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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>305050 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                           | (X3) DATE SURVEY COMPLETED<br><br>10/06/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Lebanon Center, Genesis Healthcare |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>24 Old Etna Road<br>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.

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| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
| <p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> | <p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record reviews, the facility failed to adhere to its policies and procedures for infection control and Legionella prevention. The facility failed to follow the established water management plan by neglecting remediation or testing of the water system after a confirmed resident case of Legionella. Furthermore, the facility failed to document the results of control measures as required by the Water Management Plan. Additionally, the facility allowed the use of a humidifier in a resident's room, which creates a potential risk for the spread and growth of Legionella. Collectively, these failures in following policies, procedures, and the Water Management Plan expose the facility's census of 80 residents to the potential spread and growth of Legionella. Findings include: Review on 10/6/25 of Resident #1's medical record revealed that Resident #1 was admitted and resided at the facility since November 2024. Resident #1 was transferred to the hospital on 9/30/25 for acute respiratory failure with hypoxia (low levels of oxygen in your body tissues).</p> <p>Review on 10/6/25 of Resident #1's Nurse Practitioner Progress Note dated 9/30/25 revealed, [name omitted] is fevering today with hypoxia and rigors, lips are purple and finger poorly perfused. [name omitted] is at high risk for decline and high risk of bacteremia given central line. Ultimately [sic] given above, [name omitted] is unable to be managed in LTC [Long Term Care] setting and decision made to send to ED [Emergency Department]. This was signed by Staff E (Nurse Practitioner).</p> <p>Review on 10/6/25 of Resident #1's hospital Medical Intensive Care Unit Progress Note dated 10/1/25 revealed, . Date of admission: [DATE]. Significant Events Last 24 Hours/Interval History . Urine legionella Ag [Antigen] positive . Active Problems and Important Diagnoses . Legionella pneumonia . Further review revealed that the urine antigen test for Legionella had been obtained and resulted on 9/30/25. The diagnoses being managed were Multi-system organ failure, Acute hypoxemic respiratory failure, Septic Shock, Metabolic acidosis, and coagulopathy.</p> <p>Interview on 10/6/25 at 11:15 a.m. with Staff E confirmed that Resident #1 had been be sent to the hospital on 9/30/25 for hypoxia where they tested positive for Legionella and passed away.</p> <p>Interview on 10/6/25 at 2:15 p.m. with Staff B (Director of Nursing) revealed that the facility followed the Centers for Disease Control and Prevention (CDC) for guidance for Infection Control.</p> <p>Review on 10/7/25 of the CDC's Clinical Guidance for Legionella Infections retrieved from <a href="https://www.cdc.gov/legionella/hcp/clinical-guidance/index.html">https://www.cdc.gov/legionella/hcp/clinical-guidance/index.html</a> revealed, . Testing for healthcare-associated Legionnaires' disease is especially important if any of the following are identified in a healthcare facility . Healthcare-associated Legionnaires' disease diagnosis in the last year .</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>              | <p>Review on 10/6/25 of the facility's policy titled Outbreak Investigation/Management revealed . An outbreak will be defined as an excess over expected (usual) level of a disease within the Center or according to defined clinical parameters. Legionnaires' Disease [greater than or equal to] one case of definite healthcare-associated Legionnaire's disease (a case in a patient who spend the entire 10 days prior to onset of illness in the facility) is identified at any time. 3. Search for additional causes and cases. 3.1 Review surveillance and lab reports. 3.2 Obtain appropriate lab specimens as directed by physician or state/local health departments.</p> <p>Review on 10/6/25 of the facility Legionella Water Management Plan reviewed September 2025 revealed, . Verification &amp; Validation. Laboratory testing will also be conducted in the event of a resident is diagnosed with legionnaire's [sic] disease to confirm the water systems in the facility were the cause of the diagnosis.</p> <p>Interview on 10/6/25 at 11:45 a.m. with Staff B (Director of Nursing) revealed that they had not tested the facility's water system or equipment where Legionella bacteria could grow and spread for Legionella after they were informed Resident #1 had tested positive for Legionella.</p> <p>Interview on 10/6/25 at 9:15 a.m. with Staff C (Maintenance Supervisor) confirmed the above water management plan and revealed that he/she had not conducted any Legionella testing after Resident #1 tested positive for Legionella.</p> <p>Review on 10/6/25 of the facility's procedure titled Legionnaires' Disease with a review date of 9/15/25 revealed, . Follow primary prevention guidelines for Legionnaires' disease . 1.2 Do not use portable room humidifier .</p> <p>Interview on 10/6/25 at 12:35 p.m. with Staff A (Licensed Nursing Assistant (LNA)) revealed that Resident #1 had a humidifier in his/her room for a couple of months. Staff A revealed that he/she was unaware that Residents could not have a humidifier in their room until after Resident #1 went to the hospital.</p> <p>Interview on 10/6/25 at 10:40 a.m. with Staff B (Director of Nursing) revealed that Staff B found out that Resident #1 had a humidifier in his/her room after they tested positive for Legionella.</p> <p>Interview on 10/6/25 at 11:46 a.m. with Staff B and Staff D (Infection Preventionist) revealed that a water sample of Resident #1's humidifier had been collected but not been tested.</p> <p>Review on 10/7/25 of the CDC's Routine Testing Legionella retrieved from <a href="https://www.cdc.gov/control-legionella/php/toolkit/routine-testing-module.html">https://www.cdc.gov/control-legionella/php/toolkit/routine-testing-module.html</a> revealed, . Legionella testing may be useful for . Non-routine purposes . Investigation potential sources of environmental exposure for people with disease . Certain types of facilities may benefit from routine testing, including those that house or treat people at increased risk for Legionnaires' disease . ?</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p> | <p>Review on 10/6/25 of the facility Legionella Water Management Plan reviewed September 2025 revealed, . IV. Control Measures and Monitoring. The facility does not monitor for Legionella. Once a week all unused rooms, showers are run to prevent Legionella. Our hot water tanks heat to 160 degrees [Fahrenheit] well above the temp[temperature] of 140 that kills Legionella . V. Ways to Intervene When Control Limits Are Not Met. Facility does not monitor for Legionella but the following interventions would be instituted, Ice Machines, eye Was [sic] Stations, Water heaters etc [sic] will be taken out of service immediately, a [sic] outside contractoe [sic] would be called in to clean, descale, and sanitize using appropriate control measures, Testing would be done to ensure units are free of Legionella before units are put back in service. Further review revealed, 3. Hot Water. The domestic hot water supply is heated by 3 indirect boilers to approximately 160 degrees Fahrenheit and transferred into two 120 gallon hot water storage tanks. Water temperatures are monitored, recorded and documented in our Tels system [a system that tracks maintenance tasks] on a weekly basis .Areas Subject to Legionella. 1. Ice Machines 2. Dead Legs 3. Less frequently used areas including eyewash stations 4. Hot water holding tanks 5. HVAC-PTAC units [Heating, ventilation, and air conditioning - Packaged Terminal Air Conditioner] Further review revealed that humidifiers were not identified to be at risk for waterborne pathogens in the water management plan.</p> <p>Interview on 10/6/25 at 9:15 a.m. with Staff C (Maintenance Supervisor) confirmed the above water management and revealed that he/she does not test for Legionella routinely as part of the facility's water management plan.</p> <p>Interview on 10/6/25 at approximately 1:00 p.m. with Staff C revealed that he/she checks but does not log the water heater temperature of the hot water tanks. Staff C revealed that he/she would clean any portable air conditioners units twice monthly. Staff C could not provide documentation to show which portable air conditioners had been cleaned.</p> |