STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305051	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Keene Center, Genesis Healthcare	677 Court Street Keene, NH 03431

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 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** 50163 Based on interview and record review, it was determined that the facility failed to follow physician's orders for 1 of 4 residents reviewed for nutrition and 1 of 5 residents reviewed for unnecessary medications in a final sample of 28 residents (Resident Identifiers #27 and #67). Findings include: Standards: [NAME], [NAME] A., and [NAME] [NAME]. Fundamentals of Nursing. 7th ed. St. Louis, Missouri: Mosby Elsevier, 2009. Page 336 - Physicians' Orders The physician is responsible for directing medical treatment. Nurses follow physician's orders unless they believe the orders are in error or harm clients. Therefore you need to assess all orders, and if you find one to be erroneous or harmful, further clarification from the physician is necessary . Resident #67 Review on 4/17/24 of Resident #67's Medication Administration Record (MAR) for April 2024 revealed a physician's order, with a start date of 4/3/24, Weigh every day shift every Wednesday for 4 weeks. Further review of the MAR revealed the following: 4/3/24 - NN (No / See nurse's note) 4/10/24 - marked done; no weight recorded 4/17/24- NN (No / See nurse's note) Review on 4/18/24 of Resident #67's nurses' notes revealed the following: 4/3/24 Weight not obtained with no further reason documented, written by Staff A (Licensed Practical Nurse (LPN)); (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/17/24 Weight not obtained with no further reason documented, written by Staff A. Review on 4/18/24 of Resident #67's Weights tab in the electronic record revealed a weight on 4/1/24 of 175. 6 pounds. Further review revealed no other weights were documented under the weights tab. Review on 4/19/24 of Resident #67's Nutritional assessment dated [DATE] revealed the Registered Dietitian's evaluation [Resident's name omitted] is consuming meals fairly well since admission however, not meeting increased needs with wound .Will monitor intake, weight, and wound healing for additional interventions if necessary . Interview on 4/19/24 at 11:20 a.m. with Staff B (Unit Manager) confirmed the above findings. 43002 Resident #27 Review on 4/18/24 of Resident #27's Medication Administration Record (MAR) for April 2024 revealed a physician's order, with a start date of 4/12/24, for Novolog insulin per sliding scale before meals and at bedtime; if over 351 recheck the blood sugar in 2 hours; if the blood sugar was over 400 to notify the provider. Further review revealed the following: 4/13/24 at 4:30 p.m. the blood sugar was 379; 4/14/24 at 11:30 a.m. the blood sugar was 425 and at 4:30 p.m. was 399; 4/15/24 at 4:30 p.m. the blood sugar was 362 and at 9:00 p.m. was 466; 4/16/24 at 9:00 p.m. the blood sugar was 384; 4/17/24 at 11:30 a.m. the blood sugar was recorded as NA and at 4:30 p.m. the blood sugar was 577; 4/18/24 at 7:30 a.m. the blood sugar was 385, at 11:30 a.m. was 452, and at 9:30 p.m. was 399; 4/19/24 at 11:30 a.m. the blood sugar was 396. Further review revealed that there was no documentation that the blood sugars were rechecked after 2 hours per the physician's order. Review on 4/18/24 of Resident #27's progress notes for the above dates revealed; 1. No documentation that the provider was notified of the blood sugar above 400; 2. No documentation that a follow up blood sugar was done after 2 hours of blood sugar above 351; 3. No documentation that on 4/17/24 at 11:30 a.m. the physician was aware the blood sugar was not checked. Interview on 4/19/24 at 1:03 p.m. with Staff B (Unit Manager) confirmed the above findings. (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 4/19/24 of Resident #27's Care Plan revealed .Focus .diagnosis of diabetes: Insulin Dependent . Interventions .Access and record blood glucose levels as ordered .Administer hypoglycemic medications as ordered .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 50163 Based on observation, interview, and record review, it was determined that the facility failed to ensure the medication error rate was not greater than 5% (percent) for 2 of 36 medication opportunities observed (Resident Identifier #11). Findings include: Review on 4/19/24 of Resident #11's Medication Administration Record (MAR) included a physician's order for: Losartan potassium 25 milligrams (mg) 2 tabs [tablets] once daily and Sertraline 100 mg 2 tabs once daily. Observation on 4/19/24 at 7:40 a.m. of Staff C (Licensed Practical Nurse (LPN)) during medication administration revealed that Staff C had prepared Resident #11's medication and was going to administer one tab of Losartan 25 mg and one tab of Sertraline 100 mg. Interview on 4/19/24 at 7:45 a.m. with Staff C (LPN) confirmed the above findings. Review on 4/19/24 of the facility's policy 6.0 General Dose Preparation and Medication Administration revised 1/1/22 revealed: .Facility staff should: .4.1.1 Verify each time a medication is administered that it is the correct medication, at the correct dose, . as set forth in facility's medication administration schedule . There were 2 medication errors out of 36 medication administration opportunities resulting in a 5.56% error rate.

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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. 50163 Based on observation, interview, and policy review, it was determined that the facility failed to ensure that medications were secured in 2 of 3 medication carts observed and that medications were labeled in accordance with professional principles in 1 of 3 medication carts observed. Findings include: Observation on 4/19/24 at 7:40 a.m. of Staff C (Licensed Practical Nurse (LPN)), during medication administration revealed Staff C left the medication cart unlocked and no staff were within the line of sight of the medication cart. Further observation at 7:50 a.m. revealed that a second medication cart down the hall from the first medication cart was unlocked and no staff were within the line of sight of the medication cart. Interview on 4/19/24 at 8:00 a.m. with Staff C confirmed that he/she was the nurse for both hallways on the unit and was administering medications to residents from both carts. Staff C confirmed the medication carts were unlocked and unattended. Review on 4/19/24 of the facility's policy titled 6.0 General Dose Preparation and Medication Administration revised 1/1/22, revealed: .Procedure .3.10 Facility staff should not leave medications or chemicals unattended .7. Facility should ensure that medication carts are always locked when out of sight or unattended . Interview on 4/19/24 at 10:10 a.m. with Staff E (Director of Nursing) confirmed medication carts should be locked when unattended. 43002 Observation on 4/17/24 at 9:46 a.m. of the third floor North Medication Cart revealed an opened bottle of Latanoprost Ophthalmic Solution for Resident #56. There were instructions written on the outside container that read do not use after 42 days. There was no open or open expiration date written on the container. The pharmacy label indicated this medication had been filled on 12/30/23. Interview on 4/17/24 at 9:46 a.m. with Staff D (LPN) confirmed the above finding. Review on 4/17/24 of Resident #56's April 2024 Medication Administration Record revealed Latanoprost Ophthalmic solution 0.005% [percent] instill 1 drop in both eyes at bedtime for glaucoma. Further review revealed the medication had been signed off as administered daily through 4/18/24. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review on 4/19/24 of the facility's policy Storage and Expiration Dating of Medications, Biologicals revised on 8/7/23, revealed .Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container (vial, bottle, inhaler) when the medication has a shorted expiration date once opened .5.4 When an ophthalmic solution or suspension has a manufacturer's shortened beyond use date once opened, facility staff should record the date opened and the date to expire on the container .