STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305061	A. BUILDING _____ B. WING _____	**03/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CRESTWOOD CENTER	**40 CROSBY STREET MILFORD, NH 03055**

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 0623 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that the facility failed to issue a transfer notice of discharge to the resident/resident representative in 1 resident in a final sample size of 21 residents. (Resident identifier is #79.) The facility also failed to notify the resident/resident representative(s) at discharge of their appeal rights, provide the contact information for the Ombudsman's office, and send a copy of the notice of transfer/discharge to the Ombudsman's office in 4 residents in a final sample size of 21 residents. (Resident identifiers are #65, #71, #72, and #78) Findings include: Resident #72 Review on 3/3/20 of Resident #72's electronic Change in Condition Evaluation dated 11/17/19 at 2:00 p.m. revealed the resident was sent to the hospital for abnormal vital signs. Review on 3/3/20 of a letter dated 11/18/19 to Resident #72's representative read This is to notify you that (name omitted) has been transferred to (Local Hospital) on 11/17/2019. We felt (pronoun omitted) needs could not be met at the facility and it was in (pronoun omitted) best interest to be transferred out to be evaluated. If you have any question regarding this notice, please do not hesitate to contact me. Continued review revealed it was signed by the Staff C (Center Executive Director). The notice did not include information on appeal rights or the contact information for the Ombudsman's office. Review on 3/3/20 of Resident #72's electronic medical record Nursing Progress Note dated 11/20/19 revealed the resident readmitted to the facility on [DATE]. Review on 3/3/20 of Resident #72's electronic Change in Condition Evaluation dated 1/30/20 at 2:48 a.m. revealed the resident was sent to the hospital for nausea/vomiting and shortness of breath. Review on 3/3/20 of a letter dated 1/30/20 to Resident #72's representative read This is to notify you that (name omitted) has been transferred to (Local Hospital) on 1/30/2020. We felt (pronoun omitted) needs could not be met at the facility and it was in (pronoun omitted) best interest to be transferred out to be evaluated. If you have any question regarding this notice, please do not hesitate to contact me. Continued review revealed it was signed by the Staff C. The notice did not included information on appeal rights or the contact information for the Ombudsman's office. Interview on 3/3/20 at approximately 1:49 p.m. with Staff C and Staff D (Corporate Regional Director) confirmed that the letter was the facility's practice for notifying residents of transfer and discharge, and that the facility had not sent a copy to the Office of the State Long-Term Care Ombudsman. Resident #65 Review on 3/03/20 10:23 a.m.of Resident #65's Electronic Medical Record (EMR) revealed that the resident had a hospitalization on [DATE]. Resident #65 was discovered by facility staff to be in an unresponsive state. There is documentation that the Power of Atorney (POA) was contacted. Review revealed a document dated 1/10/20, titled Hospital Discharge Document, addressed to Resident #65's POA. The letter stated: This is to notify you that (name omitted) has been transferred to (name omitted) on 1/10/20. We felt (pronoun omitted) needs could not be met at the facility and it was in (pronoun omitted) best interest to be transferred out to be evaluated. The notice did not include information on appeal rights or the contact information for the Ombudsman's office. Resident #71 Review on 3/3/20 of Resident #71's progress notes revealed that Resident #71 was transferred to the hospital on [DATE]. Review on 3/3/20 of Resident #71's medical record in the section labeled Miscellaneous revealed a document dated 12/8/19 titled Hospital Discharge Document. This document was in letter form addressed to Resident #71's activated power of attorney. The letter stated: This is to notify you that (name omitted) has been transferred to (name omitted) on 12/8/19. We felt (pronoun omitted) needs could not be met at the facility and it was in (pronoun omitted) best interest to be transferred out to be evaluated. The notice did not include information on appeal rights or the contact information for the Ombudsman's office. Interview on 3/3/20 at approximately 1:49 p.m. with Staff C (Center Executive Director) and Staff D (Corporate Regional Representative) confirmed that the letter was the facility's practice for notifying residents of transfer and discharge, and that the facility had not sent a copy to the Office of the State Long Term Care Ombudsman. Resident #78 Review on 3/3/20 of Resident #78's care plan meeting note dated 12/10/19 revealed that Resident #78 has reached their baseline in therapy and tentative discharge date is scheduled on 12/16/19. Review on 3/3/20 of Resident #78's nurses note dated 12/19/19 revealed that Resident #78 was discharged to home with services on 12/19/19. Review on 3/3/20 of Resident #78's paper and electronic medical records revealed that contents of the written notice of transfer or discharge date d 12/15/19 did not have the Office of the State Long-Term Care Ombudsman information. Further review of Resident #78's paper and electronic medical records revealed no copy of the notice of discharge date d 12/15/19 sent to the Office of the State Long-Term Care Ombudsman information Interview on 3/4/20 at 10:00 a.m. with Staff A (Director of Nursing) confirmed the above findings for Resident #78. Staff A was unable to provide explanation on why the notice of discharge for Resident #78 was not sent to the Office of the State Long-Term Care Ombudsman. Resident #79 Review on 3/3/20 of Resident #79's nurse's note dated 12/13/19 revealed that Resident #79 was sent to ER (emergency room) for evaluation on 12/13/19. Review on 3/3/20 of Resident #79's paper and electronic medical records revealed no written notice of transfer or discharge given to the resident or resident representative. Review on 3/3/20 of Resident #79's paper and electronic medical records revealed no copy of a written notice of transfer or discharge sent to the Office of the State Long-Term Care Ombudsman information. Interview on 3/4/20 at 10:00 a.m. with Staff A confirmed the above findings for Resident #79.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, it was determined that the facility failed to ensure that a drug (medication) was labeled in accordance with current accepted professional principles for 1 resident out of a final sample size of 21 residents and ensure proper storage of expired drug and biologicals of 1 out of 2 medication rooms observed. (Resident identifier is #57.) Findings include: Interview on 3/2/20 at 11:30 a.m. with Staff B (Registered Nurse) revealed that expired medication was returned to the pharmacy and kept in the plastic pharmacy return bag that was hooked to the inside of the medication room door. Observation on 3/2/20 at 11:30 a.m. with Staff B of the 200-300 unit medication room revealed that there was one unopened bottle of Over the Counter (OTC) Aspirin (Non-Steroidal Anti-[MEDICAL CONDITION]) 325 mg (milligram) with an expiration date of 6/19 that was found with the unexpired OTC medications. Further observation

