STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305078	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harris Hill Center, Genesis Healthcare	20 Maitland 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. 51399 Based on observation, interview, and record review, it was determined that the facility failed to determine if self-administration of medications were appropriate for 1 of 2 residents reviewed for choices in a final sample of 18 residents (Resident identifier is #25). Findings include: Observation on 3/19/25 at approximately 10:02 a.m. of Resident #25's room revealed a small container of a whitish cream on Resident #25's night stand. Interview on 3/19/25 at approximately 10:05 a.m. with Resident #25 revealed that the container of whitish cream was Voltaren and they self apply the cream as needed for pain. Resident #25 stated that the nurse will refill the container as needed. Review on 3/19/25 of Resident #25's medical record revealed a physician's order for Diclofenac Sodium External Gel (Voltaren) 1 % (percent) Apply to back and legs topically two times a day for osteoarthritis pain, with a start date of 11/11/2024. Further review of Resident 25's medical record revealed that there was no assessment for self-administration of Voltaren. Observation on 3/21/25 at approximately 8:23 a.m. revealed that the container with the whitish cream (Voltaren) remained at Resident #25's beside. Interview on 3/21/25 at approximately 8:23 a.m. with Staff F (Medication Nursing Assistant) confirmed that there was a container of whitish cream (Voltaren) at Resident #25's bedside. Staff F stated that Resident #25 does not have an order to self-administer the Voltaren Cream. Review on 3/21/25 of Resident #25's Quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/22/25 revealed a BIMS (Brief Interview of Mental Status) score of 15/15, indicating little to no impairment. Interview on 3/21/25 at approximately 10:42 a.m. with Staff C (Clinical Corporate Nurse) confirmed that Resident #25 did not have an assessment to self-administer medications. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review on 3/21/25 of the facility's policy titled NSG: Medications: Self-Administration, reviewed on 10/15/24, revealed . Patients who request to self-administer medications will be evaluated for safe and clinically appropriate capability based on the patient's functionality and health condition. If it is determined that the patient is able to self administer: A physician/advanced practice provider (APP) order is required .Patient must be instructed in self-administration Evaluation of capability must be performed initially, quarterly, and with any significant change in condition .

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 47129 Based on record review and interview, it was determined that the facility failed to refer residents with an evident or possible serious mental disorder for a Level II Pre-Admission Screening and Resident Review (PASARR) for 1 of 1 resident reviewed for PASARR in a final sample of 18 residents (Resident identifier is #16). Findings include: Review on 3/21/25 of Resident #16's medical record revealed that Resident #16 admitted to the facility in August 2024 with a known diagnosis of schizoaffective disorder, bipolar type, anxiety disorder, and panic disorder. Further review revealed a PASARR Level 1 completed 8/18/2024 and signed by a medical professional indicating a temporary admission for a convalescent stay with a maximum length of stay for 90 days, determined no Level II PASARR was needed at the time. Review on 3/21/25 of Resident #16's Level I PASARR form (completed on 10/1/24 and signed by a medical professional) revealed: Section 2A: Suspected Diagnosis: Bipolar, Schizophrenia/schizoaffective, and Severe Anxiety/panic and Psychiatric Inpatient, Associated with a mental health agency, Medication management, and At-home supportive services were checked yes. Section 2B: Interpersonal Function: Easily upset/anxious and Fearful of strangers were checked yes. Section 2D: Adaptation to Changes: Mental health intervention due to increased symptoms were checked yes. Section 8: Level I Screening Summary: Required PASARR involvement - Level II face to face and Length of stay requesting for Level II: Long Term Care were checked. Interview on 3/21/25 at 1:20 p.m. with Staff G (Social Service Director) revealed that Resident #16 never had a Level II PASARR as required from their PASARR Level I screening. Review on 3/21/25 of facility policy titled, Pre-admission Screening for Mental Disorder and/or Intellectual Disability Patients, dated 2/16/24, revealed: . 1.1 It is learned after admission that the Pre-Admission Screening and Resident Review was not completed or is incorrect, or .2.1 Refer to the appropriate state designated authority when a patient is identified as having an evident or possible MD, ID or related condition .

