

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 305095	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2024
NAME OF PROVIDER OR SUPPLIER Derry Center for Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 20 Chester Road Derry, NH 03038	

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 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>38218</p> <p>Based on observation, record review and interview, it was determined that the facility failed to implement residents care plan regarding supervision with meals for 2 of 2 residents reviewed for supervision with meals (Resident Identifiers are #1 and #2).</p> <p>Findings include:</p> <p>Interview on 6/4/24 at approximately 8:00 a.m. with Resident #1 revealed that he/she eats alone in his/her room and staff set him/her up.</p> <p>Observation on 6/4/24 at approximately 8:45 a.m. of Resident #1 revealed that he/she was eating breakfast alone in bed.</p> <p>Interview on 6/4/24 at approximately 8:45 a.m. with Staff C (Licensed Nursing Assistant (LNA)) revealed that Resident #1 always eats alone in his/her room after meal set up.</p> <p>Review on 6/4/24 of Resident #1's care plan revealed:</p> <p>FOCUS: ADL [Activities of Daily Living]: [pronoun omitted] has an ADL self care performance deficit related to declined mobility, deconditioning, weakness. Eating: Staff supervision after set-up. Encourage [pronoun omitted] to get out of bed for meals as tolerated; Revision Date 4/26/24.</p> <p>Review on 6/4/24 of Resident #1's LNA documentation under tasks for Eating over the last 30 days revealed the following meals without supervision:</p> <p>Independent at meals -7 times;</p> <p>Setup or clean up assistance- 35 times.</p> <p>Resident #2</p> <p>Observation on 6/4/24 at approximately 8:45 a.m. revealed Resident #2 was eating breakfast alone in his/her room.</p> <p>Review on 6/4/24 of Resident #2's care plan revealed:</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>38218</p> <p>Based on observation, record review and interview, it was determined that the facility failed to ensure that a resident received adequate supervision to prevent choking accidents during meals for 1 out of 2 residents reviewed for supervision with meals (Resident Identifier #1).</p> <p>Findings include:</p> <p>Interview on 6/4/24 at approximately 8:00 a.m. with Resident #1 revealed that he/she eats alone in his/her room and staff set him/her up.</p> <p>Observation on 6/4/24 at approximately 8:45 a.m. of Resident #1 revealed that he/she was eating breakfast alone in bed.</p> <p>Interview on 6/4/24 at approximately 8:45 a.m. with Staff C (Licensed Nursing Assistant (LNA)) revealed that Resident #1 always eats alone in his/her room after meal set up.</p> <p>Review on 6/4/24 of Resident #1's care plan revealed:</p> <p>FOCUS: ADL [Activities of Daily Living]: [pronoun omitted] has an ADL self care performance deficit related to declined mobility, deconditioning, weakness. Eating: Staff supervision after set-up. Encourage [pronoun omitted] to get out of bed for meals as tolerated, Revision Date 4/26/24.</p> <p>Review on 6/4/24 of Resident #1's medical record, nursing notes revealed the following nursing note: dated, 5/2/24: approx. [approximately] 1740 [5:40 p.m.] resident began to choke on [pronoun omitted] dinner. Staff member called this nurse for assistance and immediately sat resident up with bed controls. Upon arrival this nurse observed resident attempting to cough without sound. With the assistance of other staff this nurse pulled resident into a full 90 degree sitting position, patted him on the back two times and encouraged him to attempt to say something back to me. Resident was able to speak and then immediately able to expel the piece of food that [pronoun omitted] had been choking on . Further review of Resident #1's medical record revealed a diagnosis of Dysphagia.</p> <p>Review on 6/4/24 of Resident #1's LNA documentation under tasks for Eating over the last 30 days revealed the following meals without supervision:</p> <p>Independent at meals -7 times;</p> <p>Setup or clean up assistance- 35 times.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>47129</p> <p>Based on observation, interview and record review, it was determined that the facility failed to provide food that is palatable and served at an appetizing temperature (Resident Identifiers are #9 and #10).</p> <p>Findings include:</p> <p>Review on 6/4/24 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: .Chapter 3 .Temperature and Time Control 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57oC [Celsius] (135oF) [Fahrenheit] or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54oC (130oF) or above .