STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305081	A. BUILDING _____ B. WING _____	**08/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COLONIAL HILL CENTER	**62 ROCHESTER HILL ROAD ROCHESTER, NH 03867**

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 record review, interview, and policy review, it was determined that the facility failed to meet professional standards by following physician orders for 1 of 1 residents reviewed for enteral feeding (Resident #1) and for 2 of 2 residents reviewed for wound treatments out of a survey sample of 11 residents. (Resident identifiers are #1, #2 and #6). Findings include: 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 physician's 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 . Resident #1 Review on 8/12/20 of Resident #1's MAR (Medication Administration Record) revealed that Resident #1's order to receive tube feedings was discontinued on 8/6/20 at 2:38 p.m. and a new order for PRN (as needed) tube feedings was ordered on [DATE] at 12:37 a.m. Resident #1's physician orders were: Enteral Feed Order every shift [MEDICATION NAME] 10.5 CAL (calorie) Administer continuous via Pump 60 ml (milliliter) per hour. Start Date 7/27/20, D/C (discontinued) date 8/6/20 at 2:38 p.m. Enteral Feed Order as needed for Nutrition supplement and comfort Administer [MEDICATION NAME] 1.5 CAL 35 ml/HR (hour) PRN- per residents request. Stop administration if resident has s/sx (signs and symptoms) of nausea/vomiting. Start Date 8/11/20 at 12:37 a.m. Review on 8/12/20 of Resident #1's physician progress notes [REDACTED].History of Presenting Problem .Tube feed is running at only 35 cc (cubic centimeters)/hr. Nursing reports feed was off more last night than it was on . Plan .(pronoun omitted) is not meeting (pronoun omitted) nutrition requirements. The tube feed cause unnecessary suffering. He has abdominal discomfort, nausea and vomiting. At risk for repeat aspiration and aspiration PNA (pneumonia) with continued use of tube feeds. Interview on 8/12/20 with Staff A (Director of Nurses) confirmed that the physicians order was discontinued on 8/6/20 for the tube feeding and was not reinstated until 8/11/20. Interview on 8/12/20 with Staff C (Anonymous) confirmed that Resident #1 had received [MEDICATION NAME] during the days when there was no physician order (8/7/20 to 8/12/20) Review on 8/13/20 of the facility policy titled, NSG213 Enteral Management, revision date 11/1/19 revealed: .If unavoidable, enteral feedings will be provided through nasogastric, gastrostomy, or jejunostomy tube according to written physician/APP (Advanced Practice Providers) order. Resident #2 Review of Resident #2's Treatment Administration Record (TAR) for June 2020 revealed the following orders: Sacral wound- cleanse, apply collagen with antisept, cover with vitale dressing. Change daily every day shift for wound care, Start Date 5/22/20 and DC (discontinued) date 6/15/20. There was no documentation on the TAR on 6/2/20, 6/10/20, 6/12/20, 6/13/20, 6/14/20 or 6/15/20 that this treatment was administered. Sacral wound- cleanse, coat cutimed gauze with collagen powder and pack into wound, cover with silicone border dressing. Change daily every day shift for wound care, start date 6/16/20 and DC on 6/22/20. There was no documentation on the TAR on 6/17/20, 6/19/20 or 6/22/20 that this treatment was administered. Sacral wound- cleanse coat cutimed gauze with collagen powder and pack into wound, skin prep to skin around wound, cover with silicone border dressing, change daily every day for wound care, start date 6/23/20. There was no documentation on the TAR on 6/25/20, 6/27/20 or 6/29/20 that this treatment was administered. Review of Resident #2's TAR for July 2020 revealed the following order: Sacral wound- cleanse coat cutimed gauze with collagen powder and pack into wound, skin prep to skin around wound, cover with silicone border dressing, change daily every day for wound care, start date 6/23/20. There was no documentation on the TAR on 7/2/20, 7/6/20, 7/7/20, 7/8/20, 7/9/20, 7/10/20, 7/11/20, 7/12/20, 7/13/20, 7/15/20, 7/16/20, 7/20/20, 7/22/20, 7/23/20, 7/24/20, 7/25/20, 7/29/20 or 7/31/20 that this treatment was administered. Review of Resident #2's TAR for August 2020 revealed the following order: Sacral wound- cleanse coat cutimed gauze with collagen powder and pack into wound, skin