STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305045	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant View Center	239 Pleasant Street Concord, NH 03301

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure that residents were assessed to self-administer medication for 1 of 4 residents reviewed for choices in a final sample of 30 residents. (Resident identifier is #1.)Findings include:Observation on 6/2/26 at approximately 8:30 a.m. of Resident #1's bedside table revealed a Phenylephrine HCL (hydrochloride) 1% (percent) nasal spray, expiration date 10/25.Interview on 6/2/26 at approximately 9:00 a.m. with Staff A (Registered Nurse) confirmed the above findings.Interview on 6/2/26 at approximately 8:30 a.m. with Resident #1 revealed that he/she used the nasal spray every night since purchasing the nasal spray months ago and Resident #1 had left the nasal spray on his/her bedside table.Review on 6/4/26 Resident #1's medical record revealed Resident #1 did not have a physician's order for the above medication and that Resident #1 had not been assessed to self-administer medication. Interview on 6/4/26 at approximately 8:00 a.m. with Staff E (Director of Nursing) confirmed Resident #1 was not assessed to self-administer medication and that Resident #1 did not have a physician's order for the Phenylephrine HCL 1% nasal spray.Review on 6/4/26 of the facility policy titled, Resident Self-Administration of Medication, Revision Date: 12/25 revealed . A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely .4. The results of the interdisciplinary team assessment is recorded and placed in the resident's medical record .8. All nurses and aides are required to report to the charge nurse on duty any medication found at the bedside not authorized for bedside storage .

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

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to ensure that an alleged violation of abuse was reported timely to the State Survey Agency (SSA) for 1 of 5 resident reviewed for Abuse or Neglect. (Resident Identifier is #137.) Findings include:Interview on 6/2/26 at approximately 10:40 a.m. with Resident #137 revealed that he/she recalled an incident in the dining room when Resident #137 felt that a staff member was rude and condescending. Resident #137 further revealed that the incident occurred in front of other residents and family. Resident #137 stated that he/she did complain to staff. Observation on 6/2/26 at approximately 10:45 a.m. of Resident #137 revealed that while recounting the incident he/she became teary and emotional. Interview on 6/2/26 at approximately 11:43 a.m. with Resident #137's spouse revealed that he/she observed part of the incident. Resident #137's spouse further revealed that the staff member was standing over the resident and their voice was aggressive and escalating in tone. Interview on 6/4/26 at approximately 1:15 p.m. with Staff N (Licensed Practical Nurse) revealed that they reported the incident to Staff L immediately after it occured. Interview on 6/4/26 at approximately 1:28 p.m. with Staff L (Assistant Director of Nursing) revealed that they were made aware of the incident on 5/27/26 at approximately around 2:30 p.m. Staff L further revealed that he/she did not report the incident to the administrator. Review on 6/4/26 of the facility reported incident, initial report, submitted to the SSA revealed that it was submitted on 5/29/26.Interview on 6/4/26 at approximately 1:33 p.m. with Staff Q (Administrator) confirmed that the alleged violation was reported late to the SSA. Review of the facility's policy Abuse, Neglect and Exploitation, last reviewed 6/25, revealed, V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur . VII. Reporting/Response A. 1. Reporting of alleged violations to the administrator, state agency, adult protective services and to all other required agencies .a. Immediately, but not later than 2 hours after the allegation is made, if the events that caused the allegation involve abuse . B. The administrator will follow up with government agencies, during business hours, to confirm the initial report was received .

