STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305101	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belknap County Nursing Home	30 County Drive Laconia, NH 03246

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 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 observation, interview, and record review, it was determined that the facility failed to follow professional standards for 1 of 1 resident observed for medication administration via gastrostomy tube (g-tube) (Resident identifier is #2).Findings include:Review on 9/4/25 of [NAME] A. [NAME] and [NAME], Clinical Nursing Skills & Techniques. 10th ed. St. Louis, Missouri: Elsevier, 2022. revealed on Page 617-Administering Medications Through Feeding Tube 12.b. To administer more than one medication, give each separately and flush between medications with 15ml [milliliter] to 30ml of water.Observation on 9/3/2025 at approximately 8:45 a.m. with Staff C (Medication Nursing Assistant (MNA)) during Resident #2's medication administration via g-tube revealed that Staff C was administering five crushed medications (amlodipine 10mg (milligrams), Aspirin 81mg, Levothyroxine 50mcg (micrograms), Gabapentin 100mg, and Pepcid 20 mg) without flushing the g-tube with water in between medications. Interview on 9/3/2025 at approximately 8:45 a.m. with Staff C confirmed the above observation.Review on 9/3/25 of Facility policy titled Enteral Nutrition & Medication Administration Policy dated reviewed and revised 7/17/25 revealed .IV. Medication Administration via Feeding Tube .6. Flush between meds with ˆ [greater than or equal to] 15 ml water .

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
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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 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 implement infection control policies and procedures for hand hygiene and glove for 1 of 1 resident reviewed for skin condition in a final sample of 15 residents. (Resident identifier is #33).Findings include:Review on 9/4/25 of Resident #33's physician's order dated 7/2/25 revealed a wound treatment for the right buttocks to gently cleanse area with wound wash, pat dry, apply non-sting barrier wipe, apply santyl to wound bed and cover with small Mepilex border (3x3), change dressing daily.Observation on 9/4/25 at 10:30 a.m. of Resident #33's wound dressing change with Staff A (Licensed Practical Nurse) revealed Staff A wore a gown and gloves, removed the dirty dressing from Resident #33's right buttock and discarded it in the trash. Staff A opened the clean dressing supplies with the same gloves and did not perform hand hygiene. Staff A removed the dirty gloves and revealed that Staff A had worn a second pair of gloves underneath the first pair. Staff A cleanse the wound, applied santyl ointment on the wound bed, and covered the wound with mepilex (foam) dressing. Staff A did not remove gloves and perform hand hygiene between cleaning the wound and applying the santyl ointment and mepilex dressing. Interview on 9/4/25 at approximately 10:30 a.m. with Staff A confirmed the above findings.Review on 9/4/25 of facility's policy titled Infection Control-Standard Precautions, date of revision 6/19/25, revealed .1. Hand washing should be done a) After contact with blood, body fluids, excretions., whether gloves are worn b) after gloves are removed, e) before and after touching wounds., j) When indicated between tasks and procedures on the same resident to prevent cross-contamination. Gloves 7. Gloves must be replaced as soon as possible when contaminated.