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	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jaffrey Rehabilitation and Nursing Center	20 Plantation Drive Jaffrey, NH 03452

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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. Based on interview and record review, it was determined that the facility failed to ensure that the Minimum Data Set (MDS) assessment accurately reflected the residents' status for 2 of 3 resident reviewed for hospice in a final sample of 18 residents (Resident Identifiers are #12 and #38). Findings include: Resident #12 Review on 4/15/25 of Resident #12's medical record revealed that Resident #12 was admitted to hospice on 2/6/25. Review on 4/15/25 of Resident #12's MDS for significant change dated 2/13/25 revealed that Section O- Special Treatments, procedures and Programs, K1 Hospice was marked no. Resident #38 Review on 4/15/25 of Resident #38's medical record revealed that Resident #38 was admitted to hospice on 12/16/24 prior to his/her admission to the facility on 2/6/25. Review on 4/15/25 of Resident #38's admission MDS revealed that Section O- Special Treatments, procedures and Programs, K1 Hospice was marked no. Interview on 4/16/25 at approximately 11:17 a.m. with Staff A RN- MDS Coordinator) confirmed that the MDS for Residents #12 and #38 did not correctly indicate that the resident were on hospice.

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 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 observation, interview, and record review, it was determined that the facility failed to follow professional standards for 1 of 1 residents reviewed for respiratory care in a final sample of 18 residents (Resident identifier is #223). Findings include: Resident #223 [NAME], [NAME] A., and [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 . Observation on 4/14/25 at approximately 9:30 a.m. of Resident #223 revealed him/her to be using oxygen via nasal canula. Review on 4/14/25 of Resident #223's physician orders revealed no orders for oxygen. Review on 4/14/25 of Resident #223 nursing admission note dated 4/13/25 revealed oxygen in use at 6 liters. Observation on 4/15/25 at approximately 2:45 p.m. of Resident #223 revealed he/she was in bed with the head of bed elevated and oxygen on at 4 liters via nasal canula. Observation on 4/16/25 at approximately 11:00 a.m. Resident #223 revealed he/she was in bed with the head of bed elevated and oxygen on at 3 liters via nasal canula. Interview on 4/16/25 at approximately 11:00 a.m. with Staff H (Licensed Practical Nurse (LPN)) confirmed Resident # 223 was recieving oxygen and that there were no physician orders in place for oxygen or oxygen titration. Review on 4/16/25 of facility policy titled Oxygen Administration dated October 2010 revealed .Preparation 1. Verify there is a physician's order for this procedure .

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, it was determined that the facility failed to ensure that a Registered Nurse (RN) was on duty for at least eight (8) consective hours a day, 7 days a week, for 2 days in Fiscal Year Quarter 1 2025. Findings include: Review on 4/14/25 of the Payroll Based Journal Staffing Data [NAME] Report for Fiscal Year Quarter 1 2025 revealed that the facility triggered for failing to have Registered Nurse (RN) hours for 8 consecutive hours a day for 78 days during October 2025, November 2025, and December 2025. Review on 4/16/25 of the facility's Payroll Detail and Daily Attendance Report revealed that there was no RN coverage on 10/7/24 and 11/24/24. Interview on 4/16/25 at 2:37 p.m. with Staff K (Human Resources) confirmed there was no RN coverage on 10/7/24 and 11/24/24.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, it was determined that the facility failed to ensure a medication error rate less than 5 percent (%) for 2 of 28 medication administrations observed. (Resident Identifiers are #38 and #224). Findings include: Resident #38 Observation on 4/14/25 at 9:02 a.m. of the morning medication administration for Resident #38 with Staff L (Licensed Practical Nurse (LPN)) revealed Staff L prepared one tablet of Calcium Carbonate 600 milligrams (mg) and one tablet of Vitamin D 1000 units and attempted to administer the medications to Resident #38. Review on 4/14/25 of Resident #38's April 2025 Medication Administration Record (MAR) revealed a physician's order for Calcium Carbonate (600 mg) with Vitamin D and minerals (400 units) and to give 1 tablet by mouth daily. Interview on 4/14/25 at 9:02 am. with Staff L revealed that the facility did not have the Calcium Carbonate (600 mg) with Vitamin D (400 units) and minerals at the facility. Interview on 4/14/25 at 1:55 p.m. with Staff L confirmed the above and that he/she had administered the incorrect medication. Resident #224 Observation on 4/14/25 at 9:40 a.m. of Staff H (LPN) administering medications to Resident #224 revealed that Staff H obtained a bag of Ceftriaxone (an antibiotic) solution 2-2.22 grams in 50 milliliters (ml) of sodium-dextrose. Further observation revealed that the instructions on the pharmacy label indicated to infuse the medication over 30 minutes. Further observation revealed that Staff H set the intravenous (IV) pump to have 30 ml to be infused at a rate of 50 minutes. Review on 4/14/25 of Resident #224's April 2025 MAR revealed an order for Ceftriaxone 2 grams IV once a day. The physician's order did not contain the volume or the rate of the Ceftriaxone to be infused. Interview on 4/14/25 at 9:43 a.m. with Staff H confirmed that he/she had set the IV pump incorrectly by reversing the numbers. Staff H then reset the IV pump to run 50 ml over 30 minutes. Review on 4/15/25 of the facilities policy titled Administering Medications revised April 2019, revealed, . 10. The individual administering the medication checks the label THREE(3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication . There were 2 medication errors out of a total of 28 medication administration opportunities resulting in a 7.14% error rate.