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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, interview, and record review, the facility failed to follow professional standard for medication administration via jejunostomy tube for 1 of 3 residents observed for medication administration. (Resident identifier is #14.)Findings include: Standard: [NAME], [NAME] A., and [NAME] [NAME]. Fundamentals of Nursing. 10th edition St. Louis, Missouri: Elsevier, 2021. Page 608 Because the nurse who administers the medication is responsible for any errors related to it, nurses administer only the medications they prepare. You cannot delegate preparation of medication to another person and then administer the medication to the patient. Page 614 .It is essential to verify the accuracy of every medication you give to your patients with the patient's order. If the medication order is incomplete, incorrect, or inappropriate, or if there is a discrepancy between the original order and the information on the MAR [Medication Administration Record]. consult with the health care provider. 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 . Page 618-619, .Administering Medications Through an Enteral Tube (Nasogastric Tube, G-tube [gastrostomy tube], J-tube [jejunostomy tube], or Small-Bore Feeding Tube .Steps .Before administration of enteral medications, verify placement of feeding tube according to agency policy and determine that tube is placed in the stomach or small intestine correctly .Check placement of feeding tube by observing gastric contents and checking pH of aspirate contents .Check for gastric residual volume . Observation on 6/3/26 at approximately 2:00 p.m. with Staff A (Registered Nurse) during Resident #14's medication administration revealed that Staff A prepared and crushed the following medications then placed it in individual medicine cups: Baclofen 20 milligram (mg), Oxycodone 5 mg, Tizanidine 2 mg, Ondansetron 4 mg, and Excedrin (250ˆmg acetaminophen, 250ˆmg aspirin, 65ˆmg caffeine). Staff A administered the medications via Resident #14's J-tube and did not verify the placement of the J-tube prior to administering the medications. Further observation revealed that after administering the medications to Resident #14, one of the medication cups had crushed white powder (medication) mixed with liquid (water) left in the cup. Observation also revealed that Staff A documented and saved the above mentioned medications as administered in the electronic Medication Administration Record (eMAR), except for Excedrin, using Staff O's (Medication Nursing Assistant (MNA)) eMAR login. Interview on 6/3/26 at approximately 2:00 p.m. with Staff A confirmed the above observation and that the medication cup that was thrown in the trash and had crushed white powder left was Resident #14's Tizanidine 2 mg medication. Staff A revealed that only the licensed nurses were to administer medications to Resident #14's J-tube and not MNAs. Review on 6/4/26 of Resident #14's June 2026 MAR revealed that on 6/1/26 the following medications were documented as administered via J-tube by Staff O: Ondansetron 4 mg, Excedrin, Baclofen 20 mg, and Tizanidine 2mg. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 6/4/26 at approximately 12:00 p.m. with Staff O revealed that he/she did not administer medications to Resident #14's J-tube and that it was the licensed nurses that were responsible in administering Resident #14's J-tube medication. Staff O confirmed that he/she documented the above mentioned medications as administered to Resident #14 on 6/1/26; however, he/she did not administer those medications on that date. Interview on 6/4/26 at approximately 12:00 p.m. with Staff P (Registered Nurse) revealed that he/she administered Resident #14's above mentioned medications on 6/1/26, which had been prepared by Staff O. Staff P also revealed that the medications were already crushed before he/she was called to administer the medications to Resident #14's J-tube. Review on 6/4/26 of Resident #14's enteral feeding tube care plan, revision date 1/5/26, revealed an intervention to check patency and placement of the J-tube daily before administering feedings and medications. Review on 6/4/26 of the facility policy titled, Medication Administration via Enteral Tube, revision date 12/2025, revealed, .Enteral tube placement must be verified prior to administering any fluid or medication .