STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305083	A. Building B. Wing	02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wolfeboro Bay Center	39 Clipper Drive Wolfeboro, NH 03894

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, record review, and interview, it was determined that the facility failed to meet professional standards for 1 of 4 nursing staff observed for medication administration and 1 of 2 residents reviewed for pain in a final sample of 16 residents (Resident identifiers are #164 and #214). Findings include: [NAME], [NAME] A., and [NAME]. Fundamentals of Nursing. 10th edition St. Louis, Missouri: Elsevier, 2021. Page 614 .Do not give a medication until you are certain that you can follow the seven rights of medication administration . Page 672 .seven rights of medication administration include right medication, right dose, right patient, right route, right time, right documentation and right indication . Resident #214 Observation on 2/20/25 at approximately 9:00 a.m. of Staff E (Medication Nursing Assistant (MNA)) revealed that Staff E administered medications to Resident #214 including Fluticasone Propionate Diskus Inhalation Powder 250mcg/ACT. Further observation revealed that Staff E did not have Resident #214 rinse his/her mouth with water after the inhaler. Interview on 2/20/25 at approximately 9:00 a.m. of Staff E confirmed the above findings. Review on 2/20/25 of Manufacturer instructions for use for Fluticasone Propionate Diskus Inhalation Powder revealed .Step 5 (final step). Rinse your mouth . Review on 2/21/25 of facility policy titled Medication Administration reviewed/revised 9/1/24 revealed Policy Explanation and Compliance Guidelines: .17. Administer medication as ordered in accordance with manufacturer specifications . Resident #164 Interview on 2/19/25 at 11:00 a.m. with Resident #164 revealed that Resident #164 had chronic pain and was prescribed Oxycodone every six hours. Resident #164 stated that the facility had run out of his/her medication a few weeks ago. Review on 2/21/25 of Resident #164's medical record revealed a physician's order for the following: Oxycodone HCl (Hydrochloride) Tablet 30 mg (Milligram), give 1 tablet by mouth every 6 hours for (continued on next page)

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	chronic pain, start date 1/8/25 and discontinued 1/24/25. Oxycodone HCl Tablet 30 mg, give 1 tablet by mouth every 6 hours for chronic pain, start date 1/24/25. Review on 2/21/25 of Resident #164's January 2025 Medication Administration Record (MAR) revealed the Resident #164's Oxycodone HCl Tablet 30 mg was not signed off as administered on 1/24/25 at 9:00 a.m., 1/25/25 at 3:00 a.m., and 1/26/25 at 9:00 a.m. Further review revealed that on 1/25/25 at 9:00 a.m., Resident # 164 was administered 25 MG of Oxycodone not the ordered 30 mg. Review on 2/21/25 of Resident #164's nursing notes on 1/24/25 through 1/26/25 revealed that on 1/24/25 at 9:00 a.m., 1/25/25 at 3:00 a.m., and 1/26/25 at 9:00 a.m., there was documentation that the Oxycodone 30 HCl Tablet 30 MG was unavailable or waiting on delivery from the pharmacy. Interview with 2/21/25 at 2:09 p.m. with Staff F (Nurse Practitioner) revealed that Staff F was unaware that Resident #164 had not been administered his/her scheduled Oxycodone on the above dates and times and that the Oxycodone HCl 30 MG was not available in the facility. Review on 2/21/25 of Resident #164's pain care plan revealed a goal of .will achieve acceptable level of pain control . revised on 1/3/25 and an intervention dated 1/3/24 .Medicate resident as ordered for pain and monitor for effectiveness and monitor for side effects, report to physician as indicated.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, it was determined that the facility failed to ensure a medication error rate was less than 5 percent (%) for 11 of 35 medication administrations observed. (Resident identifiers are #38) Findings include: Resident #38 Observation on 2/21/25 at approximately 8:45 a.m. of Staff B (Licensed Practical Nurse) revealed Staff B prepared the following 11 medications for Resident #1: Aspirin 81 mg (milligram) enteric coated, Magnesium Oxide 400 mg, Vitamin D3 1000 iu (units), Senna 8.6 mg, Miralax 17gm (grams), Buspirone 15 mg, Olanzapine 15 mg (3), Paroxetine 50 mg, Metformin 1000 mg, Carvedolil 25 mg, and Lisinopril 20 mg. Further observation revealed Staff B entered the wrong residents room. Staff B introduced themselves to Resident #38 and was prepared to administer the medications. The surveyor intervened. Interview on 2/21/25 at approximately 8:45 a.m. with Staff B confirmed he/she was going to administer Resident #1's medications to Resident #38. Review on 2/21/25 of facility policy titled Medication Administration reviewed/revised 9/1/24 revealed Policy Explanation and Compliance Guidelines: .10. Ensure that the 6 rights of medication administration are followed: a Right resident . There were 11 medication errors out of a total of 35 medication administration opportunities resulting in a 31.43% error rate.