STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205078	A. BUILDING ______ B. WING ______	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINSHIP GREEN CENTER FOR HEALTH & REHAB, LLC	51 WINSHIP ST BATH, ME 04530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 7/8/24 through 7/11/24 on-site visits were conducted at Winship Green Center for Health and Rehab for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification and to investigate complaints #ME00043361, #ME00045357, #ME00045513, #ME00046397, #ME00046854 and facility reported incidents #ME00047854, #ME00048020. It was determined that Winship Green Center for Health and Rehab was not in compliance with 42 CFR Part 483, Subpart B-Requirements for Long Term Care Facilities.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that a call bell was accessible to 1 of 24 sampled residents observed for 2 of 3 days of survey (#10). Findings: During medical record review, Resident #10 has diagnoses to include quadriplegia and is totally dependent on staff for all Activities of Daily Living. He/she is only able to rotate his/her head from left to right and uses a tap call bell by the right side of his/her head to ask for assistance.	F 558	Resident # 10's call bell was immediately placed within reach. A House audit of call bell placement was completed on all residents to ensure no other residents were affected by this practice. The SDC/designee has educated staff, including nursing, rehab, and dept heads on placing call lights within patient reach. The DNS/designee will complete random audits 3 x per week for 60 days to ensure call lights are within the reach of the residents. The results of these audits will be reviewed with the QAPI committee to ensure compliance is maintained. The DNS is responsible for compliance.	8/15/24

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

Administrator 07/31/24

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.

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F 558	Continued From page 1 Review of Resident #10's care plan updated 4/4/24 states "Ensure/provide ...Call light in reach ..." On 7/09/24 at 9:53 a.m. Resident #10 was observed lying in bed, touch call bell observed on right side behind pillow and not in reach. On 7/10/24 at 7:38 a.m., Resident #10 was observed lying in bed, touch call bell observed on top of pillow to right side of resident's head and not in reach. During an interview, resident was asked to demonstrate how he/she would call for help if needed. Resident #10 moved his/her head in an attempt to use the bell but was unable to reach it. During an interview on 7/10/24 at 7:41 a.m., Certified Nursing Assistant (CNA1) indicated that the only way Resident #10 can call for help is to use his/her tap call bell and it has to be on the right side of his/her head and in reach. At this time CNA1 entered the room and confirmed call bell was not in reach. During an interview on 7/10/24 at 8:43 a.m., in the presence of 2 surveyors the above was discussed with Administrator.	F 558		
F 576 SS=E	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense.	F 576		

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F 576	Continued From page 2 §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on interviews, the facility failed to deliver resident mail in a timely manner to 2 out of 4 residents who receive mail in the facility. (#48 and #63) Findings:	F 576	Resident # 48 and Resident # 63 are receiving mail 6 days per week. All residents have the potential to be affected by this practice. The Administrator/ designee has educated the activity staff and business office manager on the mail delivery policy/procedure. The Administrator/designee will complete random 3x week audits on mail delivery x 60 days. The results of these audits will be reviewed with the QAPI committee to ensure compliance is maintained. The Administrator is responsible for compliance.	8/15/24

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F 576	Continued From page 3	F 576		

Reviewed Policy titled: "Therapeutic Recreation" last revised 10/2023 that states "Ensure that mail is delivered to the person unopened or postmarked (for outgoing mail) within 24 hours, including Saturday."

On 7/11/24 at 10:45 a.m., in an interview with with Resident #48 and Resident #63, stated they are not receiving their mail for 2 or 3 days after it arrives at the facility.

On 7/11/24 at 11:00 a.m., in an interview with the Activities Director, stated that Activities deliver the mail but they have to wait until the Business Office sorts it and that can take a few days.

On 7/11/24 at 11:20 a.m., in an interview with the Business Office Manager, the staff confirmed that sometimes mail doesn't get delivered within 24 hours, especially Saturday's mail. They stated that getting the mail sorted and out to residents timely has been a known challenge because residents have complained.

