STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305054	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cheshire County Home	201 River Road Westmoreland, NH 03467

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 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 2 of 33 medication administration opportunities observed. (Resident Identifier is #21).Findings include:Observation on 9/10/25 at 9:06 a.m. of the morning medication administration for Resident #21 with Staff C (Licensed Practical Nurse) revealed Staff C to prepare one tablet of Vitamin D3 10 mcg (micrograms) and 17 g (grams) of Polyethylene Glycol (laxative) and prepared to administer the medications to Resident #21.Review on 9/10/25 of Resident #21's September Medication Administration Record (MAR) revealed a physician's order for Vitamin D3 25mcg. Further review revealed a physician's order to administer Polyethylene Glycol 8.5 g with the morning medication administration.Interview on 9/10/25 at approximately 9:08 a.m. with Staff C confirmed that he/she was going to administer the wrong doses Vitamin D3 and Polyethylene Glycol to Resident #21.Review on 9/11/25 of facility policy titled Medication Administration- General guidelines, revised December 2019, revealed .FIVE RIGHTS- Right resident, right drug, right dose, right route and right time, are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away. a. Check #1: Select the Medication- label, container and contents are checked for integrity and compared against the medication administration record (MAR) by reviewing the 5 Rights. b. Check #2: Prepare the dose- the dose is removed from the container and verified against the label and the MAR by reviewing the 5 Rights. c. Check#3: Complete the preparation of the dose and re-verify the label against the MAR by reviewing the 5 Rights.There were 2 medication errors out of a total of 33 medication administration opportunities resulting in a 6.06% error rate.

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
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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on record review and interview, it was determined that the facility failed to collaborate in the development of a coordinated plan of care for each resident receiving hospice services for 1 of 2 residents reviewed for hospice services in a final sample of 23 residents (Resident Identifier is #12).Findings include:Review on 9/9/25 of Resident #12's medical record revealed an order, dated 8/27/25, to admit to hospice. Further review of Resident #12's medical record revealed no information regarding frequency of visits by hospice staff or services to be provided.Review on 9/10/25 of Resident #12's hospice binder revealed no information regarding the frequency of visits by hospice staff or services to be provided.Interview on 9/10/25 at approximately 12:07 p.m. with Staff A (Unit Manager) confirmed that there was no plan of care from the hospice provider with frequency of visits or services provided for Resident #12. Staff A stated they were not aware of when hospice staff were coming to provide services for Resident #12.

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on interview and record review, it was determined that the facility failed to remove equipment from use that was not in safe working order for 1 of 2 residents reviewed for falls in a final sample of 23. (Resident Identifier is #11.)Findings include:Interview on 9/9/25 at approximately 9:30 a.m. with Resident #11 revealed that he/she had a fall last week due to his/her wheelchair brake not locking properly. Further interview revealed that Resident #11 lost his/her balance and fell when transferring from their recliner to their wheelchair.Review on 9/11/25 of Resident #11's medical record revealed a progress note, dated 9/6/25, Resident stating [pronoun omitted] was getting up to use the bathroom and [pronoun omitted] wheelchair wasn't locked fully-when [pronoun omitted] went to sit in the wheelchair it moved and [pronoun omitted] fell. Interview on 9/11/25 at approximately 8:40 a.m. with Staff D (Rehabilitation Technician) revealed that Staff D was aware of Resident #11's wheelchair brake not working properly at times. Staff D stated that he/she did check Resident #11's wheelchair brakes after the fall and the brakes did require tightening at that time, the same tightening that had been required periodically (approximately 1-2 weeks) prior to the fall. Interview on 9/11/25 at approximately 9:15 a.m. with Staff F (Licensed Nursing Assistant) revealed that Resident #11's wheelchair brakes were loose about 3 weeks ago. Staff F reported this to the Rehabilitation Technician. Interview on 9/11/25 at approximately 9:30 a.m. with Staff E (Rehabilitation Director) revealed that Staff E was aware of the brakes being loose prior to Resident #11's fall. Staff E further revealed they had been checking Resident #11's wheelchair brakes routinely to see if they need to be tightened but did not document it. Review on 9/12/25 of facility policy titled Durable Medical Equipment Maintenance and Replacement, dated October-2022, revealed .will provide adequate, safe and clean w/c's [wheel chairs], walkers, wheelchair . will be clean and in working order, . f. Examples of needed repairs: . Loose or poorly locking brakes, .