

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 04/17/2025
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 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>48515</p> <p>Based on interview and record review, it was determined that the facility failed to facilitate the inclusion of the resident and/or representative in quarterly care plan meetings for 2 residents in a final sample of 18 residents. (Resident identifiers are #4 and #54).</p> <p>Findings include:</p> <p>Resident #4</p> <p>Interview on 4/14/25 at approximately 11:00 a.m. with Resident #4's Durable Power of Attorney (DPOA) revealed that he/she had not been notified or invited and had not attended a care plan meeting in about two years.</p> <p>Review on 4/14/25 of Resident #4's medical record revealed that Resident #4 was admitted to the facility in 2023 and there were no care plan meeting notes after 2023.</p> <p>Interview on 4/14/25 at approximately 1:00 p.m. with Staff A (Director of Social Services) revealed that Resident #4 was on the calendar for care plan meetings on 12/3/24 and 5/28/24 but Staff A had no documentation or recollection of the meetings or of Resident #4's DPOA being invited to the meeting.</p> <p>47129</p> <p>Resident #54</p> <p>Interview on 4/15/25 at 9:10 a.m. with Resident #54's DPOA revealed that Resident #54 was admitted to the facility in January 2024 and had been to one care plan meeting in October 2024. The DPOA would like to be in attendance to know about the goals being set for Resident #54.</p> <p>Review on 4/15/25 of Resident #54's medical record revealed that Resident #54's DPOA was activated. Further review revealed a care plan meeting note, dated 10/21/24, which Resident #54's DPOA was in attendance. Further review revealed that there was no documentation of a care plan meeting for Resident #54 prior to or after 10/21/24.</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 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 4/15/25 at 1:54 p.m. with Staff A confirmed that there was not a care plan meeting for Resident #54 to prior to or after 10/21/24.</p> <p>Review on 4/14/25 of facility policy titled Person-Centered Care Plan, dated 10/24/22, revealed .9. The Center has the responsibility to assist patients to participate by: 9.1 Extending invitations to patient and HCDM (Health Care Decision Maker) sent in advance; 9.3 Facilitating the inclusion of the patient/resident representative(s) to attend .10. Care plan meetings will be documented by the use of the Care Plan Meeting note .</p>		

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<p>F 0582</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>51267</p> <p>Based on interview and record review, it was determined that the facility failed to provide the resident and/or resident representative a timely Notice of Medicare Non-Coverage (NOMNC) for 1 out of 3 residents, and failed to provide the resident and/or representative the Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) for 2 out of 3 residents reviewed for beneficiary notices. (Resident identifiers are #53 and #48).</p> <p>Finding include:</p> <p>Resident #48</p> <p>Review on 4/15/25 of Beneficiary Notice - Residents discharged Within the Last Six Months form, completed by the facility, revealed that Resident #48's last covered day of Medicare Part A Services was on 4/8/25 with benefit days remaining. Resident #48 remained in the facility.</p> <p>Review on 4/15/25 of Resident #48's NOMNC revealed a last covered day of 4/8/25. Resident #48 was notified on 4/7/25.</p> <p>Interview on 4/15/25 at approximately 1:30 p.m. with Staff H (Business Office Manager) confirmed that Resident #48's NOMNC was not given 48 hours notice. Further interview with Staff H revealed that the SNF ABN was not provided to Resident #48.</p> <p>Resident #53</p> <p>Review on 4/15/25 of Beneficiary Notice - Residents discharged Within the Last Six Months form, completed by the facility, revealed that Resident #53's last covered day of Medicare Part A Services was on 12/22/24 with benefit days remaining. Resident #53 remained in the facility.</p> <p>Interview on 4/15/25 at approximately 1:30 p.m. with Staff H confirmed that the SNF ABN was not provided to Resident #53.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47129</p> <p>Based on interview and record review, it was determined that the facility failed to follow professional standards for physician ordered medication parameters for 1 of 8 residents reviewed for unnecessary medications in a final sample of 18 residents (Resident Identifier is #38).</p> <p>Findings include:</p> <p>Standards:</p> <p>[NAME], [NAME] A., and [NAME] [NAME]. Fundamentals of Nursing. 