STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305100	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview Nursing Home	203 Lowell Road Hudson, NH 03051

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review, the facility failed to ensure that grievances from Resident Council were acted upon and demonstrate their response to the group for 3 of 4 months of meeting minutes reviewed. Findings include:Interview on 1/21/26 at 2:02 p.m. during Resident Council Meeting revealed that call lights being turned off without being assisted was an on-going concern for several months. All five residents who attended the meeting revealed that the facility did not follow up with them to inform them if any action(s) had been taken to address their concerns. Review on 1/21/2026 of the facility's Resident Council Meeting minutes from September 2025 to December 2025 revealed the following documented concerns under nursing:9/25/25 - Call bells being turned off without providing assistance. 10/24/25 - Call bells still being turned off without assistance being given. 11/28/25 - Be right back never returning.12/31/25 - Call bells being turned off without help being provided. Interview on 1/22/26 at 1:34 p.m. with Staff L (Activities Director) confirmed the above concerns from Resident Council. Staff L confirmed there was no follow-up of actions documented in the meeting minutes for the months following the continued concerns regarding call bells. Staff L revealed that the last documented communication they had regarding the above concerns (call bells being turned off without assistance) was from an email dated 10/9/25 to nursing unit managers. Review on 1/22/26 of an email from Staff L to Staff M (Unit Manager) and Staff N (Unit Manager), dated 10/9/25, revealed the following: . The only feedback they [the residents] had was that sometimes their call bells are still being turned off without being assisted, and sometimes they are being told they have to wait because 'You are not on my list'. Interview on 1/22/26 at 1:44 p.m. with Staff M revealed that they had not heard of any concern from Resident Council Meeting in the past several months and that they did not know of any recent issues with call lights being shut off without assistance. Interview on 1/22/26 at 1:55 p.m. with Staff N revealed that they had not been notified of concerns from Resident Council Meetings in approximately 3 months. Staff N revealed that they were not aware of call lights being turned off without assistance since October 2025 and could not recall if anything was done about it. Interview on 1/23/26 at 12:11 p.m. with Staff K (Director of Nursing) revealed that they had not heard of any recent concerns from Resident Council Meeting, including the above concern about call bells being turned off without assistance. Review on 1/23/26 of the facility's undated policy titled Resident Council Policies and Procedures revealed, . 5. Communication With Facility Staff. Councils submit concerns, suggestions, or request in writing to administration. Facility must respond in a timely manner and support council activities.

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, it was determined that the facility failed to ensure that residents were assessed to self-administer medications for 2 of 5 residents reviewed for choices in a final sample of 19 residents. (Resident identifiers are #21 and #70.)Findings include:Resident #21Observation on 1/21/26 at approximately 10:30 a.m. in Residents #21's room revealed a bottle of saline nasal spray on his/her dresser and a bottle of Saline Nasal Spray on his/her bedside table.Interview on 1/21/26 at approximately 10:30 a.m. with Resident #21 revealed he/she has multiple bottles, keeps it at bedside, and administers when they feel they need it. Observation on 1/21/26 at approximately 2:45 p.m. in Residents #21's room revealed a bottle of saline nasal spray on his/her dresser and a bottle of Saline Nasal Spray on his/her bedside table.Review on 1/21/26 of Resident #21's medical record revealed there was no physician order for Saline Nasal Spray. Further review revealed that there was no assessment done with Resident #21 to self-administer medication.Interview on 1/21/26 at approximately 2:45 p.m. with Staff A (Unit Manager) confirmed the above findings.Resident #70Observation on 1/21/26 at approximately 10:45 a.m. in Resident #70's room revealed a bottle of Dry Eye Relief Drops on his/her bedside table.Interview on 1/21/26 at approximately 10:45 a.m. with Resident #70 and revealed that Resident #70 administers the eye drops daily.Observation on 1/21/26 at approximately 2:45 p.m. in Resident #70's room revealed a bottle of Dry Eye Relief Drops on his/her bedside table.Review on 1/21/26 of Resident #70's medical record revealed there was no physician order for Dry Eye Relief Drops. Further review revealed that there was no assessment done with Resident #70 to self-administer medication.Interview on 1/21/26 at approximately 2:45 p.m. with Staff A confirmed the above findings.Review on 1/21/26 of the facility policy titled, Administering Medications, Revision Date April 2019 revealed, . 4. Medications are administered in accordance with prescriber orders, . 27. Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely.