F 578 SS=E — Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) — F 578

§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

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F 578	Continued From page 4	F 578		

§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).
(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on record review and interviews the facility failed to provide/obtain residents/representatives written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive for 8 of 23 residents reviewed for advanced directives (#10, #35, #46, #67, #37, #9, #63 and #23).

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F 578	Continued From page 5 Findings: 1. Resident #10 was admitted to the facility on 9/27/22. Review of Resident #10's clinical record lacked evidence that the facility provided/obtained resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. During an interview on 7/9/24 at 11:10 a.m., Resident #10's family member indicated he/she is legal guardian and has documentation but has never been asked to supply it. 2. Resident #35 was admitted to the facility on 10/16/22. Review of Resident #35's clinical record lacked evidence that the facility provided/obtained resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and or formulate an advance directive. 3. Resident #46 was admitted on 12/12/23. Review of Resident #46's clinical record lacked evidence that the facility provided/obtained resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and or formulate an advance directive. 4. Resident #63 was admitted on 3/20/24. Review of Resident #63's clinical record lacked evidence that the facility provided/obtained resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and or formulate an advance directive.	F 578	Resident #10 Resident #35, Resident # 46, Resident #67, Resident # 37, Resident #9, Resident # 63, Resident # 23, advanced directives have been declined or current wishes are reflected in medical record. House audit of advanced directive wishes on all residents has been completed to ensure no other residents were affected by this practice. The Administrator /designee has educated the social service staff, business office mgr, director of admissions and nursing staff , on the advanced directives process The administrator/designee will complete random weekly audits on advanced directives x 60 days. The results of these audits will be reviewed with the QAPI committee to ensure compliance is maintained. The administrator is responsible for compliance.	8/15/24

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F 578	Continued From page 6 5. Resident #23 was admitted on 6/11/24. Review of Resident #23's clinical record lacked evidence that the facility provided/obtained resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and or formulate an advance directive. 6. Resident #9 was admitted to the facility on 1/2/22. Review of Resident #9's clinical record lacked evidence that the facility provided/obtained resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. 7. Resident #37 was admitted to the facility on 6/5/24. Review of Resident #37's clinical record lacked evidence that the facility provided/obtained resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. 8. Resident #67 was admitted to the facility on 6/3/24. Review of Resident #67's clinical record lacked evidence that the facility provided/obtained resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. During an interview on 7/10/24 at 11:43 a.m., with 2 surveyors, Regional Director of Operations confirmed advanced directives were not obtained and/or offered/declined for above residents.	F 578		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		

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F 584 Continued From page 7 F 584

§483.10(i) Safe Environment.
The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

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F 584	Continued From page 8 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to adequately maintain maintenance services necessary to maintain the facility in good repair and sanitary condition for the ceiling air vents and surrounding ceiling tiles, all unit shower rooms, and bathrooms in Rooms 31, 33, and 35 on the Sequin Unit. Findings: 1. On 7/9/24 at 8:00 a.m., a surveyor observed that all the ceiling vents in all hallways and in the main dining room have a moderate to heavy buildup of black material on the vents and on the ceiling surrounding the vents for 3 of 3 Resident units. This was confirmed with the Administrator at that time. 2. On 7/10/24 at 10:00 a.m., during the facility tour with the Administrator and the Maintenance Manager, the following were observed: Passport Unit - The Shower room has a moderate to heavy buildup of black substance on shower grout. Pemaquid Unit - The Shower room has brown stain on shower room floor and buildup of black substance on shower grout. Room 31, the bathroom contains unlabeled salad tongs on the back of the toilet. Also, the shared bathroom for Rm 35 and 33 has a glove box holder that is broken and has sharp edges.	F 584	All ceiling vents were cleaned. The housekeeping and maintenance staff have been educated and a cleaning schedule established to ensure ongoing compliance. The Passport Unit shower room grout was cleaned. The Pemaquid Unit shower room floor and grout has been cleaned. The salad tongs in bathroom of room 31 were discarded. Room 33 and 35 glove box holder with sharp edges have been replaced. Sequin Unit shower room grout has been cleaned and areas re-caulked, door frame has been repaired and no longer has sharp edges. A house environmental audit was completed to ensure no other areas were affected by this practice. The Administrator/designee has educated the maintenance dept, housekeeping dept and nursing on environmental rounding policy /procedure. The administrator/designee will complete weekly IDT environmental audits x 60 days. The results will be reviewed with the QAPI committee to ensure compliance is maintained. The administrator is responsible for compliance.	8/15/24

