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	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harris Hill Center, Genesis Healthcare	20 Maitland Street Concord, NH 03301

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure that a resident that self-administered medications was assessed as clinically appropriate for 1 of 2 residents reviewed for choices in a final sample of 20 residents. (Resident identifier is #31.)Findings include: Observation on 4/13/26 at approximately 10:40 a.m. in Resident #31's room revealed that Resident #31 had a medicine cup with pills and was self-administering the pills with no staff present. Review on 4/13/26 of Resident #31's self-administration of medication assessment, dated 1/8/26, revealed that Resident #31 required assistance to administer oral medications and was not approved for self-administration of medications. Review on 4/13/26 of Resident #31's April 2026 Medication Administration Record revealed the following medications documented as administered on 4/13/26 (scheduled 8:00 a.m., 9:00 a.m., and 10:00 a.m.): Ascorbic Acid 500 mg (milligram) one tablet, Blood-Builder-Supplement one tablet, Calcium Citrate two tablet, Cholecalciferol (Vitamin D) 1000 unit one tablet, Choline-Inositol 250-250 mg one capsule, Vitamin A 5000 unit, Vitamin B Complex 2 capsules, and Lactobacillus two capsules. Review on 4/13/26 of Resident #31's active physician orders revealed the no orders to self-administer medications. Interview on 4/14/26 at approximately 12:45 p.m. with Staff G (Licensed Practical Nurse) revealed that he/she was the nurse for Resident #31 on 4/13/26 day shift (7:00 a.m. to 3:00 p.m.) and gave the above medications to Resident #31 to self-administer. Staff G confirmed the above findings that Resident #31 did not have an order to self-administer. Review on 4/14/26 of the facility policy titled, Medications: Self-Administration, review date of 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, self-administration and medication self-storage must be care planned .

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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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview, the facility failed to send a copy of the notice of transfer to the Long-Term Care (LTC) Ombudsman for 2 of 3 closed records reviewed and 1 of 2 hospitalizations reviewed in a final sample of 20 residents (Resident Identifiers are #77, #1, and #79).Findings include:Resident #77 Review on 4/14/26 of Resident #77's progress notes revealed that Resident #77 was transferred to the hospital on 3/7/26. There was no documentation that the LTC Ombudsman was sent a copy of Resident #77's notice of transfer. Interview on 4/15/26 at approximately 2:00 p.m. with Staff A (Administrator) confirmed the above finding. Staff A was unable to provide documentation that the LTC Ombudsman was sent a copy of the notice of transfer to the hospital for Resident #77. Resident #79 Review on 4/14/26 of Resident #79's progress notes revealed that Resident #79 was discharge home on 2/11/26. There was no documentation that the LTC Ombudsman was sent a copy of Resident #79's notice of discharge. Interview on 4/15/26 at approximately 2:00 p.m. with Staff A confirmed the above finding. Staff A revealed that Resident #79 discharged Against Medical Advice. Staff A was unable to provide documentation that the Long-Term Care Ombudsman was sent a copy of the notice of discharge for Resident #79. Resident #1 Review on 4/13/26 of Resident #1's medical record revealed a hospitalizations on 1/30/26. Review on 4/15/26 of Resident #1's record revealed no completed notice of transfer/discharge available and no evidence the notice was sent to the LTC Ombudsman for the above hospitalizations. Interview on 4/15/26 at approximately 12:30 p.m. with Staff A confirmed the above findings. Review on 4/15/26 of facility policy titled COR412 Discharge Record Processing revised 1/15/26 revealed .PROCESS.2. discharge documentation must include:.2.4 Notice of Transfer or Discharge.