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure that a resident with pressure ulcers received necessary treatment and services to promote healing for 1 of 1 resident reviewed for pressure ulcers in a final sample of 30 residents. (Resident identifier is #38).Findings include:Review on 6/3/26 of Resident #38's Admission/Re-Admission/Quarterly Screening (an assessment form) with an effective date of 5/19/26 revealed under Section K Skin Integrity that the resident readmitted to the facility with the following pressure areas:1. Right heel pressure area 2.5 cm (centimeters) length by 3 cm width by 0.3 depth; 2. Left heel pressure area 0.5 cm length by 0.5 cm width by 0.2 cm depth;3. Sacrum pressure 1.5 cm length by 1.5 cm width by 0.2 cm depth.Further review revealed that the pressure ulcers were not staged and there was no other description of the wounds or the surrounding tissue. Review on 6/3/26 of Resident #38's provider note for date of service 5/21/26 and signed by the provider on 6/3/26 revealed the following under Wound Care, . wounds [sic] are to the right heel measuring 2 cm x [by] 1.5 cm x 0.2 cm with moderate sanguinous drainage and no sign of infection, no pain or discomfort. Treatment at this time is to clean with warm cleanser, pat dry and apply Anasept get and AG silver and cover with for me [sic] dressing. Area of the sacrum measuring 2 cm x 1.5 cm x 0.4 cm with moderate sanguinous drainage 2 cm x2 cm and 0.2 cm moderate sanguinous drainage with no sign of infection [sic]. Treatment will clean with wound cleanser, pat dry and apply Anasept gel and calcium Ag to wound bed cover with foam dressing . Area to the left heel is closed but fragile skin, no drainage, no sign of infection and no complaint of pain or discomfort. Treatment cleanse with wound cleanser, pat dry, Skin-Prep and cover with foam dressing . Further review revealed that the pressure ulcers were not staged. Review on 6/3/26 of Resident #38's Treatment Administration Record for May 2026 and June 2026 and current physician's orders revealed that there were no physician's orders for treatments for the above pressure areas. Review on 6/3/26 of Resident #38's Weekly Skin Review Assessment revealed the following:On 5/23/26 and 5/26/26 revealed that under Section 1.1 Skin Intact was coded no. Further review revealed that if no, a wound assessment must be completed. Further review revealed under Section 3.1 Skin Observations that no pressure areas were documented. On 6/3/26 the right and left foot had pressure areas, the coccyx had redness. Further review revealed that the pressure ulcers were not staged, measured or described. Review on 6/3/26 of a Late Entry progress note, dated 5/27/26 and entered on 6/3/26, revealed, Area to L [left] heel closed but fragile skin. no drainage, no s/sx [signs or symptoms] of infection, no c/o [complaints of] pain or discomfort. Treatment: cleanse with wound cleanser, pat dry, skin prep and cover with foam dressing. Area to right heel measure 2cm x2 cm x0.2 cm, moderate sero sang [serosanguinous] drainage. no s/sx of infection, no c/o pain or discomfort. Treatment: clean with wound cleander [sic], pat dry, apply anasept gel and AG silver and cover with foam dressing. Area to sacrum measuring at 2cm x1.5 cm x 0.4 cm. moderate sero sang drainage 2cm x2 cmx0.2 cm, moderate sero sang drainage. no s/sx of infection, no co/o pain or discomfort. Treatment cleanse with wound cleanser, pat dry, apply anasept gel and calcium ag to wound bed cover with foam dressing . Further review revealed the pressure ulcers were not staged. Observation on 6/3/26 at 10:20 a.m. of Resident #38's dressing revealed an undated dressing on the right heel and a dressing to the sacral area dated 6/2/26 3-11 shift. There was no dressing on the left heel. Observation on 6/03/2026 at 1:41 p.m. of Staff U (Wound Care Nurse) and Staff G (Registered Nurse) providing wound care to Resident #38 revealed the following:1. The right heel had an open area with dry black flaky skin surrounding it. Staff U measured the wound as 2.5 cm length by 2 cm width by 0.3 cm depth. The area was cleansed, anasept gel and silver alginate applied and covered with foam dressing. 2. The left inner heel had dark red area, not open. There were no measurements taken. The area was cleansed, skin-prep applied and covered with foam dressing. 