10th edition St. Louis, Missouri: Elsevier, 2021. Page 614 .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 .</p> <p>Review on 4/16/25 of Resident #38's medical record revealed the following a physician's orders: Morphine Sulfate Oral Tablet 30 MG (Milligram) (Morphine Sulfate), give 30 mg by mouth every 4 hours as needed for pain (PRN) 7/10 (a pain level of 7 out of 10) or greater, start date 2/17/25 and discontinued 3/20/25.; and Morphine Sulfate Oral Tablet 30 MG (Morphine Sulfate), give 1 tablet by mouth every 4 hours as needed for pain 5/10 (a pain level of 5 out of 10) or greater, start date 3/20/25 and discontinued 4/14/25.</p> <p>Review on 4/16/25 of Resident #38's Medication Administration Record (MAR) for March and April 2025 revealed that Resident #1's as needed (PRN) Morphine Sulfate 30 MG tablet was administered on 3/1 at 6:08 a.m. and 2:39 p.m., 3/4 at 10:59 p.m., 3/5 at 9:42 p.m., 3/12 at 10:12 p.m., 3/14 at 9:41 p.m., 3/16 at 4:28 a.m., 3/18 at 4:18 p.m., 3/19 at 1:55 a.m., 3/25 at 8:32 a.m., 3/30 at 4:05 a.m., 4/2 at 12:50 a.m., 4/3 at 6:33 p.m., 4/8 at 1:46 p.m., 4/12 at 9:24 a.m. with 0 pain level documented.</p> <p>Interview on 4/16/25 at 1:27 p.m. with Staff E (Unit Manager) confirmed that Resident #38 received the above medication and there was 0 pain (no pain) level documented.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>51267</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to provide sufficient nursing staff for 24 out of 30 days of nursing staff schedules reviewed reviewed between 3/15/25 and 4/15/25. (Resident identifiers are #34, #36, #52, #54, #55, and #278).</p> <p>Findings include:</p> <p>Interview on 4/14/25 at approximately 10:47 a.m. with Resident #278 revealed that he/she waits for staff to get him/her up and dressed. Resident #278 stated that he/she is at the facility for short-term rehabilitation following a back fracture and he/she requires assistance for care. Resident #278 stated that he/she has had an incontinent episode while waiting for his/her call bell to be answered to go to the bathroom.</p> <p>Interview on 4/17/25 with Staff I (Scheduling Coordinator) revealed that the schedule has been consistently short staffed since they started three weeks ago.</p> <p>40522</p> <p>Interview on 4/11/25 with Staff N (Anonymous direct care staff) revealed that the facility does not have enough Licensed Nursing Assistant (LNA) staff to care for the residents on a routine basis. Staff N stated that the facility has ongoing short staffing of LNAs on evening shift.</p> <p>Interview on 4/14/25 at approximately 3:30 p.m. with Staff J (LNA) and Staff K (LNA) revealed they are short staff for at least 3 times a week and that on 7:00 p.m. to 11:00 p.m. shift, there would be one LNA instead of two LNA's working on the 200 unit. Staff J stated that resident's call lights would be answered when they can and at times residents would have to wait for a period of time.</p> <p>Interview on 4/16/25 at approximately 9:08 a.m. with Staff E (Registered Nurse) and L (Registered Nurse) revealed that they are short staff and often works as LNA's or as a direct care nurse on a medication cart to cover shifts which is not their primary role. Staff E and Staff L stated that they cannot do their managerial duties as they are covering shifts as LNA's and direct care nurses.</p> <p>Interview on 4/17/25 at approximately 8:30 a.m. with Staff M (Infection Preventionist) revealed that he/she would cover shift as an LNA on top of his/her primary role as an Infection Preventionist and he/she often missed meetings with the nurse practitioner to discuss resident's on antibiotics and antibiotic stewardship.</p> <p>Review on 4/17/25 of the facility's matrix revealed that there were 14 residents admitted to the facility for the past 30 days.</p> <p>47129</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 - Few</p>	<p>Interview on 4/14/25 at 11:18 a.m. with Resident #52 revealed that he/she has been waiting approximately over an hour for staff to assist him/her back to bed. Resident #52 stated that he/she had asked Staff F (LNA) to assist her back to bed and was told by Staff F that he/she was the only LNA on the 100 unit this morning so he/she would have to wait.</p> <p>Interview on 4/14/25 with Staff F confirmed that Resident #52 had to wait because he/she was assisting another resident. Staff F stated that he/she was the only LNA assigned to the unit due to a staff call out and there was not another LNA assigned to the unit. Staff F also stated that there should be 2 LNA's assigned to 100 unit.