

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 305053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/31/2025
NAME OF PROVIDER OR SUPPLIER Grafton County Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 3855 Dartmouth College Highway North Haverhill, NH 03774	

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)
<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>Based on observation, record review, and interview, it was determined that the facility failed to determine if a device was a restraint for 1 of 1 resident reviewed for restraints in a final sample of 24 residents (Resident identifier is #58).</p> <p>Findings include:</p> <p>Observation on 1/30/25 from 8:05 a.m. to 8:20 a.m. revealed that Resident #58 was sitting in their wheelchair with a lap tray prior to being served breakfast.</p> <p>Observation on 1/31/25 at approximately 8:20 a.m. of Resident #58 revealed that Resident #58 was alone in his/her room with the lap tray attached to his/her wheelchair prior to breakfast being served.</p> <p>Review on 1/31/25 of Resident #58's medical record revealed Resident #58's latest Brief Interview for Mental Status (BIMS), dated 11/25/24, revealed that Resident #58 scored a 9 (indicating moderate cognitive impairment).</p> <p>Review on 1/31/25 of Resident #58's medical record revealed that there was no pre-restraining assessment.</p> <p>Review on 1/31/25 of facility policy, Use of Restraints, revised April 2017, revealed .1. Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts normal access to one's body.3 lap cushions and trays that the resident cannot remove .6. Prior to placing a resident in restraints, there shall be a pre-restraining assessment .</p>

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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<p>F 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>Based on record review and interview, it was determined the that the facility failed to ensure that the Minimum Data Set (MDS) assessment accurately reflected the residents' status for 2 out of 2 residents reviewed for dental in a final sample of 24 residents (Resident Identifiers are #25 and #63).</p> <p>Findings include:</p> <p>Resident #25</p> <p>Review on 1/31/25 of Resident #25's Annual MDS, Assessment Reference Date (ARD) of 6/5/25, revealed under section L0200: Oral/Dental Status was coded none of the above were present indicating that Resident #25 did not wear dentures.</p> <p>Interview on 1/31/25 at 8:31 a.m. with Staff U (Registered Nurse) confirmed that Resident #25 had worn dentures in June at the time of the assessment.</p> <p>Resident #63</p> <p>Review on 1/31/25 of Resident #63's Annual MDS, with ARD of 11/1/24, revealed under section L0200: Oral/Dental Status was coded none of the above were present indicating that Resident #63 had no dental issues.</p> <p>Review on 1/31/25 of Resident #63's dental notes dated 9/24/24 revealed that Resident #63 had a lost filling, a cavity, and a missing crown with extensive decay.</p> <p>Interview on 1/31/25 at 1:52 p.m. with Staff T (MDS Coordinator) confirmed the above findings and that the MDS was coded incorrectly for Resident #25 and Resident #63.</p>