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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** Based on observation, interview, and record review, the facility failed to follow professional standards for 1 out of 5 residents observed for medication administration and for 2 of 2 wound care observations in a final sample of 20 residents (Resident Identifiers are #16, #51, and #7).Findings include:Standard: [NAME], P.A, [NAME], A.G., Stockhart, P.A., & Hall, A. (2021). Fundamentals of Nursing. Elsevier. Page 1262. Changing Dressings A Health care provider's order for wound care indicates the dressing type, the frequency of changing, and any solutions or ointments to be applied to the wound. Resident #16 Review on 4/13/26 of Resident #16's April 2026 Treatment Administration Record revealed an order dated 4/10/26 for Wound Care: wash lower legs with wound cleanser, pat dry, apply collagen to left lateral and right medial lower legs wounds. Cover with collagen AG sheet. Apply Xeroform to any other open or weeping areas. Cover with ABDs, secure with conform rolled gauze. Ace bandage from base of toes to just below bend of knee. Every evening shift on Mon, Fri for wound care. Further review revealed it signed as completed on 4/10/26 and 4/13/26. Observation on 4/13/26 at approximately 12:00 p.m. of Resident #16's bilateral lower legs revealed ace wraps on each leg, that were intact with a date of 4/8/26 on both legs. Interview on 4/13/26 at approximately 12:00 p.m. of Resident #16 revealed that dressings were not done all the days they are scheduled, and some were skipped. Observation on 4/15/26 at approximately 9:45 a.m. of Resident #16's wound care being performed revealed both leg dressings that were removed were dated 4/8/26. Interview on 4/15/26 at approximately 9:45 a.m. with Staff B (Physician's Assistant) and Staff C (Wound Nurse) confirmed the findings above and concluded the dressings had not been changed when ordered. Resident #51 Review on 4/15/26 of Resident #51's April 2026 Treatment Administration Record revealed an order for Wound Care: left heel pressure injury: cleanse with wound cleanser, pat dry, skin prep to intact skin, Pluogel to slough, cover with bordered Optifoam HEEL dressing Heelzup in bed to offload heels. Everyday Mon, Weds, Fri for wound care. Further review revealed it signed as completed 4/13/26. Observation on 4/15/2026 at approximately 10:45 a.m. of Resident #51's wound care being performed revealed the left heel dressing removed was dated 4/11/26. Interview on 4/15/26 at approximately 10:45 a.m. with Staff B (Physician's Assistant) and Staff C (Wound Nurse) confirmed the findings above and concluded the dressing had not been changed when ordered. Interview on 4/15/26 at approximately 11:15 a.m. with Staff D (Registered Nurse) revealed that the dressing on resident #51's left heel was documented as completed on 4/13/26, but the treatment was not done. (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 4/15/26 of facility policy titled NSG236 Skin Integrity and Wound Management revised 9/15/25 revealed, .PRACTICE STANDARDS.6.13 Implement special wound care treatments/techniques, as indicated and ordered. Resident #7 Standard: [NAME], [NAME] A., and [NAME] [NAME]. Fundamentals of Nursing. 10th edition St. Louis, Missouri: Elsevier, 2021. Page 614 .It is essential to verify the accuracy of every medication you give to your patients with the patient's order. If the medication order is incomplete, incorrect, or inappropriate, or if there is a discrepancy between the original order and the information on the MAR [Medication Administration Record]. consult with the health care provider. 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 . Observation on 4/14/26 at approximately 8:14 a.m. with Staff H (Licensed Practical Nurse) revealed that Staff H popped 1 capsule of Gabapentin 100 mg (milligram) from a medication bingo card and administered it to Resident #7. Interview on 4/14/26 at approximately 8:14 a.m. with Staff H confirmed the above findings. Staff H revealed that he/she gave 1 capsule (100 mg) because the Gabapentin 100 mg bingo card instruction indicated to give 100 mg by mouth twice daily. Review on 4/14/26 during Resident #7's medication administration observation with Staff H revealed that the electronic medication administration record revealed an order for Gabapentin capsule give 100 mg by mouth twice a day for nerve pain, and give two capsules (order date of 12/16/25). The Gabapentin 100 mg bingo card indicated to give 100 mg by mouth twice a day for nerve pain. Review on 4/14/26 of Resident #7's provider note dated 12/16/25 revealed that Gabapentin 200 mg once daily was increase to 200 mg twice daily for sciatica pain. Interview on 4/14/26 at approximately 2:44 p.m. with Staff I (Advanced Practice Registered Nurse) confirmed that the order for Gabapentin was for 200 mg twice daily. Review on 4/15/26 of the facility policy titled, Medication Administration, dated 1/26, revealed, .Medications are administered in accordance with written orders of the prescriber .Verify medication is correct three (3) times before administering the medication. 1. when pulling medication package from med cart b. when dose is prepared c. before dose is administered .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to administer drugs and biologicals to 1 of 1 resident reviewed for new admissions in a final sample of 20 residents (Resident Identifier is #82).Findings include:Interview on 4/13/26 at approximately 9:30 a.m. of Resident #82 revealed that he/she did not receive all of his/her medications when they were admitted . Further interview revealed he/she came into the facility on 4/10/26.Review on 4/13/26 of Resident #82's April 2026 Medication Administration Record revealed on 4/10/26 the following 8pm and 9pm medications: Bupropion XL 300mg, Celexa 20mg, Insulin Lispro 100unit/ml, Metformin 1000mg, Metoprolol Tartrate 25mg, Topiramate 25mg, Vancomycin 125mg were all documented as not given with NN [Nurses Note].Review on 4/14/26 of Resident #82's progress notes confirmed Resident #82 was admitted [DATE]. Further review revealed no nurse notes for 4/10/26 missed medications. Nurses notes dated 4/11/26 state the following medications were not available from the pharmacy: Metformin, Insulin Glargine 100 unit/ml, Metoprolol Tartrate, Vancomycin, Topiramate, Celexa, and Bupropion. There was no documentation of provider notification.Interview on 4/15/26 at approximately 9:00 a.m. with Staff E (Regional Clinical Lead) confirmed above findings. Review on 4/15/26 of facilities medications 'Inventory on Hand' list for their general and emergency use medications available in the medication room revealed the following medications were in the facility: Celexa, Metformin, Metoprolol Tartrate, and Vancomycin (5 out of 7 medications of his/her missed medications).

