

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  305084	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/21/2025
NAME OF PROVIDER OR SUPPLIER  Mineral Springs		STREET ADDRESS, CITY, STATE, ZIP CODE 1251 White Mountain Highway North Conway, NH 03860	

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)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>38218</p> <p>Based on interview and record review, it was determined that the facility failed to ensure the residents' right to formulate advance directives for 2 out of 2 residents reviewed for Advance Directives in a final sample of 15 residents. (Resident Identifier's are #102 and #152.)</p> <p>Findings include:</p> <p>Resident #102</p> <p>Review on 2/19/25 of Resident #102's medical record revealed a physician's order, dated 2/15/25, for Full Code (meaning the patient wishes to receive all possible life-saving measures in the event of a cardiac or respiratory arrest). Further review of Resident #102's medical record revealed a Portable Do Not Resuscitate (DNR) form, dated 7/11/22, that indicated Resident #102 was a DNR (meaning the patient wishes not to have cardiopulmonary resuscitation attempted on them if their heart or breathing stops).</p> <p>Review on 2/20/25 of Resident #102's care plan for advanced directives revealed Resident #102's code status was DNR.</p> <p>Interview on 2/20/25 at approximately 12:20 p.m. with Staff C (Registered Nurse) confirmed the above findings.</p> <p>Resident #152</p> <p>Review on 2/19/25 of Resident #152's physician orders revealed an order for DNR, dated 2/18/25.</p> <p>Review on 2/19/25 of Resident #152's care plan for advanced directive revealed was Full Code, dated 2/14/25.</p> <p>Interview on 2/20/25 at approximately 11:30 a.m. with Staff A (Nurse Manager) confirmed the above findings.</p> <p>37488</p>