prep to skin around wound, cover with silicone border dressing, change daily every day for wound care, start date 6/23/20. There was no documentation on the TAR on 8/5/20, 8/7/20, 8/8/20 or 8/9/20 that this treatment was administered. Review on 12/17/20 of the facility policy titled, NSG 241 Treatments, revision date 11/01/19 revealed the following: A licensed or medical technician, per state regulations, will perform ordered treatments. Accepted standards of practice will be followed .Practice Standards .4. Perform treatment .9. Document 9.1 Administration on Treatment Administration Record (TAR). Interview on 12/12/20 at approximately 1:15 p.m. with Staff A (Director of Nurses) confirmed that there was no documentation that the above treatments were performed. Resident # 6 Review of Resident #6's physician orders revealed the following order with a start date of 7/31/20: Cleanse skin tear sites RUE, RLE, LUE, LLE (right upper extremity, right lower extremity, left upper extremity, left lower extremity) with skin integrity, pat dry. Apply [MEDICATION NAME] gel. Cover with [MEDICATION NAME], abd (abdominal) pad and wrap with kling every day shift every two days(s) for skin tear. Further review also revealed the following order with a start date of 7/30/20: Cleanse skin tear sites RUE, RLE, LUE, LLE with skin integrity, pat dry. Apply [MEDICATION NAME] gel. Cover with [MEDICATION NAME], abd pad and wrap with kling as needed for wound healing. Review on 8/12/20 of Resident #6's progress notes dated 8/4/20 revealed the following: Dressings were saturated in blood and dated 7/29/20. Strong foul smelling order noted to LUE, skin lifting upon dressing removal. Old dressing soaked with saline for easier removal .Wound dressed as ordered. LLE noted to have strong smelling order .Serosanguineous drainage noted at all sites. Resident stated These hurt so bad, I have been asking for someone to change them. Interview on 12/12/20 at approximately 1:15 p.m. with Staff A confirmed the above findings.
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** Based on record review, interview, and policy review, it was determined that the facility failed to determine what may have contributed to the fall or properly assess the resident after a fall as necessary for 1 of 3 residents reviewed for falls out of a survey sample of 12 residents. (Resident identifier is Resident #4). Findings include: Review on 8/12/20 of Resident #4's progress notes dated 7/16/20 at 11:41 p.m., written by Staff B (Nurse) revealed the following: During shift report at 2300 (11:00 p.m.), this writer received report that resident had fallen approx (approximately) 1900 (7:00 p.m.). At 2300 upon assessment it was noted that resident had severe right hip pain, and this writer noted a large bruise on the right side of resident's forehead. Call placed to telehealth and order received from (physician name removed) to send resident to ed (emergency department) for eval and tx (evaluation and treatment). Review on 8/12/20 of Resident #4's progress notes dated 7/16/20 revealed no documentation of the description of the fall. Review on 8/12/20 of the Communication Form, dated 7/16/20 at 8:47 p.m. revealed the following: There was no change in the mental and functional status and the resident did not have pain. The primary care clinician was notified of the fall at 7:30 p.m. and the family was notified at 7:45 p.m The recommendations of the primary clinician was to perform neurological assessments. Review of Resident #4's assessments revealed there was no documentation of neurological assessments. Interview on 8/17/20 at approximately 6:30 a.m. with Staff B revealed that Staff B went to Resident #4 after report and Resident #4 said they were

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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) in a lot of pain in their right hip. Staff B assessed Resident #4 and found that Resident #4 could not move their hip. Staff B called the physician and Resident #4 was transferred to the hospital. Staff B said that Resident #4 was diagnosed at the hospital with a broken hip. Staff B did not see that any neurological assessments were done. Interview on 8/12/20 with Staff A (Director of Nursing) confirmed there was no documentation of the details of the fall or of neurological assessments in Resident #4's medical record.