STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305050	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lebanon Center, Genesis Healthcare	24 Old Etna Road Lebanon, NH 03766

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. 43408 Based on interview and record review, it was determined that the facility failed to notify the resident and/or representative of quarterly care plan meetings for 1 of 19 residents reviewed for care plans (Resident Identifier #52). Findings include: Resident #52 Interview on 7/9/24 at approximately 12:00 p.m. with Resident #52's activated alternate Durable Power of Attorney (DPOA) revealed he/she had been invited to two care plan meetings since Resident #52 was admitted in April of 2023. Review on 7/10/24 of Resident #52's medical record revealed two quarterly care plan attendance sheets dated 4/26/23 and 2/27/24. Both attendance sheets had identified that the DPOA and the alternate DPOA were in attendance. Interview on 7/10/24 at approximately 2:20 p.m. with Staff K (Social Services) confirmed the above findings. Staff K was unable to provide documentation of other quarterly care plan meetings.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50163 Based on interview, observation, and record review, it was determined that the facility failed to ensure that the residents' Minimum Data Set (MDS) accurately reflected the resident's status for 4 of 19 residents (Resident Identifiers #11, #24, #53, and #76). Findings include: Resident #11 Review on 7/10/24 of Resident #11's Quarterly MDS dated [DATE], section P0100- Restraints and Alarms, revealed that the section Used in Bed; A. Bed rail was coded with a #2, indicating it was used daily. Review on 7/11/24 of Resident #11's Bed Rail Evaluation, dated 1/6/20, revealed that Resident #11 requested to use two half upper rails on the bed to enable mobility and assist with transfers and was not a restraint. Interview on 7/11/24 at approximately 11:00 a.m. with Staff A (MDS Coordinator) confirmed the above findings. 38218 Resident #53 Review on 7/10/24 of Resident #53's MDS dated [DATE], section P0100- Restraints and Alarms, revealed that the section Used in Bed; A. Bed rail was coded with a #2, indicating it was used daily. Interview on 7/9/24 at approximately 9:30 a.m. with Staff B (Licensed Practical Nurse) revealed that Resident #53's bed rail was not a restraint. Interview on 7/11/24 at approximately 11:00 a.m. with Staff A confirmed that Resident #53's bed rail was not a restraint and that the MDS submitted was not accurate. 43408 Resident #76 Review on 7/9/24 of Resident #76's MDS, dated [DATE], section P0100- Restraints and Alarms, revealed that the section Used in Bed; A. Bed rail was coded with a #2, indicating it was used daily. Interview on 7/11/24 at approximately 11:00 a.m. with Staff A confirmed that Resident #76's bed rail was not a restraint and that the MDS submitted was not accurate. 47129 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Resident #24 Review on 7/10/24 of Resident #24's MDS, dated [DATE], section P0100- Restraints and Alarms, revealed that the section Used in Bed; A. Bed rail was coded with a #2, indicating it was used daily. Review on 7/11/24 of Resident #24's Consent for Use of Bed rails dated 4/10/24 revealed that Resident #24's bed rails were used as a mobility enabler and not a restraint. Interview on 7/11/24 at 11:06 a.m. with Staff A revealed that Resident #24's MDS had been incorrectly coded.

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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** 38218 Based on observation, interview and record review, it was determined that the facility failed to ensure that a resident received medication as ordered for 1 out of 26 medications observed (Resident Identifier #32). 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 . Observation on 7/9/24 at approximately 1:00 p.m. with Staff B (Licensed Practical Nurse) of the Intravenous (IV) medication of Heparin administration, revealed Staff B administered 50 units of Heparin. Review on 7/9/24 of Resident #32's Medication Administration Record (MAR) revealed the following physician's order: Heparin Sodium (Porcine) Injection Solution (Heparin Sodium (Porcine)) Use 100 units intravenously two times a day for flush right arm piccline, Start Date 6/19/24. Interview on 7/9/24 at approximately 1:00 p.m. with Staff B confirmed that he/she administered the incorrect dose.

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F 0680 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. 47129 Based on interview and record review, it was determined that the facility failed to ensure the activities program was directed by a qualified professional for a facility census of 88 residents. Findings include: Interview on 7/10/24 at 12:47 p.m. with Staff H (Activities Aide) revealed that there was no Director of the Activities program at the facility. Interview on 7/10/24 at 2:36 p.m. with Staff G (Administrator) confirmed thier was currently no Director of Activities program and that the past director left the position in February 2024. Review on 7/10/24 of the facility's job description for Director of Recreation Services, revised 4/25/17, revealed: The Director of Recreation Services is responsible for the development, implementation, and supervision of the full scope of recreation services in the nursing center . Review on 7/10/24 of the facility's policy titled, Recreation Program Components, revised 4/1/18, revealed .1. The Recreation Director will ensure that the recreation programs may include the following .

