STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305083	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wolfeboro Bay Center	39 Clipper Drive Wolfeboro, NH 03894

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review it was determined that the facility failed to ensure PRN (as needed) orders for antipsychotic drugs are limited to 14 days in 1 of 5 residents reviewed for unnecessary medications (Resident identifier is #11). Findings include:Review on 4/15/26 of Resident #11's medical record revealed an order for Olanzapine 5mg (milligrams) 1 tablet by mouth every 12 hours as needed for vascular dementia, moderate, with agitation for 60 days with a start date of 2/26/26. Further review revealed that Resident #11 received the PRN dose on April 1, 3, 4, 6, 14, and 15, 2026. Review on 4/15/26 of Resident #11's Medication Regime Review, dated 3/12/26 revealed a recommendation for, Currently has an active order for Olanzapine prn (as needed) with a duration of 60 days. Please note that CMS guidelines do not allow maintaining orders for PRN antipsychotics for greater than 14 days on medication profiles . Prescriber responded: disagree, already documented need for over 14 days. Interview on 4/15/26 at approximately 2:15 p.m. with Staff C (Clinical Consultant) confirmed the above order for Olanzapine 5mg every 12 hours as needed. Review on 4/15/26 of facility policy titled Use of Psychotropic Medications, dated 10/28/2025, revealed, b. PRN orders for antipsychotic medications only, shall be limited to 14 days with no exceptions.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on record review and staff interview, the facility failed to ensure medications were administered in accordance with physician orders. This failure resulted in multiple insulin administration errors for 1 of 1 resident reviewed for insulin. (Resident identifier is #33.)Findings include: Resident #33 Record review on 4/14/26 showed a physician's order dated 1/16/26 for NovoLog Flex Pen Subcutaneous Solution Pen-inject 100 unit/ml (Insulin Aspart). Inject 20 units subcutaneously before meals for DM2(Diabetes Mellitus type 2) Hold for BS (blood sugar) under 110. Review of the Medication Administration Record (MAR) on 04/14/2026 revealed insulin was administrated outside ordered parameters on: On January 21st Insulin was administered when the BS was 96 at 7:00 a.m.On January 28th Insulin was administered when the BS was 99 at 5:00 p.m. On February 11th Insulin was administered when the BS was 99 at 5:00 p.m.On February 12th Insulin was administered when the BS was 106 at 11:30 a.m., and at 5:00 p.m. one MAR entry for this date was left blank with no documentation of a BS level and no indication whether insulin was administered or held. On March 4th Insulin was administered when the BS was 103 at 7:30 a.m.On March 9th Insulin was administered at all three meals when BS readings were 109 at 7:30 a.m., 109 at 11:30 a.m., and 97 at 5:00 p.m.On March 13th Insulin was administered when the BS was 91 at 7:30 a.m.On March 19th Insulin was administered when the BS was 72 at 5 :00 p.m. During an interview on 4/15/26 at 1:38 p.m., Staff B (Unit Manager) confirmed the above findings. Review of the facility's policy titled Timely Administration of Insulin, revised 10/28/25, showed under Policy Explanation and Compliance Guidelines . 1. All insulin will be administered in accordance with physician's orders.