STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305064	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Exeter Center	8 Hampton Road Exeter, NH 03833

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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 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 observation, interview, and record review, the facility failed to follow professional standards for medication administration for 1 of 5 residents observed for medication administration, follow physician's order for 1 of 5 residents reviewed for unnecessary medications, and obtain wound dressing orders for 1 of 1 resident reviewed for skin condition. (Resident identifiers are #8, #13, and #45.)Findings include:[NAME], P.A, [NAME], A.G., Stockhart, P.A., & Hall, A. (2021). Fundamentals of Nursing. Elsevier.Page 1262. Changing Dressings A Health care provider's order for wound care indicates the dressing type, the frequency of changing, and any solutions or ointments to be applied to the wound. Resident #13 Observation on 4/28/26 at approximately 9:37 a.m. of Resident #13 revealed that Resident #13's was in bed and his/her right hand had red drainage (blood-like) on the fingers. Further observation revealed that the red drainage (blood-like) came from an area on his/her right medial leg and that there was a dressing peeled back revealing red drainage. Interview on 4/28/26 at approximately 9:40 a.m. with Staff A (Licensed Practical Nurse) confirmed that Resident #13 was actively bleeding on the right medial leg and that it was blood on their fingers. Staff A revealed Resident #13 has a history of picking his/her skin. Review on 4/29/26 of Resident #13's medical record revealed an active diagnosis of excoriation (picking) and a care plan for risk of picking to provide wound care as ordered. Further review of Resident #13's medical record revealed no wound dressing order for the above mentioned wound dressing. Interview on 4/30/26 at approximately 9:40 a.m. with Staff M (Registered Nurse) revealed that there was no documentation of Resident #13 having a right medial leg wound and that Staff M was not made aware during report from the prior shift. Interview on 4/30/26 at approximately 9:42 a.m. with Staff D (Licensed Nursing Assistant) confirmed that Resident #13 had a right medial leg wound that was covered with a dressing. Interview on 4/30/26 at approximately 10:17 a.m. with Staff I (Advanced Practice Registered Nurse) revealed that he/she was unaware of any open areas for Resident #13 and that he/she would expect a phone call and for provider to provide an order for wound dressings including type of dressing, frequency of the dressing change and any ointments to be applied. Interview on 4/30/26 at approximately 11:46 a.m. with Staff B (Director of Nursing) confirmed that (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #13's medical record contained no information regarding open area on Resident #13's right medial leg or notification to the provider for wound dressing orders. Review on 4/30/26 of the facility's policy: Skin Integrity and Wound Management with a revision date of 9/15/25, revealed, 6.2 Document newly identified skin/wound impairments as a change of condition; 6.3 Document skin/wound findings on the 24-hour report; .6.6.1 Document daily monitoring of ulcer/wound site with or without dressing 9. Notify physician/APP (advanced practice provider) to obtain orders. Standard: [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 .Correct Administration .Use aseptic technique and proper procedures when handling and giving medications . Resident #45 Review on 4/29/26 revealed a physician's order dated 4/9/26 for Oxycodone HCl [Hydrochloride] oral tablet 5 mg [milligrams] Give 1 tablet by mouth every 4 hours as needed for pain level 8-10 for 14 days. Review on 4/29/26 of the Medication Administration Record (MAR) revealed that the Oxycodone 5 mg was administered outside of the ordered parameters on the following dates and at the documented pain levels: April 13, 2026 the Oxycodone was given for a pain level of 4. April 16, 2026 the Oxycodone was given for a pain level of 7. April 18, 2026 the Oxycodone was given for a pain level of 3. April 19, 2026 the Oxycodone was given for a pain level of 6. April 22, 2026 the Oxycodone was given for a pain level of 5. Interview on 4/30/26 at 8:54 a.m. with Staff B confirmed the above findings. Review on 4/30/26 of facility policy titled Medication Administration General Guidelines dated 01/26 revealed, 1. Medications are administered in accordance with written orders of the prescriber. Standards:[NAME], [NAME] A., and [NAME] [NAME]. Fundamentals of Nursing. 10th ed. St. Louis, Missouri: Mosby Elsevier, 2021, Chapter 31, Medication Administration, Page 618-619, .Administering Medications Through an Enteral Tube (Nasogastric Tube, G-tube [gastrostomy tube], J-tube [jejunostomy tube], or Small-Bore Feeding Tube .Steps .Before administration of enteral medications, verify placement of feeding tube according to agency policy and determine that tube is placed in the stomach or small intestine correctly .Check placement of feeding tube by observing gastric contents and checking pH of aspirate contents .Check for gastric residual volume . