

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/23/2025
NAME OF PROVIDER OR SUPPLIER Beaumont Rehab & Skilled Nursing Ctr - Northboro		STREET ADDRESS, CITY, STATE, ZIP CODE 238 West Main Street Northborough, MA 01532	

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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations, and interviews, the facility failed to properly follow sanitation and food handling practices to prevent the risk of foodborne illness in accordance with professional standards for food service safety in the facility's main kitchen.</p> <p>Specifically, the facility failed to ensure that resident food was prepared and distributed appropriately to prevent the potential for cross contamination by staff in the main kitchen when:</p> <ul style="list-style-type: none"> -Dietary Staff #1 was observed handling food items and food trays and walked around other areas of the main kitchen touching surfaces using the same gloves. Dietary Staff #1 was also handling dirty trays and resident food items on the food service line and did not change gloves or perform appropriate hand hygiene. -Dietary Staff #2 did not change gloves or perform appropriate hand hygiene between working on the resident food service line, moving around other areas of the kitchen and returning to the serving line. <p>Findings include:</p> <p>Review of the facility policy for Glove Use in the Dining Services Department, last revised 4/1/25, indicated:</p> <ul style="list-style-type: none"> -plastic gloves will be worn when handling food that will not be cooked further to ensure that bacteria are not transferred from the food handler's hands to the food product being served. -if used, single use gloves shall be used for only one task, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. -hands are to be washed when entering the kitchen and before putting plastic gloves on. -wash hands after removing gloves. <p>Review of the facility policy for Food Services- Hand Hygiene last revised 4/1/25, indicated that hands should be washed with soap and water at the following times:</p> <ul style="list-style-type: none"> -before each shift <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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> -before putting on (donning) gloves -between handling raw and cooked foods -after handling soiled silverware/utensils -after handling garbage -after removing gloves -after any activity that may contaminate hands <p>On 6/23/25 the surveyor observed the following during the breakfast meal service in the facility main kitchen:</p> <p>-At 8:29 A.M., the surveyor and the Food Service Director (FSD) observed Dietary Staff #1 step away from the serving line with gloved hands to walk to the corner of the kitchen to grab a tray of muffins. Dietary Staff #1 placed the tray on a table closer to the food she was serving, took a muffin off the tray with her gloved hand and placed it on a resident's tray. Dietary Staff #1 then proceeded to continue to serve food on the resident trays with the same gloved hands. The surveyor observed the FSD instructing Dietary Staff #1 to remove her gloves and wash her hands. During an interview at the time, the FSD said that Dietary Staff #1 should have changed her gloves and washed her hands as soon as she stepped away from the serving line and she did not.</p> <p>-At 8:34 A.M., the surveyor observed Dietary Staff #1 step away from the serving line to take a dirty metal tray to the dirty dish area of the kitchen. Dietary Staff #1 did not remove her gloves, wash her hands or don a new pair of gloves prior to returning to the serving line and proceeding to serve breakfast with the same gloved hands.</p> <p>-At 8:36 A.M., the surveyor observed Dietary Staff #2 step away from the serving line to retrieve a serving utensil from another area of the kitchen. Dietary Staff #2 did not remove her gloves, wash her hands or don a new pair of gloves prior to returning to the serving line and proceeding to serve breakfast with the same gloved hands. The surveyor then observed the FSD instructing both Dietary Staff #1 and Dietary Staff #2 to remove their gloves and wash their hands prior to returning to the serving line.</p> <p>During an interview at the time, the FSD said that Dietary Staff #1 and Dietary Staff #2 should have removed their gloves and washed their hands after stepping away from the food serving line and they did not.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Resident #10 was admitted to the facility in July 2020 with diagnoses including open wound of the abdominal wall and atherosclerosis of native arteries of left leg with ulceration of heel and midfoot.</p> <p>Review of Resident #10's Physician's order for June 2025, indicated:</p> <p>-Enhanced Barrier Precautions (EBP) related to lower leg wounds.