STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305093	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sullivan County Health Care	5 Nursing Home Drive Unity, NH 03743

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, it was determined that the facility failed to ensure resident care plans were revised for 2 residents in a final sample of 24 residents. (Resident Identifiers are #34 and #121). Findings include:Resident #34 Review on 12/10/25 of Resident #34's nursing notes revealed the following note dated 10/17/25: Spoke this shift with DPOA [Durable Power of Attorney] about this resident found in another male residents room lying on the bed with [pronoun omitted] pants off, still had a brief on and a bra half on . The DPOA states [pronoun omitted] was sexually active at the last facility and as long as [pronoun omitted] and the other resident are willing participants they do not want us to try and stop the interactions between the two residents. Review on 12/11/25 of Resident #34's care plans revealed that there was no care plan implemented for sexual expression. Interview on 12/11/25 at approximately 10:00 a.m with Staff F (Director of Nursing) confirmed the above findings. Review on 12/9/25 of Resident #34's nursing notes in his/her medical record, revealed that Resident #34 had an unwitnessed fall on 11/28/25. Further review revealed that Resident #34 did not have any footwear on his/her feet. Interview on 12/10/25 at approximately 2:00 p.m. with Staff E (Unit Manager) revealed that the root cause of the fall was improper footwear and that no new interventions were put into place after the fall. Review on 12/11/25 of Resident #34's care plans revealed, no new interventions were added after Resident #34's fall to ensure Resident #34 proper footwear. Review on 12/11/25 of the facility policy titled, Falls, Dated 8/5/20, revealed: . m. update the resident's care plan and add new interventions to prevent a fall or injury. Interview on 12/11/25 at approximately 9:00 a.m. with Staff F (Director of Nursing) confirmed that there was no new intervention initiated in Resident #34's care plan after his/her fall on 11/28/25. Resident #121 Interview on 12/09/25 at approximately 9:51 a.m. with Resident #121 revealed they have hearing loss and use hearing aids. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305093	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sullivan County Health Care	5 Nursing Home Drive Unity, NH 03743

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review on 12/10/25 11:05 a.m. of Resident #121's medical record revealed an audiology note, dated 10/20/25, that stated .fit hearing aids, fits well; Patient hearing well; Nurse will insert and remove hearing aid; Nurse will change hearing aid batteries . Further review of Resident #121's medical record revealed the care plan was not revised to include the use of hearing aids. Interview on 12/10/2025 at approximately 12:19 p.m. with Staff A (Unit manager) confirmed their were no updates to Resident #121's comprehensive care plan to identify that he/she used bilateral hearing aids.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, it was determined that the facility failed to ensure that a resident was assisted with meals in accordance with the resident's care plan for 2 of 2 dining observations. (Resident identifier is #31.)Findings include: Observation on 12/9/25 at approximately between 12:08 p.m. to 1:00 p.m. in the 4000 unit during lunch dining observations revealed that Resident #31 was in bed in their room with his/her eyes closed and his/her lunch was in front of him/her, untouched. Further observation revealed that there was no staff assisting Resident #31 with his/her lunch. Review on 12/10/25 of Resident #31's ADL care plan with a revision date of 10/27/25 revealed the following ADL care plan interventions: Resident #31 requires moderate assistance by one staff to eat, initiated 12/8/25; One staff assist with all meals, initiated 12/9/25; Offer feeding assistance and encourage upright head of bed position during meals, initiated 12/9/24; If the resident refuses care, notify the nurse to attempt to intervene, initiated 9/25/24. Observation on 12/10/25 at approximately between 8:10 a.m. to 9:06 a.m. in the 4000 unit during breakfast dining observations revealed that in Resident #31 was in bed in their room with his/her eye closed and his/her breakfast was in front of him/her, untouched. Further observation revealed that there was no staff assisting Resident #31 with his/her breakfast. Observation in the 4000 unit also revealed that the 4 of 5 Licensed Nursing Assistants (LNA) on the unit were assisting other residents with their breakfast. Interview on 12/10/25 at approximately 9:06 a.m. with Staff J (Unit Manager) revealed that Resident #31 had a recent decline in eating that he/she would need staff assistance with meals. Staff J was not aware if anyone was assisting Resident #31 with his/her breakfast. Interview on 12/10/25 at approximately 9:06 a.m. with Resident #31 and Staff J revealed that Resident #31 stated that he/she wanted to eat his/her breakfast. Interview on 12/10/25 at approximately 9:15 a.m. with Staff K (Registered Nurse) revealed that he/she was Resident #31's nurse and had not received any report that Resident #31 declined to eat breakfast. Staff K was not aware if anyone was assisting Resident #31 with his/her breakfast. Interview on 12/10/25 at approximately 9:15 a.m. with Staff L (LNA) revealed that he/she was Resident #31's LNA and that Resident #31 needed one staff assist with meals. Staff L had not offered Resident #31 with assistance with breakfast and was not aware if anyone was assisting Resident #31 with his/her breakfast.