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #8 Observation on 4/29/26 at approximately 8:32 a.m. with Staff A (Licensed Practical Nurse) during Resident #8's medication administration revealed Staff A flushed the Resident #8's gastrostomy tube (G-tube) with water, administered 60 milliliters (mL) of Lactulose 10 gm/15 mL mixed with water, and then performed a postˆmedication water flush of the G-tube. Staff A did not check or verify the placement or patency of Resident #8's Gˆtube before flushing it or administering the Lactulose. Interview on 4/29/26 at approximately 9:00 a.m. with Staff A confirmed that he/she did not check Resident #8's G-tube placement and patency prior to administering the Lactulose. Review on 4/29/26 of Resident #8's April 2026 Medication Administration Record (MAR) revealed an order to administer Lactulose 10 gm/15mL give 60 mL via G-tube four times a day. Review on 4/29/26 of Resident #8's enteral feeding tube (G-tube) care plan, initiated date 11/22/22, revealed an intervention to check patency and placement of the G-tube daily, and before administering feedings and medications. Review on 4/30/26 of the facility's policy titled, Medication Administration Enteral Tubes, dated 1/26, revealed, PROCEDURES .8. Verify tube placement per facility protocol. 9. Check the patient's gastric contents for residual feeding. Return any residual volume to the stomach .14 .Administer liquid medication first . Review on 4/30/26 of the facility's policy titled, Enteral Feeding: Administration by pump, revision date 2/24/25, revealed, .8. Evaluate patient's abdomen for distention. 9. Evaluate tube and site for damage, leakage, or irritation . 10. Auscultate abdomen for bowel sounds. 11. Measure the external length of the tube from the point of entry into the skin to the end of the tube to verify placement. 12. Draw up 10-30 mL of air into syringe and connect to the end of the enteral tube. Inject air slowly into the tube, Pull back slowly and aspirate gastric contents. 13. Check gastric residual volume (GRV) .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that medication error rate remained below 5 percent for 4 of 34 opportunities of medication administration observed. (Resident identifiers are #41 and #46.)Findings include: Resident #46 Observation on 4/29/26 at approximately 8:45 a.m. with Staff A (Licensed Practical Nurse) during Resident #46's medication administration revealed that Staff A prepared Resident #46' scheduled morning medication and placed the oral medications in a medication cup that included one Over-The-Counter (OTC) Calcium with Vitamin D 600 mg-200 unit tablet, one Metoprolol Tartrate 12.5 milligram (mg) dose tablet, and one Digoxin 125 microgram (mcg) tablet. After preparing the medications, Staff A brought the medication cup, a 4% Lidocaine patch, and a cup of water to Resident #46's room. Staff A then obtained Resident #46's blood pressure and heart rate using a wrist blood pressure monitor, which showed a blood pressure of 117/65 and a heart rate of 59. Staff A handed Resident #46 the medication cup, and Resident #46 took the medications, including the above mentioned medications. Review on 4/29/26 at approximately 8:45 a.m. of Resident #46's Electronic Medication Administration Record (EMAR) with Staff A during Resident #46's medication administration revealed the following scheduled ordered morning medications on 4/29/26:Calcium with Vitamin D 600-400 (mg-unit) one time a day, there was no route indicated on the order;Digoxin 125 mcg by mouth one time a day every Monday, Wednesday, and Saturday for heart failure hold for heart rate less than 60; andMetoprolol Tartrate give 12.5mg by mouth every morning and at bedtime for hypertension Hold for systolic blood pressure (SBP) less than 100 mmHg (millimeters of mercury) and heart rate (HR) less than 60. Interview on 4/29/26 at approximately 9:00 a.m. with Staff A confirmed the above findings. Interview on 4/29/26 at approximately 1:21 p.m. with Staff J (Advanced Practice Registered Nurse) revealed that he/she reviewed Resident #46's above mentioned Metoprolol tartrate order and that the Metoprolol Tartrate should be held when the SBP was below 100 mmHg with a heart rate (HR) of 60 or greater; when the HR was below 60 with an SBP of 100 mmHg or greater; and when the SBP was below 100 mmHg and the HR was below 60. Resident #41 Review on 4/29/26 at approximately 9:08 a.m. of Resident #41's EMAR with Staff J (Registered Nurse) during Resident #41's medication administration revealed an order for Cetirizine Hydrochloride (HCl) 10 mg give one tablet by mouth twice a day. Observation on 4/29/26 at approximately 9:08 a.m. with Staff J during Resident #41's medication administration revealed Staff J prepared the scheduled morning medications and placed the oral medications into a medication cup. Staff J did not obtain the Cetirizine Hcl 10 mg tablet to place in the medication cup prior to completing the EMAR documentation, locking the medication cart, and proceeding to Resident #41's room to administer the medications. Interview on 4/29/26 at approximately 9:21 a.m. with Staff J confirmed he/she did not obtain the Cetirizine Hcl 10 mg tablet to place in the medication cup prior to clicking yes and completing the EMAR documentation for the morning medication including the Cetirizine Hcl 10 mg, locking the medication cart, and proceeding to Resident #41's room. Standard: [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 . Review on 4/30/26 of facility policy titled, Medication Administration General Guidelines, dated 01/26, revealed, Medications are administered in accordance with written orders of the prescriber .There were 34 opportunities of medication administration observed and 4 of the 34 medications were not administered in accordance with physician's orders, resulting in a medication error rate of 11.76%.