STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305052	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood Center, Genesis Healthcare	25 Ridgewood Road Bedford, NH 03110

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 26364 Based on interview and record review, it was determined that the facility failed to develop and implement a comphrensive care plan for 1 of 4 residents reviewed for mood and behavior in a final sample of 23 residents. (Resident identifier is #92.) Findings include: 47129 Resident #92 Review on 1/7/25 of Resident #92's medical diagnosis list revealed that Resident #92 with a diagnosis of Post Traumatic Stress Disorder (PTSD). Review on 1/7/25 of Resident #92's Admission Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 4/1/24, revealed that it was documented in Section I6100, Diagnosis, that Resident #92 had PTSD. Review on 1/7/25 of Resident #92's comprehensive care plan revealed that there were no focus, triggers, or interventions for Resident #92's PTSD. Interview on 1/8/25 at 9:00 a.m. with Staff I (Unit Manager) confirmed that there were no focus, triggers, or interventions for PTSD in Resident #92's comprehensive care plan.

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

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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** 45419 Based on record review and policy review it was determined that the facility failed to follow the professional standards of care for 3 residents in a final sample to 23 residents. (Resident identifier is #273, #101, and #73.) Findings include: 26364 Standard: [NAME], [NAME] A., and [NAME] [NAME]. Fundamentals of Nursing. 10th ed. St. Louis, Missouri: Mosby Elsevier, 2021. Chapter 31 Medication Administration Page 595, .Medications that are time critical most likely cause harm or have subtherapeutic effects if they are not administered in time (usually 30 minutes before and after the scheduled dose). Non-time-critical medications most likely do not cause harm if they are given within 1 hour to 2 hours before or after the schedule time. Thus, you need to administer time-critical medications at a precise time, within 30 minutes before and after a scheduled time. You administer non-time-critical medications within 1 to 2 hours of their scheduled times . Resident #73 Interview on 1/6/25 at approximately 10:45 a.m. with Resident #73 revealed that he/she is given his/her insulin late frequently. Resident #73 thought in December that his/her insulin given over three hours late. Review on 1/8/25 of Resident #73's Medication Administration Audit Report for December 2024 and January 2025 revealed the following insulin administrations were not given within 30 minutes before or after the scheduled time: Humalog insulin 100 units/ml 5 units was scheduled for 11:30 a.m. 12/22/24 given at 12:41 p.m. 12/26/24 given at 1:17 p.m. 12/29/24 given at 1:00 p.m. 12/31/24 given at 12:25 p.m. Humalog insulin 100 unit/mg sliding scale scheduled for 11:30 a.m. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/22/24 given at 12:41 p.m. 12/26/24 given at 1:17 p.m. 12/31/24 given at 12:25 p.m. Humalog insulin 100unit/ml 5 units scheduled for 7:30 a.m. 12/21/24 given at 8:54 a.m. 12/29/24 given at 9:21 a.m. 12/31/24 given at 9:55 a.m. 1/1/25 given at 9:21 a.m. 1/7/25 given at 10:19 a.m. Humalog insulin 100 unit/mg sliding scale scheduled for 7:30 a.m. 12/31/24 given at 9:55 a.m. Humalog insulin 100unit/ml 5 units scheduled for 4:30 p.m. 12/21/24 given at 7:54 p.m. Humalog insulin 100 unit/mg sliding scale scheduled for 4:30 p.m. 12/21/24 given at 7:54 p.m. Tresiba FlexaTouch 200 units/ml 82 units was scheduled for 8:00 a.m., 12/29/24 given at 10:08 a.m. 12/31/24 given at 9:55 a.m. 1/7/25 given at 10:19 a.m. Interview on 1/8/25 at approximately 11:00 a.m. with Staff D (Director of Nursing) confirmed the above findings. 38218 Resident #101 Interview on 1/6/25 at approximately 9:15 a.m. with Resident #101 revealed that he/she was concerned that sometimes his/her medications and insulin had not been administered timely. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review on 1/7/25 of Resident #101's December 2024 and January 2025's Medication Administration Audit Report revealed the following insulin administrationswere not given within 30 minutes and other medication were not given within 60 minutes before or after the scheduled time: Insulin Glargine 100 unit/ml (milliliters) scheduled for 6:00 p.m. 12/7/24 given at 8:05 p.m. 12/8/24 given at 8:06 p.m. 12/15/24 given at 8:53 p.m. 12/27/24 given at 9:29 p.m. 12/28/24 given at 9:40 p.m. 1/1/25 given at 11:18 pm 1/2/25 given at 8:14 p.m. 1/3/25 given at 10:23 p.m. 1/6/25 given at 8:10 p.m. Humalog insulin 100 unit/ml sliding scale scheduled for 7:00 p.m. 12/11/24 given at 8:22 p.m. 12/24/24 given at 11:25 p.m. 12/26/24 given at 8:19 p.m. Metoprolol Succinate Extended Release 50 mg (milligrams) daily scheduled for 9:00 a.m. 12/8/24 given at 12:11 p.m. 12/9/24 given at 1:35 p.m. 12/11/24 given at 12:51 p.m. 12/12/24 given at 3:06 p.m. 12/17/24 given at 2:41 p.m. 12/18/24 given at 3:43 p.m. 12/19/24 given at 11:59 a.m. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/23/24 given at 12/48 p.m. 12/24/24 given at 1:31 p.m. 12/27/24 given at 2:08 p.m. 12/29/24 given at 1:02 p.m. 12/30/24 given at 12:26 p.m. 1/1/25 given at 4:57 p.m. Gabapentin 100 mg, 3 times daily scheduled for 12:00 p.m. 12/12/24 given at 3:05 p.m. 12/15/24 given at 6:13 p.m. 12/18/24 given at 3:42 p.m. 12/21/24 given at 2:44 p.m. 1/1/25 given at 4:57 p.m. Humalog insulin 100 unit/ml sliding scale scheduled for 12:00 p.m. 12/18/24 given at 3:42 p.m. Gabapentin 100 mg, 3 times daily scheduled for 8:00 a.m. 12/19/24 given at 11:59 a.m. Humalog insulin 100 unit/ml sliding scale scheduled for 5:00 p.m. 12/27/24 given at 6:36 p.m. Gabapentin 100 mg, 3 times daily scheduled for 6:00 p.m. 12/28/24 given at 9:34 p.m. Interview on 1/8/25 at approximately 9:30 a.m with Staff D (Director of Nursing) confirmed the above findings. Standard Page 336- Physicians' Orders (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 #273 Observation on 1/6/25 at approximately 10:00 a.m. of Resident #273 revealed an undated dressing on his/her left knee. Interview on 1/6/25 at approximately 10:20 a.m. with Staff A (Registered Nurse) confirmed the above finding. Interview on 1/7/25 at approximately 8:30 a.m. with Staff A revealed that Resident #273 did have an order for a dressing change and there was no documentation of the dressing being done. Resident #101 Observation on 1/6/25 at approximately 9:15 a.m. of Resident #101's right leg revealed he/she had 3 undated dressings applied. (1 on right knee, 1 on right outer shin and 1 on right ankle). Interview on 1/6/25 at approximately 10:20 a.m. with Staff A confirmed the above findings. Review on 1/7/25 of Resident #101's January 2025's TAR's revealed the following order: Cleanse abrasions to right lower leg with VASHE. Leave gauze saturated with VASHE to wounds for approximately 1 minute Interview on 1/7/25 at approximately 8:30 a.m. with Staff A confirmed that the order is not clear as to how many abrasions Resident #101 had orders for a dressing to be applied to.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26364 Based on interview and record review, it was determined that the facility failed to ensure that a resident who attends dialysis had interventions to care and monitor their access site and that they received physician ordered medications for 1 of 1 resident reviewed for dialysis in a final sample of 23 residents. (Resident identifier is #1.) Findings include: Interview on 1/7/25 at 1:35 p.m. with Resident #1 revealed that he/she attends dialysis 3 times a week on Monday, Wednesday, and Friday and is away from the facility from approximately 11:30 a.m. until 5:00 p.m. Review on 1/7/25 of Resident #1's January's 2025 Medication Administration Record (MAR) revealed that the medication Calcium Acetate (a phosphate binder) were documented as AW (away from center; meaning not administered) on 1/2, 1/4, and 1/6/25. Further review of Resident #1 MAR revealed that he/she has an order for Midodrine HCL (hydrochloride) Oral Tablet 5 MG (milligram) Give 2 tablets by mouth three times a day for low blood pressure 10 mg and to hold if the SBP (Systolic blood