

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 305075	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/20/2025
NAME OF PROVIDER OR SUPPLIER Mountain Ridge Center, Genesis Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Baldwin Street Franklin, NH 03235	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on interview and record review, it was determined the facility failed to provide needed care for 2 of 3 residents reviewed for quality of care. (Resident identifiers are #5 and #17).</p> <p>Findings include:</p> <p>Resident #5</p> <p>Review on 6/19/25 of Resident #5's Bowel Movement Size Task Record revealed the following:</p> <p>Resident #5 had a bowel movement on 5/21/25 and 5/31/25. Resident #5 did not have a bowel movement on 5/22/25-5/30/25 (9 days). Resident #5's most recent bowel movement was on 6/12/25. Resident #5 did not have a bowel movement on 6/13/25-6/18/25 (6 days).</p> <p>Review on 6/19/25 of Resident #5's May and June 2025's MAR's (Medication Administration Records) revealed the following physician orders:</p> <p>May 2025</p> <p>Milk of Magnesia Suspension 400 mg/ml (milliliters) (Magnesium Hydroxide) Give 30 ml by mouth as needed for Constipation give at bedtime if no BM (Bowel Movement) in 3 days, start date 5/15/25. This was not documented as being offered to Resident #5 from 5/25/25-5/30/25.</p> <p>Dulcolax Suppository 10 mg (milligrams) (Bisacodyl) Insert 1 suppository rectally as needed for Constipation, if no result from MOM-Miralax by next shift, start date 4/10/25. This was not documented as being offered to Resident #5 from 5/26/25-5/30/25.</p> <p>June 2025</p> <p>Milk of Magnesia Suspension 400 mg/ml (milliliters) (Magnesium Hydroxide) Give 30 ml by mouth as needed for Constipation give at bedtime if no BM (Bowel Movement) in 3 days, start date 5/15/25. This was not documented as being offered to Resident #5 from 6/16/25-6/18/25.</p> <p>Dulcolax Suppository 10 mg (milligrams) (Bisacodyl) Insert 1 suppository rectally as needed for Constipation, if no result from MOM-Miralax by next shift, start date 4/10/25. This was not documented as being offered to Resident #5 from 6/17/25-6/18/25.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 6/19/25 at approximately 1:00 p.m. with Staff B (Director of Nursing) confirmed that on the dates listed above there were no documented interventions offered or given to Resident #5.</p> <p>Resident #17</p> <p>Interview on 6/19/25 at approximately 11:00 a.m. with Staff Z (Nurse Practitioner) revealed that residents are not going to appointments outside of the facility when he/she refers residents to specialists. Staff Z stated that this is usually because of lack of transportation, or the appointment not being made. Further interview with Staff Z revealed Resident #17 had missed several dermatology referrals/appointments.</p> <p>Review on 6/19/25 of Resident #17's medical record revealed the following physician's orders: Refer to Dermatology, order dated 10/22/24. Further medical record review revealed there was no documentation of Dermatology appointment being scheduled. Further review of physician orders an order for a MRI (Magnetic Resonance Imaging) head and neck, order dated 4/14/25. Review further revealed that there was no documentation of the MRI being scheduled or completed.</p> <p>Review on 6/19/25 of Resident #17's medical record revealed the following provider visit notes for wounds:</p> <p>On 11/22/24 . Patient evaluated for left neck wound. This started as a scratch then subsequently ulcerated and has not healed. Neoplasm of uncertain behavior of skin, Dermatology referral made. Continue wound care to site.</p> <p>On 11/29/24 . Patient evaluated for left neck wound. This started as a scratch then subsequently ulcerated and has not healed. [pronoun omitted] has been referred to Dermatology Outpatient for biopsy/evaluation/treatment. Neoplasm of uncertain behavior of skin, Continue wound care, see Dermatology.</p> <p>On 1/10/25 . [pronoun omitted] has been referred to Dermatology Outpatient for biopsy/evaluation/treatment Neoplasm of uncertain behavior of skin, [pronoun omitted] needs to see Dermatology. Continue wound care.</p> <p>On 1/24/25 . Patient evaluated for left neck wound. This started as a scratch then subsequently ulcerated and has not healed. Ongoing concern for underlying malignancy. An appointment was made with dermatology this week, unfortunately [pronoun omitted] missed [pronoun omitted] appointment. Neoplasm of uncertain behavior of skin, Continue wound care. Dermatology appointment to be rescheduled.</p> <p>On 1/31/25 . Patient evaluated for left neck wound. This started as a scratch then subsequently ulcerated and has not healed. Ongoing concern for underlying malignancy. An appointment was made with dermatology this week, unfortunately [pronoun omitted] missed [pronoun omitted] appointment, it has reportedly been rescheduled for March. Neoplasm of uncertain behavior of skin, Deterioration ongoing. Referral to Derm (Dermatology) appointment reportedly rescheduled.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/13/25 . Patient evaluated for left neck wound. This started as a scratch then subsequently ulcerated and has not healed. Ongoing concern for underlying malignancy. [pronoun omitted] has an appointment scheduled in March with dermatology. [pronoun omitted] developed redness, pain, odor, increased swelling and drainage at wound site. Culture obtained and this grew MRSA (Methicillin-resistant Staphylococcus aureus) and Morganella Morganii, . Neoplasm of uncertain behavior of skin, deterioration at site continues. Wound orders updated. Follow up with Dermatology.</p> <p>On 2/21/25 . Patient evaluated for left neck wound. This started as a scratch then subsequently ulcerated and has not healed. Ongoing concern for underlying malignancy. [pronoun omitted] has an appointment scheduled in March with Dermatology. [pronoun omitted] has developed redness, pain, odor, increased swelling and drainage at wound site. Culture obtained and this grew MRSA (Methicillin-resistant Staphylococcus aureus) and Morganella Morganii both sensitive to gentamicin. Infection cleared with gentamicin ointment. Neoplasm of uncertain behavior of skin, [pronoun omitted] needs to see Dermatology for treatment.</p> <p>On 2/28/25 . Patient evaluated for left neck wound. This started as a scratch then subsequently ulcerated and has not healed. Ongoing concern for underlying malignancy. [pronoun omitted] has an appointment scheduled in March with Dermatology. Neoplasm of uncertain behavior of skin, Continue wound care. Dermatology appointment upcoming.</p> <p>On 4/7/25 . Patient evaluated for left neck wound. This started as a scratch then subsequently ulcerated and has not healed. Ongoing concern for underlying malignancy. Several referrals to Dermatology have been requested. [pronoun omitted] had an appointment with Dermatology but this was missed. Thankfully an appointment was made for this week, spouse will transport. Pain has been stable at site, nursing has noted increased drainage and odor. Neoplasm of uncertain behavior of skin, Wound orders updated to include Dakins gauze packing and increased dressing change frequency. Follow up with Dermatology.</p> <p>On 5/9/25 . Patient evaluated for malignant left neck wound. Pathology confirmed squamous cell carcinoma. [pronoun omitted] has been referred to ENT (Ear, Nose, and Throat) Oncology. The wound has continued to deteriorate and there has been persistent signs of disease progression. Unspecified malignant neoplasm of skin of scalp and neck, Disease progression is evident. Wound orders updated. ENT Oncology referral made, appointment was 5/8 but had to be rescheduled due to no transport (transportation) .</p> <p>Review on 6/19/25 of Resident #17's Surgery Consultation Notes, dated 4/28/25 revealed: . presents to surgical consultation with large left neck wound .this wound is from squamous cell carcinoma and has been there are a least several years . No surgical debridement recommended at this time.</p> <p>Interview on 6/20/25 at approximately 9:20 a.m. with Staff B (Director of Nursing) confirmed that there was no documentation of Dermatology being contacted from the initial order dated 10/22/24, and no documentation of the MRI being scheduled or completed.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>Based on interview and record review, it was determined that the facility failed to maintain weight for 1 of 2 residents reviewed for nutrition in a complaint survey. (Resident identifiers are #16).</p> <p>Findings include: Resident #16</p> <p>Review on 6/20/25 of the facility provided matrix revealed that Resident #16 had significant weight loss.</p> <p>Review on 6/20/25 of Resident #16's Weight Summary revealed:</p> <p>5/1/25 Resident #16's weight was 154.6</p> <p>6/6/25 Resident #16's weight was 144.0 (9.4 pound loss)</p> <p>Review on 6/20/25 of Resident #16's Nutrition Assessments revealed that the last time he/she was seen by the dietician was 2/18/25.