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on observation, interview, and record review, the facility failed to obtain laboratory services as ordered for 1 of 1 residents reviewed for anticoagulant in a final sample of 18 residents. (Resident identifier is #5.)Findings include:Review on 4/28/26 of Resident #5's medical record revealed a physician's orders for an International Normalized Ratio (INR) to be drawn on 4/27/26. Further review of the medical record under laboratory (lab) results revealed that there was no INR laboratory report on 4/27/26.Review on 4/29/26 of Resident #5's After-Hours Telehealth Consult note, dated 4/26/26, revealed that Resident #5's INR was subtherapeutic from lab results for 4/26/26 and that the provider ordered a repeat INR for 4/27/26.Interview on 4/29/26 at approximately 1:42 p.m. with Staff A (Licensed Practical Nurse) confirmed the above findings and that the INR was not completed as ordered.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow infection control policies and professional standards for hand hygiene, disinfection of equipment, enhanced barrier precaution (EBP), and urinary catheter maintenance for 1 of 1 resident reviewed for Transmission Based Precaution (TBP) and 2 of 2 residents reviewed for urinary catheter. (Resident identifiers are #8, #13, and #41.)Findings inclcude:Resident #8 Observation on 4/28/26 at approximately 9:48 a.m. of Resident #8 in his/her bed revealed that there was an urinary catheter bag on the floor next to the bed. Observation on 4/30/26 at approximately 8:19 a.m. of Resident #8 in his/her bed revealed that the urinary catheter bag was touching the edge of cushioned fall mat that was on the floor by Resident #8's bed. Interview on 4/30/26 at approximately 8:20 a.m. with Staff D (Licensed Nursing Assistant (LNA)) confirmed the above findings and further revealed that the urinary catheter bag should not be touching the fall mat or the floor. Observation on 4/30/26 at approximately 8:45 a.m. of Resident #8 in his/her bed revealed that the urinary catheter bag was on the edge of the cushioned fall mat by Resident #8's bed. Interview on 4/30/26 at approximately 9:42 a.m. With Staff M (RN) confirmed that the urinary catheter bag was on the edge of the cushioned fall mat and that the catheter should not be touching the fall mat or the floor. Interview on 4/30/26 at approximately 9:30 a.m. with Staff F (Market Lead Clinical Specialist) revealed that the facility followed Center for Disease Control (CDC) guidance for infection prevention. Review of CDC Guidelines for Prevention of Catheter Associated Urinary Tract Infections found at https://www.cdc.gov/infection-control/media/pdfs/Guideline-CAUTI-H.pdf revealed, .III. Proper Techniques for Urinary Catheter Maintenance . B. Maintain unobstructed urine flow.2. Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor. Resident #13 Review on 4/28/26 of Resident #13's medical record revealed that Resident #13 had a physician's order for a urinary catheter for a medical diagnosis of neurogenic bladder. Further review of the medical record revealed a indwelling device care plan with an intervention for Enhanced Barrier Precautions (EBP). Observation on 4/28/26 at approximately 9:45 a.m. revealed that there was an EBP precautions sign outside Resident #13's room indicating that to wear gown and gloves (PPE) for high contact activities. Observation on 4/28/26 at approximately 11:50 a.m. revealed Staff F (RN) and an LNA entering Resident #13's room and repositioned Resident #13 while in bed. Further observation revealed that the two staff were wearing gloves and no gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/28/026 at approximately 12:00 p.m. with Staff F (RN) confirmed the above observation. Staff F revealed that the Resident #13 was on EBP would require gloves and gown for high contact activities including repositioning in bed. Review of the facility's Procedure: Enhanced Barrier Precautions revealed, Enhanced barrier precautions applies to .indwelling medical devices (e.g urinary catheter .) . PPE use for these situations .During high contact care activities .Required PPE Gown, gloves prior to high contact activity. Resident #41 Review on 4/28/26 of Resident #41's active care plan for acute infection and at risk for sepsis related to gastrointestinal and positive Cryptosporidium antigen revealed an intervention for contact precautions. Review on 4/28/26 of Resident #41's Ova and Parasite (O&P) microscopic examination and Enzyme Immunoassay (EIA) antigen test report, dated 4/18/26, revealed a positive result for the Cryptosporidium antigen. Observation on 4/28/2026 at approximately 11:56 a.m. in Resident #41's