

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 305072	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Jaffrey Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 20 Plantation Drive Jaffrey, NH 03452	

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 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>47129</p> <p>Based on interview and record review, it was determined that the facility failed to offer therapeutic dietary recommendations to maintain body weight and failed to monitor parameters of nutritional status per facility protocol for 2 of 3 residents reviewed for nutrition in a final survey sample of 22 residents (Resident Identifiers #36 and #61).</p> <p>Findings include:</p> <p>Resident #36</p> <p>Review on 4/24/24 of Resident #36's medical record revealed that Resident #36 was admitted to the facility in February 2024.</p> <p>Review on 4/25/24 of Resident #36's Weights and Vitals Summary revealed the following recorded weights:</p> <p>3/27/24 - 126.4 pounds (Wheelchair);</p> <p>4/10/24 - 126.8 pounds (Wheelchair);</p> <p>4/17/24 - 117.6 pounds (Wheelchair);</p> <p>4/25/24 - 116.6 pounds (Wheelchair).</p> <p>Review on 4/25/24 of Resident #36's Dietary Note, signed by Staff N (Dietician), dated 3/21/24, revealed a recommendation to trial 4-ounce nutrition shakes daily and to add ice cream to provide supplemental calories.</p> <p>Review on 4/26/24 of Resident #36's Physician and Dietary orders revealed no orders for the above Dietician recommendations from 3/21/24.</p> <p>Interview on 4/26/24 at 9:36 a.m. with Staff A (Director of Nursing) confirmed the above findings.</p> <p>Review on 4/26/24 of Resident #36's Progress Note, dated 4/19/24, revealed that Resident #36's weight was 117.6 pounds, a loss of 5 percent change over 30 days, and a loss of 3 percent change from the last weight. Staff N requested a reweight.</p> <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 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review on 4/26/24 of Resident #36's progress note dated 4/25/24 revealed that Resident #36's reweight was 116.6 pounds.</p> <p>Interview on 4/26/24 at 9:38 a.m. with Staff A confirmed the above findings. Staff A stated that Resident #36 should have been reweighed within 24 hours of the request on 4/19/24. Interview further revealed that the order for nutrition shakes was not placed until 4/19/24 a month after the dietician's recommendation.</p> <p>Review on 4/25/24 of the facility's policy titled Weight Management, undated, revealed, . The healthcare staff will perform the following best practice guidelines to manage the risk of significant unplanned weight change . 3. Residents are weighed in a consistent manner. For example: use the same scale, consistent time off [sic] day, and consistent clothing/devices on at the time of weight .5. Weights are verified and documented in the medical record as they are obtained. 6. Check the previous monthly weight(s) for any significant weight change. If there is a significant weight change of + or - 5% in 30 days, 7.5% in 90 days or 10% in 180 days, schedule resident to be reweighed within 24 hours .</p> <p>43002</p> <p>Resident #61</p> <p>Review on 4/23/24 of Resident #61's Care Plan revealed a risk titled weight loss, weight fluctuation, and malnutrition due to variable meal intake that was initiated on 10/16/23 and revised on 4/2/24. Further review revealed interventions revised on 4/9/24 included monitoring weight per facility protocol, ensuring consistent weighing method, and recommending 6 ounces of juice supplement daily and 30 milliliters of protein supplement twice daily for wound healing and malnutrition.</p> <p>Review on 4/23/24 of Resident #61's Weights and Vitals Summary revealed the following recorded weights;</p> <p>2/28/24 - 267.6 pounds (Wheelchair);</p> <p>3/5/24 - 310.5 pounds (Mechanical Lift);</p> <p>3/28/24 - 156.1 pounds (Mechanical Lift);</p> <p>4/1/24 - 255 pounds (Wheelchair).</p> <p>Interview on 4/25/24 at 12:38 p.m. with Staff J (Unit Manager) confirmed the above weights and revealed there should have been reweights obtained.</p> <p>Review on 4/25/24 of Resident #61's Progress Notes revealed the following;</p> <p>3/12/24 a 42.9-pound weight gain over 6 days with inaccuracy was suspected. Weight recheck requested. This note was signed by Staff M (Dietician).</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4/9/24 the resident had wide fluctuations in weight measurements and an overall downward trend was noted. Recommend 6 ounces of juice supplement daily and 30 milliliters of protein supplement twice daily for wound healing and malnutrition. This note was signed by Staff N.</p> <p>Review on 4/26/24 of Resident #61's Physician's Progress Note, dated 4/17/24, revealed: .Dietician was in for a follow-up visit and to review weights with new recommendations for juice supplement [by mouth] once daily, ProSource [protein supplement] [by mouth twice daily] for wound healing .</p> <p>Interview on 4/26/24 at 10:25 a.m. with Staff A confirmed that reweights had not been done for the above weights. Staff A confirmed that the dietary recommendations for the juice or protein supplement from 4/9/24 had not been started.</p>