</p> <p>Interview on 4/15/25 at approximately 9:00 a.m. with Resident #54's Durable Power of Attorney (DPOA) revealed that Resident #54 had told him/her that Resident #54 would wait up to an hour for care. Resident #54's DPOA stated that Resident #54 liked to stay in bed but he/she can't get up herself so if he/she needed something he/she had to press the call bell. Resident #54's DPOA stated that he/she had spoken to staff and was told a lot of times they only have one LNA on duty so there were long wait times for care.</p> <p>Review on 4/15/25 of the Resident Council Meeting Minutes dated 2/27/25 revealed that there were concerns with very long call bell wait times for getting up.</p> <p>Interview on 4/15/25 at 10:23 a.m. with the Resident Council revealed that all 7 residents in attendance had concerns with call bells being answered timely. 6 out of 7 residents who reside on the 100 and 200 unit stated that it worse on the 3-11 shift. They stated that on most weekends, either a Saturday and/or a Sunday or sometimes both and 2- 3 days during the week, there was one LNA responsible for 28-30 residents on the 100 or 200 halls. One resident stated that it was a rare day when there are more than two LNA's working during the same shift.</p> <p>Interview and observation on 4/15/25 at 10:25 a.m. with Resident #55 (Resident Council President) revealed that staffing was a real problem in the facility. Resident #55 stated that he/she was 20 minutes late to the meeting because there was not enough staff to assist him/her to get out of bed and dressed.</p> <p>Interview on 4/16/25 at 12:01 p.m. with Staff C (LNA) confirmed that Resident #55 was late to the Resident Council Meeting on 4/15/25 because they were short on help.</p> <p>48515</p> <p>Resident #55</p> <p>Interview on 4/14/25 at 10:18 a.m. with Resident #55 revealed that he/she was not able to go to the music activity that started at 10:00 a.m. today because there was not enough staff to get Resident #55 out of bed on time. Resident #55 further revealed that this occurs frequently because there is only one LNA (Licensed Nursing Assistant) for 30 residents in the 200's unit.</p> <p>Interview on 4/14/25 at approximately 1:00 p.m. with Staff C (Licensed Nursing Assistant) revealed that he/she was the only LNA on the 200 unit that morning.</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 - Few</p>	<p>Interview on 4/15/25 at approximately 10:00 a.m. with Staff D (Director of Nurses) revealed that there are 8 residents that require mechanical lifts for transfer, 11 residents that require extensive care, and 3 residents that require 2 assist with care on the 200 unit.</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>48515</p> <p>Based on observation and interview, it was determined that the facility failed to ensure that expired medications were removed from stock and multi-dose vials were dated when opened in 1 of 1 medication room observed.</p> <p>Findings include:</p> <p>Observation on 4/14/25 at approximately 8:15 a.m. of Medication Room with Staff B (Registered Nurse) revealed the following expired and opened/undated medications and biological: One opened bottle of Tuberculin Purified Protein Derivative (Mantoux) solution with no open date or open expiration date in the vaccine reffridgerator;</p> <p>One bottle of opened Afluria, Influenza Vaccine 2024-2025 Formula with no open date or open expiration date in the vaccine reffridgerator; Three bags of IV (Intravenous) Vancomycin (antibiotics) 850 mg (milligrams)/267 ml (milliliters) NS (Normal Saline) for Resident #48 with an expiration date of 3/10/25 in the medication room refrigerator; Three bags of IV Zosyn (antibiotic) Intravenous Solution 3-0.375 GM (Grams)/50 ml for Resident #46 with an expiration date of 3/26/25 in the medication room refrigerator.</p> <p>Interview on 4/14/25 at approximately 8:15 a.m. with Staff B confirmed that the above findings had no open date and open expiration date, the Tuberculin and Afluria vaccine vials had been used, and that the IV antibiotics were expired.</p> <p>Review on 4/14/2025 of the manufacturers instructions for Afluria, Influenza Vaccine revealed: 16.2 Storage and handling -Once the stopper of the multi-dose vial has been pierced the vial must be discarded within 28 days.</p> <p>Review on 4/14/25 of the manufacturers instructions for Tuberculin Purified Protein Derivative revealed: A vial of Tubersol which has been entered and in use for 30 days should be discarded.</p> <p>Review on 4/14/25 of facility policy titled Medication Storage, dated 1/25 revealed .14. Outdated, contaminated, discontinued or deteriorated medications .are immediately removed from stock, disposed of according to procedures for medication disposal .</p>		