3. The sacral area had an open area with a crusty brown covering part of the wound. Staff U measured the wound as 2 cm length by 1 cm width by 0.2 cm depth. The area was cleansed, anasept gel and silver alginate applied and covered (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with foam dressing. Interview on 6/4/26 with Staff U and Staff E (Director of Nursing) confirmed that the wounds had not been staged and that there were no physician orders to treat the wounds. Review on 6/4/26 of the facility's policy titled Documentation of Wound Treatment revised on 12/2025 revealed, .1. Wound assessments are documented upon admission, weekly, and as needed if the resident or wound condition deteriorates. 2. The following elements are documented as part of a complete wound assessment . b. Stage of the wound, if pressure injury (stage 1, 2, 3, 4, deep tissue pressure injury, unstageable pressure injury) . d. Description of wound characteristics: i Color of the wound bed ii Type of tissue in the wound bed (i.e., granulation, slough, eschar, epithelium) iii. Condition of the peri-wound skin (dry, intact, cracked, warm, inflamed, macerated) iv. Presence, amount and characteristic of wound drainage/exudate v. Presence or absence of odor vi Presence of absence of pain 3. Wound treatments are documented at the time of each treatment .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, and record review, the facility failed to ensure that ordered devices were used to maintain mobility for 1 of 1 residents reviewed for range of motion in a final sample of 30 residents. (Resident identifier is #145.) Findings Include: Review on 6/3/26 of Resident #145's medical record revealed an order to Apply right palmar protector after breakfast until dinner always removing for meals, with a start date of 5/21/26. Observation on 6/2/26 at approximately 1:30 p.m. of Resident #145 revealed Resident #145 was in a sitting Broda chair near the nurses' station with his/her right hand closed tightly and no palm protector in place. Observation on 6/3/26 at 11:51 a.m. of Resident #145 revealed Resident #145 was sitting in Broda chair with right hand closed tightly and no palm protector in place. Interview on 6/3/26 at 12:06 p.m. with Staff I (Occupational Therapist) revealed that Resident #145 worked with occupational therapy for decreased range of motion on right hand with a discharge date of 5/29/26. Staff I further revealed that multiple palm protectors had been provided for Resident #145. Interview on 6/3/26 at approximately 12:30 p.m. with Staff J (Licensed Nursing Assistant), revealed that Staff J provided care to Resident #145 that morning and that Resident #145 does have a palm protector for their right hand. Staff J confirmed he/she did not apply the palm protector to Resident #145 after breakfast. Review on 6/3/26 of Resident #145's occupational therapy discharge note, dated 5/29/26, revealed Pt [patient] tolerating palmar protector well in order to avoid further contractions and skin breakdown.Review on 6/3/26 of Therapy to Nursing Communication Form, dated 5/20/26, and labeled with Resident #145's name revealed Pt to wear built up palm protector during day remove during meals .

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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. Based on observation, interview and record review, the facility failed to ensure medications were labeled according to professional standards and that expired medications were not available for use for 2 of 2 medication rooms and 2 of 3 medication carts observed. Findings include: Observation on 6/2/26 at approximately 8:13 a.m. of the Second Floor North Medication Cart with Staff V (Licensed Practical Nurse (LPN)) revealed the following open and used medications with no open date or discard dates: Resident #11's Latanoprost Ophthalmic Solution 0.005% (percent), with a dispensed date of 5/14/26 and no open date or open expiration date. Resident #55's Ventolin 90 mcg (microgram) inhaler with a dispensed date of 1/7/25 and no open date or open expiration date. Resident #137's Olopatadine Hydrochloride Solution 0.2%, with a dispense date of 3/31/26 and no open date or open expiration date. Resident #137's Gentamicin Sulfate 0.3% Ophthalmic Solution with a dispensed date of 4/13/26 and no open date or open expiration date. Interview on 6/2/26 at approximately 8:36 a.m. with Staff V confirmed the above findings. Observation on 6/2/26 at approximately 8:41 a.m. with Staff P (RN) of the Second Floor Medication room revealed two open Tuberculin Purified Protein Derivative in the refrigerator with a dispensed date of 4/8/26 and no open date or open expiration date. Interview on 6/2/26 at approximately 8:45 a.m. with Staff P confirmed the above findings. Review on 6/2/26 of Resident #137's physician's orders revealed that Olopatadine Ophthalmic solution was discontinued on 