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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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>38218</p> <p>Based on interview and record review, it was determined that the facility failed to inform each resident before, or at the time of admission, of services available in the facility and of charges for those services for 1 resident in a final sample of 15 residents. (Resident identifier is #43.)</p> <p>Findings include:</p> <p>Interview on 2/19/25 at approximately 12:00 p.m. with Resident #43's DPOA (Durable Power of Attorney) revealed that his/her spouse was admitted to the facility in December 2024. He/she stated that they gave the facility their prescription card but was told that they needed to use the facility's pharmacy. Interview revealed they have been billed monthly for co-pays from the facility's pharmacy. They would not have co-pays at their pharmacy and the facility did not tell them they would be charged.</p> <p>Interview on 2/21/25 at approximately 8:30 a.m. with Staff B (Admissions Coordinator) revealed that during the admission process, the option of using an outside pharmacy was not discussed with Resident #43 or their DPOA. Staff B also revealed that Resident #43's DPOA gave him/her an outside pharmacy prescription card during admission.</p> <p>Review on 2/21/25 of the facility policy titled Arrangements with Noncontract Pharmacy, dated 8/20, revealed the following: Policy, A resident or responsible party may request that medications be obtained from a pharmacy other than the facility's contract provider pharmacy, .Procedures, 1. The facility informs the resident and/or responsible party of relevant policies and procedures related to purchasing medications from a noncontract pharmacy</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51399</p> <p>Based on interview and record review, it was determined that the facility failed to follow physician's orders for 1 of 2 residents review for pain management in a final sample of 15 residents (Resident identifier is #44.)</p> <p>Findings include:</p> <p>[NAME], [NAME] A., and [NAME] [NAME]. Fundamentals of Nursing. 10th edition St. Louis, Missouri: Elsevier, 2021. Page 614 .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 .</p> <p>Review on 2/20/25 of Resident #44's Medication Administration Record (MAR) revealed a physician order for Acetaminophen Tablet 325 mg [milligrams] Give 2 tablet by mouth every 4 hours as needed for Mild Pain More than 3 doses in 48 hours, notify physician/advanced practice nurse .</p> <p>Review on 2/20/25 of Resident #44's MAR for January and February 2025 revealed that Resident #44 received 4 doses within 48 hours of the above PRN order during the following time periods:</p> <p>Between 1/28/25 and 1/29/25 (1/28/25 at 1:28 am. and 3:54 p.m., 1/29/25 at 4:47 p.m. and 11:07 p.m.)</p> <p>Between 2/4/25 and 2/6/25 (2/4/25 at 4:36 p.m., 2/5/25 at 1:26 a.m. and 10:51 a.m., 2/6/25 at 2:36 a.m.)</p> <p>Further review of Resident #44's MAR for January and February 2025 revealed that Resident #44 was reporting pain at 5 or above on a numeric pain scale of 1 to 10 for the following days:</p> <p>1/2/25 at 6:19 a.m., 1/6/25 at 7:18 p.m., 1/9/25 at 7:45 a.m. and 4:49 p.m., 1/13/25 at 4:27 p.m., 1/17/25 at 2:09 a.m., 1/18/25 at 2:31 a.m., 1/20/25 at 5:06 a.m., 4:41 p.m. and 11: 07 p.m., 1/22/25 at 4:59 p.m., 1/23/25 at 6:43 a.m., 1/25/25 at 5:58 a.m., 1/26/25 at 2:36 p.m. and 6:53 p.m., 1/27/25 at 4:39 p.m., 1/28/25 at 1:28 a.m. and 3:54 p.m., 1/29/25 at 11:07 p.m., 1/30/25 at 11:55 a.m. and 5:58 p.m. and 1/31/25 at 4:20 p. m.</p> <p>2/1/25 at 1:57 a.m., 2/2/25 at 5:21 a.m. and 11:54 p.m., 2/4/25 at 4:36 p.m., 2/5/25 at 1:26 a.m. and 10:51 a. m., 2/6/25 at 2:36 a.m., 2/7/25 at 12:47 a.m. , 2/8/25 at 2:18 a.m., 2/9/25 at 12:49 a.m., 2/10/25 at 2:05 a.m., 2/12/25 at 1:36 a.m., 2/13/25 at 3:50 p.m., 2/16/25 at 6:34 a.m., 2/17/25 at 5:43 a.m., 2/18/25 at 6:04 a.m., 2/19/25 at 2:37 p.m., and 2/20/25 at 3:04 a.m.</p> <p>Review on 2/20/25 of Resident #44's medical record revealed no documentation that the provider was notified when Resident #44 used more than 3 doses in 48 hours of the Acetaminophen PRN order or that they were given Acetaminophen when experiencing pain outside of the PRN order parameters.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 2/20/25 at approximately 1:20 p.m. with Staff A (Nurse Manager) confirmed that there was no documentation that the provider was notified when Resident #44 used more than 3 doses in 48 hours of the Acetaminophen PRN order. Staff A revealed that mild pain would be considered less than 5 on a numeric pain scale of 1 to 10. Staff A also confirmed that Resident #44 was given Acetaminophen outside of the PRN order parameters and there was no documentation that the provider was notified.</p> <p>Interview on 2/20/25 at approximately 2 p.m. with Staff G (Advanced Practical Registered Nurse) confirmed that they had not been notified that Resident #44 had used more than 3 doses in 48 hours of the Acetaminophen PRN order or that they were given Acetaminophen when experiencing pain outside of the PRN order parameters.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>48515</p> <p>Based on interview and record review, it was determined that the facility failed to ensure that a Registered Nurse (RN) was on duty for 8 consecutive hours a day, 7 days a week, for 4 days in the month of September 2024.</p> <p>Findings include:</p> <p>Review on 2/19/25 of the Facility's Payroll Based Journal Staffing Data Report for Quarter 4 2024 (July 1-September 30, 2024) revealed that there were no RN hours submitted for the following days: 9/1/24, 9/15/24, 9/28/25, and 9/29/24.</p> <p>Interview on 2/20/25 at 1:00 p.m. with Staff D (Director of Nursing) confirmed the above findings and revealed that the facility could not provide documentation to show that there was an RN on duty during the above dates.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45419</b></p> <p>Based on observation, interview and manufacturer's instruction review, it was determined that the facility failed to ensure that medications were labeled and dated in accordance with currently acceptable professional principles for 2 out of 2 medication carts observed. (Resident identifiers are #152 and #36.)</p> <p>Findings include:</p> <p>Observation on 2/19/25 at 9:07 a.m. of the [NAME] Front medication cart revealed a small clear plastic medication cup in the top drawer containing 3 pills (medications). The cup was unlabeled and undated.</p> <p>Interview on 2/19/25 at 9:10 a.m. with Staff C (Registered Nurse) confirmed the above findings and revealed that the medications belonged to Resident #36.</p> <p>Observation on 2/19/25 at 9:45 a.m. of the [NAME] Woods medication cart revealed one Symbicort inhaler, not in a box or bag, with no resident identifier or open date or open expiration date. Further observation revealed an Advair Diskus inhaler in a box for Resident #152 without an open date or open expiration date. The pharmacy instructions on the box stated to discard one month after opening.</p> <p>Interview on 2/19/25 at 9:50 a.m. with Staff E (Registered Nurse) confirmed the above findings and revealed that both inhalers had been used. Staff E did not know to whom the Symbicort belonged.</p> <p>Review on 2/19/25 of the Manufacturer's Instructions for Symbicort revealed that the inhaler should be discarded when the labeled number of inhalations and have been used or within 3 months after removal from the pouch.</p> <p>Review on 2/19/25 of the Manufacturer's Instructions for the use of Advair Diskus revealed that the inhaler should be discarded one month after opening the foil pouch or when the counter reads 0.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>45419</p> <p>Based on interview, record review, and policy review, it was determined that the facility failed to ensure that medical records were accurately documented for 1 out of 1 resident reviewed for Post Traumatic Stress Disorder. (Resident Identifier is #202.)</p> <p>Findings include:</p> <p>Review on 2/20/25 of Resident #202's medical record revealed a diagnosis list, dated 2/13/25, that showed Resident #202 had a diagnosis of Post Traumatic Stress Disorder. Further review of Resident #202's medical record revealed a Social Services Assessment and Documentation, signed on 2/17/25 by Staff F (Social Worker). Section C of the assessment titled Mental Health and Wellness .4. Trauma History: Does the patient/resident report or does the medical record reflect any history of trauma and/or Post-Traumatic Stress Disorder (PTSD)?</p> <p>The box is shaded in for the answer 2 NO</p> <p>Interview on 2/20/25 at 1:49 P.M. with Staff F revealed that he/she did not ask Resident #202 about the trauma and did not completed the assessment accurately.</p> <p>Review on 2/20/25 of the facility's policy titled: Trauma Informed Care dated 09/01/2024 2. The facility will use a multi-pronged approach to identifying a resident's history of trauma, as well as his or her cultural preferences. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools such as the Resident Assessment Instrument (RAI), Admission Assessment, the history and physical and social history/assessment, and others. 6. The facility will identify triggers which may re-traumatize residents with a history trauma. Trigger-specific interventions will identify way to decrease the resident's exposure to triggers which re-traumatize the resident , as well as identify ways to mitigate or decrease the effect of the trigger on the resident, and will be added to the residents care plan.</p>		