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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 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Based on interview and record review the facility failed to conduct a criminal background check on staff prior to providing direct resident care for 1 of 6 staff records reviewed. (Staff identifier is Q.)Findings include:Review on 1/23/2026 of Staff Q's (Licensed Nursing Assistant) file revealed no criminal background record check. Interview on 1/23/2026 at approximately 2:30 p.m. with Staff J (Staff Development Coordinator) confirmed there no background criminal record check was for Staff Q.Review on 1/23/2026 of facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program revised April 2021 revealed .Policy Interpretation and Implementation.1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not limited to:.e. staff from other agencies;.4. Conduct employee background checks and not knowingly employ or otherwise engage any individual who has: a. been found guilty of abuse, neglect, exploitation or misappropriation of property, or mistreatment by a court of law;.

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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. Based on observation, interview, and record review, it was determined that the facility failed to ensure that medications were given according to professional standards and manufacturer's instructions for 1 of 30 medication administration observations (Resident #72) and according to physician orders for 2 residents in a final sample of 19 residents. (Resident identifiers are #39 and #55.) Findings include: Resident #55 Review on 1/22/26 at approximately 12:59 p.m. of Resident #55's Medication Administration Record (MAR) revealed that Resident #55 had a physician's order for Humalog Kwik pen Subcutaneous Solution Pen-Injector 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale .350-999 [blood sugar]= 16 Units Administer 16 units [insulin] and call Provider. Resident #55 had an elevated Blood Sugar of 378 on 1/10/26. Review on 1/22/26 of Resident #55's medical record revealed no documentation of provider notification for the above elevated blood sugar. Interview on 1/22/26 at approximately 1:50 p.m. with Staff A (Unit Manager) confirmed the above findings. Interview on 1/23/26 at approximately 12:14 p.m. with Staff H (Nurse Practitioner) confirmed that he/she was not notified of the above Blood Sugar on 1/10/26. Staff H further confirmed that he/she was the on-call provider on 1/10/26. Resident #39 Review on 1/21/26 of Resident #39's December 2025's and January 2026's Medication Administration Record revealed the following physician's orders: B/P (blood pressure) & HR (heart rate) Medication Parameter Orders- Hold for SBP (systolic blood pressure) <100 or HR <50. If medication is held greater than x3 within x1 week. Notify medical provider and document results in nurses note. Metoprolol Succinate ER (extended release) . 25 mg (milligrams) Give 1 tablet by mouth 1 time a day. Further review of the MAR revealed: December 16th Resident #39's BP was documented 98/68 and Metoprolol checked on the MAR as being administered, December 17th Resident #39's BP was documented 92/68 and Metoprolol checked on the MAR as being administered, December 18th Resident #39's BP was documented 98/65 and Metoprolol checked on the MAR as being administered. January 3rd Resident #39's BP was documented 99/68 and Metoprolol checked on the MAR as being (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered, January 4th Resident #39's BP was documented 91/60 and Metoprolol checked on the MAR as being administered, January 9th Resident #39's BP was documented 95/56 and Metoprolol checked on the MAR as being administered, and January 22nd Resident #39's BP was documented 98/58 and Metoprolol checked on the MAR as being administered. Interview on 1/23/26 at approximately 9:45 a.m. with Staff K (Director of Nursing) confirmed the above findings and confirmed the Metopropol should not have been administered when Resident #39's blood pressure was below the parameters in the order. Review on 1/23/26 of the facility policy titled, Administering Medications, Revision Date April 2019 revealed: . 