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 43408 Based on record review and interview, it was determined that the facility failed to provide sufficient nursing staff as determined by their facility assessment. Findings Include: Review on 7/9/24 of the facilities Payroll Based Journal Staffing Data report Quarter 2, 2024 (January 1-March 31) revealed the facility had excessively low weekend staffing. Review on 7/11/24 of the facility assessment nursing staff and personnel total number needed revealed that the facility assessment determined the required Hours Per Patient Day (HPPD) for nurses aides was 1.63 HPPD. Review on 7/10/24 of the nursing staff punch reports for 6/9/24-7/10/24 revealed the following weekend dates had staffing that was below the staffing numbers determined by the facility assessment: Sunday 6/9/24- Nurse aides 1.57 HPPD; Saturday 6/22/24- Nurses aides 1.49 HPPD; Sunday 6/23/24- Nurse aides 1.45 HPPD; Saturday 6/29/24- Nurses aides 1.49 HPPD; Saturday 7/6/24- Nurses aides 1.47 HPPD; Sunday 7/7/24- Nurses aides 1.43 HPPD. Interview on 7/11/24 at approximately 1:15 p.m. with Staff M (Scheduler/Human Resources) confirmed the above findings.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 43408 Based on record review and interview, it was determined that the facility failed to update the posted daily nurse staffing information of the actual hours worked at the beginning of each shift on a daily basis. Findings include: Review on 7/11/24 of the facility daily nursing staff postings from 6/9/24 through 7/10/24 revealed they did not match the daily nursing schedules provided. Interview on 7/11/24 at approximately 1:30 p.m. with Staff M (Scheduler/Human Resources) verified the above information. Staff M stated that they did not update and change the postings to reflect the actual staffing. Review on 7/11/24 of facility policy titled Posting Staffing, revised 8/7/23, revealed .In accordance with federal and state regulations, Centers will post the census, shift hours, number of staff, and total actual hours worked by licensed and unlicensed nursing staff who are directly responsible for patient care for each shift and on a daily basis .3. The posting should be: .3.4 Adjusted either upward or downward if staffing changes .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 38218 Based on interview and record review it was determined that the facility failed to ensure that orders for psychotropic drugs are limited to 14 days for 1 of 1 residents reviewed for psychotropic/opiod side effects (SE) in a final sample of 19 residents reviewed (Resident Identifier #83). Findings include: Review on 7/10/24 of Resident #83's Medication Administration Record (MAR) revealed the following physician's order: Ativan Oral Tablet 0.5 milligrams (mg) (Lorazepam) Give 1 tablet by mouth every 4 hours as needed for Anxiety/Nausea, Start Date 6/16/24 with no stop date indicated. Further review revealed of Resident #83's MAR revealed that Resident #83 received 10 doses of the as needed Ativan after 14 days of the order being initiated. Interview on 7/11/24 at approximately 10:45 a.m. with Staff D (Director of Nurses) confirmed the above findings. Review on 7/11/24 of the facility policy titled, 3.8 Psychotropic Medication Use, Revision Date 10/24/22 revealed: .8. PRN (as needed) psychotropic medications should be ordered for no more than 14 days

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 50163 Based on interview, observation, review of facility policy, and review of the facility menu, it was determined that the facility failed to offer the residents a nourishing snack at bedtime while having 15 hours between the evening meal and the breakfast meal. Findings include: Interview on 7/9/24 at approximately 2:00 p.m. with the facility's Resident Council (13 residents) revealed that the majority of the residents that attended did not receive bedtime snacks. The Resident Council President stated he/she met with Staff F (Food Service Director) back in January to request more substantial snacks such as tuna, egg salad or chicken salad be available in the kitchettes. Review on 7/10/24 of the facility dining times revealed the following meal schedule: Breakfast 7:30 a.m.; Lunch 11:30 a.m.; Dinner 4:30 p.m. Review on 7/11/24 of the facility's Week At A Glance Menu of week 2 revealed the following evening snack: Sunday: Cranberry Juice and Oatmeal Creme Cookie; Monday: Apple Juice and Chocolate Creme Cookie Tuesday: Cranberry Juice and [NAME] Crackers; Wednesday: Apple Juice and Oatmeal Creme Cookies; Thursday: Cranberry Juice and Chocolate Creme Cookies; Friday: Apple Juice and [NAME] Cookies; Saturday: Cranberry Juice and Oatmeal Creme Cookies. Interview on 7/11/24 at approximately 9:30 a.m. with Staff F (Food Service Director) confirmed that the above snacks are the available snacks in the kitchenettes. Review on 7/11/24 of the facility policy titled, Snacks, with a revision date of 10/2022 revealed: (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.Policy Statement .Bedtime (HS) snacks will be provided for all residents .Procedures .1. The Dining Services Department will collaborate with the residents/patients, nursing and management team to identify necessary beverage and snack items to be provided to each resident/patient .6. Nursing Services is responsible for delivering the individual snacks to the identified residents and for offering evening snacks to all other residents. 47129 Resident #88 Interview on 7/11/24 at 12:59 p.m. with Resident #88 revealed the he/she was not offered a snack in the evening. Resident #71 Interview on 7/9/25 at 11:00 a.m. with Resident #71 revealed that he/she was not offered a snack anytime during the day or night. Resident #71 stated that the snacks available in the kitchenette were oatmeal cookies, goldfish crackers, and/or chips.