pressure) more than 160 and to be given with his/her meals. On the following dates it was documented as AW on 1/2, 1/4, and 1/6/25. Further review of the MAR revealed no orders to hold medications on dialysis days. Review on 1/7/24 of Resident #1's medical record revealed that he/she was readmitted to the facility on [DATE] and he/she goes to dialysis 3 times a week. Interview on 1/7/25 at approximately 11:00 a.m. with Staff C (Unit Manager) confirmed there were no orders in place to hold medications while at dialysis. Review on 1/7/25 or Resident #1's care plan revealed the care plan did not identify what kind of dialysis access site that Resident #1 had and there were no interventions to care of monitor thier access site. Interview on 1/7/25 with Staff C confirmed the above finding.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51267 Based on observation and interview, it was determined that the facility failed to ensure that food trays were stored dry and in sanitary condition in the main kitchen. Findings include: Standard: Review on 1/7/25 of the U.S. FDA (Food Drug and Administration) Food Code (2017), retrieved from: https://www.fda.gov/media/110822/download, [page 151-153] revealed the following: 4-901.11 Equipment and Utensils, Air-Drying Required. After cleaning and SANITIZING, EQUIPMENT and UTENSILS: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in 151 antimicrobial formulations (food-contact surface SANITIZING solutions), before contact with FOOD; and (B) May not be cloth dried except that UTENSILS that have been air-dried may be polished with cloths that are maintained clean and dry. 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles. (A) Except as specified in (D) of this section, cleaned EQUIPMENT and UTENSILS, laundered LINENS, and SINGLE-SERVICE and SINGLEUSE ARTICLES shall be stored: (1) In a clean, dry location; (2) Where they are not exposed to splash, dust, or other contamination . (B) Clean EQUIPMENT and UTENSILS shall be stored as specified under (A) of this section and shall be stored: (1) In a self-draining position that allows air drying; and (2) Covered or inverted . Observation on 1/7/25 at approximately 7:15 a.m. of Staff J (Dietary Aide) and Staff K (Dietary Aide) on the breakfast serving line revealed Staff J picked up trays that were stored wet in a large stack and dried each tray off with a dish towel. Interview on 1/7/25 at approximately 7:20 a.m. with Staff L (Dietary Manager) confirming the above findings and revealed they had stored the trays wet the night before.

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 45419 Based on record review and interview, it was determined that the facility failed to maintain complete records for 1 of 1 record reviewed for death in a final sample of 23 (Resident identifier is #11.) Findings include: Review on 1/07/25 of Resident #11's nursing progress note ,dated 01/04/25 at 14:48, revealed .Resident time of death at 14:42 [2:42 p.m.], 2 RN [Registered Nurse] pronouncing death . No other information was present for this entry. Review on 1/07/25 at 3:15 p.m. of the facility's policy titled NSG104 Pronouncement of Patient Death, effective 5/01/23, revealed .Nurses will comply with all applicable laws and regulations regarding determination of death .1.5. A RN who has determined and pronounced death will document the clinical criteria for such determination and pronouncement in the patient's medical record. 1.5.1 Description of the discovery of the patient; 1.5.2 Any treatment of the patient undertaken; 1.5.3 Findings from assessment (presumptive and conclusive signs identified): 1.5.3.1 No carotid and peripheral pulse, 1.5.3.2 Pupils are fixed and nonreactive to light, 1.5.3.3 No response to tactile stimuli, 1.5.3.4 No respirations for one full minute, 1.5.3.5 No heart sounds for one full minute; 1.5.4 Date and time of death; 1.5.5 Individuals notified of the patient's status/death 1.5.6 Results of any communications . Interview on 1/8/25 at 12:30 p.m. with Staff D (Director of Nursing) confirmed the above findings and that the expectation is that the nurse would document in the medical record all clinical signs of death.