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F 584	Continued From page 9 Sequin Unit - The Shower room has a heavy amount of black substance on shower grout and the doorframe going into shower room has a large chip out of paint that has a sharp edge. All these findings were confirmed with the Administrator upon the conclusion of the facility tour at approximately 11:00 a.m.	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656		

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resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and interviews, the facility failed to update/implement goals and interventions in the area of depression for 1 of 4 residents reviewed (#10), In addition facility failed to ensure care plan was updated/implemented on the areas of elopement, and diabetes for 1 of 4 care plans reviewed (#13).

Findings:

1. Resident #10 was originally admitted on 9/27/24 with diagnoses to include traumatic brain hemorrhage, quadriplegia, depression, bilateral extremity contractures and expressive aphasia.

Review of quarterly Minimum Data Set (MDS) dated 4/26/24 revealed Resident #10 has bilateral hand/arm contractures and is totally dependent on staff for all Activities of Daily Living and is dependent on G-tube [gastronomy tube]

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F 656	Continued From page 11 for all nutrition needs. Review of Resident #10's care plan, updated 4/4/24, states "[Resident #10] has depression r/t physical limitations secondary to quadriplegia, TBI... Intervention: Monitor/document/report PRN any risk for harm to self: suicidal plan,.. risky actions (stockpiling pills... or writing a note), intentionally harmed or tried to harm self..." During an interview on 7/10/24 at 8:43 a.m., in presence of 2 surveyors, the Administrator indicated Resident #10 does not have the ability to independently move his/her hands/arms and would have no ability to harm/hurt him/herself, and does not have access to any pills. At this time Administrator confirmed Resident #10's care plan has not been updated to accurately reflect his/her needs. 2. Resident #13 was originally admitted on 8/2/21 with diagnoses to include dementia, history of traumatic brain injury (TIA), and seizure disorder. Further review of Resident #13's care plan updated 5/21/24 states '(#13) at a High Risk for Elopement r/t wandering risk scale, wandering behavior pattern, attempts at opening doors to outside he demands to be brought to store at times with difficulty redirecting; Wanderguard to wheelchair EXP 10/14/23 9000-0139I. Observation of wander guard on Resident #13's wheelchair on 7/11/24 at 10:01 a.m., Revealed Resident #13's wander guard expiration date 3/5/24 9000-01391. Further review of Resident #13's clinical record lacked evidence his/her care plan was updated to appropriately reflect wander guard expiration date. During an interview on	F 656	Resident # 10 depression care plan has been updated. Resident # 13 care plan has been updated to include wander guard expiration date and the diabetes foot care current intervention. A House audit was completed on care plans for depression and diabetic foot care to ensure no other residents were affected by this practice. The DNS/designee has educated the nursing staff on developing pt specific care plans and revising care plans with updates. Focus on care plan interventions individualized and timeliness of revisions of depression and diabetic foot care. The DNS/designee will complete Care Plan random weekly audits of depression and diabetic foot care interventions x 60 days. The results of these audits will be reviewed with the QAPI committee to ensure compliance is maintained.	8/15/24

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WINSHIP GREEN CENTER FOR HEALTH & REHAB, LLC	**51 WINSHIP ST BATH, ME 04530**

