STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305075	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Ridge Center, Genesis Healthcare	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.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure residents were free from potential exposure to bloodborne pathogens when staff used a resident's insulin pen on two residents (Resident identifiers are #62 and #70). The facility also failed to implement infection control policies for hand hygiene and disinfection of equipment for 2 of 7 residents observed during medication administration (Resident identifiers are #41 and #48). Findings include: Resident #62 and Resident #70 Interview on 5/28/26 at approximately 8:30 a.m. with Resident #62 revealed he/she received someone else's insulin yesterday afternoon. Interview on 5/28/26 at approximately 9:30 a.m. with Staff B (Licensed Practical Nurse (LPN)) revealed that on 5/27/26, he/she used Resident #70's used Novolog (insulin) pen to administer a lunch meal dose of insulin to Resident #62 then put back Resident #70's insulin pen in the medication cart. At approximately 4:00 p.m., Staff B was notified by Staff E (Director of Nursing) that he/she administered insulin to the wrong resident. Resident #70's insulin pen was not removed from the cart or discarded. Staff B stated that he/she administered Resident #70's dinner meal dose of insulin at 4:30 p.m. with the insulin pen that was earlier administered to Resident #62. Staff B then put the insulin pen back in the medication cart. Review on 5/28/26 of Resident #70's May's 2026 Electronic Medication Administration Record (EMAR) revealed an active physician's order for Novolog Penfill Solution Cartridge 100 Unit and was administered on 5/27/26 at 5:09 p.m. Interview on 5/28/26 at approximately 1:00 p.m. with Staff E confirmed that when the medication error was discovered, Resident #70's insulin pen was not removed from use. Review on 5/29/26 of the Novolog manufacturer's instruction revealed: .Warnings and precautions . Never share a Novolog Flex Pen, Novolog Flex Touch, Penfill Cartridge or PenFill Cartridge Device between patients, even if the needle is changed. Patients using Novolog vials must never share needles or syringes with another person. Sharing poses a risk for transmissions of blood-borne pathogens Review on 5/29/26 of the Centers for Disease Control and Prevention (CDC) handout, retrieved from https://www.cdc.gov/injection-safety//1anonly.html, revealed, .Insulin Pens: Recommendation for Safe Use. Protecting your patients from infection is a basic standard of care. Reusing insulin pens and other injection equipment for more than one person can spread infection to your patient. Insulin pens and other injection equipment are mean to be used on one person only. Insulin pens should never be used for more than one person, even when the need is changed. (continued on next page)

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

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review on 6/1/26 of the facility's policy, Insulin Pens, revised 5/1/25, revealed .Insulin pens containing multiple doses of insulin are meant for single patients use only and must never be used for more than one person, even when the needle is changed . Resident #48 Observation on 5/26/26 between 8:00 a.m. and 8:30 a.m. with Staff F (LPN) during medication administration revealed that after administering medication to Resident #66, they did not perform hand hygiene before dispensing and administering medication to Resident #48. Interview on 5/26/26 at approximately 8:30 a.m. with Staff F confirmed they did not perform hand hygiene between Resident #66's and Resident #48's medication administration. Review on 5/26/26 of the facility policy titled Hand Hygiene revised 5/1/25, revealed, .1. Perform hand hygiene: 1.1 Before patient/resident (hereinafter patient) care; 1.2 Before an aseptic procedure; 1.3 After any contact with blood or other body fluids, even if gloves are worn; 1.4 After patient care; 1.5 After contact with the patient's environment. Resident #41 Observation on 5/26/26 between 11:40 a.m. and 11:50 a.m. of Staff A (LPN) during medication administration, revealed that after testing Resident #55's blood glucose with the EvenCare G2 meter, they did not clean and disinfect the glucometer before using it to test Resident #41's blood glucose. Interview on 5/26/26 at approximately 11:50 a.m. with Staff A confirmed the above observation. Review on 5/26/26 of the Center for Disease Control and Prevention website Considerations for Blood Glucose Monitoring and Insulin Administration retrieved at: https://www.cdc.gov/injection-safety/hcp/infection-control/index.html revealed, If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per the manufacturer's instructions, to prevent the spread of blood and infectious agents. If the manufacturer does not specify how the device should be cleaned and disinfected, it should not be shared. Review on 5/26/26 of the EvenCareG2 Meter manufacturer instructions revealed, .Cleaning and disinfecting your meter and lancing device is very important in the prevention of infectious disease.The following products are validated for disinfecting the EvenCare G2 meter and lancing device: Dispatch hospital cleaner disinfecting towels with bleach.Clorox Healthcare Bleach Germicidal and Disinfectant Wipes.Medline Micro-Kill Clean Bleach Germicidal Bleach Wipes. Review on 5/26/26 of the facility procedure titled Fingerstick glucose measurement revised on 7/15/25, revealed, .23. Clean and disinfect the blood glucose meter after use with EPA [Environmental Protection Agency}] approved disinfectant, following manufacturer's instructions.