

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 305053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026
NAME OF PROVIDER OR SUPPLIER Grafton County Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 3855 Dartmouth College Highway North Haverhill, NH 03774	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to identify personal humidifiers in their Water Management Plan in which Legionella and other opportunistic waterborne pathogens could grow and spread. There were humidifiers on 3 of 4 units observed. (Granite, Profile and Maple Units). Findings include: Review on 3/31/26 of the facility's policy titled Legionella Water Management Program, revised on 3/7/25 revealed, . 3. The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease. 5.c. The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria, including the following. (6) misters, atomizers, air washers and humidifiers. Review on 3/31/26 of the facility's Staff Education for Legionella Disease dated March 3, 2026, revealed Possible pathways for exposure to Legionella Bacteria that humidifiers were listed. Observation on 3/31/26 at 1:00 p.m. and on 4/1/26 at 9:49 a.m. of the Granite Unit revealed that there were humidifiers in rooms 204, 211, 212, 215 and 217. Observation on 4/1/26 of the Profile Unit revealed that there were humidifiers in rooms [ROOM NUMBERS]. Observation on 4/1/26 at 9:45 a.m. of the Maple Unit revealed there was one humidifier in room [ROOM NUMBER]. Review on 4/1/26 of the facility's Water Management Program does not identify that there are humidifiers in use in the facility or controls to prevent the growth of Legionella and other opportunistic waterborne pathogens. Interview on 4/1/26 at 12:08 p.m. with Staff F (Infection Preventionist) confirmed humidifiers were in use in the building but not included in the Water Management Plan.</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>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interview and record review it was determined that the facility failed to report allegations of abuse to the state survey agency for 2 allegations of abuse reviewed residents. (Resident identifiers are #11, #29, #55, and #82). Findings include: Resident #11</p> <p>Review on 3/31/26 of Resident #82's medical record revealed a nursing note dated 3/27/26 at 9:04 p.m. revealed Staff L (Licensed Practical Nurse) entered Resident #82's room and observed Resident #11 laying back in the recliner. Brief pulled off, pajama pulled up above pelvis. Resident #82 kneeling down in front of recliner attempting to have sex with Resident #11. Further review of the nursing note revealed that Staff L notified Staff H (Director of Nurses) and Staff G (Administrator) and Staff H informed Staff L to allow social services to contact the families on Monday.</p> <p>Review on 3/31/26 of Resident #82 and Resident #11's medical record, revealed that Resident #82 had a BIMS (Brief Interview for Mental Status) score of 02, indicating severe cognitive impairment on the Quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/13/26, and Resident #11 had a BIMS score of 00, indicating severe cognitive impairment on the Quarterly MDS with an ARD of 2/6/26.</p> <p>Interview on 4/1/26 at approximately 2:50 p.m. with Staff L confirmed that when he/she entered Resident #82's room he/she observed Resident #82 kneeling in front of the chair exposed completely and manually trying to enter Resident #11. Staff L further confirmed that he/she separated the residents, notified Staff H immediately, and placed Resident #82 on 1:1 safety checks.</p> <p>Interview on 4/1/26 at approximately 11:50 a.m. with Staff H who confirmed that he/she was notified by Staff L of the interaction between Resident #82 and Resident #11 and it was not reported to the State Agency.</p> <p>Interview 04/01/2026 at approximately 2:30 p.m. with Staff G confirmed that it was not reported to the State Agency.</p> <p>Review on 4/1/26 of the facilities policy titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating Revised September 2022 revealed .Reporting Allegations to the Administrator and Authorities 1.Suspicion must be reported immediately to the administrator and to other officials according to state law .2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons' or agencies: a. the state licensing/certification agency responsible for surveying/licensing the facility. b. the local/state ombudsman. c. the residents' representative. Adult protective services (where state law provides jurisdiction in long-term care). e. Law enforcement officials. f. The residents' attending physician; and g. The facility medical director. 3. immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.</p> <p>Resident #29</p> <p>Review on 3/31/26 of resident #29's medical record revealed a nurses note, dated 3/10/26 at 4:34 a.m., that read .LNA [Licensed Nursing Assistant] staff witnessed resident coming out of [pronoun omitted] room and grabbing the back of peers wheelchair and shaking it back and forth aggressively. (continued on next page)</p>		

