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	08/14/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, it was determined that the facility failed to determine if self-administration of medications was clinically appropriate for 2 of 3 residents reviewed for choices in a final sample of 18 residents. (Resident identifiers are #6 and #8.) Findings include:Resident #6 Observation on 8/12/25 at approximately 10:08 a.m in Resident # 6's room revealed that there were 2 prescription lotions, Ammonium Lactate External Lotion 12% and Anti-Itch External Lotion 0.5-5%, located on the Resident's windowsill. Interview on 8/12/25 at approximately 10:08 a.m with Resident #6 revealed that Resident #6 would have the above mentioned lotion applied by nursing staff and that he/she would also apply the lotion as needed. Observation on 8/12/25 at approximately 10:18 a.m. of Resident #6's room revealed that the prescription lotions remained at the resident's bedside on a bedside table. Observation on 8/13/25 at approximately 1:50 p.m. with Staff A (Licensed Vocational Nurse) revealed that the 2 prescription lotions remained in the resident's room, at that time the prescription lotions were on resident dresser with other toiletries. Review on 8/13/25 of Resident #6's medical record revealed that there was no self administration assessment, care plan, or order. Review on 8/13/25 of Resident #6's orders for Ammonium Lactate External Lotion 12% and Anti-Itch External Lotion 0.5-5% did not include MD instruction for the resident to self administer. Interview on 8/13/2025 at approximately 3:22 p.m. with Staff A confirmed that Resident #6 did not have a self administration assessment, care plan or order to self administer the medications. Resident #8 Observation on 8/12/25 at approximately 9:30 a.m. of Resident #8's room revealed Resident #8 sleeping in his/her bed. There was a clear medicine cup containing a white capsule and a white round tablet on the tray table over the bed. Interview on 8/12/25 at approximately 9:30 a.m. with Staff I (Licensed Practical Nurse) revealed that the white capsule was gabapentin and the white tablet was atorvastatin. Further interview revealed that Resident #8 receives Gabapentin and Atorvastatin on the evening shift. (continued on next page)

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review on 8/12/25 of Resident #8's August 2025 MAR (Medication Administration Record) revealed that the last administered dose of Gabapentin and Atorvastatin was on the evening of 8/11/25. Interview on 8/13/25 at approximately 9:30 a.m. with Resident #8 revealed that they preferred the nursing staff to leave the medications with him/her so they could take them at their own pace. Resident #8 stated that he/she must have fallen asleep before they finished taking their medication on the evening of 8/11/25. Review on 8/13/25 of Resident #8's medical record revealed no care plan, no physician order, and no assessment to self-administer medications. Interview on 8/13/25 at approximately 1:30 p.m. with Staff L (Registered Nurse) confirmed that Resident #8 had no care plan, no physician order, and no assessment to self-administer medications. Review on 8/13/25 of the facility policy titled NSG309 Medication Self Administration revised 10/15/24, revealed .Patients who request to self-administer medication swill be evaluated for safe and clinically appropriate capability based on the patient's functionality and health condition. If it is determined that the patient is able to self administer: A physician/advanced practice provider (APP) order is required. Self-administration and medication self- storage must be care planned. When applicable, patient must be provided with a secure, locked area to maintain medications.Evaluation of capability must be performed initially, quarterly and with any significant change in condition.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview, it was determined that the facility failed to hold routine interdisciplinary care plan meetings for 2 of 18 residents and failed to develop and update comprehensive care plans for 1 of 18 reviewed in a final sample of 18 residents. (Resident identifiers are #13, #24 and #47.)Findings include:Resident #13Interview on 8/13/25 at approximately 8:41 a.m. with Resident #13 revealed that they have had meetings about his/her care, but not for several months. Resident #13 would like to attend his/her care planning meetings.Review on 8/13/25 of Resident #13's medical record revealed that the last documented care plan meeting was 9/4/24.Interview on 8/13/25 at approximately 2:08 p.m. with Staff F (Director of Social Services) confirmed the above findings. Resident #24Interview on 8/12/25 at approximately 2:05 p.m. with Resident #24's DPOA (Durable Power of Attorney) revealed that he/she was invited to a care plan meeting twice last year. The last meeting he/she recalled attending was in December of 2024. DPOA stated that he/she attended all meetings possible.Review on 8/12/25 of Resident #24's medical record revealed that the last documented care plan meeting was 12/17/24.Interview on 08/13/2025 at approximately 2:17 p.m with Staff F confirmed that they did not hold quarterly interdisciplinary care plan meetings for Resident #13 and Resident #24. Resident #47Observation on 8/12/25 at approximately 10:14 a.m. of Resident #47's room revealed a continuous positive airway pressure (CPAP) machine on Resident #47's bedside table. Interview on 8/13/2025 at approximately 3:12 p.m. with Resident #47 revealed that the resident used the CPAP machine nightly. Review on 8/13/25 of Resident #47's care plan revealed that there was no care plan for the use or maintenance of a CPAP machine.Interview on 8/13/25 at approximately 3:26 p.m. with Staff G (Registered Nurse) confirmed that there was no care plan for Resident #47's nightly use of the CPAP machine.