STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305062	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpine Healthcare Center	298 Main 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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on interview and record review it was determined that the facility failed to ensure the appropriate use of a restraint for 1 of 1 residents reviewed for restraints (Resident identifier is #1). Findings Include:Interview on 1/20/26 at approximately 11:15 a.m. with Staff D (Licensed Nursing Assistant) revealed that he/she witnessed Staff C (Licensed Nursing Assistant) with Resident #1's back against Staff C's chest and his/her arms around Resident #1. Staff D further revealed that Resident #1's feet were off the ground while Resident #1 was moved to another area. Staff D stated that the incident occurred on or around January 1, 2026 and that he/she reported the incident on 1/14/2026. Interview on 1/21/26 at approximately 12:00 p.m. with Staff C revealed that Resident #1 was combative and had struck Staff C in the nose and genitals. Staff C then approached the resident from behind and put their arms around Resident #1's shoulder's. Staff C moved Resident #1 four to five feet. Staff C indicated the he/she felt that Resident #1 was a danger to themselves and others at that time and no one else wanted to do anything about it.Review on 1/20/26 of Resident #1's medical record revealed no progress notes on or around January 1, 2026 indicating any behaviors or use of a manual method to restrain Resident #1. Review on 1/20/26 of Resident #1's Treatment Administration Report for December 2025 and January 2026 indicated no behaviors from 12/26/25 through 1/12/26. Review on 1/20/26 of Resident #1's current care plan revealed no interventions for the use of a manual method for behavior management. Interview on 1/21/26 at approximately 11:30 a.m. with Staff B (Director of Nursing) confirmed the above findings and revealed there is no policy for the use of physical restraint by manual method.

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview, record review, and policy review, the facility failed to implement the facility's abuse policy for reporting and investigating allegations of abuse, staff abuse training, and staff screening for 3 out of 3 allegations of abuse reviewed and 4 out of 5 staff reviewed for abuse (Resident Identifiers are #1, #2 and #3) (Staff identifiers are C, D, H and J). Findings include:Resident #1Interview on 1/20/26 at approximately 11:15 a.m. with Staff D (Licensed Nursing Assistant) revealed that he/she witnessed Staff C (Licensed Nursing Assistant) with Resident #1's back against Staff C's chest and his/her arms around Resident #1. Staff D further revealed that Resident #1's feet were off the ground while Resident #1 was moved to another area. Staff D stated that the incident occurred on or around January 1, 2026 and that he/she reported the incident on 1/14/2026. Interview on 1/20/26 at approximately 10:45 a.m. with Staff A (Administrator) confirmed that he/she was aware of the incident as of 1/14/26 and the above allegation was not investigated or reported to the State Survey Agency (SSA). Resident #2Review on 1/20/26 of email provided by Staff B (Director of Nursing), dated 1/4/26, from Staff G (Registered Nurse) to Staff B revealed the following: At approximately 2125 [9:25 p.m.] hours on Thursday, January 1. 2026.Upon opening the door to Room [number omitted], I observed the resident standing beside [pronoun omitted] bed screaming with [name omitted, Staff C] LNA [Licensed Nursing Assistant], yelling at [pronoun omitted] to get into bed. When the resident did not comply, I observed [name omitted] pick [pronoun omitted] up off the floor and forcefully place [pronoun omitted] onto the bed.Interview on 1/20/26 at 10:30 a.m. with Staff B confirmed the above email and stated that on 1/1/26 they had been called by Staff G and informed of above incident. Staff B confirmed that the above incident was not investigated and not reported to the SSA when they were notified on 1/1/26.Resident #3Interview on 1/20/26 at approximately 10:00 a.m. with Staff I (Unit Manager) revealed that Staff I was on call on the night of 11/19/25 and was called regarding Resident #3 was found with scratches and blood on his/her face. Staff I further indicated that staff were unaware of how Resident #3 got the scratches and that he/she reported this to both Staff A (Administrator) and Staff B (Director of Nursing). Interview on 1/20/26 at approximately 10:45 a.m. with Staff A confirmed that he/she was aware of the above incident on 11/19/25 was not reported to SSA. Review on 1/20/26 of facility policy titled Abuse, Neglect and Exploitation, revised on 10/23/24, revealed .V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigation include: 1. Identify staff responsible for the investigation; 2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g. not tampering or destroying evidence); 3.Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation. VII Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the event that caused the allegation involved abuse or results in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.Review on 1/20/26 of Staff C's (Licensed Nursing Assistant) human resources file revealed their date of hire was 3/4/25. Further review of Staff (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C's human resources file revealed no criminal background check.Interview on 1/20/26 at approximately 12:15 p.m. with Staff A (Administrator) confirmed the above.Review on 1/20/26 of Staff D's (Licensed Nursing Assistant) education file revealed the last education on abuse was completed on 6/21/21.Review on 1/20/26 of Staff H's (Registered Nurse) education file revealed the last education on abuse was completed on 9/29/21.Review on 1/20/26 of Staff J's (Medication Nursing Assistant) education file revealed the last education on abuse was completed on 5/29/23.Interview on 1/20/26 at approximately 1:00 p.m. with Staff A confirmed the above findings for education and background checks.Review on 1/20/26 of facility policy titled Abuse, Neglect and Exploitation, revised on 10/23/24, revealed .The components of the facility abuse prohibition plan are discussed herein: 1. Screening A. Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. 1. Background, reference, and credentials' checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants.3. The facility will maintain documentation of proof that the screening occurred.Employee training .B. Existing staff will receive annual education through planned in-services and as needed. Training topics will include: 1.Prohibiting and preventing all forms of abuse, neglect, misappropriation of resident property, and exploitation; 2. Identifying what constitutes abuse, neglect, exploitation, and misappropriation of resident property; 3. Recognizing signs of abuse, neglect, exploitation, and misappropriation of resident property, such as physical or psychosocial indicators; 4. Reporting process for abuse, neglect, exploitation, and misappropriation of resident property, including injuries of unknown sources; 5. Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect such as: a. Aggressive and/or catastrophic reactions of residents; b. Wandering or elopement-type behaviors; c. Resistance to care d. Outbursts or yelling out; and e. Difficulty in adjusting to new routines or staff .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to ensure that alleged violations of abuse were reported immediately to the State Survey Agency (SSA) for 3 of 3 residents reviewed for abuse. (Resident identifiers are Resident #1, #2 and #3.)Findings include:Resident #1 Interview on 1/20/26 at approximately 11:15 a.m. with Staff D (Licensed Nursing Assistant) revealed that he/she witnessed Staff C (Licensed Nursing Assistant) with Resident #1's back against Staff C's chest and his/her arms around Resident #1. Staff D further revealed that Resident #1's feet were off the ground while Resident #1 was moved to another area. Staff D stated that the incident occurred on or around January 1, 2026 and that he/she reported the incident on 1/14/2026. Interview on 1/20/26 at approximately 10:45 a.m. with Staff A (Administrator) confirmed that he/she was aware of the incident as of 1/14/26 and the above allegation was not reported to SSA. Resident #3 Interview on 1/20/26 at approximately 10:00 a.m. with Staff I (Unit Manager) revealed that Staff I was on call on the night of 11/19/25 and was called regarding Resident #3 was found with scratches and blood on his/her face. Staff I further indicated that staff was unaware of how Resident #3 got the scratches and that he/she report this to both Staff A and Staff B (Director of Nursing). Interview on 1/20/26 at approximately 10:45 a.m. with Staff A confirmed that he/she was aware of the above incident on 11/19/25 and did not reported to SSA. Resident #2 Review on 1/20/26 of email provided by Staff B (Director of Nursing), dated 1/4/26, from Staff G (Registered Nurse) to Staff B revealed the following: At approximately 2125 [9:25 p.m.] hours on Thursday, January 1. 2026.Upon opening the door to Room [number omitted], I observed the resident standing beside [pronoun omitted] bed screaming with [name omitted, Staff C] LNA [Licensed Nursing Assistant], yelling at [pronoun omitted] to get into bed. When the resident did not comply, I observed [name omitted] pick [pronoun omitted] up off the floor and forcefully place [pronoun omitted] onto the bed. Interview on 1/20/26 at 10:30 a.m. with Staff B confirmed the above email and stated that on 1/1/26 they had been called by Staff G and informed of incident. Interview on 1/20/26 at 10:45 p.m. with Staff A (Administrator) confirmed that the above incident was not reported to the SSA. Review on 1/20/26 of facility policy titled Abuse, Neglect and Exploitation, revised on 10/23/24, revealed .VII Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the event that caused the allegation involved abuse or results in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to ensure that alleged violations of abuse were thoroughly investigated for 2 of 3 residents reviewed for an alleged violation of abuse. (Resident identifiers are Resident #1 and #2.)Findings include:Resident #1 Interview on 1/20/26 at approximately 11:15 a.m. with Staff D (Licensed Nursing Assistant) revealed that he/she witnessed Staff C (Licensed Nursing Assistant) with Resident #1's back against Staff C's chest and his/her arms around Resident #1. Staff D further revealed that Resident #1's feet were off the ground while Resident #1 was moved to another area. Staff D stated that the incident occurred on or around January 1, 2026 and that he/she reported the incident on 1/14/2026. Interview on 1/20/26 at approximately 10:45 a.m. with Staff A (Administrator) confirmed that he/she was aware of the above incident as of 1/14/26 and the above incident was not investigated. Resident #2 Review on 1/20/26 of email provided by Staff B (Director of Nursing), dated 1/4/26, From Staff G (Registered Nurse) to Staff B revealed the following: At approximately 2125 [9:25 p.m.] hours on Thursday, January 1. 2026.Upon opening the door to Room [number omitted], I observed the resident standing beside [pronoun omitted] bed screaming with [name omitted, Staff C] LNA [Licensed Nursing Assistant], yelling at [pronoun omitted] to get into bed. When the resident did not comply, I observed [name omitted] pick [pronoun omitted] up off the floor and forcefully place [pronoun omitted] onto the bed. Interview on 1/20/26 at 10:30 a.m. with Staff B (Director of Nursing) confirmed the above email and stated that they did not remove Staff C from working and did not investigate the incident when notified on 1/1/26. Review on 1/20/26 of facility policy titled Abuse, Neglect and Exploitation, revised on 10/23/24, revealed .V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigation include: 1. Identify staff responsible for the investigation; 2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g. not tampering or destroying evidence); 3.Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation.