

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 305050	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/07/2025
NAME OF PROVIDER OR SUPPLIER Lebanon Center, Genesis Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 24 Old Etna Road Lebanon, NH 03766	

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 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p>Based on record review and interview, it was determined that the facility failed to obtain written authorization of a resident to act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility for 3 of 5 residents reviewed. (Resident identifiers are #1, #2, and #3.) Findings include: Resident #1 Review on 7/7/25 of Resident #1's Resident Statement Landscape for January 1, 2025 to June 30, 2025 revealed that Resident #1's social security benefit was direct deposited into their resident fund on 1/3/25, 2/3/25, 3/3/25, 4/3/25, 5/2/25, and 6/3/25. The following amounts of money were transferred directly to the facility with description Care Cost Auto WDL: \$3058.04 on 1/9/25; \$40.00 on 1/21/25; \$1399.00 on 2/3/25; \$1399.00 on 3/3/25; \$1399 on 4/3/25; \$1399.00 on 5/2/25; and \$949.00 on 6/3/25. Review on 7/7/25 of Resident #1's Resident Fund Management Service form, the facility's authorization and agreement to handle resident funds, dated 5/31/24, revealed that Resident #1 did not authorize the facility to automatically transfer care cost payments due to the facility and was not signed by the resident or Resident #1's guardian. Resident #2 Review on 7/7/25 of Resident #2's Resident Statement Landscape for January 1, 2025 to June 30, 2025 revealed that Resident #2's social security benefit was direct deposited into their resident fund and an amount of \$1498.00 was automatically transferred to the facility under the description Care Cost Auto WDL on 1/3/25, 2/3/25, 3/3/25, 4/3/25, 5/2/25, and 6/3/25. Review on 7/7/25 of Resident #2's Resident Fund Management Service form, the facility's authorization and agreement to handle resident funds, dated 2/7/24, revealed that Resident #2 did not authorize the facility to direct deposit their social security benefit payments or to automatically transfer care cost payments due to the facility. Resident #3 Review on 7/7/25 of Resident #3's Resident Statement Landscape for January 1, 2025 to June 30, 2025 revealed that Resident #2's social security benefit was direct deposited into their resident fund and an amount of \$1334.07 was automatically transferred to the facility under the description Care Cost Auto WDL on 1/3/25, 2/3/25, 3/3/25, 4/3/25, 5/2/25, and 6/3/25. Review on 7/7/25 of Resident #3's Resident Fund Management Service form, the facility's authorization and agreement to handle resident funds, dated 11/09/24, revealed that Resident #3 did not authorize the facility to direct deposit their social security benefit payments.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 305050	If continuation sheet Page 1 of 3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 305050	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/07/2025
NAME OF PROVIDER OR SUPPLIER Lebanon Center, Genesis Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 24 Old Etna Road Lebanon, NH 03766	

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 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.</p> <p>Based on record review and interview, it was determined that the facility failed to provide Quarterly statements in writing to the resident or the resident's representative within 30 days after the end of the quarter for 2 of 5 residents reviewed for personal funds. (Resident identifiers are #1 and #2.) Findings include: Resident #1 Review on 7/7/25 of Resident #1's quarterly statement for the quarter ending 12/31/24 revealed the quarterly statement was signed by Staff A (Administrator) on 2/3/25, not Resident #1 or Resident #1's guardian. Review on 7/7/25 of Resident #1's quarterly statement for the quarter ending 3/31/25 revealed the quarterly statement was signed by Staff A on 4/14/25, not Resident #1 or Resident #1's guardian. Interview on 7/7/25 at approximately 1:45 p.m. with Resident #1's guardian revealed that they had not received quarterly statements for Resident #1's personal fund account. Resident #2 Interview on 7/7/25 at 11:20 a.m. with Resident #2 revealed they had not received any quarterly statements for their personal funds and thought they might be sent to their power of attorney. Review on 7/7/25 of Resident #2's quarterly statements for the quarter ending 3/31/25 revealed the quarterly statement was signed by Staff A on 2/3/25, not by Resident #2 or Resident #2's power of attorney. Review on 7/7/25 of Resident #2's quarterly statements for the quarter ending 3/31/25 revealed the quarterly statement was signed by the administrator on 4/14/25, not by Resident #2 or Resident #2's power of attorney. Interview on 7/7/25 at 1:40 p.m. with Resident #2's activated power of attorney revealed that they had not received any quarterly statements for Resident #2's personal funds. Interview on 7/7/25 at approximately 2:15 p.m. with Staff A confirmed the above quarterly statements for Resident #1 and Resident #2 were not given to the residents or their representatives.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 305050	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/07/2025
NAME OF PROVIDER OR SUPPLIER Lebanon Center, Genesis Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 24 Old Etna Road Lebanon, NH 03766	

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 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the facility failed to notify a resident when the amount in the resident's personal fund account reaches or exceeds \$200 less than the SSI (supplemental security income) recourse limit for 1 of 5 residents reviewed for personal funds. (Resident identifier is #1.) Findings include: Review on 7/7/25 of Resident #1's Resident Statement Landscape for January 1, 2025 to June 30, 2025 revealed the following monthly balances: January \$5784.29; February \$5335.58; March \$4958.66; April \$4550.90; May \$3604.10; June \$4102.22. Interview on 7/7/25 at 1:00 p.m. with Staff B (Regional Business Office Manager) revealed that the [NAME] Medicaid SSI resource limit is \$2500. Interview on 7/7/25 at 1:53 p.m. with Staff A (Administrator) revealed the facility did not notify Resident #1 that they had exceeded their SSI resource limit each month from January 2025 through June 2025. Review on 7/7/25 of the facility's policy titled Accounts Receivable Policies and Procedures, AR600 Resident Funds, with a revision date of 1/16/23, revealed the following: .10. Medicaid Eligibility Letters: 10.1 In accordance with state and federal regulations, all Medical Assistance residents must be notified monthly when he resident's account reaches \$200 of the state's asses level for Medicaid eligibility 10.2 Maintain a copy of the notification letter in the resident's file.</p>