STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225682	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Knoll Rehabilitation and Healthcare Center	9 Arbetter Drive Framingham, MA 01701

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)
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, and interview, the facility failed to adhere to infection control and prevention standards related to multi-resident medical equipment use for one Unit (Sub Acute) out of two units observed, to mitigate the development and transmission of communicable diseases and infections. Specifically, the facility failed to:1. ensure that facility staff cleaned and disinfected a blood glucose monitor (BGM - device used to measure the amount of glucose [sugar] in the blood) between multi-resident use after Nurse #2 used the BGM to obtain finger stick blood sugar (FSBS) levels on two residents and before storing the BGM device in the medication cart with clean equipment.2. ensure the facility staff cleaned and disinfected a wrist blood pressure cuff (machine used to check blood pressure) between multi-resident use when Nurse #2 used the wrist blood pressure cuff to obtain blood pressure readings on three residents, placed the wrist blood pressure cuff in her pocket after use on the three residents, and placed the contaminated device on the surface of the medication administration cart after exiting the three residents rooms. Findings include: Review of the facility policy titled: Cleaning and Disinfection of Resident-Care Items and Equipment, revised September 2022, indicated the following: -Reusable items are cleaned and disinfected or sterilized between residents. -Reusable resident care equipment is decontaminated and/or sterilized between residents according to manufacturers' instructions. -Durable medical equipment (DME) is cleaned and disinfected before reuse by another resident. Review of the facility policy titled: Blood Sampling- Capillary (Finger Sticks), revised September 2014, indicated the following: -The purpose of this procedure is to guide the safe handling of capillary-blood sampling devices to prevent transmission of bloodborne diseases to residents and employees. -Equipment and supplies: Alcohol pledgets. Disinfected blood glucose meter (glucometer) with sterile lancet; or singly resident use spring-loaded device (e.g., Pen let) or automatic or safety type lancet. Disposable lancet. Personal protective equipment (e.g. gloves) (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Sharps Container. Approved EPA registered disinfectant for cleaning of sampling device. -General guidelines: - Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between residents uses. -Following the manufacturer's instructions, clean and disinfect reusable equipment, parts, and/or devices after each use. On 2/11/26, during a medication administration observation, the surveyor observed the following: -At 7:45 A.M., Nurse #2 performed a blood pressure measurement on a resident on Enhanced Barrier Precautions (EBP - mandates the use of gowns and gloves during high-contact resident care, such as dressing, bathing, or changing linens to reduce the transmission of multidrug-resistant organisms) in his/her room with a wrist blood pressure cuff. Nurse #2 placed the wrist blood pressure cuff in her pocket after obtaining the blood pressure reading from the resident and failed to clean or disinfect the wrist blood pressure cuff after use. Nurse #2 exited the resident's room and removed the wrist blood pressure cuff from her pocket, placed the wrist blood pressure cuff on top of her medication administration cart and documented the resident's blood pressure reading. -At 7:49 A.M., Nurse #2 obtained a blood glucose level on a resident, using a BGM. The surveyor observed Nurse #2 place the BGM back in the basket containing the BGM supplies without cleaning or disinfecting the equipment and then place the basket on top of the medication administration cart and document the resident's blood glucose reading. - At 7:56 A.M., Nurse #2 obtained a blood pressure reading on a second resident in his/her room with the wrist blood pressure cuff and placed the wrist blood pressure cuff in her pocket after obtaining the blood pressure reading from the second resident. Nurse #2 was not observed cleaning or disinfecting the wrist blood pressure cuff after use on the second resident. Nurse #2 exited the second resident's room and removed the wrist blood pressure cuff from her pocket, placed the wrist blood pressure cuff on top of her medication administration cart and documented the second resident's blood pressure reading. - At 8:11 A.M., Nurse #2 obtained a blood pressure reading on a third resident in his/her room with the wrist blood pressure cuff and placed the wrist blood pressure cuff in her pocket after obtaining the blood pressure reading from the resident without cleaning or disinfecting the equipment before or after use on the third resident. Nurse #2 then obtained a blood glucose reading with the BGM on the same resident and failed to clean and disinfect the BGM prior to use. The surveyor observed Nurse #2 place the BGM back in the basket containing the BGM supplies, exited the resident's room and removed the wrist blood pressure cuff from her pocket, placed the wrist blood pressure cuff and the basket containing the BGM on top of her medication administration cart, and documented the blood pressure reading and the blood glucose reading. Nurse #2 was not observed to clean or disinfect the BGM and the wrist blood pressure cuff after multi-resident use. During an interview on 2/11/26 at 8:41 A.M., Nurse #2 said she forgot to clean the BGM and the wrist blood pressure machine after each resident use. Nurse #2 said she should have disinfected the BGM (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and the wrist blood pressure cuff after each resident use, but she did not. During an interview on 2/11/26 at 8:47 A.M., Unit Manager (UM) #2 said the facility used germicidal bleach wipes to disinfect the BGM after each resident use. UM #2 said Nurse #2 should have cleaned the wrist blood pressure cuff after each resident use. UM #2 further said Nurse #2 should have disinfected the BGM with the facility approved disinfecting wipes.