STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305059	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pheasant Wood Center	50 Pheasant Road Peterborough, NH 03458

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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 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, it was determined that the facility failed to provide the resident and/or resident representative a Notice of Medicare Non-Coverage (NOMNC) and/or the Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) for 3 of 3 residents reviewed for beneficiary notices. (Resident identifiers are #69, #145 and #146.) Findings include: Resident #69 Review on 6/13/25 of Beneficiary Notice - Residents discharged Within the Last Six Months form, completed by the facility, revealed that Resident #69's last covered day of Medicare Part A Services was on 6/4/25 with benefit days remaining. Resident #69 remained in the facility. The facility was unable to provide Resident #69's NOMNC and SNF ABN. Resident #145 Review on 6/13/25 of Beneficiary Notice - Residents discharged Within the Last Six Months form, completed by the facility, revealed that Resident #145's last covered day of Medicare Part A Services was on 1/6/25 with benefit days remaining and Resident #145 was discharged home. The facility was unable to provide Resident #145's NOMNC. Resident #146 Review on 6/13/25 of Beneficiary Notice - Residents discharged Within the Last Six Months form, completed by the facility, revealed that Resident #146's last covered day of Medicare Part A Services was on 2/6/25 with benefit days remaining and Resident #146 was discharged home. The facility was unable to provide Resident #146's NOMNC. Interview on 6/13/25 at approximately 8:15 a.m. with Staff E (Administrator) confirmed that he/she could not provide the above NOMNC or SNF ABN.

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review it was determined that the facility failed to follow its grievance policy for grievances for 2 out of 5 residents reviewed for grievances (Resident Identifiers are #67 and #80). Finding include: Review on 6/12/25 of the facility's policy Grievance/Concern revised 10/15/24, revealed .3. Upon receipt of the grievance/concern, the Grievance/Concern Form will be initiated by the staff member receiving the concern. Patients and/or patient representatives/families may complete a Grievance/Concern form and submit the completed form to a staff member .4. Upon receipt of the Grievance/Concern Form, the Administrator or designee will document the grievance/concern on the Grievance Concern Log . 6. The department manager will: . 6.2 Investigate the grievance; 6.3 Take corrective action, if needed .6.5. Notify the person filing the grievance in a timely manner . Resident #67 Interview on 6/11/25 at 10:25 a.m. with Resident #67 revealed he/she had filed numerous grievances about waiting over an hour for his/her call bell light to be answered during the 3-11 shift. He/she indicated there had been no resolution. Review on 6/12/25 of the facility 2024/2025 grievance log revealed that there were no grievances from Resident #67 about call bell lights. Review on 6/12/23 of Resident #67's care plan note, dated 5/22/25, revealed that . [Pronoun omitted] has filed a couple of grievances and set up weekly check in meetings with the Unit Manager to discuss problems . Interview on 6/13/25 at 8:42 a.m. with Staff K (Unit Manager) revealed that Resident #67 had complained about an LNA (Licensed Nursing Assistant) who he/she felt had an attitude with him/her and waiting a long time for as needed pain medication. Interview further revealed that Staff K had not documented Resident #67's complaints on a grienvance/concern form. Resident #80 Interview on 6/11/25 at 10:15 a.m. with Resident #80 revealed that Resident #80 was admitted to the facility in 3/2025 and he/she had filed multiple grievances to staff since he/she was admitted . He/she stated that he/she waited for over 2 hours in a soiled brief a few weeks ago and that he/she had told an LNA the next day and no one had come to talk to him/her about it. Interview on 6/12/25 at 11:58 a.m. with Staff I (LNA) revealed that Resident #80 had complained approximately three weeks ago about sitting in a soiled brief for a long time. Staff I stated that he/she reported the grievance to Staff K. Review on 6/12/25 of the facility 2025 grievance log revealed that there was no grievances documented for Resident #80. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 6/13/25 at approximately 1:30 p.m. with Staff E (Administrator) confirmed that the grievances from Resident #67 and Resident #80 were not forwarded to him/her and therefore there were no grievances documented on the grievance log for Resident #67 and Resident #80.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview, it was determined that the facility failed to ensure as needed (PRN) orders for psychotropic drugs were limited to 14 days for 1 of 1 residents reviewed for medication side effects in a final sample of 18 residents. (Resident identifier is #8.) Findings include: Review on 6/11/25 of Resident #8's June 2025 MAR (Medication Administration Record) revealed the following order: Lorazepam Oral Tablet 0.5 mg (milligrams) (Lorazepam) Give 1 tablet by mouth every 4 hours as needed for increased anxiety, dated 5/9/25. The order had no stop date indicated. Review on 6/11/25 of Resident #8's May 2025 MAR (Medication Administration Record) revealed the following order: Lorazepam Oral Tablet 0.5 mg (milligrams) (Lorazepam) Give 1 tablet by mouth every 4 hours as needed for increased anxiety, dated 5/9/25. The order had no stop date indicated. Further review revealed Resident #8 received 2 doses on 5/31/25. Interview on 6/12/25 at approximately 11:30 a.m. with Staff C (Director of Nursing) confirmed the above findings. Review on 6/12/25 of the facility policy titled, Medication Management, Dated 1/25 revealed: .Type of PRN (as needed) PRN orders for Psychotropic medications, excluding antipsychotics, Time Limitation 14 days, Order may be extended beyond 14 days if the attending physician or prescribing practitioner believes it is appropriate to extend the order .