4. Medications are administered in accordance with prescriber orders, . Resident #72 Observation on 1/21/26 at approximately 11:45 a.m. of Resident #72's morning medication administration with Staff G (Registered Nurse) revealed Staff G crushed Resident #72's Wellbutrin XL (extended release) 150 mg (milligrams) tablet and administered the crushed medication to Resident #72. Review on 1/21/26 of Resident #72's Wellbutrin XL medication card revealed the following warning: Medication has boxed warning: Not to be chewed or crushed; . Interview on 1/21/26 at approximately 11:45 a.m. with Staff G confirmed the above findings. Review on 1/23/26 of Wellbutrin XL manufacturer's instructions, Dated 7/09 revealed: . Do not chew, cut, or crush Wellbutrin XL tablets. You must swallow the tablets whole. Tell your doctor if you cannot swallow medicine tablets. Review on 1/23/26 of the facility policy titled, Administering Medications, Revision Date April 2019 revealed: . 8. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns. Observation on 1/21/26 at approximately 11:45 a.m. of Resident #72's morning medication administration with Staff G revealed Staff G administered Resident #72's 9:00 a.m. dose of Baclofen 5 mg (milligrams) (muscle relaxant) at 11:39 a.m. Review on 1/22/26 of Resident #72's Medication Administration History Report revealed: . 1/21/26 Resident #72 received their 9:00 a.m. dose of Baclofen at 11:39 a.m. and then received their 2:00 p.m. dose of Baclofen on 1/21/26 at 1:42 p.m. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 1/23/26 at approximately 12:30 p.m. with Staff H (Nurse Practitioner) revealed that Staff H was not aware of Resident #72 receiving their morning medication late on 1/21/26 and would not have expected Resident #72's 2:00 p.m. dose of Baclofen to be administered so close together. Review on 1/23/26 of the facility policy titled, Administering Medications, Revision Date April 2019 revealed: .4. Medications are administered in accordance with prescriber orders, including any required time frame.7. Medications are administered within one (1) hour of their prescribed time.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, interview, and record review, it was determined that the facility failed to provide appropriate adaptive equipment to maintain independent wheelchair mobility for 1 of 1 residents reviewed for physical restraints in a final sample of 19 residents (Resident identifier is #4).Findings include:Interview on 1/21/26 at approximately 10:40 a.m. with Resident #4 revealed that he/she does not have the ability to independently move his/her new tilt in space wheelchair that is on loan to them. Resident #4 further revealed that he/she was able to independently move his/her personal custom wheelchair prior to using the tilt in space chair. Resident #4 reports that the rehabilitation department is working to get him/her a new chair because of his/her multiple falls but that this could take several months. Observation on 1/21/26 at approximately 10:41 a.m. of Resident #4 revealed that he/she was sitting in his/her tilt in space wheelchair in the entrance to his/her room. Resident #4 was observed to be reaching for the doorframe of his/her room and bouncing his/her body in the tilt in space wheelchair trying to move the wheelchair. Resident #4 was observed reaching for the wheels but was unable to reach the wheels. Further observation noted that the seat of the chair was in a tilted position and Resident #4 was unable to reach the floor with his/her feet. Interview on 1/23/26 at approximately 9:14 a.m. with Staff F (Director of Rehabilitation) revealed that Resident #4 received the tilt in space wheelchair on 1/13/26 for improved positioning and safety to prevent falls. Staff F further revealed that Resident #4 was able to independently move around the facility with his/her previous chair. Interview on 1/23/26 at approximately 9:40 a.m. with Staff N (Unit Manager) revealed that Resident #4 was unable to independently move in the tilt in space wheelchair and was able to independently move around the facility in his/her prior wheelchair. Staff N further revealed that no restraint evaluation was performed at the time of the wheelchair change. Review on 1/23/26 of the facility's policy Physical Restraint Application revealed .Physical restraint .any device that has the effect on a resident of restricting freedom of movement .