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.

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F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) with Staff B of the 200-300 unit medication room revealed that there were two opened and two unopened boxes of iodine swabs with expiration dates of 5/19, 7/19, and two 12/18, respectively, found with the unexpired medications and biologicals. Observation with Staff B of the 200-300 unit medication room refrigerator also revealed that Resident #57's [MEDICATION NAME] Concentrate (Anti-anxiety) 2 mg/ml (milliliter) bottle had no open date labeled on the bottle or the medication container. Further observation of the opened [MEDICATION NAME] Concentrate 2 mg/ml bottle revealed that medication had a label that stated medication was to be discarded 90 days after opening and that [MEDICATION NAME] Concentrate bottle had a dispensed dated of 10/19/19. Interview on 3/2/20 at 11:45 a.m. with Staff B confirmed the above observations. Staff B stated that the OTC Aspirin 325 mg and the boxes of iodine swabs should have been discarded as they were expired. Staff B also stated that the [MEDICATION NAME] Concentrate 2 mg/ml should have been dated when it was opened. Review on 3/2/20 of Resident #57's active pharmacy order revealed that Resident #57 has an active order for [MEDICATION NAME] Concentrate 2 mg/ml. Review on 3/2/20 of Resident #57's February 2020 Electronic Medication Administration Record [REDACTED]. Review on 3/2/20 of the facility's policy titled, Storage and Expiring Dating of Medication, Biologicals, Syringes and Needles, revision date 10/28/19, revealed that .Facility should ensure that medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer that recommended by manufacturer or supplier guidance . are stored separately from other medications until destroyed or returned to the pharmacy or supplier .Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration date for opened medications. Facility staff should record the date opened on the primary container (vial, bottle, inhaler) when the medication has shortened expiration date once opened or opened . Review on 3/2/20 of the facility's pharmacy medication storage guidance, dated November 2018, revealed that .[MEDICATION NAME] Concentrate Oral Solution ([MEDICATION NAME]) .If kept in the refrigerator, date when opened and discard 90 days after opening .