</p> <p>Review on 6/20/25 of Resident #16's Physician Regulatory Visit, dated 5/31/25 revealed no mention of recent weight loss, under Past Medical History mentioned weight loss</p> <p>Review on 6/20/25 of Resident #16's documented meal intake titled, Eating Task, Amount eaten (last 30 days) revealed:</p> <p>5/23 1 meal documented eaten</p> <p>5/25 2 meals documented eaten</p> <p>5/26 1 meal documented eaten</p> <p>5/28 1 meal documented eaten</p> <p>5/30 1 meal documented eaten</p> <p>5/31 2 meals documented eaten</p> <p>6/1 1 meal documented eaten</p> <p>6/2 1 meal documented eaten</p> <p>6/3 1 meal documented eaten</p> <p>6/4 1 meal documented eaten</p> <p>6/5 no meals documented eaten</p> <p>6/6 1 meal documented eaten</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>Based on record review and interview, it was determined that the facility failed to provide sufficient nursing staff to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in a census of 68 residents.</p> <p>Findings include:</p> <p>Review on 6/19/25 of Mountain Ridge Facility Assessment 2025 revealed staff/personnel required listed staff by shift for the entire facility and did not list staff/personnel required per resident unit.</p> <p>Review on 6/19/25 of personnel files revealed the following staff with light duty restrictions: Staff F (LNA with a 10 pound lifting restriction) and Staff R (LNA with a 10 pound lifting restriction).</p> <p>Interview on 6/19/25 at approximately 1:00 p.m. with Staff A (Administrator) revealed that the facility considered Licensed Nursing Assistant (LNA) that are on light duty as a full duty staff when scheduling.</p> <p>Review on 6/19/25 of 30 days of staffing schedules from 5/20/25 to 6/18/25 revealed the following days with Staff F and/or Staff R working on light duty:</p> <p>On 5/20/25, 5/21/25, 5/26/27, 5/27/25, 5/28/25, 5/29/25, 5/31/25, 6/2/25, 6/3/25, 6/4/25, 6/5/25, 6/9/25, 6/11/25, 6/12/25 6/14/25, and 6/18/25. There was one LNA on light duty on the 7:00 a.m. to 3:00 p.m. shift.</p> <p>On 6/15/25 and 6/17/25 7:00 a.m. to 3:00 p.m. there were two LNAs on light duty on the 7:00 a.m. to 3:00 p.m. shift.</p> <p>Interview on 6/19/25 at 7:55 a.m. with Staff I (Anonymous) revealed that the 200 unit works with one LNA at times. The LNAs cannot complete all the require tasks, such as showers, with light duty staff working as a full duty assignment.</p> <p>Interview on 6/19/25 at approximately 8:00 a.m. with Staff O (Anonymous) revealed that on a recent Sunday there were 72 residents and three LNAs working. Two of the LNAs were on light duty with restrictions. Staff O stated, The two other LNA's that were scheduled had restrictions and one LNA cannot physically or mentally take care of 72 residents. Further interview revealed that light duty staff have full assignments frequently and showers are not being given.</p> <p>Interview on 6/20/25 at approximately 11:00 a.m. with Staff A revealed that the facility has approximately 33 residents that are dependent on staff or a two person assist for care. Staff A revealed that on 5/28/25 Staff R (LNA on light duty) was scheduled to work alone on the 200 unit.</p> <p>Interview on 6/19/25 at approximately 7:10 a.m. with Staff L (Anonymous) stated that the staffing at the facility is unsafe. There has been an increase in falls, there are always LNAs that are on light duty scheduled with full assignments. Residents have to wait a long time to be cared for.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 6/19/25 at approximately 7:15 a.m. with Staff K (Anonymous) revealed that he/she felt that there was not enough LNAs to answer call lights and not enough LNAs to assist with resident transfers.</p> <p>Interview on 6/19/25 at approximately 7:20 a.m. with Staff N (Anonymous) revealed that having one LNA assigned to each wing is unsafe. Interview revealed there were 6-7 resident requiring hooyer lifts for transfers (requiring assistance of two LNAs) on the 200 Wing. Residents have to wait in bed until there is someone available to help with their transfers. Residents do not get showers when there are three LNAs scheduled.</p> <p>Interview on 6/19/25 at 7:20 a.m. with Staff D (Anonymous), revealed that the staffing for the whole building is usually two LNAs and one Light Duty aide during the evening and night hours. The building has many two person assist. The facility is also still taking new admissions.</p> <p>Interview on 6/19/25 at approximately 7:30 a.m. with Staff M (Anonymous) revealed that the dining room is frequently shut down due to inadequate staffing. If there are 3 LNAs scheduled, then showers are not getting done.</p> <p>Interview on 6/19/25 at 7:30 a.m. with Staff E (Anonymous) revealed that the 100 Unit has 9 residents that require a hooyer lift and how quickly a resident is transferred depends on the nurse if they can help or not. A good staffing day on the 100 unit is two LNA's and two nurses, but they usually have one LNA and one nurse.