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to provide appropriate adaptive equipment to maintain their ability to carry out Activities of Daily Living (ADL's) for 2 of 2 residents reviewed for ADL's in a final sample of 24 residents. (Resident identifiers #5 and #58)</p> <p>Findings include:</p> <p>Resident #5</p> <p>Observation 1/30/25 from approximately 8:45 a.m. to 9:10 a.m. revealed that Resident #5 was eating in his/her room alone from a styrofoam container.</p> <p>Review on 1/31/25 of Resident #5's care plan revealed that Resident #5 has a lip plate per resident request.</p> <p>Observation on 1/31/25 at approximately 9:00 a.m. revealed that Resident #5 was eating in his/her room from a styrofoam container with intermittent assistance.</p> <p>Interview on 1/31/25 at approximately 9: a.m. with Staff Q (Licensed Nursing Assistant) confirmed that Resident #5 was eating from a styrofoam container and did not have a lip plate.</p> <p>Resident #58</p> <p>Observation on 1/30/25 at approximately 9:00 a.m. revealed that Resident #58 was eating his/her meal from styrofoam container with weighted utensils.</p> <p>Observation on 1/31/25 at approximately 8:50 a.m. revealed that Resident #58 was eating his meal from a styrofoam container.</p> <p>Interview on 1/31/25 at approximately 8:10 a.m. with Staff Q confirmed that Resident #58 was eating from a styrofoam container.</p> <p>Review on 1/31/25 of Resident #58's care plan revealed that Resident #58 had an intervention to use a lip plate and weighted utensils to maximize independence with eating.</p> <p>Review on 1/31/25 of the facility's policy titled, Assistance with Meals, revised March 2022, revealed .Residents Who May Benefit from Assistive Devices: 1. Adaptive devices (special eating equipment and utensils) will be provided for residents who need or request them. These may include devices such as silverware with enlarged/padded handles, plate guards, and/or specialized cups .</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>Based on interview and record review, it was determined that the facility failed to identify resident preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for 1 of 3 residents reviewed for behavioral-emotional in a final sample of 24 residents. (Resident identifier is #38.)</p> <p>Findings include:</p> <p>Review on 1/31/25 of Resident #38's medical record revealed that Resident #38 was admitted to the facility on 10/2024. Further review of Resident #38's medical record revealed the following progress notes:</p> <p>Dated 1/5/25, Resident expressed to LNA [Licensed Nursing Assistant] this am, that [pronoun omitted] grew up in foster care with a Father figure who was inappropriate with [pronoun omitted] growing up and [pronoun omitted] feels uncomfortable with male caregivers. Nurse updated care plan to not have male caregivers at this time.</p> <p>Dated 1/7/25, [name omitted] disclosed that [pronoun omitted] was SA'd [sexually assaulted] many years ago, which has resulted in trauma symptoms including panic when physically touched by males and anxiety. [pronoun omitted] said [pronoun omitted] didn't know [pronoun omitted] would have a reaction with a male caregiver until a recent incident. [pronoun omitted] wanted to share that the boy did nothing wrong. [pronoun omitted] was very kind and explained what [pronoun omitted] was going to do. but [pronoun omitted] reaction was instant and controllable for [pronoun omitted] ., written by Staff H (Social Services).</p> <p>Review on 1/31/25 of Resident #38's care plans revealed that there was no interventions regarding male caregivers added to Resident #38's care plan in place for Resident #38's history of sexual abuse until 1/7/25.</p> <p>Interview on 1/31/25 at approximately 12:30 p.m. with Staff F (Administrator) revealed that there is no assessment to determine if trauma has occurred with residents on admission.</p> <p>Interview on 1/31/25 at approximately 12:45 p.m. with Staff G (Social Service Director) revealed that he/she meets with residents as they are admitted to the facility and does not ask specific questions in regards to identifying past trauma. Further interview revealed that Staff G likes to develop a relationship prior to asking specific questions.</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>Based on interview and record review, it was determined that the facility failed to ensure that a resident obtained routine dental care for 2 of 2 residents reviewed for dental in a final sample of 24 residents (Resident identifiers are #25 and #63).</p> <p>Findings include:</p> <p>Resident #25</p> <p>Interview on 1/29/25 at 11:35 a.m. with Resident #25 revealed that he/she had dentures but he/she doesn't wear them as they hurt because they don't fit right. Resident #25 stated that he/she had told staff but had not seen a dentist.</p> <p>Review on 1/29/25 of Resident #25's medical record revealed Resident #25's latest Brief Interview for Mental Status (BIMS), dated 12/4/24, revealed that Resident #25 scored a 15 (indicating cognitively intact).</p> <p>Interview on 1/31/25 at approximately 8:30 a.m. with Staff U (Registered Nurse) confirmed that Resident #25 had complained that his/her dentures hurt when he/she had them in so he/she did not wear them.</p> <p>Interview on 1/31/25 at approximately 1:59 p.m. with Staff E (Director of Nursing) revealed that the facility was unable to find documentation from the dentist they had been seen by a dentist since Resident #25's dentures had been realigned in November.</p> <p>Resident #63</p> <p>Interview on 1/30/25 at 8:18 a.m. with Resident #63 revealed that he/she had issues with their teeth and had not seen a dentist since her teeth were cleaned by the hygienist in September 2024.</p> <p>Review of Resident #63's medical record revealed Resident #63's latest Brief Interview for Mental Status (BIMS) dated 11/1/24 revealed that Resident #63 scored a 13 (indicates cognitively intact).