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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>Interview on 4/1/26 at approximately 1:45 p.m. with Staff J (LNA) revealed that on 3/10/26 they had witnessed Resident #29 shake and push forward the wheelchair of Resident #55 while yelling at him/her.</p> <p>Interview on 4/1/26 at approximately 2:30 p.m. with Staff G (Administrator) confirmed the incident on 3/10/26 involving Resident #29 and Resident #55 was not reported to the State Survey Agency (SSA) or other law enforcement.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on interview and record review, the facility failed to ensure that 2 of 2 allegations of abuse were investigated and reported to the State Agency. (Resident identifiers are #11, #29, #55, and #82). Findings include: Resident #11</p> <p>Review on 3/31/26 of Resident #82's medical record revealed a nursing note dated 3/27/26 at 9:04 p.m. revealed Staff L (Licensed Practical Nurse) entered Resident #82's room and observed Resident #11 laying back in the recliner. Brief pulled off, pajama pulled up above pelvis. Resident #82 kneeling down in front of recliner attempting to have sex with Resident #11. Further review of the nursing note revealed that Staff L notified Staff H (Director of Nurses) and Staff G (Administrator) and Staff H informed Staff L to allow social services to contact the families on Monday.</p> <p>Review on 3/31/26 of Resident #82 and Resident #11's medical record, revealed that Resident #82 had a BIMS (Brief Interview for Mental Status) score of 02, indicating severe cognitive impairment on the Quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/13/26, and Resident #11 had a BIMS score of 00, indicating severe cognitive impairment on the Quarterly MDS with an ARD of 2/6/26.</p> <p>Interview on 4/1/26 at approximately 2:50 p.m. with Staff L (Licensed Practical Nurse) confirmed that when he/she entered Resident #82's room he/she observed Resident #82 kneeling in front of the chair exposed completely and manually trying to enter Resident #11. Staff L further confirmed that he/she separated the residents, notified Staff H immediately, and placed Resident #82 on 1:1 checks.</p> <p>Interview on 4/1/26 at approximately 11:50 a.m. with Staff H (Director of Nursing) revealed no investigation was initiated.</p> <p>Review on 4/1/26 of the facilities policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating Revised September 2022 revealed. Reporting Allegations to the Administrator and Authorities. 6. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents. Investigating Allegations. 1. All allegations are thoroughly investigated . 4. The administrator is responsible for keeping the resident and his/her representative (sponsor) informed of the progress of the investigation.</p> <p>Resident #29</p> <p>Review on 3/31/26 of resident #29's medical record revealed a nurses note, dated 3/10/26 at 4:34 a.m., that read .LNA [Licensed Nursing Assistant] staff witnessed resident coming out of [pronoun omitted] room and grabbing the back of peers wheelchair and shaking it back and forth aggressively.</p> <p>Interview on 4/1/26 at approximately 1:45 p.m. with Staff J (LNA), revealed that on 3/10/26 they had witnessed Resident #29 shake and push forward the wheelchair of Resident #55 while yelling at them.</p> <p>Interview on 4/1/26 at approximately 12:45 p.m. with Staff H (Director of Nursing) revealed the incident on 3/10/26 involving Resident #29 and Resident #55 had not been investigated.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>Based on observation, interview, and record review, the facility failed to ensure that a resident with limited mobility receives appropriate services and equipment to maintain or improve mobility for 1 of 2 residents reviewed for position and mobility in a final sample of 27 residents. (Resident identifier is #4). Findings include: Resident #4 Review on 3/31/26 of Resident #4's care plan revealed the following intervention for their activities of daily living care plan, initiated on 7/9/25, .Dependent on application of AFO [Ankle Foot Orthosis] prior to OOB [out of bed] to right lower leg [sic]. Review on 4/1/26 of Resident #4's medical record revealed a Physician order, dated 3/2/26, OT [Occupation Therapy] Consult- have R [right] AFO sent for repair (broken strap). Further review of the medical record revealed no indication that an OT consult had been completed or that anyone had been contacted about the AFO needing repair. Interview on 3/31/26 at approximately 10:00 a.m. with Resident #4 revealed they had told their provider that their foot rolls out of the AFO and it causes them pain when worn. Resident #4 stated that no one has come into see them or talk to them about the AFO since they spoke to their provider a few weeks ago. Observation on 3/31/26 at approximately 10:00 a.m. of Resident #4's room revealed an AFO lying on their bed with the ankle strap missing.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure that medications were removed from use from 2 of 4 medication carts observed and failed to ensure that medication carts were secured/locked when unattended on 1 of 4 units observed. (Resident identifiers are #23 and #55). Findings include:Maple Unit Short Cart</p> <p>Observation on 3/31/26 at 1:11 p.m. of the Maple Unit Short Hall Cart with Staff A (Licensed Medication Aide) revealed a bottle of Timolol Maleate solution for Resident #55 with pharmacy instructions to instill 1 drop in each eye twice daily for glaucoma expires in 28 days after opening. Handwritten on the box was opened on 2/27 and expires on 3/27 (28 days).</p> <p>Interview on 3/31/25 at 1:11 p.m. with Staff A confirmed the above finding.</p> <p>Review on 4/1/26 of the manufacturer's instructions for Timolol Maleate Ophthalmic Solution, provided by the facility, revealed, . the unit dose container should be. used within one month after the foil package has been opened.</p> <p>Meadow Unit Long Hall Cart</p> <p>Observation on 3/31/26 at 1:33 p.m. of the Meadow Unit Long Hall Cart with Staff B (Registered Nurse) revealed a bottle of for Latanoprost Solution 0.005% for Resident #23. Handwritten on the pill container was written opened on 2/9/26 and expires on 3/23/26 (42 days).