

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225759	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2024
NAME OF PROVIDER OR SUPPLIER Recuperative Services Unit-Hebrew Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 Centre Street Boston, MA 02131	

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 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>50338</p> <p>Based on record review and interviews the facility failed to ensure a Minimum Data Set (MDS) assessment was accurately coded for one Resident (#28) out of three sampled closed records. Specifically, for Resident #28, the facility failed to accurately code the correct discharge location on the MDS assessment.</p> <p>Findings include:</p> <p>Resident #28 was admitted to the facility in May 2024 with diagnoses that include diabetes, chronic kidney disease, and hyponatremia (levels of sodium in the blood is low).</p> <p>Review of MDS assessment, dated 6/5/24, indicated Resident #28 was discharged to a short-term general hospital.</p> <p>Review of Resident #28's Case Management/Social Work Discharge Assessment, dated 6/4/24, indicated he/she would discharge home on 6/5/24 with services for Nursing, Physical Therapy, and Occupational Therapy.</p> <p>During a phone interview on 7/17/24 at 10:06 A.M., the MDS Nurse said that the discharge destination should have been coded as discharge to home and it was not.</p> <p>During an interview on 7/17/24 at 3:12 P.M., the Director of Nursing (DON) said the MDS assessment should be coded according to the RAI (Resident Assessment Instrument) manual.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>48990</p> <p>Based on observations, interviews, and record review, the facility failed to implement the plan of care for one Resident (#434) out of a total sample of 12 residents. Specifically, the facility failed to provide supervision with eating for Resident #434.</p> <p>Findings include:</p> <p>Resident #434 was admitted to the facility in July 2024 with diagnoses including failure to thrive and dysphagia (difficulty swallowing).</p> <p>Review of the most recent Minimum Data Set (MDS) assessment, dated 7/16/24, indicated Resident #434 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of 15.</p> <p>Review of Resident #434's plan of care related to dysphagia, dated 7/16/24, indicated:</p> <ul style="list-style-type: none"> - Supervision recommendations: 100% of the time, need for cueing, Encourage self-feeding. - Supervision: Feeds self with close, line of sight/direct supervision to load to utensil with food, encouragement to continue eating. <p>Review of the speech therapy evaluation, dated 7/12/24 and signed by the physician on 7/14/24, indicated:</p> <ul style="list-style-type: none"> - Pt (patient) presents with presbyphagia (age-related swallowing changes) in conjunction with dentition changes and superimposed by delirium. Presence of delirium is influencing his/her mealtime efficiency which may influence his/her nutritional status if the correct level of mealtime support is not supplied. - Supervision recommendations: 100% of the time, need for cueing, Encourage self-feeding. - Safe Swallow strategies comments: Supervision: Feeds self with close, line of sight/direct supervision to load to utensil with food, encouragement to continue eating. <p>Review of speech therapy progress note, dated 7/16/24, indicated:</p> <ul style="list-style-type: none"> -Supervision: Feeds self with close, line of sight/direct supervision to load to utensil with food, encouragement to continue eating. <p>On 7/16/24 at 8:26 A.M., the surveyor observed Resident #434 eating a cut up muffin, oatmeal, and coffee alone in his/her room. Resident #434 had a basin filled with vomit next to him/her. Resident #434 said he/she throws up every morning at breakfast and staff was aware. There were no staff within direct sight line of Resident. The staff communication board in his/her room indicated:</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- 1:1 set up and support at meals (encouragement, spoon loading).</p> <p>On 7/17/24 from 8:53 A.M to 9:03 A.M., the surveyor observed Resident #434 eating cut-up pancakes, cut-up bananas, orange juice, and coffee alone in his/her room. There were no staff within direct sight line of the Resident or in the corridor near his/her room during this time frame.</p> <p>During an interview on 7/17/24 at 9:03 A.M., Resident #434 said he/she was discouraged because he/she was having trouble eating breakfast. The Resident said this was because his/her arms were weak, and he/she couldn't see the food on his/her breakfast tray.</p> <p>On 7/17/24 from 12:14 P.M. to 12:27 P.M., the surveyor observed Resident #434 eating mashed potatoes, minced meatloaf, and juice alone in his/her room. There were no staff within direct sight line of the Resident or in the corridor near his/her room during this time frame.</p> <p>During an interview on 7/17/24 at 12:27 P.M., Resident #434 said he/she often gags on food and has a history of difficulty with swallowing. Resident #434 said he/she was very concerned about having difficulty swallowing and gagging. Resident #434 said staff does not supervise or provide assistance with his/her meals even though his/her staff communication board in his/her room says they should.