STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305102	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coos County Nursing Home	364 Cates Hill Rd Po Box 416 Berlin, NH 03570

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 49819 Based on observation, record review, and interview, it was determined that the facility failed to keep residents free from physical restraints for 1 of 1 residents reviewed for physical restraints in a final sample of 18 residents (Resident identifier is #72). Findings include: Observation on 12/16/24 at approximately 12:00 p.m. revealed Resident #72 in the unit dining room, sitting in his/her broda chair with the back wheels locked, and his/her feet on the ground. Resident #72 was attempting to push back away from the table and attempted to tip table over. Interview on 12/16/24 at approximately 12:00 p.m. with Staff J (Licensed Nursing Assistant) confirmed the back wheels of Resident #72's broda chair were locked and the resident was unable to move the broda chair back. Observation on 12/18/24 at approximately 8:00 a.m. revealed Resident #72 in the unit dining room, sitting in his/her broda chair with the back wheels locked, and his/her feet touching the ground. Interview on 12/18/24 at approximately 9:10 a.m. with Staff J revealed Staff J locked the back wheels of Resident #72's broda chair primarily at dining table so Resident #72 will stay at the table to eat. Review on 12/18/24 of Resident #72's physician orders, assessments and care plan revealed no orders, assessment or care plan in place for restraint the resident's wheel chair during dining. Review on 12/18/24 of facility policy title RESTRAINTS-PHYSICAL , dated 11/3/2006, revealed . IMPLEMENTATION 1. Restraints will only be used after alternatives have been tried unsuccessfully, .A physician order is required with associated diagnosis. A Pre-Restraining Assessment Form will be completed to determine if a restraint is needed because Medical symptom(s) warrant restraint use .2 .A restraint is any method or device which restricts freedom of movement .3. Physical restraints shall not be used to limit resident mobility or for the convenience of the staff .

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 38218 Based on interview and record review, it was determined that the staff failed to report an alleged violation of abuse immediately to the Administrator and the facility failed to report to the State Survey Agency (SSA) for 1 of 1 resident reviewed for abuse in a final sample of 18 residents (Resident identifier is #57). Findings include: Review on 12/16/24 of Resident #57's provider progress notes, written by Staff B (Advanced Practice Registered Nurse), revealed the following: 12/10/24, .Resident states [pronoun omitted] R [right] shoulder is in increased pain. [pronoun omitted] says one of the LNA's [Licensed Nursing Assistant] pulled [pronoun omitted] and [pronoun omitted] has [pronoun omitted] right shoulder and upper arm hurts now . Interview on 12/17/24 at approximately 2:15 p.m. with Staff B revealed that Staff B did not report the allegation to the administrator. Review on 12/18/24 of the facility policy titled, Instructions For Reporting Alleged Resident Abuse, revision date 11/24, revealed .2. Notify NHA (Nursing Home Administrator) and DON (Director of Nursing) (or their designees) of all mistreatment, abuse, neglect and misappropriation of resident property incidents via home/cell phone as soon as possible . Review on 12/18/24 of the facility policy titled, Abuse Policy and Procedures, revision date 11/24, revealed .Reporting Resident Abuse or Neglect, Observation or suspicion of alleged resident abuse, neglect or misappropriation of resident property must be reported and investigated IMMEDIATELY .

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 49819 Based on record review and interview, it was determined that the facility failed to refer residents with newly evident or possible serious mental disorder and intellectual disability for a Level I Pre-Admission Screening and Resident Review (PASARR) for 1 of 4 residents reviewed for PASARR in a final sample of 18 residents (Resident identifier is #1). Findings include: Review on 12/16/24 of Resident #1's most recent Level I PASARR screening completed on 7/23/13 for new admission, revealed no indication of mental illness or intellectual disability. Review on 12/16/24 of Resident #1's medical diagnosis list revealed a diagnosis of Post Traumatic Stress Disorder (PTSD) dated 8/22/24 and Personal History of Traumatic Brain Injury (TBI) dated 8/3/17. Review on 12/16/24 of Resident #1's mental health provider note, dated 8/19/24, revealed Resident #1 had an episode of recent aggression with an aide when attempt was made to redirect from the elevator focus on military and past trauma related to this .h/o [history of] TBI .confused about immediate situation and conflates this with past events leading to aggression as response . Review on 12/16/24 of Resident #1's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 12/3/24, revealed in Section I (Active Diagnosis) lists Traumatic Brain Dysfunction as primary reason for admission, it also revealed TBI and PTSD selected. Review on 12/16/24 of Resident #1's care plan revealed PTSD and TBI had interventions in place for cognition and behaviors At times I talk about past events as though they are current (or delusions as I believe happened in my past, but are not true/accurate) e.g. I have cockroaches in my room and the Communist (but did not) .I display verbal behaviors (yelling and cursing) I reject care @ x's [at times] . Interview on 12/17/24 at approximately 2:15 p.m. with Staff L (Social Services Director) confirmed above findings and further revealed they have no process for referring for Level I PASARR screening with newly identified mental/intellectual disabilities.

