STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305059	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pheasant Wood Center	50 Pheasant Road Peterborough, NH 03458

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 26364 Based on interview and record review, it was determined that the facility failed to ensure that the resident's Minimum Data Set (MDS) accurately reflected the resident's status for 3 of 23 residents reviewed for MDS in a final sample of 23 residents (Resident Identifiers are #22, #29 and #56). Findings include: Resident #22 Review on 6/26/24 of Resident #22's Quarterly MDS with an Assessment Reference Date (ARD) of 5/6/24 revealed under Section O, Special Treatments, Procedures, and Programs, that the resident was receiving chemotherapy, radiation, dialysis, hospice, isolation/quarantine for active infectious disease, and Intravenous (IV) therapy all while a resident. Review on 6/26/24 of Resident #22's medical record revealed no documentation that the resident was receiving the above coded treatments/services during the 5/6/24 Quarterly MDS timeframe. Interview on 6/26/24 at 1:45 p.m. with Staff A (Director of Nursing) confirmed Resident #22 did not receive the above special treatments during the above MDS timeframe and that the MDS had been coded in error. Resident #29 Review on 6/27/24 of Resident #29's Quarterly MDS with an ARD of 5/23/24 revealed under Section P, Restraints and Alarms, that Trunk Restraint was coded as being used less than daily when in a chair or out of bed. Interview on 6/27/24 at approximately 2:00 p.m. with Staff E (Licensed Practical Nurse (LPN)) revealed that Resident #29 had not used a restraint since his/her admission to the facility, including the above timeframe in May 2024. Interview on 6/27/24 at approximately 2:00 p.m. with Staff G (Assistant MDS Coordinator) confirmed that Resident #29's 5/23/24 Quarterly MDS was incorrectly coded for a restraint. 40522 (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Resident #56 Review on 6/26/24 of Resident #56's active physician's order revealed an order for Apixaban (anticoagulant) 2.5 milligram (mg) by mouth two times a day for atrial fibrillation with a start date of 1/2/24. Review on 6/26/24 of Resident #56's Quarterly MDS with an ARD of 5/9/24 revealed that under Section N, High-Risk Drug Classes: Uses and Indication, anticoagulant was not checked as is taking and/or indication noted. Review on 6/26/24 of Resident #56's May 2024 revealed that Resident #56 received Apixaban medication from 5/2/24 to 5/8/24 during the assessment timeframe for the 5/9/24 Quarterly MDS. Interview on 6/26/24 at 1:50 p.m. with Staff A confirmed the above findings. Interview with Staff A revealed that anticoagulant use and indication noted should have been coded as is taking and indication noted in the above mentioned MDS.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 40522 Based on interview, record review, and policy review, it was determined that the facility failed to act upon the Medication Regimen Review (MRR) recommendations for 1 of 5 residents reviewed for unnecessary medications in a final sample size of 23 residents (Resident Identifier #59). Findings include: Resident #59 Review on 6/27/24 of Resident #59's pharmacy consultation report dated 4/23/24 revealed that Resident #59 received an anticholinergic medication Benzotropine 0.5 milligram (mg) three times a day for prevention or treatment of extrapyramidal symptoms without evidence of a Gradual Dose Reduction (GDR). Pharmacy recommendation was to attempt a GDR of Benzotropine 0.5 mg to two times a day with the end goal of discontinuation. Further review of Resident #59's pharmacy consultation report revealed that the provider accepted the recommendation and to implement as written on 4/26/24. Review on 6/27/24 of Resident #59's active physician orders revealed that the Benzotropine 0.5mg medication order remained at three times a day instead of a GDR of two times a day as mentioned in the above pharmacy recommendation for Resident #59. Interview on 6/27/24 at approximately 9:00 a.m. with Staff A (Director of Nursing) confirmed the above findings for Resident #59. Review on 6/27/24 or the facility's policy titled, Medication Regimen Review, revision date of 6/1/24, revealed: .Facility should encourage physician/prescriber or other responsible parties receiving the MRR and the director of nursing to act upon the recommendations contained in the MRR .For those issues that require physician/prescriber intervention, facility should encourage physician/prescriber to either accept and act upon the recommendations contained within the MRR or reject all or some of the recommendations contained in the MRR .