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F 656	Continued From page 12 7/11/24 at 10:16 a.m., Licensed Practical Nurse (LPN #1) indicated it was nursing's responsibility to ensure wander guard expiration date is correct. Further review of Resident #13's "care plan" updated 5/21/24 states "[Resident #13] has Diabetes Mellitus, Wash feet daily with mild soap and water. Dry thoroughly. Apply lotion." During an interview on 7/11/24 at 10:17 a.m., LPN#1 confirmed Resident #13's order to wash feet was discontinued a while ago and that was an old order that never got updated in the care plan.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 657		

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F 657	Continued From page 13 (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, and policy review, the facility failed to review and revise the care plan by an interdisciplinary team (IDT) meeting, which included the participation of the resident and resident's representative, after each Minimum Data Set (MDS) 3.0 assessments, for 6 of 6 residents whose care plans were reviewed (#16, #10, #13, #26, #23, #31). Findings: 1. A surveyor reviewed the clinical documentation of Resident #16, which included review of a comprehensive Quarterly MDS dated 1/1/24, 3/8/24 and 6/8/324. The surveyor could not locate evidence, after completion of the above 3 MDS assessments, that a care plan meeting was held by the IDT that included, to the extent possible, participation of Resident #16 and/or his/her representative to review and revise the care plan. On 7/10/24 at 9:46 a.m., during an interview with the Social Services Director (SW), she confirmed the above IDT meetings were not completed. 2. A surveyor reviewed the clinical documentation of Resident #10, which included a review of quarterly MDS's dated 10/25/23, 1/25/24 and 4/26/24. Review of Resident #10's clinical record lacked evidence that a care plan meeting was held by the IDT that included, to the extent	F 657	Care plan meetings with IDT on Resident # 16 , Resident # 10, Resident #13, Resident # 26, Resident # 23 and Resident # 31 have had care plan meetings and invited patient & designated healthcare agent. A house audit of in-house residents' last care plan meetings was completed to ensure no other residents are affected by this practice. Plan to complete any missing conferences over the next 90 days. The Administrator /designee has educated the Director of social service, and the IDT team on care plan meeting process. The QAPI plan is to complete any missing IDT care plan meetings over the next 90 days. The administrator /designee will complete random weekly audits x 90 days on residents' quarterly care planning mtg process. The results of these audits will be reviewed with the QAPI team to ensure the process meets regulatory requirement for compliance. The administrator is responsible for compliance.	8/15/24

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F 657	Continued From page 14 possible, participation of Resident #10 and/or his/her representative to review and revise the care plan. During a telephone interview on 7/9/24 at 11:10 a.m., Resident #10's guardian indicated that someone at the facility informed him/her that they only held care plan meetings every 6 months and has not been invited to once since 2023. 3. A surveyor reviewed the clinical documentation of Resident #13's, which included a review of quarterly MDS's dated 9/4/23 and 12/4/23. Review of Resident #13's clinical record lacked evidence that a care plan meeting was held by the IDT that included, to the extent possible, participation of Resident #13 and/or his/her representative to review and revise the care plan. During an interview on 7/10/24 at 11:26 a.m., Resident #13 family member indicated he/she can't remember when the last care plan meeting was, but it has been quite a while. During an interview on 7/9/24 at 2:19 p.m., SW confirmed care plan meetings were not held for Resident's #10 and #13. 4. A surveyor reviewed the clinical documentation of Resident #31, which included review of a comprehensive Quarterly MDS dated 3/6/24 and 6/13/24. The surveyor could not locate evidence, after completion of the above 2 MDS assessments, that a care plan meeting was held by the IDT that included, to the extent possible, participation of Resident #31 and/or his/her representative to review and revise the care plan. 5. A surveyor reviewed the clinical documentation	F 657		

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F 657	Continued From page 15	F 657		

of Resident #23, which included review of a comprehensive Quarterly MDS dated 7/24/23, 10/24/23, 11/28/23, 2/28/24, 5/27/24 and 6/17/24. The surveyor could not locate evidence, after completion of the above 6 MDS assessments, that a care plan meeting was held by the IDT that included, to the extent possible, participation of Resident #23 and/or his/her representative to review and revise the care plan.