4/27/26. Review on 6/2/26 of Resident #137's Medication Administration Record (MAR) revealed that Resident #137 stopped receiving the Gentamicin Ophthalmic solution on 4/20/26. Observation on 6/2/26 at approximately 8:10 a.m. of the fourth floor medication room with Staff B (Medication Nursing Assistant (MNA)) revealed an open vial of Tuberculin Purified Protein Derivative (PPD) with an open date of 4/8/26. Interview on 6/2/26 at approximately 8:15 a.m. with Staff B confirmed the above finding. Review on 6/2/26 of manufacturers' instructions for PPD revealed: Storage . Vials in use more than 30 days should be discarded . Interview on 6/3/26 at approximately 9:00 a.m. with Staff W (Regional Director of Staff Development and Infection Prevention) revealed that there were eight residents that received PPD's between (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/8/26 and 6/2/26. Review on 6/2/26 at approximately 8:45 a.m. of third floor south west cart with Staff T (MNA) revealed one bottle of Timolol Maleate 0.05% for Resident #54 revealed a manufacturer's expiration date of 4/2026. Further observation revealed a bottle of Latanoprost 0.005% eye drops with no open date and no open expiration date and a bottle of Dorzolamide Hydrochloride and Timolol Maleate 2%/0.5% for Resident #160 with no open date or open expiration date. Interview on 6/2/26 at approximately 8:50 a.m. with Staff T confirmed the above findings in the third floor south west medication cart. Review on 6/4/26 of the facility policy titled, Medication Storage, Revision Date 10/22 revealed: 8.whichever comes first. Unused Medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, . These medications are destroyed in accordance with out Destruction of Unused Drugs Policy. 9. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. Review on 6/2/26 of the Manufacturer's instructions for Gentamicin Ophthalmic Solution revealed, . Storage note: Once open, sterile eye drops lose effectiveness after about 4 weeks . Review on 6/4/26 of Manufacturer's instructions for Latanoprost Ophthalmic Solution 0.005% revealed, Once a bottle is opened for use, it may be stored at room temperature . for 6 weeks. Review on 6/4/26 of the Manufacturer's instructions for Ventolin 90 mcg revealed, The inhaler should be discarded when the counter reads 000 or 12 months after removal from the moisture protected foil pouch, which ever comes first.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on interview and record review, the facility failed to assist a resident to obtain dental care for 1 of 1 resident reviewed for dental in a final sample of 30 residents. (Resident identifier is #51.)Findings include: Interview on 6/2/26 at approximately 8:45 a.m. with Resident #51 revealed he/she has been complaining of dental pain. Resident #51 stated, My teeth are rotten and I have been asking to see the dentist for months. They hurt and no one is helping me see a dentist. Review on 6/3/26 of Resident #51's dental record revealed he/she was last seen by the dentist at the facility on 9/15/25 with a recall date of 9/1/26. Review on 6/3/26 of Resident #51's physician's progress note, dated 4/16/26, revealed, . [pronoun omitted] reports overall dental pain and would like to see the in house dentist. dental pain reported, . Dental care needs: Referral placed for in-house dental consult. Interview on 6/4/26 at approximately 10:45 a.m. with Staff E (Director of Nursing) revealed the facility dentist has been in the building on 5/11/26 and 6/1/26, and Resident #51 had not been seen by the dentist since 4/16/26. Review on 6/4/26 of Resident #51's current care plan revealed he/she did not have interventions for dental care. Interview on 6/4/26 at approximately 10:45 a.m. with Staff C (Staff Development Coordinator/Infection Preventionist) confirmed Resident #51 did not have a dental care plan.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, it was determined that the facility failed to implement infection control policies and procedures for 1 of 4 Residents reviewed for Enhanced Barrier Precautions (EBP). (Resident identifier is #35).Findings include:Observation on 6/2/26 of Resident #35's door to his/her room revealed signage for EBP.Review on 6/2/26 of Resident #35's physician orders revealed that he/she had an order dated 3/9/26, Maintain Enhanced Barrier Precautions for Indwelling Medical Device(s). Specify device: suprapubic catheter.Observation on 6/2/26 at approximately 10:54 a.m. revealed Staff H (Licensed Nursing Aide (LNA)) opened Resident #35's door from the