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 28881 Based on observation, interview and facility policy review, it was determined that the facility failed to have a secondary lock secured for a controlled medication in 1 of 2 medication rooms (Resident Identifier #76). Finding includes: Review on 6/25/24 of Resident #76 medical record revealed an order for Lorazepam 2 milligram (mg) 1/milliliter (ml), give 0.5 ml (1 mg) by mouth twice a day and as needed every 6 hours for anxiety. Observation on 6/25/24 at approximately 8:45 a.m. of the second floor medication room with Staff D (Licensed Practical Nurse) revealed the medication refrigerator was not locked with one 30 ml bottle of Lorazepam 2 mg/1 ml labeled with Resident #76's name inside. Interview on 6/25/24 at approximately 8:45 a.m. with Staff D confirmed the findings. Staff D indicated controlled substances should be double locked in the medication room. Interview on 6/25/24 at approximately 10:30 a.m. with Staff A (Director of Nursing) confirmed the above finding. Review of the facility policy titled, NSG300 Controlled Drugs: Management of, with a last revised date of 4/1/22, revealed: .All controlled substances are stored under double lock, separate from other medications .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40522 Based on observation, interview, and policy review, it was determined that the facility failed to ensure that dishes were sanitized according to manufacturer's instruction for food services safety in the main kitchen. Findings include: Interview on 6/25/24 at approximately 8:45 a.m. with Staff L (Dietary Manager) revealed that the facility utilized a high temperature dish machine to sanitize utensils and dishes. Observation and interview on 6/25/24 at approximately 8:45 a.m. during dishwashing in the kitchen revealed that Staff K (Dietary Aide) was washing food debris off dishes with water and lining them on a tray. The tray with dishes was then placed in the dish machine. During the rinse cycle, the rinse temperature was 170 degrees Fahrenheit (F). Staff K and Staff L (Dietary Aide) did not check the wash and rinse temperature gauge on the dish machine while it was running. After the rinse cycle, Staff L removed the tray with dishes from the dish machine and was going to store the dishes to air dry. Interview with Staff K confirmed the observation on the rinse cycle temperature. The tray went through the dish machine the second time and the rinse temperature was 175 degrees Fahrenheit. The tray with dishes went through the dish machine the third time and the rinse temperature was 180 degrees Fahrenheit. Observation and interview on 6/25/24 at approximately 2:19 p.m. during dishwashing in the kitchen with Staff K and Staff L revealed that a tray with dishes was placed in the dish machine and during the rinse cycle the rinse temperature was 176 degrees Fahrenheit. Staff K and Staff L did not check the wash and rinse temperature gauge while the dish machine was running. Staff L was going to store the dishes on the tray to air dry. Interview with Staff K confirmed the observation on the rinse cycle temperature. The tray with dishes went through the dish machine the second time and the rinse temperature was 178 degrees Fahrenheit and the third time the rinse temperature was 180 degrees Fahrenheit. Review on 6/25/24 of the FDA Food Code 2017, retrieved from:https://www.fda.gov/media/110822/download, revealed: .4-501.15 Warewashing Machines, Manufacturers' Operating Instructions. (A) A WAREWASHING machine and its auxiliary components shall be operated in accordance with the machine's data plate and other manufacturer's instructions .501.112 Mechanical Warewashing Equipment, Hot Water Sanitization Temperatures. (A) Except as specified in (B) of this section, in a mechanical operation, the temperature of the fresh hot water SANITIZING rinse as it enters the manifold may not be more than 90oC (194oF), or less than: .(2) For all other machines, 82oC (180oF) . Review on 6/25/24 of the ECOLAB XL-HT dish machine specification revealed .Operating temperatures sanitizing rinse (minimum) 180 F . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review on 6/25/24 of the facility's policy titled, Machine Warewashing and Sanitizing, effective date of 5/1/23, revealed: .The dishwasher is used for machine warewashing. High temperature or low temperature machines are acceptable for use. 1.1. For a high temperature machine, the wash cycle temperature ranges between 150-165 [degrees] F [Fahrenheit] the final rinse temperature is a minimum of 180 F or 165 F for a stationary, single temperature machine. 1.1.1 Manufacturer's specifications for temperatures are followed .If temperatures fall below the standard for either wash or final rinse, or the chemical sanitizer does not test at the appropriate concentration, The Director of Dining Services/Director of Culinary Services or Maintenance Department is notified immediately .If the issues cannot be corrected by facility staff, the chemical supply service representative is notified and warewashing is discontinued until the issues is corrected .