</p> <p>&gt;Special Instructions: Gown/Glove Use for High Contact Care: dressing, bathing/showering, transferring, providing hygiene, changing linens.</p> <p>On 6/20/25 at 8:01 A.M., the surveyor observed CNA #2 remove soiled linen from Resident #10's bed and place the linen in a bag on the floor next to the Resident's bed in his/her room. CNA #2 was observed wearing gloves but not wearing a gown. CNA #2 was further observed to exit Resident #10's room with the soiled gloves still in place, and proceed into the hallway and remove clean linen from a linen cart in the hallway. The surveyor observed CNA #2 go back into Resident #10's room with the clean linen and make the Resident's bed with the soiled gloves still in place. When CNA #2 finished making the bed, she doffed the dirty gloves and sanitized her hands.</p> <p>During an interview on 6/20/25 at 8:10 A.M., CNA #2 said she was aware Resident #10 was on EBP related to leg wounds. CNA #2 said she did not don a gown because she was not providing high contact care to Resident #10. The surveyor and CNA #2 reviewed the EBP sign at the Resident's door and CNA #2 said she should have worn a gown while changing Resident #10's bed, but she did not. CNA #2 further said she should have removed her gloves and sanitized her hands before exiting the Resident's room to obtain clean linen, but she did not.</p> <p>During an interview on 6/20/25 at 8:14 A.M., Unit Manager (UM) #1 said she was unsure whether the CNAs are expected to wear gowns or gloves when changing linens on the bed for residents on EBP and would get back to the surveyor.</p> <p>During an interview on 6/20/25 at 8:42 A.M., UM #1 said that CNAs were expected to wear gowns and gloves when changing linens for residents on EBP. UM #1 said that CNA #2 should have worn a gown when making Resident #10's bed but she did not.</p> <p>During an interview on 6/20/25 at 10:17 A.M., the Chief Nursing Officer (CNO) said that CNA #2 should have worn gloves and a gown when she made Resident #10's bed, but she did not.</p> <p>Based on observation, and interview, the facility failed to adhere to infection control standards of practice, increasing the risk of contamination and spread of infections on one unit ([NAME] Unit) out of two units, and for one Resident (#10) out of a total sample of 18 residents.</p> <p>Specifically, the facility failed to:</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. ensure that the staff on the [NAME] Unit wore the indicated personal protective equipment (PPE-items such as gowns and gloves worn by staff to decrease the spread of infections) when providing high contact care for residents on Enhanced Barrier Precautions (EBP-measures using protective barrier gowns and gloves as an infection control intervention designed to reduce transmission of multi-drug-resistant organisms (MDRO) during high contact resident care) when a Certified Nurses Aide (CNA) provided denture hygiene care for a unit resident.</p> <p>2. For Resident #10, ensure that staff followed the EBP ordered by the Physician when removing the Resident's dirty bed linens and performed appropriate hand hygiene and glove use when applying clean bed linens.</p> <p>Findings include:</p> <p>Review of the facility policy titled Enhanced Barrier Precautions (EBP), dated 4/6/23, indicated:</p> <ul style="list-style-type: none"> -Enhanced Barrier Precautions expands the use of PPE and refer to the use of gowns 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 care activities -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 requiring gown and glove for use of enhanced barrier precautions include: <ul style="list-style-type: none"> &gt;dressing &gt;bathing/showering &gt;transferring &gt;providing hygiene &gt;changing linens &gt;changing briefs or assistance with toileting <p>1. On 6/18/25 at 8:22 A.M., the surveyor observed the following:</p> <ul style="list-style-type: none"> -Certified Nurses Aide (CNA) #1 enter a room on the [NAME] unit with posted signs for EBP which indicated: <ul style="list-style-type: none"> &gt;Everyone must clean their hands, including before entering and when leaving the room <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>&gt;providers and staff must also:</p> <p>-wear gloves and a gown for the following high contact resident care activities:</p> <p>&gt;dressing</p> <p>&gt;bathing/showering</p> <p>&gt;transferring</p> <p>&gt;changing linens</p> <p>&gt;providing hygiene</p> <p>&gt;changing briefs or assisting with toileting</p> <p>&gt;device care or use: central line, urinary catheter, feeding tube, tracheostomy</p> <p>&gt;wound care: any skin opening requiring a dressing</p> <p>-CNA #1 was observed donning gloves but no gown, and entering the EBP room.