inside and Staff H was wearing gloves and no gown.Interview on 6/2/26 at approximately 11:15 a.m. with Staff H revealed that Staff H was providing bathing, dressing, and personal care assistance for Resident #35 while not wearing a gown. Staff H further revealed that they would wear a gown when working directly with the resident's catheter. Observation on 6/2/26 at approximately 11:00 a.m. revealed Staff K (LNA) entering Resident #35's room without donning gloves and a gown.Interview on 6/2/26 at approximately 11:15 a.m. with Staff K revealed that Staff K was assisting with transferring Resident #35 wearing gloves and no gown.Review on 6/4/26 of the facility's policy Enhanced Barrier Precautions, reviewed 9/25, revealed . Implementation of Enhanced Barrier Precautions .b. PPE for enhanced barrier precautions is only necessary when performing high-contact activities . 4. High-contact resident activities include a. Dressing b. Bathing c. Transferring d. Providing hygiene e, Changing linens f. Changing briefs or assisting with toileting g. Device care or use: .urinary catheters .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 305045	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Pleasant View Center		STREET ADDRESS, CITY, STATE, ZIP CODE 239 Pleasant Street Concord, NH 03301	

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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. Based on interview and record review, the facility failed to ensure that the Minimum Data Set (MDS) assessment accurately reflected the residents' status for 3 of 5 residents reviewed for resident assessment and 1 of 1 resident reviewed for pressure ulcer in a final sample of 30 residents. (Resident Identifier are #23, #38, #109, and #129.)Findings include:Resident #23 Review on 6/2/26 of Resident #23's Entry Tracking Record with an entry date of 3/11/26 revealed that under item A0810 - Sex was coded Male. Review on 6/2/26 of Resident #23's admission Record revealed that Resident #23 was admitted to the facility in March 2026 and had the assigned sex of female. Interview on 6/4/26 at 1:02 p.m. with Staff M (MDS Coordinator) confirmed that Resident #23's sex was incorrectly coded. Resident #38 Review on 6/4/26 of Resident #38's 5-Day MDS with an Assessment Reference Date of 5/25/26 revealed under Section M - Skin Conditions item M0210 Unhealed Pressure Ulcers/Injuries was coded No. Further review revealed under items M0300 no pressure ulcers were coded. Review on 6/3/26 of Resident #38's Admission/Re-Admission/Quarterly Screening with an effective date of 5/19/26 revealed under Section K Skin Integrity identified right heel, left heel and sacral pressure ulcers. Interview on 6/03/2026 at 9:32 a.m. with Staff U (Wound Care Nurse) revealed that Resident #38 confirmed the above pressure ulcers for Resident #38. Interview on 6/4/26 at 1:02 p.m. with Staff M confirmed that Resident #38's above 5-Day MDS for the above sections was incorrectly coded. Resident #109 Review on 6/4/26 of Resident #109's Quarterly MDS, with an Assessment Reference Date 2/17/26, revealed that hospice services was coded No indicating that Resident #109 did not receive hospice services. Review on 6/4/26 of Resident #109's physician's order revealed an order to admit to hospice on 6/7/25. Interview on 6/4/26 at approximately 1:02 p.m. with Staff M confirmed that hospice services was coded No on the above mentioned Quarterly MDS. Interview on 6/4/26 at approximately 1:30 p.m. with Staff C (Staff Development Coordinator/Infection Preventionist) revealed Resident #109 was receiving hospice services on 2/17/26. Resident #129 Review on 6/3/26 of Resident #129's Quarterly MDS, with an Assessment Reference Date (ARD) of 5/11/26 revealed under section N0415 Medications: High-Risk Drug Classes: Use and Indication E. Anticoagulant was coded taking, indicating that Resident #129 had received an anticoagulant (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	medication during the last 7 days. Review on 6/2/26 of Resident #129's Medication Administration Record for May 2026 revealed that no anticoagulant medication was ordered or administered between 5/4/26 to 5/11/26. Review on 6/4/26 of the facility's policy MDS 3.0 Completion last revised 12/2025 revealed, Policy: Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan . 4. Care Plan Team Responsibility for Assessment Completion: b. Coding of Assessment: i. All disciplines shall follow the guidelines in Chapter 3 of the current RAI [Resident Assessment Instrument] Manual for coding each assessment .