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50163</p> <p>Based on interview and record review, it was determined that the facility failed to promptly notify the ordering practitioner of critical laboratory results for 1 of 1 resident reviewed for insulin in a final survey sample of 22 residents (Resident Identifier #13).</p> <p>Findings include:</p> <p>Review on 4/24/24 of Resident #13's Final Lab Result collected on 4/23/24 at 8:06 a.m. revealed the Glucose was 26 milligrams per deciliter (mg/dL) and critically low.</p> <p>Review on 4/25/24 of Resident #13's medical record, including progress notes for nurses and physicians, revealed that there was no documentation the provider had been notified of the critically low blood glucose level.</p> <p>Interview on 4/25/24 at approximately 2:30 p.m. with Staff A (Director of Nursing) confirmed that there was no documentation that the provider had been notified.</p> <p>Interview on 4/25/24 at approximately 2:50 p.m. with Staff J (Unit Manager) revealed the above critical lab result was called to the facility on [DATE] at 5:03 p.m.</p> <p>Review on 4/26/24 of the facility's policy titled Lab and Diagnostic Test Results- Clinical Protocol revised on 11/2018, revealed: .Review by Nursing Staff: 3. A nurse will identify the urgency of communicating with the Attending Physician based on physician request, the seriousness of any abnormality, and the individual's current condition .Options for Physician Notification: 1. A physician can be notified by phone, fax, voicemail . to another person acting as the physician's agent a. Facility staff should document information about when, how, and to whom the information was provided and the response .</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47129</p> <p>Based on observation, interview, and policy review, it was determined that the facility failed to store and serve food in accordance with professional standards for food safety to prevent foodborne illness and failed to monitor the high dishwasher temperatures to ensure proper sanitization.</p> <p>Food Storage:</p> <p>Findings include:</p> <p>Review on 4/23/24 of the U.S. Food and Drug Administration Food Code, dated 2017, retrieved from https://www.fda.gov/food/FDA-food-code/food-code-2017 revealed the following: .Annex 3, Public Health Reasons/Administrative Guidelines . Chapter 3 Food .3-305.11 Food Storage .FOOD shall be protected from contamination by storing the FOOD: . On-premises preparation .(D) A date marking system that meets the criteria stated in (A) and (B) of this section may include: (1) Using a method approved by the regulatory authority for refrigerated, ready-to-eat time/temperature control for safety food that is frequently rewrapped, such as lunchmeat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; (2) Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded .(3) Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded .; or (4) Using calendar dates, days of the week, color-coded marks, or other effective marking methods .</p> <p>Observation on 4/23/24 at 8:25 a.m. of the walk-in refrigerator revealed two (2) Vanilla Mighty Shakes with no thawed date or use by date.</p> <p>Interview on 4/23/24 at 8:26 a.m. with Staff E confirmed the above findings.</p> <p>Observation on 4/23/24 at 8:40 a.m. of the [NAME] Unit refrigerator revealed three (3) Vanilla Mighty Shakes with no thawed date or use by date.</p> <p>Observation on 4/23/24 at 8:45 a.m. of the Chapel/Activities Unit refrigerator revealed thirty six (36) Vanilla Mighty Shakes with no thawed date or use by date.</p> <p>Interview on 4/23/24 at 8:46 p.m. with Staff E confirmed the above findings. Staff E was unaware of when the shakes were thawed.</p> <p>Review on 4/23/24 of the manufacturer's instructions for Vanilla Mighty Shakes under storage and handling revealed .Store frozen. Use thawed product within 14 days. Keep Refrigerated .</p> <p>Holding Temperatures:</p> <p>Review on 4/23/24 of the temperature logs of the serving (holding temperatures) of foods from 4/1/24 to 4/22/24 revealed the following:</p> <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>4/1/24 there were no internal food temperatures recorded for breakfast, lunch, and dinner.</p> <p>4/2/24 there were no internal food temperatures recorded for lunch.</p> <p>4/3/24 there were no internal food temperatures recorded for dinner.</p> <p>4/4/24 there were no internal food temperatures recorded for breakfast and dinner.</p> <p>4/5/24 there were no internal food temperatures recorded for breakfast, lunch, and dinner.</p> <p>4/6/24 there were no internal food temperatures recorded for breakfast and lunch.