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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** Based on interview and record review, it was determined that the facility failed to ensure the physician was notified of a weight change for 2 of 2 residents reviewed for notification of changes in a final sample of 18 residents. (Resident identifiers are #85 and #143.) Findings include: Standard: [NAME], [NAME] A., and [NAME]. Fundamentals of Nursing. 10th ed. St. Louis, Missouri: Mosby Elsevier, 20212, Chapter 19, page 267 revealed the following Communication with other health providers needs to be timely, acurate, and relevant to the patient's clinical situation. Resident #85 Review on 6/11/25 of Resident #85's May 2025 Treatment Administration Record (TAR) revealed the following physicians order: CHF (Congestive Heart Failure) Daily Weight: Notify the provider if: gain >(greater than) 2 lbs (pounds) in 1 day, or 5 lb in a week, one time a day for 7 days, start date 5/28/25. Further review revealed that there was no documented weight obtained on 5/29/25. Review on 6/11/25 of Resident #85's June 2025 TAR (Treatment Administration Record) revealed the following physicians order: CHF Daily Weight: Notify the provider if: gain > 2 lbs in 1 day, or 5 lb in a week, one time a day for 7 days, start date 5/28/25. Further review revealed: June 1st weight was 193.2 lbs; June 2nd no weight obtained; June 3rd weight was 205 lbs (11.8 lb gain) Resident #143 Review on 6/11/25 of Resident #143's June 2025 TAR revealed the following physicians order: Daily weight CHF: Notify the provider if: gain >2 lbs in 1 day, or 5 lb in a week in the morning, Start Date 6/8/25. Further review revealed: June 8th no weight obtained; June 9th no weight obtained; June 10th no weight obtained; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	June 11th weight refused. Interview on 6/12/25 at approximately 12:45 p.m. with Staff C (Director of Nursing) confirmed that there was no documentation of the provider being notified of the above findings. Interview on 6/12/25 at approximately 1:00 p.m. with Staff D (Nurse Practitioner) confirmed that he/she was not notified of the above findings as ordered.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the facility failed to provide sufficient nursing staff, as determined by their facility assessment, to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of the residents on the 2nd floor with a census of 47 residents. (Resident identifiers are #8, #33,#67, and #80 Findings include: Resident #33 Interview on 6/11/25 at approximately 8:45 a.m. with Resident #33 revealed he/she was concerned with not having enough staff at times for him/her to go to the bathroom. A lot of times, I end up wetting myself because it takes up to 30 minutes for them (the staff) to answer my call bell. This happens here all the time. Resident #8 Interview on 6/11/25 at approximately 9:00 a.m. with Resident #8 revealed he/she was concerned with not having enough staff at times for him/her to be able to go outside and smoke. Especially on the weekends when there is only 3 aides, sometimes I can't even get outside to smoke at times. Interview on 6/11/25 at approximately 9:10 a.m. with Staff F (Anonymous) revealed that he/she did not feel that there is enough staff to meet the residents needs on the 2nd floor, Residents are incontinent because we don't have enough staff to get to them in time. Further interview revealed that Resident #8 sometimes can not get outside to smoke because there is not enough staff. Interview on 6/11/25 at approximately 10:25 a.m. with Resident #67 revealed that call bell wait times were not answered timely on the 3-11 shift. He/she states that he/she uses oxygen continuously and he/she has had waited over an hour to be connected to his/her portable tank when he/she had wanted to leave his/her room in the afternoon or early evening to go to an activity or go outside for fresh air. Interview on 6/11/25 at approximately 10:15 a.m. with Resident #80 revealed that he/she had waited a long time for his/her call bell to be answered. He/she stated that it was worse on the 3-11 and 11-7 shift. He/she was unable