</p> <p>Review on 6/4/24 of the Food Council Meeting Minutes, dated March 28, 2024, revealed the following: The temperature of the food was brought up by all residents. They explained it is cold by the time they receive it.</p> <p>Review on 6/4/24 of the Resident Council Meeting Minutes, dated April 24, 2024, revealed the following: Grievances from the last food council meeting have not been addressed. The food still arrives cold.</p> <p>Interview on 6/4/24 at 7:15 a.m. with Staff E (Cook) revealed that the residents have complained of cold food at breakfast when served in their rooms. Interview further revealed that the dining room was not open for breakfast service.</p> <p>Interview on 6/4/24 at 7:40 a.m. with Staff E revealed that the facility did not have a plate warmer or a heated food cart for trays that were brought to resident rooms.</p> <p>Observations on 6/4/24 at 8:05 a.m. of food service being performed, identified that the holding temperature on the steam table of the scrambled eggs prior to being served was 160 degrees Fahrenheit. The holding temperature of the toast on the steam table prior to being served was 172 degrees Fahrenheit. The holding temperature of the cream of wheat on the stove prior to being served was 140 degrees Fahrenheit. A test tray was prepared and left the kitchen at 8:40 a.m. for the [NAME] unit. The last tray was served to a resident at 8:55 a.m. and the test tray was pulled from the tray cart. At that time the scrambled eggs had a temperature of 76 degrees Fahrenheit, the toast had a temperature of 81 degrees Fahrenheit, and the cream of wheat was 85 degrees Fahrenheit. The toast, scrambled eggs and the cream of wheat were tested for temperature. The toast and cream of wheat were cool when tasted. The eggs were found to be at an unappetizing low temperature.</p> <p>Interview on 6/4/24 at 8:40 a.m. with Staff F (Dietary Aide) confirmed the holding temperature of the food items on the test tray when the test tray left the kitchen.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 6/4/24 at 8:55 a.m with Staff I (Licensed Nursing Assistant) confirmed the holding temperature of the food items on the test tray when the test tray was pulled from the tray cart.</p> <p>49819</p> <p>Observation on 6/4/24 between 8:00 a.m. to 8:45 a.m. revealed that at 8:00 a.m., two standard open three-tiered rolling carts with hard plastic bowls of cream of wheat covered with a plastic lid. Further observation revealed that at 8:45 a.m. the staff started serving the bowls of cream of wheat to the [NAME] wing residents. Observation also revealed that the metal enclosed meal cart was left open while serving the East wing residents.</p> <p>Interview on 6/4/24 at approximately 9:00 a.m. with Resident #9 revealed that all his/her meals are cold all the time.</p> <p>Interview on 6/4/24 at approximately 9:00 a.m. with Resident #10 revealed that his/her scrambled eggs were cold.</p>

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide special eating equipment and utensils for residents who need them and appropriate assistance.</p> <p>38218</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to provide a resident with the necessary assistive devices for eating for 1 of 1 resident observed for assistive devices (Resident Identifier #1).</p> <p>Findings include:</p> <p>Resident #1</p> <p>Observation on 6/4/24 at approximately 8:45 a.m. of Resident #1 revealed that he/she was eating breakfast alone in bed. Further observation of Resident #1's meal tray revealed his/her meal ticket stated that Resident #1 should have a nose cup and built up silverware on his/her tray. Resident #1's breakfast tray did not have a nose cup or built up silverware.</p> <p>Interview on 6/4/24 at approximately 9:45 a.m. with Staff D (Dietary Manager) revealed that Resident #1 should have had a nose cup and built up silverware on his/her breakfast tray.</p> <p>Review on 6/4/24 of the facility policy titled, Assistance with Meals, revision date of March 2022 revealed:</p> <p>. Residents Who May Benefit from Assistive Devices: 1. Adaptive devices (special eating equipment and utensils) will be provided for residents who need or request them. These may include devices such as silverware with enlarged/padded handles, plate guards and/or specialized cups .</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47129</p> <p>Based on observation and interview, it was determined that the facility failed to ensure that dietary staff use facial hair restraints when cooking and serving food from the steam table and failed to maintain a clean environment for 1 of 1 kitchens observed for meal service and failed to store food in accordance with professional standards for food safety to prevent foodborne illness for 1 of 1 kitchenettes observed.