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on interview and record review, it was determined that the facility failed to provide services to maintain or improve his/her ability for mobility in 1 of 2 residents reviewed for rehabilitation and restorative services in a final sample of 19 residents (Resident Identifier is #78).Findings include:Interview on 1/21/2026 at approximately 10:00 a.m. with Resident #78 revealed that he/she used to walk when he/she was getting rehab but no longer gets the opportunity to walk and would like to walk more. Review on 1/21/2026 of Resident #78's Physical Therapy (PT) Discharge Summary, for the period of 9/22/25-10/23/25, revealed that Resident #78's had a recommendation for a daily ambulation program with nursing.Interview on 1/23/2026 at approximately 8:40 a.m. with Staff P (Physical Therapist) confirmed above program for Resident #78.Review on 1/21/2026 of Resident #78's Therapy Inservice Form, dated 10/8/2025, revealed staff were trained for Resident #78's Daily Ambulation Program which was to Ambulate with rolling walker and gait belt and contact guard for 100-150 ft 1-2 times a day. Review on 1/23/26 of Resident #78's current care plan revealed no interventions for ambulation. Interview on 1/23/2026 at approximately 8:45 a.m. with Staff M (West Unit Manager) confirmed Resident #78 does not have an ambulation program in place.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, it was determined that the facility failed to ensure that staff use appropriate equipment for resident transfers for 1 of 3 residents reviewed for abuse in a final sample of 19 residents. (Resident identifier is #21.)Findings include:Interview on 1/21/26 at approximately 10:30 a.m. with Resident #21 revealed he/she was awaiting an x-ray for their right ankle. Further interview revealed that the morning prior (1/20/26) Resident #21 was transported to the scale (located in the resident dining area) by an Licensed Nursing Assistant (LNA). Resident #21 state that the LNA did not apply Resident #21's oxygen and also did not install foot pedals on the wheelchair. Resident #21 revealed that he/she could not hold up their legs off the floor for the whole transport to the scale and had to drop her right leg abruptly which resulted in pain. Review on 1/3/26 of Resident #21's medical record revealed the following nursing notes:1/20/26 2:19 p.m., LNA wheeling resident to get weight. Resident unexpectedly attempted to stop wheelchair by forcefully planting feet on ground. Later resident c/o (complaints of) R (right) foot pain. Resident assessed, swelling noted to r foot ankle, no redness, skin intact. Pt. (patient) has history of bilateral edema.1/20/26 10:38 p.m. Obtain 2 view x-ray to (R) ankle d/t (due to) pain.1/21/26 12:12 p.m. Bruising note to (R) Dorsum & (R) lateral Malleolus. Bruising believed to have occurred from previous day per healthcare status note from 1/20/26 @ 2:19 p.m. Waiting for X-ray tech's (technician) arrival. Patient remains at her baseline, BLE (bilateral lower extremity) have chronic edema and is patient non-ambulatory. (R) foot elevated. Patient states pain managed with elevation & Tylenol.1/21/26 10:03 p.m. patient alert, XR (x-ray) results received and reviewed by provider, [pronoun omitted] in this evening. Shows old fracture healing, nondisplaced. No new fx. (fracture). Patient informed, icing right ankle.Interview on 1/23/26 at approximately 12:15 p.m. with Staff B Licensed Practical Nurse (LPN) revealed that it was reported to him/her on 1/20/26 that Resident #21 dropped his/her legs abruptly and rolled his/her ankle while the LNA was pushing Resident #21 in the wheelchair to get their weight. Interview on 1/23/26 at approximately 12:30 p.m. with Staff C (Physical Therapy Assistant) revealed that he/she would expect foot pedals with Resident #21's transfers. Staff C also revealed that he/she was not familiar with Resident #21's needs and did not review his/her Therapy Progression Communication Form, Resident Function Status Update prior to transferring Resident #21.