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, and record review, it was determined that the facility failed to follow menu preferences, allergies, and intolerances for 1 resident of 1 resident reviewed for food concerns and 1 resident of 1 resident reviewed for nutrition in a final sample of 18 residents. (Resident Identifiers are #17 and #73.)Findings include:Resident #17Observation on 8/12/25 at approximately 12:58 p.m. of Resident #17 in the dining room, during lunch, revealed Resident #17's meal ticket to read ADD FINGER FOODS TO MEALS. Further observation revealed no finger food items provided and Resident #17 was attempting to pick up the ground chicken and gravy with his/her fingers. Resident #17 attempted to drink their pudding from the dish.Observation on 8/13/25 at approximately 8:00 a.m. in the dining room, during breakfast, revealed Resident #17 attempting to eat a bowl of milk-soaked cereal with his /her fingers. Further observation revealed a scoop of scrambled eggs that were untouched on Resident #17's plate. There was no finger food items on Resident #17's plate.Review on 8/13/25 of Resident #17's medical record revealed the following current dietary order: Regular/Liberalized Diet with Dysphagia Advanced texture and Nectar Thickened Liquids, with a start date of 7/25/25.Further review of Resident #17's medical record revealed a Dietary Communication form, dated 7/25/25, that indicated Dysphagia Advanced consistency, Nectar thick liquids, and add finger foods to meals under preferences.Interview on 8/13/25 at approximately 12:00 p.m. with Staff N (Speech Therapist) confirmed that Resident #17 was currently working with them on meal intake and that Staff N had requested finger foods be added to the meal trays.Interview on 8/13/25 at approximately 1:00 p.m. with Staff M (Food Service Manager) confirmed that Resident #17's meal ticket stated to add finger foods to meals. Staff M stated that they had given dry cereal to Resident #17 as a finger food item as they do not have specific finger food items or a protocol as to what to offer for finger food items. Resident #73Interview on 8/12/25 at approximately 2:25 p.m. with Resident #73 stated they are not supposed to have dairy but enjoyed creamer in their coffee and ice cream without having issues. Resident #73 stated they do not offer non dairy options so their choices are limited at meals.Observation on 8/13/25 at approximately 8:00 a.m. of Resident #74 during breakfast revealed Resident #73's meal ticket to read No milk, Allergies: Lactose Intolerant.Interview on 8/13/25 at approximately 1:30 p.m. with Staff M confirmed that Resident #73 has a milk allergy. Staff M stated that the facility did have Lactose free milk as an alternative for residents that cannot have milk but have not provided any to Resident #73.Review on 8/14/25 of facility policy titled Dining and Food Preferences, revised on 10/2022, revealed .The Dining Service Director, or designee, will interview the resident or resident representative to complete a food preference Interview with in 72 hours of admission.Food allergies, food intolerances, food dislikes, and food and fluid preferences will be entered into the resident profile in the menu management software system.The individual tray assembly ticket will identify all food items appropriate for the resident/patient based on diet order, allergies & intolerances, and preferences.

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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. Based on observation, interview, and record review, it was determined that the facility failed to ensure proper storage of washed linens and ensure proper processing of linens to reduce risk of accidental contamination for 1 of 1 laundry observed. Findings include: Observation on 8/14/25 between 10:09 a.m. and 10:45 a.m. in the laundry room with Staff H (Infection Preventionist) and Staff P (Director of Housekeeping) revealed a small residential washing machine was running on normal mode and cold water setting. Interview on 8/14/25 between 10:09 a.m. and 10:45 a.m. with Staff P revealed the residential washing machine had been used for almost a year for resident's clothes, kitchen rags, bed sheets, and other linens. They use a household detergent bought from a local store on all linens and added bleach for white linens. The washing machine was not hooked up to the hot water and ran loads with cold water. Staff P was unable to provide the facility's policy for using the residential washing machine, in regards to the manufacturer's' instructions, temperature, detergent or laundry additives.Interview on 8/14/25 between 10:09 a.m. and 10:45 a.m. with Staff Q (Laundry Aide) revealed they were not able to explain how much bleach and detergent to use to wash and disinfect linens in the residential washing machine.

