STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305056	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Merrimack County Nursing Home	325 Daniel Webster Highway Boscawen, NH 03303

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview and record review the facility failed to determine that it is clinically appropriate to self-administer medications for 2 of 3 residents reviewed for choices in a final sample of 35 residents. (Resident identifiers are #115 and #227.)Findings include: Resident #115 Observation on 3/23/26 at approximately 9:35 a.m. of Resident #115 revealed a plastic bag with a box containing eye drops on his/her bedside table. Further observation revealed that the medication was Ketotifen Fumarate Ophthalmic Solution 0.035%, prescription provided by the facility, with an open date of 1/26/26. Interview on 3/23/26 at approximately 9:40 a.m. with Resident #115 revealed that he/she would self-administer their eye drops. Review on 3/24/26 of Resident #115's Minimum Data Set revealed that Resident #115 had a Brief Interview of Mental Status score of 15/15 indicating cognitively intact. Review on 3/24/26 of Resident #115's medical record revealed no documentation of a self-administration assessment or order for the resident to self-administer their eye drops. Interview on 3/24/26 at approximately 11:47 a.m. with Staff J (Licensed Practical Nurse (LPN)) revealed that the Resident #115 did not have a self-administration assessment or order to self-administer his/her medications. Interview on 3/24/26 at approximately 12:01 p.m. with Staff H (Unit Manager) confirmed the above findings. Resident #227 Observation on 3/24/26 at approximately 8:30 a.m. in Resident #227's room revealed Resident #227 was in bed with his/her eyes closed. Further observation revealed a medicine cup with multiple pills/capsules in it on his/her bedside table. There was no staff present. Interview on 3/24/26 at approximately 8:35 a.m. with Staff C (LPN) revealed he/she left Resident #227's morning medications at his/her bedside. Further interview revealed Resident #227 did not have a physician's order or an assessment to self-administer medication. Review on 3/24/26 of Resident #227's March 2026's Medication Administration Record revealed the following morning medications that were left at bedside: Furosemide 40 mg (milligrams), (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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Levetiracetam 500 mg, Metformin HCL (Hyrdrochloride) ER (extended release) 500mg (2 tablets), Metoprolol Tartrate 25 mg (1/2 tablet), Multivitamin with minerals, Omeprazole Magnesium Capsule DR (delayed release) 20.6 mg, Potassium Chloride ER 10 meq (milliequivalents), Sertraline HCL 100 mg, Synthroid 125 mcg (micrograms), and Apixaban 5 mg. Review on 3/24/26 of Resident #227's medical record confirmed there was no physician's order or assessment to self-administer medication. Interview on 3/24/26 at approximately 1:30 p.m. with Staff F (Assistant Director of Nursing) confirmed Resident #227 did not have a physician's order or assessment to self administer medication. Review on 3/25/26 of the facility's policy Self administration of medications Effective date May 2018 revealed, A. If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive (including orientation to time), physical, and visual ability to carry out this responsibility during the care planning process.D. The results of the interdisciplinary team assessment of resident skills and determination regarding bedside storage are recorded in the resident's medical record, on the care plan. For each medication authorized self-administration, the label contains a notation that it may be self- administered. E. If the resident demonstrates the ability to safely self-administer medications, a further assessment of the safety of bedside medication is conducted. Review on 3/26/26 of the facility's policy Medication times Original Date: March, 2017 revealed, 9. A resident can request self-administration of medications with provider approval and written order.