</p> <p>Interview on 6/19/25 at 7:40 a.m. with Staff H (Anonymous), revealed that the 100 Unit usually has one LNA and one nurse and that Staff H cannot help with lifting.</p> <p>Interview on 6/19/25 at 7:45 a.m. with Staff G (Anonymous) revealed that he/she needs to go to all three units to ask for help with hooyer lift transfers on the 200 unit. The floor is staffed with one LNA and one light duty.</p> <p>Interview on 6/19/25 at approximately 10:45 a.m. with Staff V (Anonymous) revealed that residents are not getting out of bed frequently due to staffing. Staff V revealed The dining room has been closed this past Saturday, Sunday, yesterday, and today due to inadequate staffing.</p> <p>Interview on 6/19/25 at approximately 11:00 a.m. with Staff Q (Anonymous) revealed that he/she has been at the facility for a few years. Staffing is the worst it has ever been. Residents are not getting to outside specialist appointments, either due to transportation not being scheduled or the appointments not being made. Staff that are here are stressed out.</p> <p>Interview on 6/20/25 at approximately 10:40 a.m. with Staff A (Administrator) revealed that a few weeks ago LNAs arrived at the building to work and refused to punch in due to lack of staff scheduled. The Director of Nursing and Administrator (not clinical) were notified and came in to the building. From approximately 7:00 a. m. until 9:00 a.m. the facility did not have any LNAs in the building.</p> <p>Interview on 6/20/25 at approximately 10:00 a.m. with Staff J (Anonymous) revealed that staffing is horrible and that residents frequently miss meaningful activities due to not being out of bed or dressed. When residents are put back to bed after lunch there is not enough staff to get them back up and they stay in bed for the rest of the day.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 6/19/25 at approximately 7:35 a.m. with Resident #4 had complaints of not enough staff at times and he/she has to wait for care and transfers because he/she requires two people to assist her because he/she uses a mechanical lift for transfers.</p> <p>Observation on 6/19/25 at approximately 7:35 a.m. of Resident #4 revealed he/she was laying in bed fully clothed with a hooyer lift pad placed underneath them.</p> <p>Observation on 6/19/25 at approximately 7:50 a.m. of a resident's room on the 100 Wing revealed three residents sitting in the room. All 3 residents were in Geriatric Chairs with their eyes closed with side tables placed in front of them and clothing protectors on.</p> <p>Interview on 6/19/25 at approximately 7:50 a.m. with Staff E (Anonymous) revealed the three residents in the room were Resident #6, Resident #7 and Resident #8. Staff E revealed that two of the residents (Resident #7 and Resident #8) reside in the room and Resident #6 was brought in the room by staff because the dining room was closed. They do this more often than not to assist the residents with breakfast when the dining room is closed. I put them all together so I can feed them.</p> <p>Review on 6/20/25 of Resident Council Minutes for May 2025 revealed:</p> <p>On 5/22/25, Departmental Requests, Concerns, Suggestions, Compliments, etc., Nursing:</p> <p>. Bells considered good during the day but bad later in day/night shift. Shower Issues. Told can't get showers since there is 1 person on the unit. Report going a long time without a shower Tired of hearing short staffed.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to ensure medications were labeled according to professional standards on 2 of 3 medication carts observed.</p> <p>Findings include:</p> <p>Observation on 6/19/25 at approximately 7:15 a.m. of the 200's Medication Cart with Staff T (Licensed Practical Nurse (LPN)) revealed the following:</p> <p>Resident #10's Incruse Ellipta inhaler, opened and not labeled with an open/expiration date</p> <p>Resident #11's Breztri inhaler, opened and not labeled with an open/expiration date</p> <p>Interview on 6/19/25 at approximately 7:15 a.m. with Staff T confirmed the above findings.</p> <p>Observation on 6/19/25 at approximately 7:30 a.m. of the 300's Medication Cart with Staff BB (LPN) revealed the following:</p> <p>Resident #5's Breztri inhaler, opened and not labeled with an open/expiration date</p> <p>Resident #12's 2 Breztri inhalers, opened and not labeled with an open/expiration date</p> <p>Resident #13's Spiriva inhaler, opened and not labeled with an open/expiration date</p> <p>Resident #14's Trelegy inhaler, opened and not labeled with an open/expiration date</p> <p>Resident #15's Incruse Ellipta inhaler, opened and not labeled with an open/expiration date</p> <p>Interview on 6/19/25 at approximately 7:30 a.m. with Staff BB confirmed the above findings.