

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  305096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/03/2025
NAME OF PROVIDER OR SUPPLIER  Goffstown Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Center Street Goffstown, NH 03045	

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 - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p>Based on interview and policy review it was determined that the facility failed to ensure that residents had access to their personal funds during off business hours. The facility manages personal accounts for 25 residents. Findings include: Review on 12/3/25 of the Facility's policy Resident Petty Cash Policy, undated, revealed Purpose To establish a clear procedure for ensuring that residents have appropriate access during evenings and weekends 3. Weekend and Evening Availability .3.1 The facility will designate evening and weekend petty cash custodians, such as charge nurses, supervisors, or on-call administrative staff. 3.2 Access to funds during these periods will occur as follows: Evenings: Available until the end of the evening shift (typically 11:00 p.m.) through the charge nurse or supervisor. Weekends: Available during both day and evening shifts through designated nursing supervisors. Interview on 12/03/25 at approximately 1:06 p.m with Staff E (Business Office Manager) revealed that residents must request cash from him/her during regular business hours because residents are unable to access their personal funds in the evening or weekends because staff do not have the access to facility's petty cash during off hours.</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
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