STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305089	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Langdon Place of Dover	60 Middle Road Dover, NH 03820

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 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, the facility failed to ensure that the resident's care plan was reviewed after the comprehensive assessment was completed for 1 of 1 residents reviewed for care planning in a final sample of 8 residents. (Resident identifier is #5). Findings include: Interview on 5/12/2026 at 12:36 p.m. with Resident #5's family member revealed that they had not attended a care plan meeting for Resident #5 and did not know when Resident #5 would be returning home with the family member. Review on 5/12/26 of Resident #5's provider progress note dated 4/20/26 revealed, . I do not feel [pronoun omitted] has the capacity for medical decision making at this time . will activate [pronoun omitted] DPOA [Durable Power of Attorney] according to his advanced directives . Review on 5/12/26 of Resident #5's medical record revealed that there was no documentation that a care plan meeting had been held after the admission Comprehensive Assessment had been completed on 4/27/26. Further review revealed that there was no documentation that Resident #5's responsible party and/or DPOA had been invited to a care plan meeting. Interview on 5/13/26 at 2:23 p.m. with Staff F (Registered Nurse) confirmed that there was no documentation that a care plan meeting had been held or that Resident #5's responsible party had been invited to a care plan meeting. Review on 5/14/26 of the facility's policy titled Care Planning-Resident Participation revised 1/22/26 revealed, Policy: This facility supports the resident's right to be informed of, and participate in their care planning and treatment (implementation of care) . 10. The facility will discuss the plan of care with the resient and/or representative at regularly scheduled care plan conferences. The facility will make an effort to schedule the conferences at the best time of the day for the resident/resident's representative. 11. If the participation of the resident and/or resident representative is determined tnt practicable for the development of the resident's care plan, an explanation will be documented in the resident's medical record.