</p> <p>Review of Resident #434's Certified Nurse Assistant documentation indicated the following assistance was provided with meals:</p> <ul style="list-style-type: none"> - 7/11/24 at 1:39 P.M., cue/setup. - 7/11/24 at 6:36 P.M., independent. - 7/12/24 at 1:48 P.M., cue/setup. - 7/13/24 at 6:00 P.M., cue/setup. - 7/14/24 at 2:32 P.M., cue/setup. - 7/15/24 at 2:53 P.M., cue/setup. - 7/15/24 at 6:00 P.M., cue/setup. - 7/16/24 at 9:39 P.M., independent. <p>During an interview on 7/17/24 at 12:44 P.M., Certified Nurse Assistant (CNA) #2 said she was not aware Resident #434 required supervision with meals, and that staff usually sets-up the meal and he/she eats it independently. CNA #2 said if Resident #434 required supervision it would either be listed on the staff communication board in his/her room, or it would be communicated to the CNA by the nurse in report at the beginning of the shift. The surveyor and CNA #2 went into Resident #434's room and observed the staff communication board, which indicated 1:1 set up and support at meals (encouragement, spoon loading). CNA #434 said she did not see that, and it was probably old because Resident #434 didn't need supervision.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/17/24 at 12:59 P.M., Nurse #3 said she was not aware Resident #434 required supervision with meals and said the Resident required set-up assistance only. Nurse #3 said if Resident #434 required supervision with meals she would communicate it to staff in report or it would be written on the staff communication board in the Resident's room. Nurse #3 said CNAs are expected to review each Resident's staff communication board each shift. Nurse #3 said care plan interventions and speech therapy interventions should be followed. Nurse #3 then looked into Resident #434's record with the surveyor and said based on the dysphagia care plan and speech therapy progress note, dated 7/16/24, Resident #434 should have had a CNA or nurse within direct line of sight of the Resident while eating.</p> <p>During an interview on 7/17/24 at 1:22 P.M., Speech Therapist #1 said Resident #434 had been recommended the intervention for direct supervision during meals on admission because of difficulty swallowing and was evaluated to continue this direct supervision during meals by speech therapy on 7/16/24. Speech Therapist #1 said this intervention should have been followed, because the physician signed this evaluation, and it was listed on the Resident's care plan. Speech Therapist #1 said ten minutes is too long for Resident #434 to not be within direct line of sight of staff while eating.</p> <p>During an interview on 7/17/24 at 1:32 P.M., the Director of Nursing (DON) said interventions listed in the dysphagia care plan should have been followed. The DON said based on Resident #434's dysphagia care plan he would expect staff to be close enough to the Resident to see or hear if the Resident was choking. The DON said the facility did not have a policy addressing assistance with meals or activities of daily living (ADLs), but the facility's expectation is to provide supervision with meals if indicated in care plan.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>15016</p> <p>Based on record review, interview and observation for one Resident (#81) of 12 sampled residents, the facility failed to provide respiratory care consistent with professional standards of practice. Specifically, the facility failed to develop a resident care policy for oxygen administration and failed to obtain a physician's order for oxygen use, which staff were actively administering to the Resident.</p> <p>Findings include:</p> <p>Review of the Healthcare Quality Association on Accreditation, dated 5/4/2017, indicated physician orders must be obtained for oxygen use and should include the amount of oxygen (flow rate) and duration.</p> <p>Review of policies indicated the facility had not developed a policy for oxygen use.</p> <p>Resident #81 was admitted to the facility in June 2024, and had diagnoses which included chronic obstructive pulmonary disorder (COPD, a lung disease limiting the ability to breath), dyspnea (labored breathing) and multiple fractured ribs.</p> <p>Review of Resident #81's Minimum Data Set assessment, dated 7/9/24, indicated there was no reference to use of oxygen therapy.</p> <p>Review of Resident #81's care plan, dated 7/9/24, indicated he/she had an unstable respiratory status due to COPD. Interventions included Oxygen per order.</p> <p>Review of Resident #81's physician orders, dated 7/9/24 through 7/16/24, indicated there was no physician's order for the use of oxygen.</p> <p>Review of his/her Medication Administration and Treatment Administration Records, dated 7/9/24 through 7/16/24, failed to indicate a reference to oxygen administration.</p> <p>Review of Resident #81's nurses' notes, dated 7/9/24, 7/13/24 and 7/16/24, indicated references to his/her use of oxygen.</p> <p>Review of Resident #81's physician note, dated 7/11/24, indicated continue with supplemental oxygen with goal O2 sat [saturation] 88% or above - wean off as tolerated.