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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, interview, and record review, it was determined that the facility failed to ensure that controlled medications were maintained in separately locked, permanently affixed compartment for 1 of 1 medications rooms observed. Findings include: Observation on 4/14/25 at 11:52 a.m. of the Chapel Medication Room revealed an unlocked refrigerator that contained a removable, unlocked combination lock box. Inside this box was vial of liquid Ativan (Schedule IV controlled substance). Further observation revealed that the numbers to unlock the box were written on the outside of the lock box. Interview on 4/14/25 at 11:52 a.m. with Staff H (Licensed Practical Nurse) confirmed that the lock box should have been secured/locked and the code should not have been on the outside of the box. Interview on 4/14/25 at 2:30 p.m. with Staff E (Director of Nursing) revealed that the Ativan should have been double locked. Review on 4/15/25 of the facility's policy titled Medication Labeling and Storage, revised February 2023, revealed, .7. Controlled substances (listed as Schedule II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976) and other drugs subject to abuse are separately locked in permanently affixed compartments, except when using single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview and record review, it was determined that the facility failed to ensure that resident medical records were accurate for 3 residents reviewed in a final sample of 18 residents (Resident Identifiers are #40, #123 and #274.) Findings Include: Resident #40 Review on 4/16/25 of Assessing Falls and Their Causes, Nursing Services Policy and Procedure Manual for Long Term Care, copyright 2001, provided by the facility revealed . Documentation When a resident falls the following information should be recorded in the resident's medical record: 1. The condition in which the resident was found (e.g., resident found lying on floor between bed and chair). 2. Assessment data, including vital signs and any obvious injuries. 3. Interventions, first aid, or treatments administered. 4. Notification of the physician, family, as indicated. 6. Appropriate interventions taken to prevent future falls . Review on 4/15/25 of Resident #40's medical record revealed a nursing note dated 3/28/25 at 10:41 a.m. [name omitted] notified of resident's fall. The name identified in the note was the Resident's representative. Further review of the medical record revealed that there was no other documentation about Resident #40's fall. Interview on 4/16/25 at approximately 10:02 a.m. with Staff E (Director of Nursing) confirmed that there was no documentation of Resident #40's fall that contained, the resident's condition, assessment, or interventions provided. Resident #274 Review on 4/15/25 of Resident #274's medical record revealed an order for surgical dressing change every 3 days. Further the Treatment Administration Record (TAR) revealed that the dressing change was completed on 4/11/25 and not completed on 4/14/25. Observation on 4/15/25 at approximately 11:38 a.m. of the residents surgical site revealed an intact dressing dated 4/14/25. Interview on 4/15/25 at approximately 11:40 a.m. with Staff F (Registered Nurse) confirmed that the dressing had been changed on 4/14/25 but had not been signed off in the TAR.Resident #123 Review on 4/16/25 of Resident #123's December 2024 TAR revealed a physician's order for Left anterior upper thigh (left hip) with surgical wound care orders to be done every 3 days. Further review revealed that the dressing was due to be changed on the day shift on 12/3/24 and 12/6/24, but was not documented as being completed until 12/9/24. Interview on 4/16/24 at 1:20 p.m. with Staff H (LPN) confirmed that he/she was working the day shift on 12/3/24 and 12/6/24. Staff H revealed that he/she would have documented that they had done the treatment and confirmed there was no documentation that the treatment had been provided. Staff H confirmed that he/she performed the wound care on 12/9/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review on 4/16/25 of Resident #123's Weekly Wound Assessment for the left hip surgical incision, dated 12/3/24, revealed the weekly wound assessment was signed and dated on 12/11/24 by Staff E. Review on 4/16/25 of Resident #123's Weekly Wound Assessment for the left hip surgical incision, dated 12/10/24, revealed the weekly wound assessment was signed and dated on 12/11/24 by Staff E. Interview on 4/16/25 at 1:40 p.m. with Staff E confirmed the above for Resident #123's TAR and Weekly Wound Assessments. Staff E revealed that he/she documented the above Weekly Wound Assessment, but did not perform the wound care or visualize the surgical wound on 12/3/24 or 12/10/24. Staff E revealed that they would get the wound information from the nursing staff on a piece of paper, then enter the information into the medical record and discard the paper. Staff E revealed that there was no documentation of who actually visualized the wound and did the assessments on 12/3/24 and 12/10/24 and confirmed that there was no documentation wound care had been provided on 12/3/24 and 12/6/24. Review on 4/16/25 of the facility's policy titled Charting and Documentation, revised July 2017, revealed, . All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care . 2. The following information is to be documented in the resident medical record . c. Treatments or services performed; d. Changes in the resident's condition; e. Events, incidents or accidents involving the resident . 3. Documentation in the medical record will be objective . completed, and accurate . 7. Documentation of procedures and treatments will include care-specific details, including: a. the date and time the procedure/treatment was provided; b. the name and title of the individual(s) who provided the care; either assessment data and/or any unusual findings obtained during the procedure/treatment; d. how the resident tolerated the procedure/treatment; e. whether the resident refused the procedure/treatment; e. notification of family, physician or other staff, if indicated; and f. the signature and title of the individual documenting .