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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 policy review, the facility failed to permit only authorized personnel to have access to medication room keys for 2 of 2 medication rooms observed. Findings include:Interview on 4/15/26 at approximately 10:27 a.m. with Staff J (Maintenance Director) revealed that he/she has keys to access the second floor and third floor medication rooms because oxygen tanks are stored there. Staff J also revealed that he/she accessed the medication rooms to perform maintenance on the HVAC (Heating, Ventilation, and Air Conditioning) systems located inside those rooms.Observation on 4/15/26 at approximately 10:27 a.m. on the third floor unit with Staff J revealed that Staff J accessed the medication room using keys that he/she keeps. The third floor medication room had oxygen tanks, medication bingo cards on the counter, over the counter medications on the shelves, and an unlocked medication refrigerator with medications in it. There were no nurses or medication nursing assistants supervising while the medication room was accessed by Staff J. Observation on 4/15/26 at approximately 10:35 a.m. on the second floor unit with Staff J revealed that Staff J accessed the medication room using keys that he/she keeps. The second floor medication room had oxygen tanks, intravenous medications on the counter, over the counter medications on the shelves, and an unlocked medication refrigerator with medications in it. There were no nurses or medication nursing assistants supervising while the medication room was accessed by Staff J. Review on 4/15/26 of the facility policy titled, Storage of Medication, dated 1/26, revealed, .The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications .Medication rooms, cabinets, and medication supplies should remain locked when not in use or attended by persons with authorized access .

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to ensure that a staff was offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine for 1 of 1 staff reviewed for COVID-19 vaccination. (Staff identifier is H.)Findings include: Review on 4/14/26 of Staff H (Licensed Practical Nurse) COVID-19 vaccine record revealed Staff H received COVIDˆ19 vaccines on 12/30/20, 1/20/21, and 12/31/21. There was no documentation of COVID-19 vaccination after 12/31/21, and no documentation that Staff H was offered the COVID-19 vaccine or given information on obtaining COVID-19 vaccine. Interview on 4/14/26 at approximately 11:00 a.m. with Staff K (Infection Preventionist) confirmed the above mentioned Staff H's COVID-19 vaccination record. Staff K revealed that he/she did not offer Staff H the COVID-19 vaccine or provide information on obtaining a COVID-19 vaccine. Staff K also revealed that they don't offer the COVID-19 vaccine or provide information on obtaining the COVID-19 vaccine to agency (e.g. contracted) staff. Interview on 4/14/26 at approximately 11:06 a.m. with Staff H revealed that he/she was not offered the COVID-19 vaccine or provided with information on obtaining a COVID-19 vaccine since working at the facility. Review on 4/14/26 of the facility policy titled, COVID-19 Vaccination, review date of 3/20/26, revealed, . 'Staff' means this individuals who work in the facility on a regular (that is, at least once a week) basis .This also includes visiting healthcare personnel/individuals under contract or arrangement .A licensed nurse or authorized health care provider will administer COVID-19 vaccinations: .In adherence with current recommendations of the Advisory Committee on Immunization Practices (ACIP) as set forth by the Centers for Disease Control and Prevention (CDC) Employees are encouraged to obtain COVID-19 vaccination from their personal health provider, health department, or community health partners. Employees who consent to COVID-19 vaccinations through their personal health provider, health department, or community health partners should consult with their supervisor regarding alternate potential sources to obtain the COVID-19 vaccination .Obtain consent .Employee COVID-19 Informed Consent in the approved automated system .Document refusal .If an employee refuses COVID-19 vaccination, document the declination on the COVID-19 Vaccine Informed Declination in the approved automated system .