</p> <p>During an interview and observation on 7/16/24 at 7:52 A.M., the surveyor observed Resident #81 awake, lying in bed, and wearing a nasal cannula. The oxygen flow rate was set to one liter of oxygen per minute. Resident #81 said sometimes he/she has difficulty breathing and that during those times staff will offer oxygen through a nasal cannula. Resident #81 then terminated the interview.</p> <p>On 7/17/24 at 7:45 A.M., the surveyor observed Resident #81 awake and lying in bed, wearing an oxygen mask. A nebulizer was attached to the mask and the oxygen flow rate was set to one liter per minute.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/17/24 at 8:01 A.M., Nurse #4 said she was unable to locate a physician's order for Resident #81's use of oxygen in either the Medication Administration or Treatment Administration Records. Nurse #4 said there was no record of the dates or times staff administered oxygen to the Resident. Nurse #4 said a physician's order was required for the administration of oxygen.</p> <p>On 7/17/24 at 8:08 A.M., the surveyor and Director of Nurses (DON) observed Resident #81 awake, lying in bed, and wearing a nasal cannula. The oxygen flow rate was set to one liter per minute. The DON said there was no order for Resident #81's use of oxygen, and that an order is required for its administration. The DON said the physician indicated in a progress note the Resident should receive oxygen, but that an order was not written for its use. The DON said the facility did not have a policy for oxygen use.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>44095</p> <p>Based on observation, policy review, record review and interview for one Resident (#18) of 12 sampled residents, the facility failed to ensure staff stored drugs and biologicals in accordance with State and Federal requirements. Specifically, for Resident #18 the facility failed to ensure nursing stored his/her physician's ordered nasal spray and timolol (medicated eye drops used to treat high pressure in the eyes) according to State and Federal requirements.</p> <p>Findings include:</p> <p>Review of the facility policy, Medication Storage, Security and Access, dated as revised 10/25/21, indicated all medications will be stored and secured in accordance with all state and federal regulations.</p> <p>Medications stored in patient care areas:</p> <ol style="list-style-type: none"> 1. Medication storage areas are accessible only to authorized personnel, as designated by the Director of Pharmacy. 2. All medications are stored in a secured location or in an area where the medication storage area is under continuous surveillance by licensed personnel. The Director of Pharmacy has authority to designate storage areas for all medications. 3. Medications are stored in specialized compartments in automated dispensing machines or in secured cabinets/drawers or medication rooms when not in use. <p>Review of the facility policy, Patient Self-Administration of Medication, dated as revised 2/22/22, indicated:</p> <p>II. Purpose:</p> <ol style="list-style-type: none"> a. To provide a process that maintains a safe environment of care as it supports self-administration of medication for patients who meet the criteria for self-administration of medication. <p>III. Policy:</p> <ol style="list-style-type: none"> d. A Provider order must be obtained permitting medication self-administration for each medication individually. <p>Resident #18 was admitted to the facility in July 2024 with diagnoses including bradycardia and spinal stenosis.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the most recent Minimum Data Set (MDS) assessment, dated 7/9/24, indicated that Resident #18 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15.</p> <p>On 7/16/24 at 8:13 A.M., Resident #18 was in bed, the surveyor observed one bottle of saline nasal spray on Resident #18's overbed table. There was a bottle of timolol eye drops on the table along the side of the room.</p> <p>On 7/16/24 at 8:49 A.M., Resident #18 was in a chair, the surveyor observed one bottle of saline nasal spray on Resident #18's nightstand. There was a bottle of timolol eye drops on the table along the side of the room. Resident #18 said that he/she keeps the nasal spray at his/her bedside and will use it for nose pain.</p> <p>Review of Resident #18's physician's order, dated 7/3/24, indicated:</p> <p>- sodium chloride 0.65% nasal spray, two sprays in both nostrils three times daily as needed for nasal congestion and dryness. Further review of the physician's order failed to include instructions to self-administer.</p> <p>Review of Resident #18's physician's order, dated 7/3/24, indicated:</p> <p>- timolol 0.25%, one drop in both eyes every morning. Further review of the physician's order failed to include instructions to self-administer.</p> <p>Review of the Medication Administration Record (MAR), dated 7/16/24 at 9:27 A.M., indicated nursing administered the timolol eye drops as ordered.</p> <p>Review of Resident #18's physician's order, dated as active on 7/16/24, failed to include orders for self-administration of medications.