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the facility failed to coordinate care to the resident provided by the LTC (Long Term Care) facility staff and hospice staff for 3 of 3 residents reviewed for hospice services in a final sample of 18 residents (Resident Identifiers are #12, #38 and #23). Findings includes: Resident #12 Review on 4/16/25 of Resident #12's medical record revealed Resident #12 was admitted to on 2/6/25. Further review of Resident #12's medical record revealed that hospice was to provide Nursing and LNA (Licensed Nursing Assistant) services. Further there was no calendar or schedule of planned hospice visits in the residents's hospice binder. Resident #38 Review on 4/16/25 of Resident #38's medical record revealed Resident #38 was admitted to the facility on [DATE] on hospice. Further review of Resident #38's medical record revealed that hospice was to provide Nursing and LNA services. Further there was no calendar or schedule of planned hospice visits in the residents's hospice binder. Interview on 4/16/25 at approximately 9:50 a.m. with Staff D (LNA) revealed that he/she is not aware of the hospice schedule. He/she further revealed that the facility staff, provide the care and let hospice know if the resident needs anything, when they show up Interview on 4/16/25 at approximately 9:57 a.m. Staff C LNA revealed that he/she has no knowledge of the hospice plan, times, days of visits. Interview on 4/16/25 at approximately 11:10 AM with Staff G (Licensed Social Worker LSW)) revealed that the hospice schedule should be in the resident binder on the unit. Further Staff G revealed that he/she has a copy of the schedule in his/her email but that he/she does not place it into the binder on the floor or verify that it is present in the hospice binder for the individual resident. Resident #23 Review on 4/14/25 at approximately 2:00 p.m. of Resident #23 hospice binder revealed a hospice admission date of 7/7/24 and no schedule of visits or services to be provided. Interview on 4/15/25 at approximately 8:20 a.m. with Staff H (Licensed Practical Nurse (LPN)) revealed nursing is unaware of when or how often hospice visits are. Review on 4/15/25 at approximately 9:00 a.m. of Resident #23's hospice care plan revealed LNA [Licensed Nursing Assistant] visits per schedule. Interview on 4/16/25 at approximately 10:45 a.m. with Staff I (Licensed Nursing Assistant (LNA)) revealed there was no prediction of when visits will take place or how often. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/16/25 at approximately 11:15 a.m. with Staff G (Social Services) revealed he/she had thought hospice was providing the units with a visits schedule. Interview further revealed, he/she was emailed the schedules but did not provide them to the units.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review it was determined that the facility failed to submit complete and accurate data for Payroll Based Journal (PBJ) for Fiscal Year Quarter 1 2025 (October 1, 2025 to December 31, 2025). Findings include: Review on 4/14/25 of the Payroll Based Journal Staffing Data [NAME] Report for Fiscal Year Quarter 1 2025 revealed that the facility failed to have Registered Nurse (RN) hours and failed to have Licensed Nursing Coverage 24 hours a day on the following dates: 10/1/24 to 10/31/24; 11/1/24 to 11/30/24; and 12/15/25 to 12/31/25. Review on 4/16/25 of the facility's Payroll Detail and Daily Attendance Report revealed that there was 24 hour of Licensed Nurse coverage on the above days. Further review revealed that there was RN coverage on all but 2 days days (10/7/24 and 11/24/24). Interview on 4/16/25 at 2:37 p.m. with Staff K (Human Resources) confirmed there was Licensed Nursing Coverage 24 hours a day and there was no RN coverage on 10/7/24 and 11/24/24. Review on 4/16/25 of Centers for Medicare & Medicaid Services (CMS) Electronic Staffing Data Submission Payroll-Based Journal Long-Term Care Facility Policy Manual, Version 2.6, effective date June 2022, revealed: .Accuracy: Staffing information is required to be an accurate and complete submission of a facility's staffing records. Facilities should run the staffing reports that are available in CASPER to verify the accuracy and completeness of their final submission prior to the submission deadline .

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review, it was determined that the facility failed to employ, at least on a part-time basis, an Infection Preventionist who had completed specialized training in infection prevention and control. Findings include: Interview on 4/15/25 at 10:06 a.m. with Staff B (Infection Preventionist (IP)) revealed that he/she was the IP for the facility for over a year. Review on 4/15/25 of Staff B's Nursing Home Infection Preventionist Training Course revealed that under the Completion had 1 course that was required (Completion for Nursing Home Infection Preventionist Training Course) and was Not Started. Interview on 4/15/25 at 2:24 p.m. with Staff B confirmed that they had not completed the above course, and still had to complete and pass the final test.