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 40522 Based on observation, interview, and record review, it was determined that the facility failed to maintain wheelchairs and tubefeeding pumps according to manufacturer's instructions for 3 of 5 residents reviewed for physical environment in a final sample of 23 residents (Resident Identifiers are #2, #3, and #65). Findings include: Resident #65 Observation on 6/25/24 at approximately 11:00 a.m. and 1:00 p.m. revealed that Resident #65 was in the common area sitting in a wheelchair with yellow dried liquid splatters that differed in sizes on the left wheel, left inner side panel, and left arm rest on the wheelchair. Further observation revealed that there was clumps of dried yellow food-like substance that differed in sizes on the left side of the chair cushion between Resident #65 and the left inner side panel of the wheelchair. Observation and interview on 6/26/24 at approximately 1:23 p.m. with Staff H (Unit Manager) confirmed the above findings of Resident #65's wheelchair conditions. Staff H stated that the wheelchairs were to be cleaned by nursing staff weekly on residents shower days. Interview on 6/26/24 at approximately 1:25 p.m. with Staff I (Licensed Nursing Assistant) revealed that he/she was not aware of a current schedule for cleaning wheelchairs for nursing staff to complete. Staff I stated that in the past there was a weekly cleaning schedule of wheelchairs on residents shower days. Review on 6/26/24 of the facility's third floor shower schedule protocol, updated date of 6/12/24, revealed that wheelchairs should be sprayed down and dried during shower times and that the 11-7 shift was to wash all wheelchairs and walkers for each shower that day if not done during shower days. Further review of the shower schedule protocol revealed that Resident #65's shower was scheduled for Tuesdays on 3-11 shift, which indicates that Resident #65's wheelchair should have been cleaned on 6/25/24. Review on 6/26/24 of Resident #65's wheelchair manufacturer's instruction revealed .Maintenance and Care . Clean your wheelchair. See the Cleaning schedule section in this manual for instructions .weekly .Cleaning . Axles, Wheels, Tires and Moving Parts: 1. Clean around the axles and wheels weekly with a damp rag . Painted Surfaces 1. Hand wash using a cloth and mild detergent 2. Dry using a clean cloth or allow wheelchair to air dry .Upholstery: 1. Hand wash using a cloth and mild detergent. 2. Allow upholstery to air dry .Plastic Components 1. Hand wash using a cloth and mild detergent .Sanitizing 1. Disinfect surfaces with over the counter disinfecting sanitizer of at least 70% [percent] alcohol wipes. Do not soak or allow pooling of cleaning solutions. 2. Allow sanitizer to remain on surface for at least 15 minutes and remove with aseptic cloth . 26364 Resident #3 (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 6/25/24 at approximately 9:00 a.m. revealed that Resident #3's wheelchair had built up dust and a dark substance on his/her wheelchair. Interview 6/25/24 at approximately 9:00 a.m. with Resident #3 revealed he/she had asked to have his/her wheelchair cleaned before and that the LNA had refused to do it .The LNA would only clean the seat. Interview on 6/27/24 at approximately 8:04 a.m. with Staff F (Infection Preventionist) confirmed the above findings. Review of the facility's policy on 6/27/24 titled, Second Floor Shower Schedule, updated 2/9/24 revealed: . Wheelchairs should be sprayed down and dried on shower time 11-7 shift: wash all wheelchairs/walkers for each shower that day if not done during shower. Easy to assess chairs during rounds . Review of the manufacturer's instruction Edition 1, dated 7/9/2020, for M3 Corpus user manual revealed: . 5. Maintenance .For the wheelchair to work well, it is important that you use it correctly and maintain it regularly. A well maintained wheelchair lasts longer and has lower of defects .5.2 Cleaning .Regular care and maintenance will prevent unnecessary wear and damage to your Permobile product .Maintenance and inspection schedule chart clean the wheelchair and upholstery weekly, check upholstery, seating, and postural supports for wear weekly . 50163 Resident #2 Observation on 6/25/24 at 8:40 a.m. of the second floor dining area revealed that Resident #2 was sleeping in a tilt-n-space wheelchair with tube feed running. Further observation revealed that Resident #2's tube feed kangaroo pump had dried off-white substance covering the top of the tube feed kangaroo pump and the screen. Observation on 6/26/24 at 1:50 p.m. of Resident #2's tube feed kangaroo pump revealed the pump had dried off-white substance covering the top of the tube feed kangaroo pump and the screen, as observed above. Interview on 6/26/24 at 2:05 p.m. with Staff E (Licensed Practical Nurse (LPN)) confirmed above findings. Observation and interview on 6/27/24 at 8:05 a.m. with Staff F (Infection Control) confirmed that Resident #2's tube feed kangaroo pump had dried off-white substance on top of the pump and dried brown substance in the grooves on the front of the pump and around the screen. Review on 6/27/24 of facility policy titled, IC201 Cleaning and Disinfecting with revision date of 5/1/24 revealed: (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.POLICY - Cleaning and disinfecting of frequently touched items and surfaces, patient/resident (hereinafter patient) care items and the environment, including common areas of the Center, will be conducted routinely and based on risk of infection involved PRACTICE STANDARDS- .3. Clean items of all foreign materials such as blood, feces, dust, or dirt before disinfecting. 4. Follow manufacturer's recommendations . Review on 6/27/24 of manufacturer's operating manual for Kangaroo Connect Enteral Feeding Pump with revision date of 11/2017, revealed: GENERAL CLEANING DIRECTIONS- Cleaning Frequency: It is recommended that the pump .be cleaned after each feeding set use for a minimum duration of 30 seconds, to prevent bacterial contamination of the pump .