</p> <p>4/7/24 there were no internal food temperatures recorded for breakfast, lunch, and dinner.</p> <p>4/9/24 there were no internal food temperatures recorded for breakfast and lunch.</p> <p>4/8/24, 4/10/24, 4/11/24, and 4/12/24 there were no internal food temperatures recorded for breakfast, lunch, and dinner.</p> <p>4/13/24 there were no internal food temperatures for breakfast and lunch.</p> <p>4/14/24 there were no internal food temperature for dinner.</p> <p>4/15/24 there were no internal food temperatures recorded for breakfast, lunch, and dinner.</p> <p>4/16/24 there were no internal food temperatures recorded for dinner.</p> <p>4/17/24 there were no internal food temperatures recorded for breakfast and lunch.</p> <p>4/18/24 there were no internal food temperatures recorded for breakfast, lunch, and dinner.</p> <p>4/19/24 there were no internal food temperatures recorded for breakfast.</p> <p>4/20/24, 4/21/24, and 4/22/24 there were no internal food temperatures recorded for breakfast, lunch, and dinner.</p> <p>Review of 4/23/24 of the facility's policy titled Food Temperatures, no date, revealed: Policy: Foods will be maintained at proper temperature to ensure food safety .Procedures: .3. The cook is responsible to see that all food is at the proper temperature. 4. The temperature will be taken and recorded for all items at all meals. Record temperatures on extended menus .</p> <p>Dishwasher Tempertures:</p> <p>Review on 4/23/24 of the facility's dishwasher temperature logs from 4/1/24 to 4/22/24 revealed there were no dishwasher temperatures recorded for 4/3/24, 4/4/24, 4/7/24, 4/8/24, 4/9/24, 4/18/24, 4/19/24, 4/20/24, 4/21/24 and 4/22/24.</p> <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>Review of 4/23/24 of the facility's policy titled Dish Washing Procedure, no date, revealed: .1. Fill dish machine . Check the temperature prior to washing dishes .Refer to manufacturer's recommended temperature range .Record temperature on dish machine temperature log .11. Dish machine temperature log will be completed for every meal .</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>47129</p> <p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, and policy review it was determined that the facility failed to use Personal Protective Equipment (PPE) when handling, processing, and transporting linens to prevent the spread of infection.</p> <p>Findings include:</p> <p>Observation on 4/25/24 at 11:00 am of Staff D (Laundry Aide) exiting the South shower room revealed that Staff D exited the shower room with a cart of overflowing soiled linens. The overflowing cart of soiled linens was in contact with Staff D's clothing. Staff D proceeded down the hallway with the overflowing cart of soiled linens with residents and other staff in the hallway.</p> <p>Interview on 4/25/24 at 11:05 a.m. with Staff C (Infection Preventionist) confirmed that Staff D was transporting a overflowing cart of soiled linens, that was in contact with his/her clothing, down a hallway with residents and staff.</p> <p>Observation on 4/25/24 at 11:30 a.m. of Staff D in the dirty laundry room revealed that Staff D was loading the washing machine with soiled linens wearing gloves but no gown.</p> <p>Interview on 4/25/24 at 11:32 a.m. with Staff C confirmed that Staff D was not wearing a gown while loading the washing machine with soiled linens.</p> <p>Interview on 4/25/24 at 11:35 a.m. with Staff D revealed that he/she was not aware of the need to wear a gown when handling soiled linen. Staff D stated that when he/she collected the soiled laundry, sorted the soiled laundry, and washed the soiled laundry he/she was not wearing a gown to protect his/her clothes from contamination. Staff D stated that he/she would then fold the clean laundry in the same clothes he/she was wearing while transporting spoiled laundry. Interview further revealed when he/she delivered the clean laundry, the clean laundry was not protected with a cover.</p> <p>Interview on 4/25/24 at 11:40 a.m. with Staff C revealed that he/she was unable to provide documentation of education to Staff D related to the laundry process.</p> <p>Interview on 4/25/25 at 11:55 a.m. with Staff G (Director of Maintenance, Housekeeping and Laundry) revealed that Staff D was educated on PPE when he/she was hired 8 years ago.</p> <p>Review on 4/25/24 of Staff D's PPE Competency Validation dated 12/6/23 revealed that the training provided was on donning (putting on) and doffing (taking off) PPE for standard and transmission based precautions. Further review revealed no documentation of training for handling, processing and transporting linens to Staff D.</p> <p>Interview on 4/25/24 at 2:00 p.m. with Staff F (Administrator in Training) confirmed the above findings.