</p> <p>Findings include:</p> <p>Review on 6/4/24 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 2 Management and Personnel .2-402 Hair Restraints 2-402.11 Effectiveness. (A) Except as provided in (B) of this section, Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens . 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: .(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 .Products which are damaged, spoiled, or otherwise unfit for sale or use in a food establishment may become mistaken for safe and wholesome products and/or cause contamination of other foods .Chapter 4 Equipment, Utensils, and Linens .Storing 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles. (A) Except as specified in (D) of this section, cleaned equipment and utensils, laundered linens, and single-serve and single-use articles shall be stored: (1) In a clean, dry location; (2) Where they are not exposed to splash, dust, or other contamination and (3) At least 15 cm (6 inches) above the floor. (B) Clean equipment and utensils shall be stored as specified under (A) of this section and shall be stored: (1) In a self-draining position that allows air drying; and (2) Covered or inverted . Chapter 6 Facilities .6-501.12 Cleaning, Frequency and Restrictions. Cleaning of the physical facilities is an important measure in ensuring the protection and sanitary preparation of food. A regular cleaning schedule should be established and followed to maintain the facility in a clean and sanitary manner. Primary cleaning should be done at times when foods are in protected storage and when food is not being served or prepared . 6-501.13 Cleaning Floors, Dustless Methods. Dustless floor cleaning methods must be used so that food; equipment, utensils, and linens; and single-service and single-use articles are not contaminated .</p> <p>Kitchen:</p> <p>Observation on 6/4/24 at 7:00 a.m. of the kitchen floor revealed that there were food particles and food debris built up under the counters and steam table. The floor was sticky and had dried liquid stains in front of the stove and around the steam table.</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 - Few</p>	<p>Interview on 6/4/24 at 7:01 a.m. with Staff E (Cook) confirmed the above finding. Interview also revealed that the floors would get swept after each meal and mopped at night after dinner services by the night staff. Staff E stated that many mornings when he/she arrived, the floors still had crumbs and dried food debris from the day before.</p> <p>Observation on 6/4/24 between 7:05 a.m. to 7:55 a.m. of Staff E in the kitchen revealed that Staff E was cooking cream of wheat, eggs and making toast. Staff E had a beard that was over an inch long that was not covered with a beard restraint.</p> <p>Interview on 6/4/24 a.m. with Staff E confirmed the above findings. Staff E revealed that he/she never wore a covering over his/her beard and that the facility doesn't have any to use.</p> <p>Observation on 6/4/24 between 7:55 a.m. to 8:25 a.m. of Staff E in the kitchen revealed that Staff E was serving food from the steam table onto plates and wasn't wearing a beard restraint.</p> <p>Observation on 6/4/24 at 9:45 a.m. of the kitchen revealed that the food mixer was not covered while not in use.</p> <p>Interview on 6/4/24 at 9:46 a.m. with Staff F (Dietary Aide) confirmed that the food mixer was not covered. Staff F was unaware of that last time it was used.</p> <p>Interview on 6/4/24 at 1:00 p.m. with Staff D (Dietary Director) confirmed that the facility did not use any coverings for facial hair.</p> <p>Review on 6/4/24 of the night cook cleaning schedule for May 27-June 2, 2024 revealed no documentation that the kitchen floor was mopped each night.</p> <p>Interview on 6/4/24 at 1:05 p.m. with Staff D confirmed the above findings.</p> <p>Review on 6/4/23 of the facility's policy titled, Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices, revised October 2017, revealed .12. Hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils and linens .</p> <p>Review on 6/4/23 of the facility's policy titled, Dining Services Cleaning Procedures, revealed .Floors .Clean Daily .</p> <p>Kitchenette:</p> <p>Observation on 6/4/24 at 10:30 a.m. of the kitchenette refrigerator revealed ten Vanilla Mighty Shakes with no thawed date or use by date.</p> <p>Interview on 6/4/24 at 10:35 a.m. with Staff F confirmed the above findings. Staff F 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>		