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F 0868 Level of Harm - Potential for minimal harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 47129 Based on interview and record review, it was determined that the facility failed to ensure that the required committee members attended meetings at least quarterly for 3 of the 4 quarterly meetings reviewed in 2023/24. Findings include: Review on 7/11/24 of the Quality Assurance Performance Improvement (QAPI) meeting attendance sheets from 2023/24 revealed the following required members were not in attendance: Quarter 1 - Medical Director; Quarter 2 - Medical Director; and Quarter 4 - Infection Preventionist. Interview on 7/11/24 1:52 p.m. with Staff G (Administrator) confirmed the above findings. Review on 7/11/24 of the facility's policy titled, Quality Assurance/Assessment and Performance Improvement Plan, revised 3/16/24, revealed: . The Quality Assessment and Assurance (QAA) Committee consists of the Director of Nursing Services, the Medical Director, the Administrator, at least two other members of the facility staff, and the infection control and prevention officer .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 38218 Based on observation, interview, record review, and policy review, it was determined that the facility failed to follow Centers for Disease Control and Prevention (CDC) guidance for Enhanced Based Precautions (EBP) for 1 of 1 residents with an Intravenous (IV) access in a final sample of 19 residents (Resident Identifier #32). Findings include: Observation on 7/9/24 at approximately 10:00 a.m. of Resident #32's room door revealed signage stating EBP required. Observation on 7/9/24 at approximately 12:55 a.m. of Staff B (Licensed Practical Nurse) accessing Resident #32's IV site revealed Staff B did not put on a gown while accessing Resident #32's IV site. Interview on 7/9/24 at approximately 12:55 p.m. with Staff B confirmed the above findings. Interview on 7/10/24 at approximately 8:00 a.m. with Staff C (Infection Preventionist) revealed that the facility would expect a gown to be worn when accessing a IV. Review on 7/10/24 of the facility policy titled, IC308 Enhanced Barrier Precautions, Revision Date 1/8/24 , revealed: .purpose, to reduce the risk of transmission of epistemologically microorganisms by direct or indirect contact Review on 7/10/24 of the CDC Implementation of Personal Protective Equipment Use in Nursing Homes to Prevent Spread of Multidrug Resistant Organisms (MDRO's), Updated July 2022 revealed: .Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO's to staff hands and clothing. MDRO's may be indirectly transferred from resident-to-resident during these high-contact activities. Nursing home resident with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDRO's. The use of gown and gloves for high-contact resident care activities is indicated, . Enhanced Barrier Precautions, Expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: .Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator .

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 38218 Based on interview, review of the facility's policy for antibiotic stewardship, review of the facility's antibiotic stewardship program, and review of the facility's antibiotic line listings from March 2024 - June 2024, the facility failed to use antibiotic use protocols that identify unnecessary or inappropriate antibiotic use for 2 out of 4 months reviewed, which could affect all residents prescribed antibiotics. Findings include: Review on 7/10/24 of the Antibiotic Line Listings revealed the following antibiotic was prescribed that did not meet the facilities criteria for determining antibiotic use: April 2024- 1 resident was prescribed antibiotics for a Urinary Tract Infection (UTI); and June 2024- 6 residents were prescribed antibiotics for UTI's. Interview on 7/11/24 at approximately 07:30 a.m. with Staff C (Infection Preventionist) confirmed that the above antibiotics were prescribed to residents without the facility's criteria for antibiotic use being met. Review on 7/11/24 of the facility policy titled, IC402 Antibiotic Stewardship, with a revision date of 7/1/24, revealed: Policy .Centers will implement an Antibiotic Stewardship Program (ASP) that includes antibiotic use protocols and systems for monitoring antibiotic use .

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 47129 Based on interview and record review, it was determined that the facility failed to ensure that training and education was provided to staff on abuse, neglect, exploitation, and misappropriation of resident property for 1 of 5 staff reviewed (Staff Identifier is Staff L (Licensed Nursing Assistant)). Finding include: Review on 7/11/24 of Staff L's education file revealed no documentation of training or education for abuse, neglect, exploitation and misappropriation of resident property. Interview on 7/11/24 at 2:30 p.m. with Staff D (Director of Nursing) confirmed that Staff L did not have training or education for abuse, neglect exploitation and misappropriation of resident property prior to Staff L's start date on 4/23/2024. Review on 7/11/23 of facility policy titled, Abuse Prohibition, revised on 10/24/22, revealed .4. Training and reporting obligations will be provided to all employees - through orientation, Code of Conduct training, and a minimum of annually - and will include . 43408