| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 305067 | A. Building<br>B. Wing | 05/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mount Carmel Rehabilitation and Nursing Center | 235 Myrtle Street<br>Manchester, NH 03104 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38218<br><br>Based on interview, observation, and record review, it was determined that the facility failed to ensure that a resident was clinically appropriate to self-administer their medications for 1 of 3 residents reviewed for choices in a final sample size of 23 residents (Resident Identifier #4).<br><br>Findings include:<br><br>Observation on 5/20/24 at approximately 9:15 a.m. in Resident #4's room revealed the following medications on a shelf near the resident sitting in his/her recliner:<br><br>1 bottle of Biotics Calcium;<br><br>1 bottle of Turmeric m1670;<br><br>1 bottle of Vitamin C 500 milligrams (mg);<br><br>1 bottle of [NAME] Liquid.<br><br>Interview on 5/20/24 at approximately 9:15 a.m. with Resident #4 revealed that he/she takes the medications on his/her own. Further interview revealed that Resident #4 administers:<br><br>[NAME] liquid -daily for his/her blood pressure;<br><br>Turmeric m1670- as needed for pain;<br><br>Vitamin C -1 or 2 times per week;<br><br>Biotics Calcium -daily.<br><br>Observation and interview on 5/21/24 at approximately 8:30 a.m. with Staff E (Licensed Practical Nurse) of Resident #4's room revealed the above medications on a shelf near the resident sitting in his/her recliner. Staff E confirmed the findings.<br><br>Review on 5/21/24 of Resident #4's May 2024 Medication Administration Record (MAR) revealed the following physician order's:<br><br>(continued on next page) |



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

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | [NAME] Oral Capsule 150 mg ([NAME]) Give 1 capsule by mouth in the morning every 2 day(s) for supplement. Unsupervised self-administration, family provides. Start Date 12/30/23. Further review of Resident #4's MAR revealed that he/she did not have physician's order for Turmeric m1670, Vitamin C 500 mg and Biotics Calcium.<br><br>Review on 5/21/24 of Resident #4's medical record revealed that there was no assessment for self administering medications done with Resident #4.<br><br>Interview on 5/21/24 at approximately 12:30 p.m. with Staff F (Director of Nursing) confirmed that Resident #4 was not assessed for the ability to self administer medications.<br><br>Interview on 5/21/24 at approximately 1:50 p.m. with Staff K (Nurse Practitioner) revealed that he/she was not aware of Resident #4 administering his/her medication. Staff K also revealed that they were not aware of Resident #4 administering the [NAME] liquid every day instead of every other day.<br><br>Review on 5/21/24 of the facility policy titled, Self-Administration By Resident, Dated 11/17 revealed:<br><br>.Procedures: 1. If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out this responsibility, during the care plan process . |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>38218<br><br>Based on interview and record review, it was determined that the facility failed to report an allegation of misappropriation to the State Survey Agency (SSA) for 1 out of 9 allegations reviewed (Resident Identifier #42).<br><br>Findings include:<br><br>Review on 5/20/24 of the facility grievance log revealed the following allegation of misappropriation that was not reported to the SSA:<br><br>Resident #42<br><br>Review on 6/4/23 a grievance was filed by Resident #42's Durable Power of Attorney (DPOA) for Resident #42's missing gold and diamond wedding ring set.<br><br>Interview on 5/20/24 at approximately 12:00 p.m. with Staff A (Social Worker) revealed that the missing items were not reported to the SSA or the local police.<br><br>Interview on 5/21/24 at approximately 8:45 a.m. with Staff D (Administrator) confirmed the above findings.<br><br>Review on 5/20/24 of the facility policy titled, Abuse Prevention and Reporting, Revision Date 10/24/22 revealed:<br><br>.3. All alleged violations involving abuse, neglect or mistreatment, including injuries of unknown source and misappropriation of resident property, will be reported immediately after the incident is discovered or observed by the employee to the employee's supervisor on duty. The supervisor on duty has the responsibility to report same immediately to the facility Administrator (or designee). The facility will investigate and report all allegations of abusive conduct to the state agency. 4. Initial Report The administrator or designee will report alleged violations involving abuse, neglect or mistreatment, including injuries of unknown source and misappropriation of resident property, and exploitation to the . the State Agency through the Ombudsman's Office reporting system immediately . |

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| F 0641<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50163<br><br>Based on interview and record review, it was determined that the facility failed to ensure that the residents' Minimum Data Set (MDS) accurately reflected the resident's status for 3 residents in a final sample of 22 residents (Resident Identifiers #83, #89 and #103).<br><br>Findings include:<br><br>Resident #103<br><br>Review on 5/22/24 of Resident #103's MDS within an Assessment Reference Date (ARD) date of 2/25/24, section A2105: Discharge Status, revealed that Short-Term General Hospital (acute hospital, IPPS) was selected.<br><br>Review on 5/22/24 of Resident #103's Notice of Transfer/ Discharge revealed that Resident #103 was discharged home on 2/23/24.<br><br>Interview on 5/22/24 at 9:44 a.m. with Staff G (Clinical Assessment Manager) confirmed the above MDS was incorrect and Resident #103 was discharged home.<br><br>47129<br><br>Resident #83<br><br>Review on 5/21/24 of Resident #83's progress note dated 12/23/23 revealed that Resident #83 was being discharged to home.<br><br>Review on 5/21/24 of Resident #83's MDS with an ARD date of 12/28/23 revealed under section A0310F, Type of Assessment - entry/discharge reporting, revealed that 99, None of the above, was coded.<br><br>Interview on 5/21/24 at 1:00 p.m. with Staff G confirmed the above finding. Staff G stated that the MDS was coded incorrectly and that the MDS should have been coded as a Discharge assessment - return not anticipated.<br><br>Resident #89<br><br>Review on 5/21/24 of Resident #89's quarterly MDS with an ARD of 4/11/24 revealed under section N0415 Medications: High-Risk Drug Classes: Use and Indication A. Antipsychotic was coded indicating that Resident #89 had received an antipsychotic medication during the last 7 days.<br><br>Review on 5/21/24 of Resident #89's Medication Administration Record for April revealed that no antipsychotic medication was ordered or administered for April 4 through April 11, 2024.<br><br>Review on 5/21/24 of Resident #89's medical record revealed that there was an order for an antipsychotic (Olanzapine) that was discontinued on 11/9/23.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Interview on 5/21/24 at 1:42 a.m. with Staff G confirmed the above findings and that the MDS dated [DATE], was coded incorrectly. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38218<br><br>Based on interview and record review, it was determined that the facility failed to follow physician orders for 1 resident out of 5 residents reviewed for unnecessary medications and for 1 of 31 medications observed for medication administration in a final sample of 23 residents (Resident Identifier #157 and #65).<br><br>Standards:<br><br>[NAME], [NAME] A., and [NAME] [NAME]. Fundamentals of Nursing. 7th ed. St. Louis, Missouri: Mosby Elsevier, 2009.<br><br>Page 336- Physicians' Orders<br><br>.The physician is responsible for directing medical treatment. Nurses follow physician's orders unless they believe the orders are in error or harm clients. Therefore you need to assess all orders, and if you find one to be erroneous or harmful, further clarification from the physician is necessary .<br><br>Review on 5/21/24 of Resident #157's May 2024 Medication Administration Record (MAR) revealed the following physician's order:<br><br>Midrodrine HCL [Hydrochloric Acid] Tablet 10 mg [milligrams], Give 1 tablet by mouth three times a day for BP [Blood Pressure] hold for SBP [Systolic Blood Pressure] greater than 160. Do not give after 6 pm., Start Date 5/7/24. Further review revealed that the medications were held with the following blood pressures:<br><br>5/17 SBP 151;<br><br>5/18 SBP 143.<br><br>Interview on 5/21/24 at approximately 1:30 p.m. with Staff F (Director of Nursing) confirmed the above findings.<br><br>Resident #65<br><br>Review on 5/20/24 of Resident #65's medication orders revealed an order for Midodrine 5mg, take by mouth three times per day related to orthostatic hypotension. Hold for SBP > (greater than symbol) than 110.<br><br>Observation on 5/20/24 at approximately 8:30 a.m. with Staff H (Licensed Practical Nurse) revealed Staff H obtained Resident #65's SBP reading of 149. Staff H then poured Midodrine (medication to prevent blood pressure from dropping) to be administered to Resident #65.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 5/20/24 at approximately 8:35 a.m. with Staff H confirmed that medication should not be administered as Resident #65's SBP was 149, which is greater than 110. Interview further revealed that Staff H did not understand the symbols used to indicate greater than in the physicians' order.<br><br>Review on 5/20/24 of Resident #65's MAR for May 2024 revealed that 5 doses of Midodrine were given with a SBP greater than 110. The doses were as follows:<br><br>On 5/2/24 the evening dose was administered with a SBP of 162;<br><br>On 5/5 24 the evening dose was administered with a SBP of 126;<br><br>On 5/7/24 the evening dose was administered with a SBP of 154,<br><br>On 5/16/24 the afternoon dose was administered with a SBP of 148;<br><br>On 5/16/24 the evening dose was administered with a SBP of 147.<br><br>Review on 5/20/24 of Resident #65's May 2024 MAR revealed the following physician's order:<br><br>Lutein Oral Capsule 6 mg, Give 1 capsule by mouth in the morning for supplement, Start Date 11/1/23. Further review revealed that on 5/2, 5/3, 5/4, 5/6, 5/8, 5/9, and 5/10 the medication was indicated as not being available.<br><br>Interview on 5/21/24 at approximately 1:30 p.m. with Staff F confirmed the above findings.<br><br>Interview on 5/21/24 at approximately 1:50 p.m. with Staff K (Nurse Practitioner) revealed that he/she was not notified of the medication not being available.<br><br>Review on 5/21/24 of the facility policy titled, 3.12 Medication Shortages, dated 9/10 revealed:<br><br>.2. Nursing staff shall, if the shortage will impact the patient's immediate need of the ordered product:<br><br>a. Notify the attending physician of the situation, explain the circumstances, expected availability and optional therapy(ies) that are available. b. Obtain a new order and cancel/discontinue the order for the non-available medication . |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>50163<br><br>Based on observation and interview, it was determined that the facility failed to ensure that medications were secured for 1 of 4 medication carts observed.<br><br>Observation on 5/20/24 at 8:20 a.m. of the third floor Westside Medication Cart revealed it was unlocked with no staff within sight. There were 4 residents seated at tables and eating breakfast within 10 feet of the unlocked medication cart.<br><br>Interview on 5/20/24 at 8:24 a.m. with Staff J (Medication Nursing Assistant (MNA)) confirmed the cart was unlocked while he/she stepped away for a few minutes.<br><br>Review of facility policy, Medication Storage, dated 01/2021, revealed:<br><br>.Procedures: .3. In order to limit access to prescription medications, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications (such as medication aides) are allow access to medication carts. Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access . |