</p> <p>Interview on 3/31/26 at 1:33 p.m. with Staff B confirmed the above and revealed that the medication had been administered and should have been discarded.</p> <p>Review on 4/1/26 of the manufacturer's instructions for Latanoprost Solution, provided by the facility, revealed, . Once a bottle is opened for use, it may be stored at room temperature. for 6 weeks. [42 days].</p> <p>Profile Long Hall Cart</p> <p>Observation on 3/31/2026 at approximately 12:25 p.m. of Profile Unit medication cart was unlocked with no nursing staff present.</p> <p>Interview on 3/31/2026 at approximately 12:30 p.m. with Staff D (Registered Nurse) confirmed above findings.</p> <p>Review on 3/31/2026 of facility policy titled Medication Labeling and Storage revised February 2023 revealed, .Medication Storage.4. Compartments (including, but not limited to,.carts.) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not let unattended if open or otherwise potentially available to others.5. Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain a safe/clean equipment for 3 of 3 residents reviewed for environment in a final sample of 27 residents. (Resident identifiers are #41, #63 and #100.) Findings include: Review on 4/1/26 of the facility's admission Procedures and Resident Information Guide revealed .Humidifiers To prevent unwanted and unnecessary illness, GCNH ([NAME] County Nursing Home) exclusively permits non-filter humidifiers. These are not provided, so either the resident or family/friend would need to purchase one. If a humidifier is brought in, nursing staff will need to be aware of it to ensure that it is on the cleaning schedule. Interview on 4/1/26 at approximately 8:51 a.m. with Staff C (Registered Nurse) revealed that Unit Aides have a book that lists residents with humidifiers and tracks cleaning. Interview on 4/1/26 at approximately 9:00 a.m. with Staff E (Licensed nursing Assistant) revealed that the Unit Aide Book did not contain any information about which Resident's had humidifiers or a tracking of cleaning dates. Interview on 4/1/26 at approximately 12:39 with Staff H (Director of Nursing) Confirmed the above. Review on 4/2/26 of the Facility's Humidifier Maintenance revised on 4/17/17 revealed .1. Nursing Staff Responsibilities .b. Ensure the device is unplugged from the electrical outlet daily. c. Ensure device if emptied, rinsed thoroughly with water, and refilled with fresh tap water in a daily basis when in use.2. Housekeeping Staff's Responsibilities: a. Housekeeping will clean humidifiers with a 1:2 solution of acetic acid and water on a monthly schedule .Resident#41 Observation on 4/1/26 at approximately 9:34 a.m. of Resident #41's room revealed a Pelonis humidifier plugged in in the resident's room. Further observation revealed that the unit was turned off. Interview on 4/1/26 at approximately 10:12 a.m. with Resident #41's family revealed that they bought the resident the humidifier and staff were made aware. Review on 4/1/26 of the Owner's manual for Resident #41's humidifier revealed . clean the humidifier regularly, typically once a week, to remove limescale and debris from the water tank and other components Remove the water tank, add a bleach solution (1 spoon bleach per gallon of water) to the tank, tighten the cap and shake well, then place the tank back on the base and let sit for 20 minutes. Observation on 4/2/26 at approximately 9:28 a.m in Resident #41's room with Staff H (Director of Nursing) revealed that Resident #41's humidifier was plugged into the wall outlet and displayed that the water tank was empty. Resident #63 Observation on 4/1/26 at approximately 9:18 a.m. revealed that Resident #63 had a Breezome humidifier in his/her room. Interview with Resident #63 revealed that he/she did not know how often the humidifier was cleaned. Review on 4/2/26 of the Manufacturer's instructions revealed . Cleaning and Maintenance .Water Tank Remove the water tank and its cover to rinse under the tap water. Fill some acid cleaner in the water tank for around 15 minutes, then descale with a cleaning brush Clean all parts of the water reservoir with a soft cloth Trouble shooting, Problem Stop working after a period of use and the red light flashes, possible cause, the filter (located at the bottom of water tank) hasn't been cleaned .Resident #100 Observation on 3/31/26 at approximately 10:13 a.m. of Resident #100's room revealed a Vick's humidifier. Review on 4/2/26 of the manufacturer's instruction for Resident #100's Vick's Filterfree Plus Cool mist Humidifier revealed .Weekly Cleaning .To properly clean your humidifier we recommend separate processes of Scale Removal and Disinfecting .Scale Removal .3. Add 2 cups undiluted, distilled vinegar to the water tank. Replace Tank Cap and swish vinegar solution around in Tank. Place Tank on base Allow vinegar to remain in Tank on Base for 15 to 20 minutes Disinfecting 1. Add 1 tsp. (teaspoon) to 1 gallon (3.8 L (Liter)) of water and add to water tank. Replace Tank Cap, Swish solution around in Tank. Place Tank on Base .2. Allow the bleach solution to remain in Tank and on Base for 15-20 minutes. Interview on 4/02/26 at approximately 9:26 a.m. with Staff C (RN) revealed that all humidifier units are cleaned with vinegar. Further interview revealed that Staff C did not know that specific manufacturers required a bleach solution. Interview on 4/2/26 at approximately 9:30 a.m. with Staff H confirmed that the facility was not following specific manufacturer's instructions for cleaning of individual humidifiers.</p>		