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An investigation survey revealed 11 deficiencies at Sullivan County Health Care, one of which resulted in the injury of a resident.

The New Hampshire  **Unity** Department of Health and Human Services conducted the survey on April 10, and a plan of correction was presented to the Sullivan County Commissioners by administrator Scott Wojtkiewicz on Tuesday.

The most serious deficiency occurred on March 31 when a resident living in the MacConnell Unit — used for people with dementia-type diseases — was able to exit

the building around 5:30 p.m. because the magnetic doors did not latch securely.

A review of the nurse's notes reveals a passerby in a car alerted the nurse that the resident had fallen down a 15-foot embankment outside the nursing home. The fall resulted in a fractured wrist.

According to the survey, the facility "must ensure that the resident environment remains as free of accident hazards as is possible." The survey indicates the requirement was not met.

The report also states the resident was taken to the hospital immediately after the fall and was diagnosed with a sprained left wrist. An addendum dated April 2 indicated

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the wrist was broken and the resident should be re-examined.

During an interview of three staff members on April 10 by DHHS, the staff stated they had no knowledge of the addendum indicating a fracture. They also stated the resident "has not been seen by a physician nor had a re-examination of the left wrist since returning from the March 31 hospital evaluation."

To correct the deficiency, Wojtkiewicz wrote that the resident had been seen by a physician and the treatment plan was upgraded. An audit of incidents resulting in injuries going back 60 days was also conducted to determine if appropriate care was given. Additionally, the defective doors were repaired.

Wojtkiewicz filed a plan of correction for the 11 deficiencies with the DHHS Health Facilities Administration on April 27 outlining the corrective actions taken by the nursing home. Filing the plan does not consti-

tute an admission of the allegations as set forth in the statement of deficiencies, according to the DHHS. Wojtkiewicz told the commissioners the state has not returned to clear the deficiencies.

Another deficiency was noted to have occurred on March 31 when containers of Vitamin A&D Ointment and Elta Seal ointment were left at the bedside of a resident. The resident "had a spoon with the above mixture on it and placed the spoon with the mixture on the resident's own tongue."

The nurse's notes indicate the resident did not ingest the mixture and the poison control center was notified. Additionally, the resident was found not to have a physician order for the use of either of the ointments.

This incident resulted in a deficiency for failing to secure all drugs and biologicals in locked compartments and permitting only authorized personnel to have access.

Wojtkiewicz wrote that the deficiency was corrected by removing the ointments from the bedside of the resident and implementing changes including the education of nursing staff regarding the proper storage of biologicals.

Other areas with deficiencies noted by the DHHS report included comprehensive care plans, quality of care, accidents, medication errors, pharmacy services, space and equipment, resident call system and life safety code standards.

At the end of the presentation to the commissioners, Wojtkiewicz said that since the investigation, the nursing home had an additional medication error.

"There was a med error after this investigation," Wojtkiewicz said. "I did call this in to be safe and the resident was OK."

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