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and medical record review, the facility failed to act promptly upon the grievances and recommendations of issues of resident care raised at Resident Council Meeting for 2 of 2 months of resident council minutes reviewed. Findings include:Interview on 5/27/26 at approximately 10:00 a.m. during Resident Council Meeting revealed that the group had complained about long call bell wait times over the last 2 months. Residents at this meeting stated they do not feel this concern was addressed and that no one had followed up to inform them of what if any actions had been taken since the initiation of the concerns.Review on 5/27/26 of the facility's Resident Council Meeting minutes revealed the following documented concerns under Nursing:March 19, 2026, minutes: Residents are concerned that call lights aren't consistently responded to timely.April 16, 2026, minutes: Residents are concerned that call lights aren't consistently responded to timely. Previous months grievances reviewed for resolution was marked No.May 21, 2026, minutes: Previous months grievances reviewed for resolution was marked No.Further review revealed that the above minutes were signed by the Staff G (Administrator) as being received and reviewed.Interview on 5/27/26 at 1:47 p.m. with Staff G confirmed the above findings and that the facility had not acted upon the residents' continued concerns.

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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. Based on observation, interview, and record review, the facility failed to ensure that insulin was administered per manufacturer's instructions for 1 of 7 residents observed for medication administration (Resident identifier is #55).Findings include: Resident #55 Review on 5/26/26 of Resident #55's physician orders revealed an order for Novolog Insulin (Aspart Insulin) per sliding scale before meals for Diabetes Mellitus. Observation on 5/26/26 at 11:45 a.m. of Resident #55's insulin administration with Staff A (Licensed Practical Nurse (LPN)) revealed when injecting the insulin, with the insulin pen, Staff A held the plunger of the insulin pen for approximately 4 seconds. Interview on 5/26/26 at approximately 11:45 a.m. with Staff A confirmed the above observation. Review on 5/26/26 of Insulin Aspart manufacturer instructions for use revealed .Keep the needle in the skin for at least 6 seconds, and keep the push-button pressed all the way in until the needle has been pulled out from the skin.This will make sure that the full dose has been given.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure residents remained free of insulin medication errors for 2 of 2 residents reviewed for significant medication error in a final sample of 19 residents. (Resident identifier are #62 and #70.) Findings include:Resident #62Interview on 5/28/26 at approximately 8:30 a.m. with Resident #62 revealed he/she received someone else's insulin yesterday afternoon. Resident #62 stated that a male staff member approached her in the dining room and asked, Are you [first name omitted]?Review on 5/28/26 of Resident #62's provider note dated 5/27/26 revealed that .Nursing discovered that this pt likely received another pt's insulin (with the same first name). This insulin [pronoun omitted] received was rapid acting, whereas the pt typically receives BID (twice a day) 70/30 (long acting) insulin. For this reason, the pt was assessed for signs of acute hypoglycemia .Review on 5/28/26 of Resident #62's active physician orders revealed the following: Novolin 70/30 Flexpen Subcutaneous Suspension Pen-Injector (70-30) 100 Unit/ML (milliliter) (Insulin NPH Isophane (Human)) (long acting insulin), Inject 29 unit subcutaneously one time a day for DM (Diabetes Milletus), schedule for 8:00 a.m.; and Novolin 70/30 Flexpen Subcutaneous Suspension Pen-Injector (70-30) 100 Unit/ML (milliliter) (Insulin NPH Isophane (Human)) (long-acting insulin), Inject 25 unit subcutaneously one time a day for DM (Diabetes Milletus), scheduled for 5:00 p.m.Review on 5/28/26 of Resident #62's May Medication Admin Audit Report revealed that on 5/27/26 at 8:34 a.m., Resident #62 was administered 29 units of Novolin 70/30 (long-acting insulin).Interview on 5/28/26 at approximately 9:30 a.m. with Staff B (Licensed Practical Nurse (LPN)) revealed that on 5/27/26 at approximately 3:30 p.m., he/she used Resident #70's Novolog (insulin) pen to administer 6 units of insulin to Resident #62. Interview revealed