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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. Based on interview and record review, it was determined that the facility failed to ensure that all alleged violations involving abuse are reported immediately, but not later than 2 hours after the allegation to the SSA (State Survey Agency) for 2 of 2 residents reviewed for abuse in a final sample of 35 residents. (Resident identifiers are #3 and #145.)Findings include:Resident #3Review on 3/24/26 of Resident #3's Nursing Progress Notes, dated 1/18/26, revealed the following, LNA [Licensed Nursing Assistant] reported to nurse that resident pushed another resident after grabbing [pronoun omitted] by the chest while shouting to 'get out'. Other resident found on the floor against the wall slouched. Other resident was able to get up with assistance from a staff member. Message left for guardian. Nursing supervisor notified. Will start 15 minute safety checks.Review on 3/24/26 of Resident #3's Social Services Progress Notes, dated 1/23/26, revealed the following: High Risk Meeting Note, . Discussion of recent res-to-res [resident to resident] altercation where [name omitted] pushed another resident who wandered in [pronoun omitted] room.Resident #145Review on 3/24/26 of Resident #145's Nursing Progress Note, dated 1/8/26, revealed the following, Alerted by floor nurse of potential altercation involving 2 residents. Camera footage was reviewed, and it was observed that there was physical contact between [name omitted] and another resident [name omitted]. [name omitted] was observed grabbing at [name omitted]. [name omitted] sustained a bruise to his/her wrist. The primary nurse was instructed to complete incident report. Notification sent to administration .Review on 3/24/26 of the facility policy titled, Abuse And Neglect Policy, Revision Dated 2/13/26, revealed, 10. All allegations of abuse or neglect, including all reportable resident to resident incidents, will be reported immediately (immediately shall be defined as within 2 hours) An internal investigation will be forwarded within 5 working days to the office of the Long Term Care Ombudsman for investigation.Interview on 3/24/26 at approximately 12:15 p.m. with Staff F (Assistant Director of Nursing) revealed that the above resident to resident incidents were not reported to the SSA.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview, and record review, it was determined that the facility failed to revise a care plan for 1 of 2 residents reviewed for falls in a final sample of 35 residents (Resident identifier is #178).Findings include:Review on 3/25/26 of Resident #178's medical record revealed he/she had a fall on 12/24/25.Review on 3/25/26 of Resident #178's fall summary report revealed that a new intervention to be added to Resident #178's care plan was for staff to offer residents to keep curtain open between the sides of the room with the exception of cares per resident choice.Review on 3/25/26 of Resident #5's care plan titled, at risk for falls, revealed that the care plan was not updated with the above intervention after Resident #178's fall on 12/24/25.Interview on 3/25/26 at 8:30 a.m. with Staff O (Unit Manager) confirmed the above findings.Review on 3/25/26 of the facility policy titled, Fall/Accident Management Program, revised 12/2024, revealed: .3. IDT fall meeting will occur weekly after a fall and will include discussion of possible causes of the fall and development of new fall prevention interventions. Resident care plan will be updated accordingly.

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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 Based on record review, observations, and interviews, the facility failed to ensure that medications were administered in accordance professional standards for 1 of 3 residents reviewed for closed records and for 2 of 3 residents observed during medication administration. (Resident's identifiers are #287, #16, and #296.)Findings include: Resident #287

[NAME], [NAME] A., and [NAME] [NAME]. Fundamentals of Nursing. 10th edition St. Louis, Missouri: Elsevier, 2021. Page 614, .It is essential to verify the accuracy of every medication you give to your patients with the patient's order. If the medication order is incomplete, incorrect, or inappropriate, or if there is a discrepancy between the original order and the information on the MAR [Medication Administration Record]. consult with the health care provider. Do not give a medication until you are certain that you can follow the seven rights of medication administration . Page 672 .seven rights of medication administration include right medication, right dose, right patient, right route, right time, right documentation and right indication .

Review on 3/24/26 of Resident #287's February Medication Administration Record (MAR) revealed the following orders for Morphine Sulfate Concentrate 20 mg/mL(milligram/milliliter), active from 2/5/26 through 2/9/26:

Moderate pain/dyspnea: Give 0.5 mL orally every 30 minutes as needed for breakthrough moderate pain or dyspnea with respiratory rate 26–28. May give PO/SL (by mouth/sublingual).

Severe pain/dyspnea: Give 1 mL orally every 30 minutes as needed for breakthrough severe pain or dyspnea with respiratory rate >29. May give PO/SL.

Review on 3/24/26 of Resident #287's February MAR documentation showed the following administration of morphine was administered outside the ordered parameters:

On 2/7/26 at 12:47 p.m., 1 mL of morphine was administered, the respiratory rate was documented as 22, and no pain level was recorded.

On 2/7/26 at 8:58 p.m., 1 mL of morphine was administrated, the respiratory rate was documented as 18, and pain level was documented as zero.

on 2/8/26 at 4:00 a.m.50 mL of morphine was administrated, the respiratory rate was documented as 22, and pain level was documented as 3.

Interview on 03/24/26 at 2:29 PM, with Staff R (physician) confirmed that the medication was administered outside the ordered parameters.