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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** 38218 Based on observation, interview, and record review, it was determined that the facility failed to follow physician orders for 1 resident out of 3 residents reviewed for pressure ulcers in a final sample of 18 residents (Resident identifier is #36). Findings include: Standards: [NAME], [NAME] A., and [NAME] [NAME]. Fundamentals of Nursing. 7th ed. St. Louis, Missouri: Mosby Elsevier, 2009. Page 336 - Physicians' Orders The physician is responsible for directing medical treatment. Nurses follow physician's orders unless they believe the orders are in error or harm clients. Therefore you need to assess all orders, and if you find one to be erroneous or harmful, further clarification from the physician is necessary . Observation on 12/17/24 at approximately 1:45 p.m. of Staff C (Licensed Practical Nurse) changing Resident #36's dressing to his/her coccyx revealed a separate dressing that was applied to his/her left gluteal fold, dated 12/16. Staff C removed the dressing and there was a pinpoint area noted to Resident #36's gluteal fold with a thick layer of cream applied under the dressing. Interview on 12/17/24 at approximately 1:45 p.m. with Staff C revealed that Staff C was unaware of any other dressing orders for Resident #36. Review on 12/17/24 of Resident #36's December 2024's TAR (Treatment Administration Record) and physician's orders revealed that there were no physicians order for the dressing applied to Resident #36's left gluteal fold. Interview on 12/17/24 at approximately 2:30 p.m. with Staff D (Assistant Director of Nurses/Wound Nurse) revealed that Staff D would not expect a dressing to be applied without a physician's order.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 43408 Based on interview and record review, it was determined that the facility failed to ensure a resident does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable for 1 of 2 residents reviewed for pressure ulcers in a final sample of 18 residents (Resident identifier is #69). Findings include: Review on 12/17/24 of Resident #69's medical record revealed the following progress notes: 11/8/24 at 11:15 a.m.: Weekly skin check done. Pt [patient] currently has a bruise on the outer left heel.; 11/8/24 at 3:12 p.m.: .very lethargic today .Laid down in [pronoun omitted] bed and has been sleeping since noon; 11/10/24 at 7:32 a.m.: Resident has been in bed since yesterday .noticed a golf [sic] size blister on [pronoun omitted] left heel that is weeping .Pillows were placed under [pronoun omitted] legs in order to float [pronoun omitted] heels. supervisor [name omitted]was notified .; 11/10/24 at 9:46 a.m.: Golf ball size blister noted to be draining serous fluid. Will notify MD [Medical Doctor].; 11/10/24 at 11:47 a.m.: New order to flush left heel blister with normal saline, pat dry, apply vaseline and cover with foam border dressing, keep moist and change dressing as needed until healed; Review on 12/17/24 of Resident #69's Skin integrity care plan that was initiated on 11/7/23 revealed the following: Focus was updated on 11/27/24 to include Stage 3 pressure injury to left heel; Interventions updated on 11/21/24 to include Keep heels elevated at all times with heels off cushion when in bed, and Multiboot to left foot when out of bed to off-load heel. Interview on 12/17/24 at approximately 1:30 p.m. with Staff D (Assistant Director of Nursing/Wound Nurse) confirmed that their were no orders for treatment of Resident #69's left heel until 11/10/24 when the blister was discovered. Staff D confirmed that there were no new care plan interventions added to Resident #69's care plan until 11/21/24. Staff D stated that they were not aware of the finding of the bruise on 11/8/24 to Resident #69's left heel until after the development of the blister on 11/10/24. Review on 12/17/24 of Resident #69's Licensed Nursing Assistant task documentation revealed the following: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Multiboot to left foot when out of bed to offload heel and Keep heels elevated at all times with heels off cushion when in bed were both initiated on 11/20/24, 12 days after the identification of the bruised area to left heel. Interview on 12/18/24 at approximately 9:30 a.m. with Staff F (Director of Nursing) confirmed the above findings.