| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **305083** | A. BUILDING _____ B. WING _____ | **08/07/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **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 0609<br><br>**Level of harm** - Potential for minimal harm<br><br>**Residents Affected** - Many | **Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.**<br><br>Based on interview, record review and policy review, the facility failed to ensure that alleged violations involving abuse, neglect, and misappropriation of resident property, were reported to other officials including to the State Survey Agency (SSA) for 4 out of 4 residents with alleged abuse reviewed. (Resident identifiers are #5, #6, #7, and #8.) Findings include: Review on 8/6/20 of facility's Abuse Prohibition policy dated 7/1/19 revealed that .7. Upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the CED or designee will perform the following .7.5 notify local law enforcement, Licensing Boards and Registries, and other agencies as required Resident #6 Review on 8/6/20 of Resident #6's grievance report dated 3/12/20 revealed that Resident #6 reported to the social worker that Resident #6 rang their call light and that Staff D (Licensed Nursing Assistant-LNA) assisted Resident #6's roommate but not Resident #6. Resident #6 also reported that Resident #6 was not provided any care by Staff D during Staff D's shift. Resident #8 Review on 8/6/20 of Resident #8's grievance report dated 4/15/20 revealed that Resident #8 reported that Resident #8 was missing $78.00. Resident #7 Review on 8/6/20 of Resident #7's grievance report dated 4/22/20 revealed that Resident #7 reported that when Staff E (Licensed Practical Nurse) was giving Resident #7 their insulin the needle broke and insulin spilled on to Resident #7 skin. Resident #7 also reported that Staff E did not give Resident #7 another dose of their insulin. Review also revealed that Resident #7 did not want Staff E to care for Resident #7 as they had issues with Staff E in the past. Resident #5 Review on 8/6/20 of Resident #5's grievance report dated 6/1/20 revealed that Resident #5 reported that Staff F (Registered Nurse) told Resident #5 you are a man, you shouldn't be pissing the bed when Resident #5 had bladder incontinence which drenched Resident #5's bed. Further review revealed that Resident #5 reported that Staff F should not be speaking in such a manner. Interview on 8/6/20 at 9:30 a.m. with Staff B (Administrator) confirmed the above findings and revealed that the above allegations were not reported to the SSA. Staff B stated that if the allegations were considered a grievance then it was not reported to the SSA. Staff B also stated that the police were not notified of Resident #8's allegation of missing money. |
| F 0658<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure services provided by the nursing facility meet professional standards of quality.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview, record review and policy review, the facility failed to ensure professional standards were followed by following physician orders [REDACTED]. (Resident identifiers are #2 and #3.) Findings include: Professional reference: Potter, Patricia A., and Anne Griffin Perry. 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 physicians' 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 . Review on 8/6/20 of facility's Diabetic Care Protocol, last revised date 12/1/2006, revealed .Perform fingerstick blood sugar monitoring as ordered and document .Report blood sugar results to physician according to ordered parameters .document: .nursing interventions, physician/representative notification and response . Resident #2 Review on 8/6/20 of Resident #2's July 2020 Electronic Medication Administration Record [REDACTED]. Review on 8/6/20 of Resident #2's blood sugar record revealed blood sugar levels of: . 563 on 7/23/20 . 541 on 7/25/20 . 546 on 7/26/20 . 569 on 7/27/20 . 587 on 7/28/20 . 554 7/29/20 . 437 on 8/5/20 . Review on 8/6/20 of Resident #2's nurses notes for July 2020 and August 2020 revealed no documentation that physician was notified of Resident #2's above blood sugar levels. Interview on 8/6/20 at approximately 10:30 a.m. with Staff A (Director of Nursing) confirmed the above findings. Interview on 8/7/20 at 9:00 a.m. with Staff C (Advanced Practice Registered Nurse) revealed that Staff C stated was not notified of Resident #2's blood sugar each time that Resident #2's blood sugar level was above 400. Resident #3 Review on 8/6/20 of Resident #3's June 2020 EMAR revealed that Resident #3 had a physician order [REDACTED].#3's June 2020 EMAR revealed that on 6/19/20 Resident #3's blood sugar at 8:00 p.m. was 371. Review on 8/6/20 of Resident #3's nurses notes revealed no documentation that the physician was notified of Resident #3's blood sugar on 6/19/20. Interview on 8/6/20 at approximately 10:15 a.m. with Staff B (Administrator) confirmed above findings. |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.