</p> <p>Review on 6/19/25 of the manufacturer's instructions for Incruse Ellipta, Revision Date December 2023 revealed: . Safely throw away Incruse Ellipta in the trash 6 weeks after you open the tray or when the counter reads 0 whichever comes first. Write the date you open the tray on the label on the inhaler.</p> <p>Review on 6/19/25 of the manufacturer's instructions for Breztri Aerosphere inhaler, Revision Date January 2022 revealed: . Throw away your inhaler in household trash when: puff indicator shows 0 or 3 months after your inhaler has been removed from the foil pouch.</p> <p>Review on 6/19/25 of the manufacturer's instructions for Spiriva Respimat inhaler, Revision Date November 2021 revealed: . Three months after insertion of cartridge, throw away the Spiriva Respimat even if it has not been used, or when the inhaler is locked, or when it expires, whichever comes first.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review on 6/19/25 of the manufacturer's instructions for Trelegy Ellipta inhaler, Revision Date 12/2022 revealed:</p> <p>. Write the tray opened and Discard dates on the inhaler label. The Discard date is 6 weeks from the date you open the tray.</p> <p>Review on 6/19/25 of the facility policy titled, 4.1 Storage of Medication, Dated 1/25 revealed:</p> <p>Policy, Medications and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations, to keep the integrity and to support safe, effective drug administration.</p>

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NAME OF PROVIDER OR SUPPLIER Mountain Ridge Center, Genesis Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Baldwin Street Franklin, NH 03235	

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)
<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>Based on interview and record review, it was determined the facility failed to provide timely laboratory services to meet the needs of its residents for 1 of 1 resident reviewed for laboratory services. (Resident identifier is #2.)</p> <p>Findings include:</p> <p>Interview on 6/19/25 at 7:55 a.m. with Staff CC (Licensed Practical Nurse) revealed that Resident #2 had a physician's order to obtain a UA (urinalysis) that had not been completed timely.</p> <p>Review on 6/19/25 of Resident #2's physician's orders revealed an order written on 5/6/25, UA with culture and sensitivity one time only for delusions</p> <p>Review on 6/19/25 of Resident #2's May 2025's Treatment Administration Record revealed that the urine had been obtained on 5/7/25.</p> <p>Review on 6/19/25 of Resident#2's medical record revealed that there were no laboratory results for UA on 5/7/25.</p> <p>Review on 6/19/25 of Resident #2's medical record revealed a nursing note, dated 5/13/25 revealed: a urine specimen was collected on 5/13/25 and brought to local laboratory.</p> <p>Interview on 6/19/25 at 11:20 a.m. with Staff Z (Nurse Practitioner) revealed that the urine specimen from 5/7/25 was forgotten in the refrigerator not tested. The specimen needed to be recollected on 5/13/25. Staff Z revealed that specimen obtained are forgotten in the refrigerator all the time and it causes a delay in treatment.</p>

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NAME OF PROVIDER OR SUPPLIER Mountain Ridge Center, Genesis Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 7 Baldwin Street Franklin, NH 03235	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0838</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.</p> <p>Based on interview and record review, it was determined that the facility failed to ensure that the facility assessment included specific staffing needs for each resident unit for a census of 68 residents.</p> <p>Findings include:</p> <p>Review on 6/19/25 of Mountain Ridge Facility Assessment 2025 revealed .3. Staff/Personnel required . Combination of RN/LPN: 24 hours Day Shift, 24 Hours evening Shift, 16 Hours night shift (Hours listed for full census) LNA Staff: 52.5 hours Day Shift, 52.5 hours Evening Shift, 22.5 Evening Shift Hours listed for full census) May fluctuate based on census and acuity Further review revealed that the facility assessment did not identify staffing needs per resident unit.</p> <p>Interview with Staff A (Administrator) on 6/20/25 at approximately 11:00 a.m. confirmed the Facility Assessment did not consider the needs of each resident unit.</p>		