</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 - Some</p>	<p>Review on 04/26/24 of the facility's policy titled Laundry and Bedding, Soiled revised September 2022, revealed: .Policy Statement: Soiled laundry/bedding shall be handled, transported, and processed according to best practices for infection prevention and control .Policy Interpretation and Implementation .Handling: 1. All used laundry is handled as potentially contaminated using standard precautions (e.g., gloves and gowns when sorting). a. Contaminated laundry is bagged or contained at the point of collection (i.e. location where it was used) .Transport: 1. Contaminated linen and laundry bags/containers are not held close to the body or squeezed during transport .6. Clean linen is protected from dust and soiling during transport and storage to ensure cleanliness .</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>47129</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to ensure that the call bell system was equipped to allow residents to call for staff assistance for a census of 73 residents.</p> <p>Finding include:</p> <p>Resident #59</p> <p>Review on 4/24/24 of Resident #59's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/6/24 revealed under Section C: Cognitive Patterns, Resident #59 had a Brief Interview for Mental Status (BIMS) score of 14, meaning, Resident #59 was cognitively intact.</p> <p>Review on 4/25/24 of Resident #59's care plan revised on 8/21/23 for toilet use and transfer revealed that Resident #59 required extensive staff for participation to use the toilets and with transfers.</p> <p>Interview on 4/24/24 at 8:25 a.m. with Resident #59 revealed he/she wishes that staff would come faster when he/she pressed the call button. Resident #59 stated that he/she has waited 45 minutes or longer. Interview further revealed that waiting 45 minutes or longer could happen at any time during the day but when he/she has to wait in the early mornings to use the bathroom it was very upsetting Resident #59 confirmed that he/she has had an accident and wet himself/herself because of the long wait times.</p> <p>Interview on 4/25/24 at 10:15 a.m. with Staff H (Licensed Nursing Assistant (LNA)) revealed that he/she would only know the call bell was going off from looking at the monitor located at the beginning of the South hallway across from the nursing station. Staff H stated that the call bell system does not continuously sound. Staff H said that the monitors were the only way to know if the residents pressed their call bell and the monitor was not always in view if he/she was in with another resident or at the other end of the hallway. Staff H stated that residents have complained about the long wait times.</p> <p>Interview on 4/25/24 at 2:00 p.m. with Staff F (Administrator in Training) revealed that when a resident initiated the call bell system there was a doorbell ring sound once and the resident's room number and location, either at the bed or bathroom would appear on the monitors that were located in the hallways of each unit.</p> <p>Interview on 4/24/24 at 10:30 a.m. during Resident Council revealed that 10 out of 21 residents who attended would wait 30 minutes or longer for call bells to be answered. Resident #32 and Resident #27 stated that call bell response time concerns were brought up monthly and nothing was being done. Both Resident #32 and Resident #27 stated that the problem was not that the call bell system wasn't working, the problem was that when staff was asked why it took so long, staff say that [pronoun omitted] can't hear when it goes off. Everyone who was in attendance agreed with Resident #27 and Resident #32.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 4/25/24 at 9:30 a.m. with Staff O (Anonymous) revealed that he/she can't hear the call system or see the monitor if he/she is in another resident room or down the opposite end of the hall, a resident could wait a long time without an LNA even knowing.</p> <p>43002</p> <p>Interview on 4/25/24 at 9:58 a.m. with Staff I (LNA) revealed that he/she observes the display monitors at the end of the halls (located near the nurse's stations and the end of Chapel and South halls) to identify if a resident's call bell was ringing. Staff I revealed that he/she would not know a call light was going off when in a resident's room or if not in an area of the building where the display monitor was visible.</p> <p>Interview on 4/26/24 at 11:15 a.m. with Staff G (Director of Maintenance) revealed that the call bell system was mechanically functioning properly.</p> <p>Review on 04/26/24 of the facility's policy titled Call Bell no date, revealed: Policy: Providing timely response to residents in need of assistance is essential to ensuring high quality resident outcomes .Procedure: .8. Answer the resident's call system as soon as possible .Call Light Monitoring: 1. If feasible, implement an electronic wireless call light system with reporting capabilities for monitoring. Call light response time . complete periodic monitoring of response time through resident council meetings and or resident interview .</p>		