that he/she had picked up a shift at the facility for the first time on 5/27/26. Staff B stated that Resident #70 was scheduled to receive a lunch meal dose of insulin. Resident #70 was not in his/her room, so Staff B asked another staff member where Resident #70 was. He/she was told that Resident #70 was attending an activity in the dining room. Staff B brought the insulin pen with him/her and went to the dining room where he/she asked another staff member who Resident #70 was. Staff B approached Resident #62 and asked Resident #62's name, the resident nodded, yes. Staff B proceeded to give Resident #62 the ordered insulin for Resident #70. Review on 5/29/26 of the Novolog manufacturer's instruction revealed: .Warnings and precaution: Hypoglycemia is the most common adverse effect of all insulins, including Novolog. Severe hypoglycemia can cause seizures, may lead to unconsciousness, may be life-threatening or cause death.Review of the facility's policy, Medication Administration General Guidelines, dated 1/26, revealed . 10. Resident are identified before medication is administered using at least two identifiers. 16. Medications supplied for one resident are never administered to another resident .Resident #70Review on 5/28/26 of Resident #70's May Medication Administration Record revealed the following:5/27/26 at 7:30 a.m., Novolog Pen Fill Solution Cartridge 100 Unit/ML (milliliter) (Insulin Aspart), Inject as per sliding scale: If 160-200=4u (unit); 201-250=6u; 251-300-8u; 301-350=10u; subcutaneously before meals for diabetes, revealed that Resident #70's blood sugar was documented as NA (not applicable) and insulin was documented as HD (hold); and 5/27/26 at 11:30 a.m., Novolog Pen Fill Solution Cartridge 100 Unit/ML (milliliter) (Insulin Aspart), Inject as per sliding scale: If 160-200=4u (unit); 201-250=6u; 251-300-8u; 301-350=10u; subcutaneously before meals for diabetes, revealed that Resident #70's blood sugar was documented as 203 and 6 units of insulin was administered. Review further identified that this medication was administered to the wrong person.Interview on 5/28/26 at approximately 12:00 p.m. with Staff B revealed that Resident #70's 7:30 a.m. and 11:30 a.m. blood sugars were not obtained, and insulin was not administered as ordered. Further interview revealed that the provider was not notified that the insulin was not administered as ordered.

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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 on 1 of 3 medication carts observed. Findings include:Review on 5/28/26 of the facility's policy, Insulin Pens, revised 5/1/25, revealed: .Insulin pens will be clearly labeled with the patient's name, physician name, dated used. Observation on 5/28/26 at approximately 9:30 a.m. of the 200's Medication Cart with Staff E (Director of Nursing (DON)) revealed the following: Resident #59's Novolog insulin pen (Insulin Aspart), the pen was not labeled with the patient or physician's name.Resident #70's Novolog insulin pen (Insulin Aspart), the pen was not labeled with the patient or physician's name.Resident #70's Lantus insulin pen (Insulin Glargine), the pen was not labeled with the patient or physician's name. Interview on 5/28/26 at approximately 9:45 a.m. with Staff E confirmed the above findings.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observations, interview, and record review, the facility failed to ensure a resident's diet preferences were followed for 1 of 4 residents reviewed for nutrition in a final sample of 19 residents. (Resident identifier is #70.)Findings include:Interview on 5/26/26 at approximately 9:50 a.m. with Resident #70 revealed, I am supposed to be on a vegetarian diet.Review on 5/27/26 of Resident #70's medical record revealed a nutritional assessment, dated 3/3/26, that stated .on a low sodium diet/Vegetarian (per [pronoun omitted] request). Nutritional care plan, created 7/12/24, revealed an intervention to honor food preferences within meal plan.Observation on 5/28/26 at approximately 12:15 p.m. of Resident #70 in the main dining room with chicken salad on their plate for lunch. Resident #70's meal ticket that read, . 2gm [gram] Sodium No salt packet! No pork; requests vegetarian diet.Interview on 5/28/26 at 1:20 p.m. with Staff C (Dietary Manager) stated that Resident #70's preference is for a vegetarian diet but since he/she has an order for a 2gm sodium diet they are only given the 2gm Sodium menu for them to choose their meals from.Interview on 5/28/26 at approximately 2:30 p.m. with Staff D (Regional Dietitian) stated that they facility does have a vegetarian menu, but Staff D had not provided that menu to Resident #70.Review on 5/29/26 of the facility policy titled Dining and Food Preferences, revised 10/2022, revealed, .5. The Registered Dietitian/Nutritionist (RDN) or other clinically qualified nutrition professional will review, and after consultation with the resident, adjust the individual meal plan to ensure adequate fluid volume and appropriate nutritional content for residents/patients that do not consume certain food or food groups.