</p> <p>-CNA #1 was observed to take a denture cup from the resident and then bring the denture cup into the resident's bathroom.</p> <p>-CNA #1 returned from the resident's bathroom with the dentures on a paper towel and handed the dentures to the resident.</p> <p>-CNA #1 doffed her gloves, performed hand hygiene and exited the room.</p> <p>During an interview on 6/18/25 at 8:26 A.M., CNA #1 said she was washing the resident's dentures in the bathroom. CNA #1 said she did not know why the resident was on precautions because she does not normally work on the [NAME] Unit. CNA #1 said she did not think she needed a gown because she had gloves on and was only cleaning the resident's dentures.</p> <p>During an interview on 6/23/25 at 12:20 P.M., the Director of Nursing (DON) said the resident on the [NAME] Unit observed by the surveyor was on EBP because the resident had a Peripherally Inserted Central Catheter (PICC line). The DON said that CNA #1 should have been wearing a gown when completing denture care for the resident because denture care is considered high contact care.</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, and interview, the facility failed to ensure that patient care equipment was maintained in safe operating condition for one Resident (#47) out of a total sample of 18 residents.</p> <p>Specifically, for Resident #47, the facility failed to ensure that an air mattress ordered by the Physician was appropriately functioning as required when the air mattress was plugged into a non-functioning electrical outlet and the Resident was not receiving the pressure relieving benefit of the air mattress.</p> <p>Findings include:</p> <p>Review of the Medline Supra CXC User Manual, undated, indicated:</p> <p>-Troubleshooting</p> <p>&gt;power is not on. Solution: check if the plug is connected to the mains, check if there is any blown fuse.</p> <p>&gt;patient is bottoming out. Solution: pressure setting might be inadequate for the patient. Adjust pressure to a higher level and wait a few minutes.</p> <p>Resident #47 was admitted to the facility in July 2024 with diagnoses including Dementia and chronic kidney disease.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE], indicated Resident #47:</p> <p>-was unable to complete the Brief Interview for Mental Status exam because they are rarely or never understood</p> <p>-was significantly cognitively impaired</p> <p>-was dependent on staff for all Activities of Daily Living (ADLs)</p> <p>-was at risk for developing pressure ulcers and utilized a pressure relieving device for bed and chair</p> <p>-was receiving Hospice services</p> <p>Review of Resident #47's Care Plan for Skin Breakdown, last revised 5/2/25, indicated:</p> <p>-the Resident is at risk for skin breakdown due to incontinence and decreased mobility</p> <p>-an intervention for an air mattress to bed</p> <p>Review of Resident #47's June 2025 Physician's orders indicated:</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-order for an air mattress with bolsters applied to the bed</p> <p>-monitor mattress for comfort setting per resident preference every shift, start date 4/28/25.</p> <p>On 6/17/25 at 8:45 A.M., the surveyor observed Resident #47 asleep in bed on an air mattress which had been plugged into a red electrical outlet (electrical outlet connected to emergency backup power). The surveyor observed the power to the Resident's mattress was not on and the mattress was deflated when the surveyor touched it.</p> <p>On 6/17/25 at 4:27 P.M., the surveyor observed Resident #47's lying in bed with an air mattress in place and plugged into a red outlet. The surveyor observed that the power to the air mattress was not on and the mattress was deflated upon examination.</p> <p>On 6/18/25 at 7:48 A.M., the surveyor observed Resident #47 asleep in bed on an air mattress that was plugged into a red outlet, but the power was not turned on and the air mattress was deflated on examination.</p> <p>Review of the Resident #47's June 2025 Medication Administration Record (MAR) indicated that the Resident's air mattress had been checked daily every shift for comfort.</p> <p>During an interview on 6/18/25 at 8:40 A.M., the surveyor and Nurse #1 observed Resident #47 asleep in the bed with an air mattress in place. Nurse #1 said that the red outlet did not appear to be working, that nursing staff should have been checking the air mattress every shift, according to the Physician's orders and they had not been.</p> <p>During an interview on 6/18/25 at 8:41 A.M., the Director of Nurses (DON) said that Resident #47's air mattress should have been working, but it had not been and that she intended to notify the maintenance department.</p>		