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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 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that resident's medical records were accurate and complete for 3 of 4 residents reviewed for closed records and 2 residents in a final sample of 30 residents. (Resident Identifiers are #9, #18, #30, #146, and #164.)Findings include: Resident #9 Interview on 6/2/26 at approximately 10:00 a.m. with Resident #9 revealed that Resident #9 had a foley catheter and no concerns. Review on 6/2/26 of Resident #9's physician's orders revealed and order dated 4/10/26 that stated, Foley catheter__ FR with __ balloon to bedside straight drainage for diagnosis/Hx (History) of need____. Further review revealed that the order audit for the foley catheter was reviewed and confirmed by Staff X (Registered Nurse Supervisor), Staff L (Assistant Director of Nurses (ADON)) and Staff R (Doctor of Medicine). Interview on 6/3/26 at approximately 1:14 p.m. with Staff L revealed that Staff L had placed the foley catheter order on 4/10/26 and confirmed the order information was incomplete. Staff L further revealed that there was no other active order that contained the complete information. Review on 6/4/26 of the facility's policy Appropriate Use of Indwelling Catheters, Revised 12/25, revealed, .4. The use of an indwelling catheter will be in accordance with physician orders, which will include the diagnosis or clinical condition making the use of the catheter necessary, size of the catheter, and frequency of change (if applicable). Resident #18 Review on 6/3/26 of Resident #18's medical record revealed a physician's order dated 5/25/26, OK to Discharge home on 5/26/26 . Review on 6/3/26 of Resident #18's Discharge summary, dated [DATE], revealed that Resident #18's anticipated discharge was on 5/26/26. Review on 6/3/26 of Resident #18's progress note, dated 5/28/26 at 5:07 p.m., revealed that, Resident discharged home with family member in stable condition. Interview on 6/4/26 at approximately 6/4/26 with Staff L confirmed the above findings for Resident #18. Staff L revealed that there was no order from the provider for discharge on [DATE]. Review on 6/4/26 of the facility's policy titled, Transfer and Discharge (including Against Medical Advice (AMA)), reviewed on 6/25, revealed .12. Anticipated Discharge to the community a. Facility will obtain a physician's order for transfer or discharge and instructions or precautions for ongoing care . Resident #164 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Pleasant View Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 239 Pleasant Street Concord, NH 03301	

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Review on 6/3/26 of Resident #164's a progress noted. dated 3/6/26, revealed that Resident #164 was having terminal secretions. Further review revealed that the Resident 164's body was released to the funeral home on 3/6/26. There was no documentation of Resident #164 assessment of death and pronouncement. Interview on 6/3/26 at approximately 2:46 p.m. with Staff G (RN) revealed that Staff G pronounced Resident #164 on 3/6/26 and confirmed that he/she did not document it the medical record. Staff G further revealed that the pronouncement order and pronouncement documentation was not in Resident #164's medical record. Resident #146 Review on 6/3/26 of Resident #146's progress note, dated 3/30/26 at 4:49 a.m., revealed [First name omitted] passed at approximately 445am. Further review revealed no documentation of clinical signs of death. Interview on 1/8/25 at 12:30 p.m. with Staff W (Regional Director of Staff Development/Infection Prevention) confirmed the above findings. Resident #30 Interview on 6/2/26 at approximately 12:10 p.m. with Resident #30 revealed he/she could not recall the last time he/she has seen a podiatrist. Review on 6/3/26 of Resident #30's medical record revealed there was no documentation of a podiatrist visit. Interview on 6/3/26 at approximately 9:30 a.m. with Staff F (Social Worker) revealed Resident #30 was seen by an outside podiatrist on 2/9/26 and there was no documentation in Resident #30's medical record of the visit. Review on 6/4/26 of the facility policy titled, Documentation in Medical Record, Revision Date 12/25, revealed, .Policy: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through, complete, accurate, and timely documentation . Review on 6/4/26 of the facility policy titled, Maintenance of Electronic Clinical Records, Revision Date 6/25, revealed, . 1. A complete and accurate electronic clinical record will be maintained on each resident . Review on 6/4/26 of the facility's Post Mortem Care policy, reviewed 12/25 revealed, 1. Upon expiration of resident within the facility, the resident shall be pronounced by the physician or other designated entity as per state and local regulations 4. The family will be contacted and follow-up and/or confirmation of the disposition of the body will be determined 25. Document in the medical record: a. Date and time resident was pronounced and by whom. b. Notifications to the physician or designee, family, funeral home, or other designated disposition location, coroner, and/or authorities (if indicated). c. Post mortem care and disposition of belongings. d. Date and time body was transported to the funeral home or other designated location.