to ambulate on his/her own when he/she was admitted . He/she stated that he/she had waited up to 2 hours in a dirty brief. Resident #80 stated that they waited over 30 minutes for help in the bathroom [ROOM NUMBER] nights ago. Review on 6/12/25 of Resident #80's care plan, initiated on 4/1/25, revealed that Resident #80 was incontinent of bowel with potential for improved control and management of bowel elimination. Further review under interventions included . Encourage resident to call for assistance if need to defecate before next schedule time .Provide assistance as needed . Review on 6/11/25 of the Resident Council Meeting Minutes, dated 4/29/25, revealed that .Sometime call-lights can take a while for staff to respond. This is inconsistent, and appears to be more prevalent on the weekends . (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 6/12/25 at approximately 10:23 a.m. with the Resident Council revealed that 7 residents in attendance who reside on the 2nd floor had concerns with call bells being answered timely. Residents stated that it was worse on the 3-11 shift or before 7:00 a.m. when there are only 2 Licensed Nursing Assistants (LNA) on the floor trying to get residents up for the day. One resident stated that they feel like residents were not able to attend activities due to not enough staff to help get them there especially in the late afternoon or early evening hours. Interview on 6/12/25 at approximately 7:00 a.m. with Staff N (Anonymous) revealed that residents have complained to him/her multiple times about waiting long for care. He/she stated that residents have been put to bed in their day clothes or left up for them to be to put to bed for the next shift. Interview further revealed that at times, residents may have to wait longer when there were only 2 LNA's scheduled and there was a resident that would need both LNA's for care. Interview on 6/13/25 at 9:47 a.m. with Staff M (Anonymous) revealed that residents were often not up out of bed or dressed and ready to get to activities. Staff M revealed that it happened more on the weekends and on the 2nd floor.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review, interview, and policy review, it was determined that the facility failed to establish and maintain a system of records of receipt and disposition of controlled drugs in sufficient detail to enable an accurate reconciliation for 1 of 5 residents reviewed for choices in a final sample of 18 residents. (Resident identifier is #8.) Findings include: Interview on 6/11/25 at approximately 9:00 a.m. with Resident #8 revealed he/she was concerned with receiving the wrong dose of his/her pain medication recently. Review on 6/13/25 of Resident #8's April 2025 Medication Administration Record (MAR) revealed the following as needed (PRN) physician orders: Hydromorphone HCL (Hydrochloric Acid) Tablet 2 mg (milligrams), Give 0.5 tablet (1mg) by mouth every 6 hours as needed for breakthrough pain 8-10, Start Date 4/1/25. Further review revealed on 4/16/25 a dose was signed as being administered at 11:18 p.m Hydromorphone HCL Tablet 2 mg, Give 1 tablet by mouth every 4 hours as needed for pain 8-10 for 30 days, discontinued on 4/1/25. Review on 6/13/25 of Resident #8's Individual Patient's Narcotic Record for the above discontinued order revealed that 1 tablet [2 mg] was given on 4/16/25 at 8:30 p.m. Interview on 6/13/25 at approximately 9:45 a.m. with Staff C (Director of Nurses) confirmed the above findings. Review on 6/13/25 of Resident #8's May 2025 MAR revealed the following physician's orders: Hydromorphone HCL (Hydrochloric Acid) Tablet 2 mg (milligrams), Give 0.5 tablet (1 mg) by mouth two times a day for chronic pain, Start Date 4/1/25. Review on 6/13/25 of Resident #8's Individual Patient's Narcotic Record for Hydromorphone 2 mg revealed on 5/3/25 one 2 mg tablet was documented as being administered at 7:20 p.m. Interview on 6/13/25 at approximately 9:45 a.m. with Staff C confirmed that Resident #8 received the wrong dose of Hydromorphone on 5/3/25. June 2025 Review on 6/13/25 of Resident #8's June 2025 MAR revealed the following physician's orders: Hydromorphone HCL (Hydrochloric