STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305072	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jaffrey Rehabilitation and Nursing Center	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview and record review it was determined that the facility failed to implement control measures from their water management plan to prevent the growth and spread of Legionella and other water borne pathogens in a facility with a census of 72 residents. Findings Include: Review on 5/20/26 of facility's Legionella Water Management Plan revealed: Control Measures and Corrective Actions 4. Flush hot water tank sediment at least annually. 7. Remove and clean shower heads (including handheld wands) used for resident bathing. Clear strainers and pressure restrictors of sediment and potential biofilm, at least annually. Interview on 5/20/2026 at 9:28 a.m. with Staff B (Director of Maintenance) confirmed that there was no documentation the above control measures were performed. Review on 5/20/26 of facility policy titled Legionella Water Management Program, revised in September 2022, revealed: 5. The water management program includes the following elements: f. The control limits or parameters that are acceptable and that are monitored .

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on Interview and record review, the facility failed to provide documentation that the resident or resident representative was informed in advance of treatment risks and benefits, options and alternatives prior to initiating psychotropic medications for 1 of 5 residents reviewed for unnecessary medications in a final sample of 18. (Resident identifier is #31.)Findings include: Review on 5/21/26 of Resident #31's current physician's orders revealed the following order Clonazepam Oral Tablet 0.5 MG (Milligrams) give 0.5 tablet by mouth one time a day for anxiety related to Dementia in other diseases classified elsewhere, unspecified severity with anxiety and give 1 tablet by mouth at bedtime; dated 11/14/25Review on 5/21/26 of Resident #31's medical record revealed there was no consent signed by the resident or resident representative at the initiation of the medication on 11/14/25.Interview on 5/21/26 at approximately 12:02 p.m. with Staff A (Director of Nursing) confirmed the above findings.Review on 5/22/26 of the facility's policy Psychotropic Medication use, Revision date February 2025, revealed .Informed Consent or Refusal 1. Prior to initiating the use of, increasing the dose of, or switching to a different psychotropic medications, the staff and physician will review the following with the resident/representative prior to obtaining documented consent or refusal: a. non-pharmacological alternatives; b. the indications and rationale for the recommendations; c. the potential risks and benefits (including possible side effects, adverse consequences, and black box warnings); and d. the resident's/representative's right to accept or decline the treatment

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure that a resident receiving psychotropic medications received a gradual dose reduction (GDR) for 1 or 5 residents reviewed for unnecessary medications in a final sample of 18 residents (Resident identifier is #6).Findings include: Resident #6 Review on 5/21/26 of Resident #6's medication orders revealed an order for Seroquel 50 milligrams (mg) with an order date of 8/17/23 and Remeron 30mg with an order date of 3/2/2023. Review on 5/21/26 of Resident #6's psychiatric notes dated 2/4/26, 2/18/26, 4/15/26, 5/13/26, and 5/18/26 revealed no clinical contraindication for a GDR. Review on 5/21/26 of Resident #6's progress notes for the last year revealed no documentation of a gradual dose reduction. Interview on 5/21/26 at approximately 12:30 p.m. with Staff A (Director of Nursing) confirmed Resident #6 had not had a GDR in the last year and that there was no documentation of a clinical contraindication for a GDR.in Resident #6's medical record. Review on 5/21/26 of facility policy titled Tapering Medication and Gradual Dose Reduction revised date February 2025 revealed .Policy Interpretation and Implementation 1. Gradual Dose Reduction (GDR) refers to the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed at a lower dose or if a medication can be discontinued. 2. All medications are considered for possible tapering/GDR.4. Tapering/GDR may be used as an approach to finding an optimal dose or determining if continued use of a medication will benefit the resident.Psychotropic medications.2. After the first year, the facility will attempt a GDR at least annually, unless clinically contraindicated.Documentation-Gradual Dose Reduction 1. Gradual dose reduction attempts are documented in the medical record. The documentation includes: a. the date of the GDR attempt; b. outcome of the dose reduction attempt; c. any return or worsening of symptoms; d. plan regarding any future GDR attempts. 2. Physician documentation contains the rationale for why GDR attempts are clinically contraindicated for the resident.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow physician's order for 1 of 2 residents reviewed for choices in a final sample of 18 residents (Resident identifier is #1).Findings include:[NAME], [NAME] A., and [NAME] [NAME]. Fundamentals of Nursing. 10th edition St. Louis, Missouri: Elsevier, 2021. Page 614 .It is essential to verify the accuracy of every medication you give to your patients with the patient's order. If the medication order is incomplete, incorrect, or inappropriate, or if there is a discrepancy between the original order and the information on the MAR [Medication Administration Record]. consult with the health care provider. Do not give a medication until you are certain that you can follow the seven rights of medication administration . Page 672 .seven rights of medication administration include right medication, right dose, right patient, right route, right time, right documentation and right indication . Review on 5/19/26 of Resident #1's May 2026 Medication Administration Record revealed the following order: a scheduled Ativan at daily bedtime. Further review revealed, Ativan was not administered on 5/5/26 through 5/9/26.Review on 5/19/26 of Resident #1's progress notes dated 5/5/26 through 5/9/26 revealed notes that the Ativan was unavailable and no documentation that the provider was notified.Interview 5/21/26 at approximately 8:20 a.m. with Staff G (Registered Nurse) confirmed the above findings.