Resident #16

Review of the American Society for Parenteral and Enteral Nutrition (A.S.P.E.N.), the preferred method for administering medications through a gastrostomy tube (G-tube) is by gravity via a syringe bolus rather than manually pushing the medication with the plunger (Boullata, 2019; A.S.P.E.N. Enteral Nutrition Practice Recommendations Task Force, 2009). The gravity bolus technique involves removing the syringe plunger, connecting the barrel to the G-tube, and allowing medications to drip in (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	naturally under the influence of gravity (A.S.P.E.N. Enteral Nutrition Practice Recommendations Task Force, 2009; Boullata, 2019). This approach is recommended to reduce clogging risk, minimize gastrointestinal discomfort, and better regulate flow rate. The push method is acceptable only when gravity administration is impractical, but it must be performed slowly and carefully to avoid undue pressure, reflux, or tube blockage (Boullata, 2019; A.S.P.E.N. Enteral Nutrition Practice Recommendations Task Force, 2009). Observation on 3/23/26 at approximately 9:15 a.m. of Staff A (Licensed Practical Nurse) administering Resident #16's medications via (by way of) Gastrostomy Tube revealed Staff A pushed the following medications: Senna Liquid 5 mls (milliliters), Oxybutnin Chloride 5 milligrams, Hyfiber liquid 30 mls, Amlodipine 5 mg, Acidophillus capsule, Tizanidine 2 mg, Amoxicillin 10 mls. Staff A pushed a 15 ml flush of sterile water before and after each medication that was administered (8 pushed flushes). Interview on 3/23/26 at approximately 9:30 a.m. with Staff A confirmed the above findings. Review on 3/25/26 of the facility policy titled, Enteral Nutritional Therapy, dated 3/2024, revealed, Medication Administration through a Feeding Tube . 3. Use a piston syringe . to deliver medication via (by way of) gravity, through feeding tube adapter. Resident #296 Observation on 3/24/26 at approximately 8:30 a.m. of Staff D (Registered Nurse) administering a Breyna inhaler to Resident #296 revealed that Staff D did not offer Resident #296 to rinse his/her mouth after the inhaler was administered. Interview on 3/24/26 at approximately 8:30 a.m. with Staff D confirmed the above findings. Review on 3/25/26 of the Breyna inhaler manufacturer's instructions, dated 9/2020, revealed, After inhalation, the patient should rinse the mouth with water without swallowing. Review on 3/25/26 of the facility policy titled, Specific Medication Administration Procedures (IIB8. Oral Inhalation Administration, dated May 2018, revealed, . Q. For steroid inhalers, provide resident with cup of water and instruct him/her to rinse mouth and spit water back into cup.

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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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observation, interview and record review the facility failed to provide special eating utensils for 1 of 3 residents reviewed for activities of daily living in a final sample of 35 Residents. Findings include:Review on 3/23/26 of Resident #91's meal ticket located on his/her breakfast tray revealed that he/she should use a divided plate, foam on spoon, non-slip mat and sip cups. Observation on 3/23/26 at approximately 8:52 a.m. revealed Resident #91 eating his/her breakfast in bed. Resident #91 was observed to using a standard utensil, standard plate, and no non-slip mat as part of Resident #91's meal set up. Further observation revealed that Resident #91 had multiple crumbs from his/her muffin and eggs on their clothing protector.Interview on 3/23/26 at approximately 9 a.m. with Resident #91 revealed that he/she had not had foam on spoon, divided plate, or a non-slip mat in a long time and the foam on the spoon made it easier for him/her to feed themselves. Observation on 3/23/26 at approximately 12:16 p.m. revealed Resident #91 was in the dining room for lunch. Resident #91 was using a standard spoon. His/her plate was placed directly on the linen tablecloth with no non-slip mat. Resident #91 attempted to eat yellow beans with the standard spoon and dropped them on his/her clothing protector. Interview on 3/24/26 at approximately 12:38 p.m. with Staff I (Licensed Practical Nurse) revealed that Resident #91's lunch tray contained a sandwich, crustless blueberry streusel, two bowls of soup, and two beverages in sippy cups. There were no foam on spoon or non-slip mat.Observation on 3/23/26 at approximately 12:45 p.m. revealed Resident #91 eating lunch in his/her bed. Resident #91 was using a standard spoon and spilled his/her soup.Interview on 3/24/26 at approximately 1:06 with Staff H (3 North Unit Manager) revealed that Resident #91 had a care plan to utilize adaptive eating devices when eating: built up utensils, sip cup, lip plate, and non-slip mat. Interview on 3/24/26 at approximately 2:18 p.m. with Staff F (Assistant Director of Nursing) revealed that the facility did not have a policy for the use of adaptive equipment.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. Based on interview and record review, the facility failed to provided specialized rehabilitation evaluation for 1 of 1 residents reviewed for rehabilitation and restorative services in a final sample of 35 residents. (Resident identifier is #196.)Findings Include:Interview on 3/24/26 at approximately 8:48 a.m. with Resident #196 revealed that he/she was ambulatory when he/she entered the facility in 2023 and has had a decline and is now unable to ambulate. Resident #196 further revealed that he/she would like to work with rehab to be able to walk again. Review on 3/24/26 of Resident #196's Plan of Care note dated 1/15/26 revealed . Per request of [Name omitted], now that [pronoun omitted] is off hospice [pronoun omitted] would like to work with PT [Physical Therapy] again. A referral has been made.Interview on 3/24/26 at approximately 2:08 p.m. with Staff H (Unit Manager) revealed a rehabilitation (rehab) screen request, dated 1/6/26. Further Staff H revealed that he/she emailed the request to the rehabilitation department. Interview on 3/24/26 at approximately 3:00 p.m. with Staff M (Rehabilitation Director) revealed that a rehabilitation screen was not completed for Resident #196. Review on 3/25/26 of the facility's policy titled, Rehabilitation Screen, dated 9/2016, revealed, Any resident requiring a rehabilitation screen will be seen within seven days of submitted request 2. A non-urgent rehabilitation screen can be requested by email to the rehab department.