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to maintain two equipment per manufacturer's instruction for 1 of 1 resident reviewed for respiratory care and 1 of 1 portable air conditioner observed. Findings include: Resident #28Observation on 4/13/26 at approximately 10:17 a.m. in Resident #28's room revealed a non-invasive mechanical ventilator machine (i.e. equipment) on top of Resident #28's bedside cabinet drawer. Interview on 4/13/26 at approximately 10:17 a.m. with Resident #28 revealed that he/she had not used the above mentioned machine for 2-3 months due to a warning indicator showing it required service from the contracted rental company. Resident #28 also revealed that the staff was aware, called the contracted rental company, and they had not come in to service the equipment.Review on 4/14/26 of Resident #28's care plan revealed that Resident #28 has sleep apnea and utilize a Continuous Positive Airway Pressure (CPAP) machine.Observation on 4/14/26 at approximately 12:46 p.m. with Resident #28 and Staff G (Licensed Practical Nurse (LPN)) revealed that Resident #28's CPAP machine turned on and initially did not display a warning sign indicator. A few minutes later after pressing buttons on the CPAP machine, it displayed a message that indicated motor life exceeded call the provider.Interview on 4/14/26 at approximately 12:46 p.m. with Staff G confirmed the above finding. Staff G was the unit manager on the third floor unit and was unaware of any issues with Resident #28's CPAP machine. Interview on 4/14/26 at approximately 12:46 p.m. with Resident #28 revealed that the CPAP machine's air filter needed to be change. Resident #28 could not recall when it was last replaced and there was no new air filter to replace it.Review on 4/14/26 of the CPAP machine manufacturer's instruction revealed, Caring for your device .Check the air filter and replace it at least every six months. replace it more often if there are any holes or blockages by dirt or dust .Design life Device, power supply unit: 5 years .Review on 4/14/26 of Resident #28's April 2026 Treatment Administration Record revealed treatment for CPAP to apply at bedtime and remove in the morning with a start date of 5/12/22. Further review revealed orders to clean the CPAP filter, reservoir, mask, and tubing weekly; and clean CPAP mask daily. Review also revealed that the CPAP machine was signed off as administered from 4/1/26 to 4/7/26 and 4/9/26 to 4/13/26.There were no orders to replace the CPAP machine's air filter every six months. Interview on 4/14/26 at approximately 1:46 p.m. with Staff G confirmed that there was no order to replace the air filter of Resident #28's CPAP machine. Staff G revealed that the nursing staff does not replace the air filter of the CPAP machine. Interview on 4/14/26 at approximately 3:15 p.m. with Staff J (Maintenance Director) revealed that they do not replace the air filter of any CPAP machine in the facility. Interview on 4/15/26 at approximately 12:38 p.m. with Staff M (Registered Nurse) revealed that he/she regularly works the night shift (11:00 p.m. to 7:00 a.m.) on the third floor unit and does not replace the air filter of Resident #28's CPAP machine. Review on 4/15/26 of the facility's contracted respiratory healthcare company form for Resident #28's CPAP machine revealed that one CPAP machine was delivered on 8/23/18. Interview on 4/15/26 at approximately 9:00 a.m. with Staff J confirmed the above finding. Staff J revealed that Resident #28's CPAP machine needed to be replaced. Staff J was unable to provide documentation of communication to the respiratory healthcare company about Resident #28's CPAP machine displaying a message motor life exceeded call the provider prior to survey.Review on 4/14/26 of the facility's policy titled, Bi-Level Positive Airway Pressure (BIPAP)/Continuous Positive Airway Pressure (CPAP) procedure, revision date of 10/15/24, revealed, Cleaning the system: .Change the intake filter per manufacturer's instructions .Replace equipment immediately when it is broken or malfunctions .replace equipment routinely in accordance with manufacturer's recommendations . Portable Air ConditionerObservation on 4/13/26 at approximately 8:35 a.m. with Staff L (LPN) in the second floor medication room revealed a portable air conditioner. Staff L also revealed that the maintenance department maintains the portable air conditioner. Observation on 4/15/26 at approximately 10:27 a.m. with Staff J in the second floor medication revealed a portable air conditioner with both an upper and lower air filter. The upper air (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	filter appeared dark with small amount of dust accumulation, and the lower air filter was heavily covered with dark dust buildup on both the front and back surfaces.Interview on 4/15/26 at approximately 10:27 a.m. with Staff J confirmed the above observation. Staff J revealed that he/she last cleaned the air filters on 4/15/26. Staff J was unable to provide documentation of verification of air filter cleaning. Review on 4/15/26 of the portable air conditioner manufacturer's instruction revealed, .Air Filter Cleaning .Maintenance Tips Be sure to clean the air filter every 2 weeks for optimal performance .