Acid) Tablet 2 mg (milligrams), Give 0.5 tablet (1 mg) by mouth two times a day for chronic pain, Start Date 4/1/25. Review on 6/13/25 of Resident #8's Individual Patient's Narcotic Record for Hydromorphone 2 mg revealed on 6/4/25 one 2 mg tablet of Hydromorphone was documented as being administered at 10:00 p.m. Interview on 6/13/25 at approximately 1:00 p.m. with Staff C confirmed that Resident #8 received (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the wrong dose of Hydromorphone on 6/4/25. Review on 6/13/25 of Resident #8's Individual Patient's Narcotic Record for Hydromorphone 2 mg 1/2 tablets, dated 4/3/25 revealed: The quantity indicated was the facility received 23 tablets. Further review revealed 2 nurses documented receiving 12 tablets. Interview on 6/13/25 at approximately 1:00 p.m. with Staff C confirmed that there was a discrepancy with the quantity received. Further interview revealed that he/she was unaware of the discrepancy. The facility did not follow their policy for notifying a supervisor of the discrepancy, did not complete a Controlled Drug Discrepancy Investigation Form, and did not initiate an investigation into the discrepancy. Review on 6/13/25 of the facility policy titled, NSG300 Controlled Drugs: Management of, Revision Date 1/31/25, revealed . The management of controlled substances-including the ordering, receipt, storage, administration, ongoing inventory, and destruction-is conducted under the direction and ultimate responsibility of the Administrator and Director of Nursing, and follows safe practice . Receipt: Controlled substances are received in separate containers with separate invoices. Licensed nursing staff must accept delivery and take responsibility for receipt of controlled substances Discrepancies noted at any step of the process will be reported to appropriate persons. If a discrepancy is noted, the nursing supervisor will be notified and immediately initiate investigation using the Controlled Drug Discrepancy investigation form .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on interview, observation and record review it was determined that the facility failed to follow currently accepted professional principles for labeling and/or storing drugs and biologicals in 2 of 3 medications carts observed. (Resident identifiers are #16 and #41.) Findings include: Observation on 6/11/25 at approximately 8:05 a.m. of the 2nd Floor Medication Cart revealed: One open bottle of Brimodine eye drops opened with no open date or open expiration date and no resident identifier; One box of Cipro ear drops for Resident #16 labeled with an expiration date of 6/6 stored in the medication cart with eye drops; and one open Breyna inhaler for Resident #41 with no open date or open expiration date. Interview on 6/11/25 at approximately 8:10 a.m. with Staff A (Licensed Practical Nurse) confirmed the above findings. Observation on 6/12/25 at approximately 7:00 a.m. of the Celtics Court Medication Cart revealed Resident #37's open Incruse Ellipta inhaler was not labeled with an open date or an open expiration date. Interview on 6/12/25 at approximately 7:00 a.m. with Staff B (Licensed Practical Nurse) confirmed the above finding. Review on 6/1/25 of the instructions for use for Incruse Ellipta, date 12/2023, revealed . Safely throw away Incruse Ellipta in the trash 6 weeks after you open the tray or when the counter reads 0, whichever comes first. Write the date you open the tray on the label on the inhaler . Review on 6/12/25 of the patient instructions for Breyna inhaler, revision date 9/2020, revealed . Throw away Breyna when the counter shows zero ('0) or 3 months after you take your Breyna inhaler out of its foil pouch, whichever comes first . Review on 6/12/25 of the Consumer Medicine Information for Brimodine, Dated May 2017, revealed . Storage . Discard the eye drops 4 weeks after opening . Review on 6/12/25 of the facility policy titled, 4.1 Storage of Medication, Dated 1/25, revealed . 4. Medications should be stored so that various routes of administration are separated 6. Eye medications are stored separately from ear medications . 14. Outdated, . are immediately removed from stock .