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F 0637 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident when there is a significant change in condition Based on interview and record review, the facility failed to ensure that a Significant Change in Status Minimum Data Set (MDS) assessment was completed timely by the 14th calendar day of a resident being admitted to or discharged from hospice services for 6 of 8 residents reviewed for resident assessment in a final sample of 35 residents (Resident Identifiers are #43, #128, #173, #196, #221, and #279).Findings include:Resident #43 Review on 3/24/26 of Resident #43's Hospice Certification of Terminal Illness revealed that Resident #43 was admitted to hospice care on 12/4/25. Review on 3/24/26 of Resident #43's Significant Change in Status MDS with an Assessment Reference Date (ARD) of 12/12/25 revealed it was signed as completed on 12/23/25 by Staff G (MDS Coordinator), five days late. Resident #128 Review on 3/24/26 of Resident #128's Hospice Certification of Terminal Illness revealed that Resident #128 was admitted to hospice care on 11/8/25. Review on 3/24/26 of Resident #128's Significant Change in Status MDS with an ARD of 11/14/25 revealed it was signed as completed on 11/24/25 by Staff G, two days late. Resident #173 Review on 3/24/26 of Resident #173's Hospice Certification of Terminal Illness revealed that Resident #173 was admitted to hospice care on 12/8/25. Review on 3/24/26 of Resident #173's Significant Change in Status MDS with an ARD of 12/19/25 revealed it was signed as completed on 1/2/26 by Staff G, eleven days late. Resident #221 Review on 3/24/26 of Resident #221's Hospice Certification of Terminal Illness form revealed that Resident #221 was admitted to hospice care on 1/31/26 Review on 3/24/26 of Resident #221's Significant Change in Status MDS with an ARD of 2/6/26 revealed it was signed as completed on 2/19/26 by Staff G, 6 days late. Resident #279 Review on 3/24/26 of Resident #279's Hospice Certification of Terminal Illness revealed that Resident #279 was admitted to hospice care on 1/2/26. Review on 3/24/26 of Resident #279's Significant Change in Status MDS with an ARD of 1/9/26 revealed it was signed as completed on 1/23/26 by Staff G, seven days late. Interview on 3/25/26 at 1:44 p.m. with Staff G confirmed that MDS assessment for Residents #43, #128, #173, #221, and #279 were completed late. (continued on next page)

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F 0637 Level of Harm - Potential for minimal harm Residents Affected - Some	Resident #196 Review on 3/24/26 of Resident #196's Hospice Discharge Summary revealed that Resident #196 was discharged from hospice care on 12/31/25. Review on 3/24/26 of Resident #43's Significant Change in Status MDS with an Assessment Reference Date of 1/9/26 revealed it was signed as completed on 1/23/26 by Staff G, nine days late. Interview on 3/24/26 at approximately 2:49 p.m. with Staff G confirmed the above findings.