

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  305051	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/08/2025
NAME OF PROVIDER OR SUPPLIER  Keene Center, Genesis Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>51399</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to implement policies and procedures for Enhanced Barrier Precautions (EBP) for 2 of 6 residents reviewed for EBP. (Residents identifier are #71 and #135.)</p> <p>Findings include:</p> <p>Resident #71</p> <p>Observation on 4/6/25 at approximately 10:30 a.m. in Resident #71's room revealed that Resident #71 had a catheter drainage bag hanging on his/her wheelchair.</p> <p>Observation on 4/8/25 at approximately 9:10 a.m. in Resident #71's room revealed that Staff D (Licensed Nursing Assistant (LNA)) was adjusting Resident #71's bed linens without wearing a gown and gloves. After adjusting the linens, Staff D donned gloves and assisted Resident #71 to the bathroom. Further observation revealed a cart containing Personal Protective Equipment. Observation also revealed a sign beside Resident #71's door indicating the use of EBP (wear gown and gloves prior to activities such as dressing, transferring, providing hygiene, changing linens, and changing briefs or assisting with toileting).</p> <p>Interview on 4/8/25 at approximately 9:10 a.m. with Staff D confirmed the above finding.</p> <p>Review on 4/8/25 of Resident #71's care plan revealed that Resident #71 has an indwelling Foley catheter. Further review of the care plan revealed that there were no care plan interventions for EBP.</p> <p>Interview on 4/8/25 at approximately 1:25 p.m. with Staff B (Director of Nursing) confirmed the above finding.</p> <p>40522</p> <p>Resident #135</p> <p>Review on 4/8/25 of Resident #135's profile in the medical record revealed that Resident #135 was on EBP.</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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 4/8/25 at approximately 10:30 a.m. in Resident #135's room revealed that Staff F (LNA) was with Resident #135 wearing gloves and no gown.</p> <p>Interview on 4/8/25 at approximately 10:30 a.m. with Staff F revealed that he/she was in the middle of Resident #135's morning care and getting Resident #135 up in the wheelchair.</p> <p>Interview on 4/8/25 at approximately 10:30 a.m. with Staff G (Licensed Practical Nurse) confirmed that Resident was on EBP and that Staff F was providing morning care to Resident #135 with gloves and no gown.</p> <p>Review on 4/8/25 of Resident #135's skin and wound evaluations, dated 4/7/25, revealed that Resident #135 had wounds on their left lateral calf and rear left thigh.</p> <p>Review on 4/8/25 of Resident #135's progress notes, dated 4/8/25, revealed that EBP was initiated for Resident #135's chronic wounds and that Resident #135 has a wound older than 30 days to his/her left posterior thigh and left calf.</p> <p>Interview on 4/8/25 at approximately 10:45 a.m. with Staff B revealed that Resident #135 was on EBP for his/her wounds.</p> <p>Interview on 4/8/25 at approximately 10:45 a.m. with Staff H (Advanced Practical Registered Nurse) revealed that Resident #135 has a history of Methicillin-resistant Staphylococcus aureas (MRSA) on their wounds and should be on EBP.</p> <p>Review on 4/8/25 of the facility's policy titled, Enhanced Barrier Precautions, revision date of 12/16/24, revealed .Implementation of EBP .Patient Status .Has a wound or indwelling medical device .Use EBP Yes, if they do not meet criteria for Contact Precautions .</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>51399</p> <p>Based on interview, observation, and record review, it was determined that the facility failed to maintain an equipment per manufacturer's instruction for 1 of 1 room air conditioner observed. (Resident identifier is #22.)</p> <p>Findings include:</p> <p>Observation on 4/6/25 at approximately 10:30 a.m. of Resident #22's room revealed an air conditioning unit that was vented outside through the window. Further observation revealed that Resident #22's room was significantly cooler than other resident rooms.</p> <p>Observation on 4/8/25 at approximately 12:20 p.m. in Resident #22's room revealed an air conditioning unit filter that had gray discoloration and was covered with dust.</p> <p>Interview on 4/8/2025 at approximately 12:20 p.m. of Resident #22 revealed he/she had been using the air conditioning unit within that last 2 weeks.</p> <p>Interview on 4/8/25 at approximately 12:20 p.m. with Staff E (Maintenance Director) confirmed the above observation. Staff E stated that the air conditioning unit filter in Resident #22's room had not been cleaned.</p> <p>Review on 4/8/25 of the Manufacturer's instructions for the air conditioner revealed .Air Filter .Air filters should be cleaned every two weeks .</p> <p>Interview on 4/8/25 at approximately 1:00 p.m. with Staff E confirmed the above air conditioner manufacturer's instructions.</p>		