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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. 45419 Based on interview and record review, it was determined that the facility failed to implement the plan of care for 1 of 1 resident reviewed for change of condition (Resident identifier is #32) and 1 of 1 resident reviewed for insulin (Resident identifier is #58) in a final sample of 18 residents. Findings include: Resident #32 Review on 3/20/25 of Resident #32's current care plan revealed the care plan intervention, initiated 2/14/25, for Congested Heart Failure: weigh daily, notify physician of weight gain greater than 2 pounds per day. Review on 3/20/25 of Resident #32's weights and vitals summary, dated 3/16/24, revealed a weight of 329.8 pounds on 3/16/25 and a weight of 333 pounds on 3/17/25 (an increase of 3.2 pounds). Review on 3/20/25 of Resident #32's medical record revealed that there was no documentation of notification to a provider on 3/17/25 when Resident #32 had an increase of greater than 2 pounds in one day. Interview on 3/20/25 at 9:30 am with Staff D (Medical Director) confirmed that he/she was not notified of the above mentioned increase in weight on 3/17/25 and there was no documentation of a provider notification in the medical record. Resident #58 Review on 3/19/25 of Resident #58's medical record revealed a progress note, dated 3/16/25, that stated [Resident #58 name omitted] was in the dayroom for super [sic], ate all [pronoun omitted] supper; but when [pronoun omitted] CBG [capillary blood glucose] was checked by 1930 [7:30 p.m.], it was 106. About 2100 [9:00 p.m.] it read 60. Glucose adm. [administered] and went up to 70 in about 20 minutes. Night nurse updated and will continue to check resident and appropriate interventions until res. [resident] CBG is stable. Further review of Resident #58's medical record revealed no documented physician notification regarding receiving Glucose for low blood sugar. Review on 3/21/25 of Resident #58's physician orders revealed an order for Insta-Glucose Gel 77.4% (percent), start date 2/21/24, Give 1 dose by mouth as needed for BG (Blood Glucose) less than 70, pt (patient) arousable, conscious and able to swallow. Hold all diabetic medications until provider authorizes resumption. Remain with pt., keep pt in bed/chair for safety. Repeat blood glucose in 15 min. (minutes). Review on 3/21/25 of Resident #58's current care plan revealed the following care plan intervention, initiated 2/23/24, for insulin dependant diabetes: Access and record blood glucose levels as ordered. Call MD [Medical Doctor] if CBG is < [less than] 70 or >[greater than] 250. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 3/21/25 at approximately 9:55 a.m. with Staff D (Medical Director) confirmed that there was no documentation of physician notification for Resident #58's low blood sugar episode requiring glucose administration. Staff D stated that a provider needed to be notified in accordance with the physician order.

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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. 48515 Based on observation, interview and record review, it was determined that the facility failed to ensure that insulin was administered per manufacturer's instructions and per facility policy and procedure for 1 of 4 residents observed for medication administration. (Resident identifier is #77.) Findings include: Review on 3/19/25 of Resident # 77's physician orders revealed an order for Novolog Flex Pen subcutaneous solution pen-injector 100 unit/ml (milliliter) Inject 4 units subcutaneously before meals for DM II (Diabetes Mellitus). Observation on 3/19/25 at approximately 12:00 p.m. of Resident #77's insulin administration with Staff A (Registered Nurse) revealed that Staff A primed the Insulin Pen with only 1 unit of insulin prior to administration of scheduled 4 unit dose and when injecting the insulin into Resident #77 he/she held the Insulin Pen in place for 3 seconds. Interview on 3/19/25 at approximately 12:00 p.m. with Staff A confirmed that he/she had primed the insulin pen with only 1 unit of insulin and had held the pen in place for 3 seconds after injecting the scheduled dose of Insulin. Review on 3/20/25 of manufacturers instructions for Novolog Flex Pen revealed: Giving the airshot before each injection E. Turn the dose selector to select 2 units . G. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0. Giving the Injection . Keep the needle in the skin for at least 6 seconds, and keep the push-button pressed all the way in . Review on 3/20/25 of facility policy titled Medication Administration Subcutaneous Insulin, dated 01/23 revealed: Always perform the safety test before each injection . A. Select the dose of units by turning the dosage selector (diagram indicates 2 units) . D. Hold the pen with the needle pointing upwards . F. Press the injection button all the way in . A. Insert the needle into the skin at a 90 degree angle. B. Deliver the dose by pressing the injection button in all the way . C. Keep the injection button pressed all the way in. Slowly count to 10 before you withdraw the needle from the skin. This ensures the full dose will be delivered.

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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. 51399 Based on observation and interview, it was determined that the facility failed to ensure that medications were appropriately labeled and expired medications removed from use for 1 of 2 medication carts observed. Finding include: Observation on 3/19/25 at approximately 9:10 a.m. of the second floor low medication cart with Staff B (Licensed Practical Nurse) revealed an Albuterol Sulfate inhaler that contained no resident identifier and the medication was not in the pharmacy dispensed container. Further observation revealed a manufacturer's expiration date of 2/23. Interview on 3/19/25 at approximately 9:12 a.m. with Staff B confirmed the above findings. Review on 3/21/25 of the Facilities Policy Titled Medication Storage: Storage of Medications, Reviewed on 1/25, revealed .7. Medications for oral inhalation are stores in the dispensed containers following manufacturer guidelines . 14. Outdated, contaminated, discontinued or deteriorated medications .are immediately removed from stock .