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, it was determined that the facility failed to ensure infection control techniques were followed for 1 of 2 Capillary Blood Glucose (CBG) tests observed and 7 of 30 medications observed. (Resident identifier is #88.)Findings include: Resident #88Observation and interview on 1/22/26 at approximately 7:15 a.m. with Staff B (Licensed Practical Nurse) revealed that he/she performing a CBG test on Resident #88's. Prior to entering Resident #88's room, Staff B stated that the glucometer was clean and ready for use. Observation of the glucometer revealed that it had dried brown substance adhered to it near the location that the strip is entered into the glucometer. The surveyor intervened and pointed out the glucometer was not clean. Staff B cleaned with a bleach wipe and the dried brown substance was removed. Staff B placed the glucometer case on Resident #88's bed, after testing Resident #88's CBG, Staff B then placed the used glucometer, used lancet, and used alcohol wipe into the glucometer case touching lancets and alcohol wipes in the glucometer case that were not used.Observation on 1/22/26 at approximately 7:20 a.m. with Staff B applied gloves prior to preparing Resident #88's pills for administration. Staff B touched multiple medication cards, medication bottles, the computer, and opened the medication cart drawers. Staff B dispensed each of Resident #88's pills in his/her hands without changing their gloves. Staff B dropped one of Resident #88's pills on top of the medication cart and picked it up and placed it into the medication cup to be administered.Interview on 1/22/26 at approximately 11:00 a.m. with Staff J (Infection Preventionist) revealed that the glucometer should be cleaned with a Sani-wipe and wait the 2-3 minutes before use.Review on 1/23/26 of the facility policy titled, Cleaning of Blood Glucose Devices, Revision Date September 2014 revealed: . Blood glucose monitoring devices must be cleaned and disinfected with Purple Sani-Cloth wipes after every resident use. Devices must air dry for 2-3 minutes to ensure full disinfectant contact time.Review on 1/23/26 of the facility policy titled, Administering Oral Medications, Revision Date October 2010 revealed: Steps in the Procedure: . 9.e. For tablets or capsules from a bottle. Pour the desired number into the bottle cap and transfer to the medication cup. Do not touch the medication cup with your hands. 9.f. For unit dose tablets or capsules. Place packaged medications directly into the medication cup. 20. If a medication falls to the floor, discard and document per facility protocol.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on interview and record review, it was determined that the facility failed to develop, implement, and maintain an effective training program for all staff for 1 of 5 staff records reviewed.Findings include:Interview on 1/23/2026 at approximately 10:45 a.m. with Staff J (Staff Development Coordinator) revealed that Staff Q was agency staff and confirmed there was no documentation of Staff Q's training.Interview on 1/23/2026 at approximately 12:30 p.m. with Staff Q (Licensed Nursing Assistant) revealed they had no orientation or trainings at the facility prior to providing direct care to residents.Review on 1/23/2026 of Facility Assessment updated August 6, 2025 revealed .3.4. Staff training/education and competencies.Resident rights and facility responsibilities; Abuse, neglect, and exploitation; Nursing equipment and incontinence supplies; Safety; Cultural competency; PointClickCare; Activities of Daily Living; Infection control; Measurements: blood pressure, body temperature, urinary output including urinary drainage bags, height and weight, redial and apical pulse, respirations, recording intake and output.Caring for residents with mental and psychological disorders, as well as residents with a history of trauma.Review on 1/23/2026 of Agency Training Policy, undated, revealed Purpose To ensure that all agency staff working within the facility understand and comply with the facility's policies, procedures, and expectations.3. Orientation Packet Completion During the first shift check-in, the agency staff member will be given the facility's Agency Orientation Packet. The Agency member must complete all required documents and acknowledge understanding of the information included.