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. Based on observation, interview, and record review, it was determined that the facility failed to implement their smoking policy for 1 of 1 residents reviewed for smoking in a final sample of 18 residents. (Resident identifier is #1.)Findings include: Review on 8/14/25 of the facility's smoking policy with a review date of 2/24/25, revealed .Smoking supplies (including, but not limited to, tobacco, matches, lighters, lighter fluid, batteries, refill cartridges, etc. [etcetera]) will be labeled with the patient's name, room number, and bed number, maintained by staff, and stored in a suitable cabinet kept at the nursing station .Interview on 8/12/25 at 10:44 a.m. with Resident #1 revealed that Resident #1 was an independent smoker and he/she kept his/her cigarettes and lighter in their room in a black bag. Interview on 8/13/25 at 2:36 p.m. with Staff L (Registered Nurse) confirmed that Resident #1 was an independent smoker and that Resident #1 kept his/her cigarettes and lighter in their room. Observation on 8/14/25 at 1:10 p.m. in Resident #1's room revealed that Resident #1's cigarette and lighter was in a black pouch and stored in an unlocked black bag. Interview on 8/14/25 at 1:10 p.m. with Staff L confirmed the above observation.

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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** Based on interview and record review, it was determined that the facility failed to ensure that the Minimum Data Set (MDS) assessment accurately reflected the residents' status for 4 residents in a final sample of 18 residents. (Resident identifiers are #1, #2, #4, and #24).Findings include:Resident #1 Interview on 8/12/25 at 10:44 a.m. with Resident #1 revealed that he/she was an independent smoker since he/she was admitted to the facility in June 2025. Review on 8/13/25 of Resident #1's smoking care plan, initiated on 6/26/25, revealed that Resident #1 was an independent smoker. Interview on 8/13/25 at 2:36 p.m with Staff L (Registered Nurse) confirmed that Resident #1 was an independent smoker since Resident #1's admission. Review on 8/13/25 of Resident #1's admission MDS with an Assessment Reference Date (ARD) of 6/30/25 revealed that under section J1300 (Current Tobacco use) Resident #1 was coded as no. Interview on 8/14/25 at 8:26 a.m. with Staff O (Director of Nursing) confirmed the above MDS findings for Resident #1. Resident #4 Review on 8/12/25 of Resident #4's June 2025's Electronic Medication Administration Record (EMAR) revealed no anticoagulant medications were administered to Resident #4. Review on 8/12/25 of Resident #4's Annual MDS with an ARD of 6/26/25 revealed that under section N (Medication) Resident #4 was coded as taking anticoagulant medications. Interview on 8/13/25 at 12:13 p.m. with Staff B (MDS coordinator) confirmed the above findings and that Resident #1 was not taking anticoagulant medications during the look back period for the Annual MDS dated [DATE]. Resident #2 Review on 8/13/25 of Resident #2's MDS with an ARD of 6/6/2025 revealed that under section M0300 (Current Number of Unhealed Pressure Ulcer/Injury at each stage) revealed that Resident #2 was coded as having 1 unstageable pressure ulcer (slough and or eschar) that was present on admission. Review on 8/13/25 of Resident #2's wound assessment dated [DATE] with Staff C (Wound Nurse) revealed wound picture revealing the presence of a deep tissue injury (pressure ulcer/injury). Interview on 8/13/25 at approximately 1:32 p.m. with Staff C confirmed the above findings. Interview on 8/13/25 at approximately 2:31 p.m. with Staff B (MDS coordinator) confirmed that the MDS was coded as Resident #2 having an unstageable pressure injury instead of a deep tissue injury. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Resident #24 Interview on 8/13/25 at approximately 9:30 a.m. with Resident #24 revealed that Resident #24 denied the use of insulin. Review on 8/13/25 of Resident #24's May 2025 EMAR revealed that Resident #24 did not take an insulin medication but rather Semaglutide injectable medication (GLP-1 (glucagon-like peptide-1)). Review on 8/13/25 of Resident #24's Quarterly MDS with ARD date of 5/29/25 revealed that under Section N (Medications) Resident #24 was coded as receiving Insulin Injections for 1 day of the 7 day look back period. (5/22 to 5/29) Review on 8/13/25 of Resident #24's February and March 2025 EMAR revealed no insulin medication administered. Review on 8/13/25 of Resident #24's Quarterly MDS with ARD date of 3/3/25 revealed that under Section N (Medications) Resident #24 was coded as receiving Insulin Injections for 1 day of the 7 day look back period. (2/24 to 3/13) Interview on 8/13/25 at 12:13 p.m. with Staff B confirmed the above findings and that Resident #24 was not taking insulin.