</p> <p>Review of Resident #18's plan of care, dated as active on 7/16/24, failed to include orders for self-administration of medications.</p> <p>On 7/16/24 at 10:53 A.M., 7/16/24 at 1:18 P.M., and on 7/16/24 at 3:11 P.M., the surveyor observed the bottle of saline nasal spray on Resident #18's bedside table.</p> <p>During an interview on 7/17/24 at 12:18 P.M., Resident #18 said that he/she no longer has his/her nasal spray. Resident #18 said nursing took it away on 7/16/24 and locked it up.</p> <p>During an interview on 7/17/24 at 12:19 P.M., Nurse #2 said saline nasal spray and eye drops should be locked up and not left out at the bedside. Nurse #2 showed the surveyor Resident #18's saline nasal spray and timolol eye drops secured in a locked medication box. Nurse #2 said she routinely cares for Resident #18 and Resident #18 has not been assessed for self-administration of medications and will ask for nasal spray.</p> <p>During an interview on 7/17/24 at 1:30 P.M., the Director of Nursing (DON) said eye drops should be locked away, but the nasal spray could be left at the bedside.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/18/24 at 11:20 A.M., the Quality Assurance (QA) Nurse said that saline nasal spray and the timolol eye drops should be secured. The QA Nurse said that Resident #18 was not assessed for self-administration of medications.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>45763</p> <p>Based on observation, policy review, and interview, the facility failed to serve food in accordance with professional standards for food service safety. Specifically, the facility failed to ensure staff did not use contaminated gloves to directly handle ready-to-eat food.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Personal Hygiene and Uniforms, revised January 2024, indicated, but was not limited to, the following:</p> <ul style="list-style-type: none"> -Culinary and Nutrition Staff will adhere to the highest standard of personal hygiene. -Proper hand washing is the single most effective way to minimize the transfer of food-borne illness. All staff must wash their hands frequently and particularly in the following situations: After coming in contact with any soiled utensil, equipment or surface and before touching anything unsoiled. <p>On 7/17/24 from 7:49 A.M. to 8:03 A.M., the surveyor made the following observations during a continuous tray line observation during breakfast service:</p> <ul style="list-style-type: none"> -The cook contaminated his gloves by picking up a toaster and moving it, he then further contaminated his gloves by touching a hanging ceiling outlet and two toaster cords when he unplugged the toaster from the hanging ceiling outlet and plugged another toaster in; the hanging ceiling outlets had visible dust/debris. The cook further contaminated the same gloves by touching the bottom of plates, and when moving a box of gloves. The cook then, using the same contaminated gloves, touched the middle of a plate where ready-to-eat food was then served. -The cook further contaminated the same gloves by touching the handle of a scoop. The cook then used the same contaminated gloves to grab a ready-to-eat muffin and removed the bottom wrapper. While removing the wrapper the cook's contaminated gloves contacted the edible portion of the muffin which he then placed on a resident plate to be served. -The cook further contaminated the same gloves by touching the bottom of a plate; the cook used the same contaminated gloves to grab a slice of ready-to-eat toast which he placed on a resident plate to be served. -The cook further contaminated the same gloves by touching the outside of two packages of bread, and a package of bagels. The cook then further contaminated his gloves when he went to the walk-in refrigerator; the cook opened the walk-in door, and brought back a package of bread. The cook then, using the same contaminated gloves, touched the middle of a plate where food was then served, and a slice of ready-to-eat toast with his contaminated gloves which he placed on a resident plate to be served. <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The cook further contaminated the same gloves by touching the outside of a package of bread, and with the same contaminated gloves grabbed two pieces of toast and placed them on a plate to be served to residents.</p> <p>-The cook further contaminated the same gloves by touching the handle of a knife, the bottom of a plate, and the handle of a scoop, and then, with the same contaminated gloves, grabbed a ready-to-eat muffin to remove the wrapper. While removing the wrapper the cook's contaminated gloves contacted the edible portion of the muffin which he then placed on a resident plate to be served.</p> <p>-The cook did not replace his gloves or wash his hands throughout the entire, continuous observation.</p> <p>During an interview on 7/17/24 at 8:05 A.M., the food service staff said that the observed food was to be served to residents on the north side of the facilities' unit.</p> <p>During an interview on 7/17/24 at 8:03 A.M., the Food Service Director (FSD) said he would expect his staff to change gloves after they contaminate them, and/or when switching between tasks.</p>		