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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. Based on observation and interview, the facility failed to ensure all drugs and biologicals were maintained in a locked cart in 1 of 2 medication carts observed (Chapel Unit medication cart).Findings include:Chapel Unit medication cartObservation on 5/19/26 at approximately 8:15 a.m. of Chapel Unit medication cart revealed the cart was left unlocked for approximately 3 minutes with no responsible staff nearby.Interview on 5/19/26 at approximately 8:15 a.m. of Staff H (Medication Nursing Assistant) confirmed the above finding.Review on 5/20/26 of facility policy titled Medication Labeling and Storage revised date February 2023 revealed . Policy Interpretation and Implementation.4. Compartments (including but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation, interview, and record review, the facility failed to ensure that a resident's dietary preferences were taken into consideration 1 of 2 residents reviewed for choices in a final sample of 18 residents. (Resident identifier is #12.)Findings include: Interview on 5/19/26 at approximately 9:08 a.m. with Resident #12 revealed that he/she does not get what they want for breakfast. Resident #12 further revealed that, The Speech pathologist made all kinds of changes to my diet and that I can't have bacon. Resident #12 revealed that he/she would like bacon with his/her breakfast each day.Observation on 5/20/26 at approximately 8:41 a.m. of Resident #12 in the main dining room revealed the Resident #12's breakfast consisted of fried eggs, oatmeal with syrup, and pancakes.Interview on 5/20/26 at approximately 8:45 a.m. with Resident #12 revealed that he/she did not have bacon with breakfast and that I am not allowed to have bacon.Review on 5/20/26 of Resident #12's medical record Health status note 5/10/26 revealed, .ST (Speech Therapist) screened resident during lunch . Pt (patient) requested bacon be added back to [pronoun omitted] diet. Educated on current diet texture implications and pt was agreeable to bacon cut into bite sized pieces . Shared findings with RN (Registered nurse) and clarified diet order. Interview on 5/20/26 at approximately 12:46 p.m. with Staff C (Dietary Director) confirmed that bacon was on the menu for breakfast this morning and that Resident #12 did not have bacon as it is not appropriate for his/her diet and would require update from speech therapist.Interview on 5/20/26 at approximately 12:49 p.m. with Staff D (Director of Rehabilitation) revealed that Resident #12 was seen by the ST on 5/10/26 and cleared for cut up bacon. Staff D further revealed that a diet order change was given to nursing for the modification.Interview on 5/20/26 at approximately 12:53 p.m. with Staff E (Registered Nurse) revealed that he/she received the updated diet slip for cut up bacon and delivered the written order to the kitchen on 5/10/26.Review on 5/20/26 of Resident #12's diet order and diet slip dated 5/10/26 and signed by the ST revealed diet change, texture bite size and notation bacon is allowed. Interview on 05/20/26 at approximately 1:05 p.m. with Staff C revealed that he/she was not aware of the diet change. Review on 5/20/26 of Resident #12's care plan revealed: Intervention to provide and serve diet as ordered. Review on 5/20/26 of the facility's policy Interdepartmental Notification of diet (Including changes and reports) revealed, Nursing services shall notify the food and nutrition services department of a resident's orders, including any changes in the resident's diet, meal service, and food preferences 1 the nurse supervisor shall ensure that the food and nutrition services department receives a written notice of the diet order.

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and record review, it was determined that the facility failed to ensure that the facility assessment included specific staffing needs for each resident unit for a census of 72 residents. Findings include:Review on 5/20/26 of the Facility Assessment revealed the following . Staffing plan 3.2 . The staffing plan is to ensure sufficient staff is available to meet the needs of the residents at any given time and will fluctuate based on acuity and staff competency Direct care staff: Day shift: 3 Licensed Nurses (RN(Registered nurse)/LPN(Licensed practical nurse)) and 7 Licensed Nurses Aides; Eve Shift: 3 Licensed Nurses (RN/LPN) and 7 Licensed Nurses Aides; Night shift: 2 Licensed nurses (RN/LPN) and 4 Licensed Nurses Aides. Further review of the facility assessment did not identify staffing needs per resident unit.Interview on 5/21/26 at approximately 10:23 a.m. with Staff F (Director of Human Resources) confirmed that the facility assessment did not break down staffing for each resident unit.