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 43408 Based on observation, interview, and record review, it was determined that the facility failed to ensure a resident with an order for a CPAP (continuous positive airway pressure) machine recieved treatment consistant with the providers orders for 1 of 2 residents reviewed for Respiratory Care in a final sample of 18 residents (Resident identifier is #18). Findings include: Interview on 12/17/24 at approximately 10:15 a.m. with Resident #18 revealed that they have not been able to use their CPAP at night due to the mask not sealing. Resident #18 stated that staff were aware and that this has been going on for at least a week. Review on 12/17/24 of Resident #18's medical record revealed an order for CPAP on at bedtime and remove in the morning related to obstructive sleep apnea, start date of 11/21/23. Further review of Resident #18's medical record revealed the following order administration notes: 12/8/24 at 9:02 a.m. did not wear CPAP last night; 12/8/24 at 11:52 p.m. CPAP mask has a tear; 12/10/24 at 12:25 a.m. CPAP is broken; 12/10/24 at 7:35 a.m. CPAP is broken; 12/14/24 at 12:33 a.m. CPAP is broken; 12/14/24 at 6:01 a.m. CPAP is broken; 12/15/24 at 4:41 a.m. CPAP mask has a tear at the top; 12/15/24 at 7:05 a.m. CPAP mask has a tear; 12/16/24 at 1:00 a.m. CPAP mask has a tear at the top; 12/16/24 at 6:06 a.m. CPAP is broken; 12/17/24 at 12:01 a.m. CPAP mask has a tear at the top; 12/17/24 at 6:23 a.m. CPAP has a tear. Interview on 12/17/24 at approximately 12:00 p.m. with Staff E (Registered Nurse) confirmed that Resident #18's CPAP was not functioning properly due to a tear in the mask and that no one had notified the provider of the CPAP not being used as ordered.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 43408 Based on record review and interview, it was determined the facility failed to ensure that medical records were accurate for 2 residents reviewed in a final sample of 18 residents (Resident identifiers are #17 and #81). Findings include: Resident #17 Interview on 12/16/24 at approximately 2:00 p.m. with Resident #17 revealed that he/she has been using a hoyer lift for transfers for a few weeks. Interview on 12/18/24 at approximately 8:30 a.m. with Staff I (Licensed Nursing Assistant (LNA)) revealed that LNA's use the Resident Profiles that are hanging in the residents closets for resident transfer statuses. Review on 12/18/24 of Resident #17's Resident Profile in Resident #17's closet in his/her room revealed . Transfers 2 assist mechanical stand lift, Instructions: [pronoun omitted] sling PRN (as needed) . Interview on 12/18/24 at approximately 9:10 a.m. with Staff H (Director of Rehabilititation) confirmed that Resident #17 was no longer safe using a stand lift and had transitioned to a hoyer lift a few weeks ago. Interview on 12/18/24 at approximately 9:15 a.m. with Staff A (Administrator) revealed that he/she expects the Resident Profiles to be updated when any changes are made with a residents care needs. Interview on 12/18/24 at approximately 9:30 a.m. with Staff F (Director of Nursing) confirmed that Resident Profiles are part of the residents medical record. Resident #81 Review on 12/18/24 of Resident #81's progress notes revealed an entry on 11/11/24, at 6:30 a.m., that stated This nurse was notified by resident's visiting POA [Power of Attorney] that [pronoun omitted] was not breathing. [name omitted] RN [Registered Nurse] notified to pronounce. Further review of Resident #81's progress notes revealed no documentation regarding pronouncement of death. Interview on 12/18/24 at approximately 9:30 a.m. with Staff F confirmed the above findings. Review on 12/18/24 of the facility policy titled Death of a Resident revised 7/15, revealed .5. The licensed nurse will make the following entries on the residents' chart: a. Time of death b. Pronouncement of death by physician or Registered Nurse . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	38218