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 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 interview and record review, the facility failed to follow physician's order for 2 of 2 residents reviewed for nutrition and notify the physician of weekly weights not being taken in a final sample of 8 residents. (Resident identifiers are #8 and #21.)Findings include: Standard: [NAME], [NAME] A., and [NAME] [NAME]. Fundamentals of Nursing. 10th ed. St. Louis, Missouri: Mosby Elsevier, 2021. Page 994 Daily Weights and Fluid Intake and Output Measurement revealed, .Daily weights are an important indicator of fluid status (Flever, 2019c). Each kilogram (2.2.lb [pound]) of weight gained or losses indicate changes in the amount of total body fluid, usually ECF (extracellular fluid), but do not indicate shift between body compartments.Compare the weight of each day with that of the previous day to determine fluid gain or losses. Look at the weights over several days to recognize trends. Interpretation of daily weights guides medical therapy and nursing care . [NAME], [NAME] A., and [NAME] [NAME]. Fundamentals of Nursing. 10th ed. St. Louis, Missouri: Mosby Elsevier, 2021, Chapter 19, page 267 revealed the following Communication with other health providers needs to be timely, accurate, and relevant to the patient's clinical situation. Resident #21 Review on 5/12/26 of Resident #21's provider progress note dated 5/1/26 revealed, Assessment and Plan . Heart Failure . Daily weights ordered . Review on 5/12/26 of Resident #21's physician's orders dated 5/1/26 revealed an order for daily weight. Please call provider for weight gain greater than 2 pounds in 24 hours or 5 pounds in 7 days. Review on 5/12/26 of Resident #21's Care Plan revealed, Focus [name omitted] exhibits or is at risk for fluid volume excess as evidenced by anasarca, cirrhosis, CHF [Congestive Heart Failure], AKI [Acute Kidney Injury] . Interventions . Monitor weight as ordered and report to physician per MD [Medical Doctor] order . Review on 5/12/26 of Resident #21's medical record, including weights and progress notes, revealed the following; On 5/1/26: 271.8 pounds. On 5/2/26: 259.6 pounds (a 12.2 weight loss). There was no documentation that the provider was notified of the weight loss. On 5/3/26: There was documentation that the resident refused to be weighed. There was no documentation the provider was notified of the refusal or attempted to reweigh. On 5/4/26: 261.4 pounds. On 5/5/26: There was no documented weight, and the resident was transported to the emergency room and returned late afternoon for an elbow infection. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/26: There was no documented weight. On 5/7/26: 262.3 pounds. On 5/8/26: No documented weight. On 5/9/26: 269.4 pounds (a weight gain of 7.1 pounds). There was no documentation the provider was notified. On 5/10/26: 276.8 pounds. On 5/11/26: 275.8 pounds. On 5/12/26: 267.2 pounds. On 5/13/26: There was documentation that the resident refused to be weighed, but there was no documentation the provider was notified of the refusal or attempted to reweigh. Interview on 5/14/26 at 1:06 p.m. with Staff G (Unit Manager) confirmed that daily weights should have been done on Resident #21 and were not. Staff G confirmed that the provider should have been notified of weight changes as per the above order. Interview on 5/14/26 at 2:08 p.m. with Staff H (Nurse Practitioner) confirmed the provider should have been notified with weight changes and that they should have attempted to get a reweight if the resident refused. Resident #8 Review on 5/14/26 of Resident #8's April 2026 Medication Administration Record (MAR) revealed the following physician's orders: Weekly shower/skin check and weight, complete UDA (user-Defined Assessment) every night shift every Wed, start date 4/15/2026, discontinued (D/C) date 5/6/26. Review on 5/14/26 of Resident #8's medical record revealed that on 4/9/26, Resident #8's weight was 153.4 pounds (lbs) and on 5/6/26, Resident #8's weight was 146 lbs. There were no documented weekly weights for Resident #8 on 4/15/26, 4/22/26, or 4/29/26. Review on 5/14/26 of Resident #8's nutrition note dated 4/28/26, revealed the following: admission weight 4/9/26 was 153.4 lbs. No updated weight available at this time; nursing notified to obtain current weight for monitoring. Goal is to maintain adequate nutritional intake to support healing and rehabilitation, with stable weight and improved glycemic control. Interview on 5/14/26 at approximately 12:45 p.m. with Staff G confirmed that there was no documentation of weights for Resident #8 between 4/10 and 5/6/26. Staff G stated that newly admitted residents were to have weekly weights taken for the first four weeks unless otherwise indicated by the provider. Interview further revealed that there was no documentation that a provider was notified that Resident #8's weekly weights weren't taken. Interview on 5/14/26 at approximately 1:00 p.m. with Staff H confirmed that he/she was not notified that Resident #8's weekly weights were not being taken until 5/6/26. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review on 5/14/26 of the facility's policy titled Weight Monitoring revised 1/22/26 revealed, A weight monitoring schedule will be developed upon admission for all residents . b Newly admitted residents - monitor weight weekly for 4 weeks .

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F 0761 Level of Harm - Minimal harm or potential for actual harm 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. Based on observation, interview, and record review, the facility failed to ensure that medication was removed from use in accordance with the manufacturer's instructions for 1 of 1 medication carts observed. (Resident identifier is #8.)Findings include:Observation on 5/13/26 at 8:35 a.m. of the Medication Cart with Staff A (Licensed Practical Nurse) revealed a Lispro Insulin KwikPen for Resident #8. Further observation revealed that on the pen was documented opened 4/13/26 and expires 5/10/26. Review on 5/13/26 of Resident #8's May 2026 Medication Administration Record with Staff A revealed that it was documented that Resident #8 had received Lispro Insulin on 5/11/26 at 11:30 a.m. and 4:30 p.m. and on 5/12/26 at 11:30 a.m. Interview on 5/13/26 at 8:35 a.m. with Staff A confirmed the Lispro Insulin KwikPen for Resident #8 had a discard date of 5/10/26. Review on 5/13/26 of the facility's policy titled Insulin Pen revised 1/22/26 revealed . Policy Explanation and Compliance Guidelines . 8. Insulin pens should be disposed of after 28 days or according to manufacturer's recommendation . Review on 5/14/26 of the manufacturer's Instructions For Use for Insulin Lispro KwikPen provided by the facility, revealed, .Preparing your Pen . Do not use your Pen past the expiration date printed on the Label or for more that 28 days after you first start using the Pen . Storing you Pen In-use Pen . Throw away the Insulin Lispro Pen you are using after 28 days, even if it still has insulin left in it .