</p> <p>Review on 1/31/25 of Resident #63's dental notes dated 9/24/24 revealed the following:</p> <p>Findings: Visible decay</p> <p>Additional Notes: Lost filling #7, recurrent caries #8, missing crown with extensive decay #30.</p> <p>Recommendations: Urgent needs identified, evaluation with dentist ASAP</p> <p>Interview on 1/31/25 at 2:00 p.m. with Staff E confirmed that Resident #63 had not been seen by a dentist for follow up after 9/24/24.</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>Maple Unit</p> <p>Interview on 1/29/25 at approximately 3:15 p.m. with Staff C (LNA) and Staff D (LNA) on the Maple Unit revealed that HS snacks are not offered routinely. Snacks are available if a resident asks for them.</p> <p>Profile Unit:</p> <p>Interview on 1/29/25 at 3:38 p.m. with Staff KK (LNA) and Staff LL (LNA) revealed that they work 3-11 shift. Resident were not offered snack in the evenings. Snacks are available if a resident asks for them. Granite Unit</p> <p>Interview on 1/29/25 at approximately 3:15 p.m. with Staff I (LNA), Staff J (LNA), Staff K (LNA), and Staff L (LNA) on the Granite Unit revealed that HS snacks are not offered routinely. Snacks are available if a resident asks for them.</p> <p>Based on observation, interview and record review, it was determined that the facility failed to offer the residents a nourishing snack at bedtime while having more than 14 hours between the evening meal and the breakfast meal for 4 of 4 units reviewed and without Resident Council consent.</p> <p>Findings include:</p> <p>Interview on 1/29/25 at approximately 2:15 p.m. at Resident Council (5 residents in attendance) revealed that HS (Hour of Sleep) snacks were not offered. The residents stated snacks were available when they asked for them.</p> <p>Review on 1/29/25 of the facility's scheduled meal service times revealed that the Supper meal time starts at 5:00 p.m. and the Breakfast meal time starts at 8:00 a.m. Further review revealed that the schedule of meal times indicated that the facility offered snacks at bed time (approximately 7:00 p.m.).</p> <p>Meadow Unit</p> <p>Interview on 1/29/25 at 3:23 p.m. with Staff R (Licensed Nursing Assistant (LNA)) revealed that he/she worked the evening shift and that snacks were given to residents that requested them and not offered to everyone.</p> <p>Interview on 1/29/25 at 3:29 p.m. with Staff S (LNA) revealed that he/she worked the evening shift and that snacks were given to residents when they requested them and not offered to everyone. Staff S revealed that most residents on the unit would not be able to ask for a snack due to memory issues.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on record review, interview, and policy review, it was determined that the facility failed to follow standards of practice for the complete medical records as it related to the pronouncement of death in 1 out of 1 record reviewed for death documentation and for the incorrect documentation of weights for 1 resident out of a final sample of 24 residents. (Resident identifier is #120 and Resident #42)</p> <p>Findings include:</p> <p>Resident #120</p> <p>Review on 1/31/25 at 12:30 p.m. of Resident #120's medical record revealed that on 12/11/24 an entry by Staff N (Licensed Practical Nurse (LPN)) on the Progress Notes stated the following: Resident passed away at 02:58 a.m., Pronounced by an RN [Registered Nurse] at 0305 [3:05 a.m.]. DON [Director on Nursing] notified and called caseworker twice by no answer and left a message for call back. Funeral home arranged.</p> <p>Interview on 1/31/25 at 1:00 p.m. with Staff E (Director of Nursing) revealed the Registered Nurse pronouncing the death would document in the record per facility policy.</p> <p>Review on 1/31/25 of the facility policy titled Death of a Resident - Implementation and Documentation, revised 11/10/22, revealed that All information pertaining to a resident's death, i.e. date, time of death, name and title of individual pronouncing the resident is dead, etc., must be recorded in the nurse's notes.</p> <p>Resident #42</p> <p>Review on 1/29/25 at 9:00 a.m. of Resident #42 medical record revealed that on 12/20/24 Resident #42's weight was recorded as 156.3 pounds. Further review of the weight record revealed that on 12/27/24 the weight was recorded as 194.7 pounds. On 1/03/25 weight was recorded as 193.7 pounds, on 1/9/25 weight was recorded at 156.6 pounds, and no other documentation regarding the discrepancy was identified.</p> <p>Interview on 1/29/25 at 12:30 p.m. with Staff V (LPN) revealed that if there is any discrepancy with the weights 3 pounds above or below then staff reweigh the next day for accuracy. Further interview with Staff V revealed that there was no reweights to verify accuracy documented for the 12/27/24, 1/3/25, and 1/9/25.</p> <p>Review on 1/29/25 of the Facility policy titled: Weigh Assessment and Intervention: Weight Assessment 3. Any weight change of 5% or more since the last weight assessment is retaken. a. If the weight is verified, nursing will immediately notify the dietitian in writing .</p>		

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<p>F 0880</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on interview and record review, it was determined that the facility failed to conduct annual reviews of it's infection prevention and control programs policies and procedures which had the potential to effect the facility census of 118 residents.</p> <p>Findings include:</p> <p>Review on 1/31/25 of the facility's infection prevention and control program policies revealed that not all of the policies had been reviewed annually.</p> <p>Interview on 1/31/25 at 2:05 p.m. with Staff F (Administrator) revealed the facility did not have a process for reviewing policies annually and they were only updated when needed.</p> <p>Interview on 1/31/25 at 2:14 p.m. with Staff HH (Infection Preventionist) revealed that the facility did not conduct a review of it's infection prevention and control policies annually.</p>		