threatening low blood pressure] .Vital Signs Blood Pressure 101/45 [decreased] .Assessment/Plan .11. Hypotension due to medication Patient still hypotensive. May take another few hours for medication to get out of [pronoun omitted] system completely .</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>26364</p> <p>Based on interview and record review, it was determined that the facility failed to take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained for reporting alleged violations of abuse and neglect.</p> <p>Findings include:</p> <p>Review on 2/26/25 of Resident #5's medical record revealed the following nursing note written by Staff E (Registered Nurse), dated 2/23/25 at 4:17 p.m.: During morning medication round I inadvertently administered the incorrect medication to the patient. While verifying the medication administration record (MAR) I recognized that the following medications were given.</p> <p>Ativan oral tab [tablet] 0.5 mg [milligrams]</p> <p>Zyprexa oral tab 7.5 mg</p> <p>Tramadol HCL [hydrochloric acid] 50 mg half tab</p> <p>Amantadine 100 mg tab</p> <p>Amlodipine 10 mg tab</p> <p>Cymbalta oral cap [capsule] delayed release particles 20 mg</p> <p>Gabapentin 300 mg capsule</p> <p>Protonix oral tab delayed release 40 mg tab</p> <p>Instead of the following prescribed medication</p> <p>Atenolol oral tab 25 mg</p> <p>Lactobacillus capsule</p> <p>Omeprazole oral capsule delayed release 20 mg</p> <p>RN [Registered Nurse] assessed Patient immediately and notified attending physician. RN continued to assess the patient. Family notified. No allergic reaction noted. MD [Physician] states to call back if any changes and ordered PRN [as needed] Naloxone spray.</p> <p>Review on 2/26/25 of the facility's QAPI agenda, dated 1/15/25 and 2/19/25, revealed no documentation for performance improvement projects for reporting alleged violations.</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 2/26/25 at approximately 11:00 a.m. with Staff B (Administrator) confirmed the above findings and that he/she had began the investigation into the above mentioned incident on 2/24/25. Staff B reported the incident to the SSA on 2/26/25.</p> <p>Review on 2/26/25 of the provider's survey history from 3/1/24 to present revealed that F609: Reporting of Alleged Violations was cited on the last four consecutive surveys (11/5/24 (investigative survey), 9/24/24 (investigative survey), 7/25/24 (recertification survey), and 3/28/24 (investigative survey)).</p> <p>Refer to F609: Reporting of Alleged Violations</p>		