room revealed a contact precaution sign was posted outside the room. The sign indicated staff, families, and visitors to clean their hands before entering and leaving the room (using hand sanitizer or soap and water), to wear a gown and gloves, and to clean and disinfect any shared equipment before using it with another patient. Further observation revealed Staff L (Phlebotomy Technician) was inside Resident #41's room seated in a chair with a black case (blood draw supplies), wearing gloves and a mask, and not wearing a gown. Staff L then obtained a gown from the PPE cart outside of Resident #41's room and donned it. Approximately a few minutes later, Staff L removed the gown, gloves, and mask, performed hand hygiene using the alcohol-based hand rub (ABHR), and exited the room carrying the black case without disinfecting it. Staff L did not wash their hands with soap and water after doffing PPE. Interview on 4/28/26 at approximately 12:00 p.m. with Staff L confirmed the above mentioned observations. Staff L revealed that they were in Resident #41's room to obtain a blood draw and that they did not have contact with Resident #41 prior to donning a gown. Staff L also revealed that the black case was storage for their blood draw supplies. Observation on 4/29/26 at approximately 9:30 a.m. with Staff J (Registered Nurse (RN)) during Resident #41's medication administration revealed Staff J donned a gown and gloves before entering Resident #41's room and brought in a nonˆinvasive vital signs monitor along with the resident's morning medications. Staff J obtained Resident #41's temperature using a handheld thermometer and measured blood pressure, heart rate, and oxygen saturation using the nonˆinvasive vital signs monitor. Staff J then administered the resident's morning medications. After completing the tasks, Staff J doffed the gown and gloves, performed hand hygiene with ABHR, exited the room with the vital signs monitor, placed the monitor outside Resident #41's room, went to the nurse's station to obtain a CaviWipes1 (tuberculocidal, bactericidal, virucidal, and fungicidal) disinfectant wipe, and returned to disinfect the vital signs monitor, its wires, its legs, and the handheld thermometer. Interview on 4/29/26 at approximately 9:50 a.m. with Staff J confirmed the above observations on 4/29/26. Staff J was unable to explain whether CaviWipes1 was an appropriate disinfectant for cleaning the vital signs monitor and the handheld thermometer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/30/26 at approximately 8:32 a.m. with Staff K (Infection Preventionist) revealed that Resident #41 was on contact precautions for Cryptosporidium. Staff K stated that public health had been contacted and advised the use of 3 percent hydrogen peroxide for disinfecting equipment. Staff K also confirmed that 3 percent hydrogen peroxide was available for this purpose. Interview further revealed that CaviWipes1 was not an appropriate disinfectant for the vital signs monitor and that handwashing with soap and water was the correct method of hand hygiene for Resident #41's Cryptosporidium infection. Review on 4/30/26 of the CDC website titled, Preventing Crypto [Cryptosporidiosis infection], dated 5/8/25, retrieved from: https://www.cdc.gov/cryptosporidium/prevention/index.html, revealed, .Practice Good Hygiene .Alcohol-based hand sanitizers are not effective against Crypto. Washing hands at key times with soap and water can help prevent infections. Note: When cleaning items and surfaces, no disinfectant is guaranteed to be completely effective againstˆCrypto. However, hydrogen peroxide is more effective than standard bleach solutions . Review on 4/30/26 of the facility policy titled, Cleaning and Disinfecting, revision date 5/1/25, revealed, .Cleaning/Disinfecting rooms/surfaces according to specific (Transmission Based) precautions and by using an appropriate EPA-approved [Environmental Protection Agency] disinfectant for the organism involved . Review on 4/30/26 of the CDC website titled, Transmission-Based Precautions, dated 4/3/24, revealed, .Use Contact Precautions for patients with known or suspected infections that represent an increased risk for contact transmission .Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens . Review on 4/30/26 of the facility's policy titled, Transmission Based Precautions, revision date 5/1/25, revealed, .Staff will apply Transmission Based Precautions, in addition to standard Precautions, to patients who are known or suspected to be infected or colonized with certain infectious agents requiring additional controls to prevent transmission. 2. The Center will use standard approached, as defined by the Centers for Disease Control and Prevention (CDC), for Transmission Based Precautions: Airborne, Contact, and Droplet Precautions. The category of Transmission Based Precautions will determine the type of personal protective equipment (PPE) to be used .Contact Precautions .Healthcare personnel caring for patients on Contact Precautions ear a gown and gloves in all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. 9.4 Donning PPE upon entry and discarding before exiting the room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination .noroviruses and other intestinal tract pathogens .