6. A surveyor reviewed the clinical documentation of Resident #26, which included review of a comprehensive Quarterly MDS dated 11/29/23, 2/29/24, and 5/31/24. The surveyor could not locate evidence, after completion of the above 3 MDS assessments, that a care plan meeting was held by the IDT that included, to the extent possible, participation of Resident #26 and/or his/her representative to review and revise the care plan.

On 7/10/24 at 2:25p.m., during an interview Resident #26's guardian indicated that the family has not been invited to any IDT meetings in the last year.

On 7/11/24 at 11:28 a.m., during an interview with the Director of Social Services, she confirmed the above IDT meetings were not completed for Resident's #31, #23, and #26.

Review of "Baseline/Comprehensive Person Centered Care Plan" dated 3/23 states "...The Comprehensive Person Centered Care Plan (CPCCP) will be developed after the completion of the comprehensive assessment (MDS). The CPCCP will be reviewed by an interdisciplinary team that includes the following representatives: The resident, The resident's family or legal

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F 657	Continued From page 16 representative, Therapeutic Recreation, Specialized Rehab and Healthcare provider... The resident and or representative has the right to participate in the development/implementation of the planning process, request meetings and has the right to request revisions to the plan of care... The CPCCP will be reviewed and revised as follows: quarterly following MDS completion..."	F 657		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, observations and interviews, the facility failed to provide residents with a continuous resident centered activities program for 1 of 1 resident reviewed for activity participation (#10). Findings: Review of facility policy "Participation Record" dated 5/14 states "An individual's level of involvement in recreation programming will be documented on the Recreation Participation Record... The current Participation Record will be maintained daily, organized, and easily accessible	F 679		

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F 679	Continued From page 17 to all Recreation ..." Review of facility policy "Individual Program Planning" dated 10/23 states "Regularly scheduled programming will be provided to all patients who are not able to tolerate or prefer not to participate in group or independent leisure opportunities and/or at risk of a lack of meaningful recreational and/or social engagement.......An individualized program will: Include interactions and experiences that support the resident's patient's overall wellbeing......The patient's engagement in individual (one-to-one) programs will be recorded on the Resident Participation Record indicating which preference was met and the patient's response to the intervention. Review of Resident #10's clinical record reveled "Activities -Initial Review" completed 8/7/23 states: "Past activities Interest "Spending time with her family and watching movies, listening to music .... " Review of Resident #10's Activity Participation Record dated May 2024 revealed he/she was offered/refused activity participation 7 of 30 days, Review of June 2024 revealed he/she was offered/refused activity participation 3 of 30 days, and July 2024 revealed he/she was offered/refused activity participation 5 of 10 days. Review of Resident #10 care plan updated 4/24/24 states "The resident is dependent on staff etc. for meeting emotional, intellectual, physical, and social needs r/t (if dependent). The resident will maintain involvement in cognitive stimulation, social activities as desired through review date...."	F 679	Resident #10 is participating in resident centered activities and documentation of attendance is maintained. All residents are at risk of being affected by this practice. The administrator/designee will educate the activity staff on the requirements around resident centered activities and documenting resident participation per regulatory requirement. The administrator/designee will complete random audits 3x week of resident activity participation documentation x 30 days then weekly x 1 month. The results of these audits will be reviewed with the QAPI committee to ensure compliance is maintained. The administrator is responsible for compliance.	8/15/24

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On 7/10/24 at 2:05 p.m., live music was playing in the dining room. Observation of participating residents noted Resident #10 was not present.

During an interview on 7/10/24 at 2:10 p.m., In presence of 2 family members, Resident #10 indicated that he/she was not asked if he/she wanted to attend the music activity and would have liked to attend. Family member indicated they had been there a while, and no one asked him/her if he/she wanted to go to listen to music.

During an interview on 7/10/24 at 2:15 p.m., Certified Nursing Assistant (CNA1) indicated she was aware that Resident #10 enjoyed music and he/she should have been asked if he/she wanted to participate.

During an interview on 7/10/24 at 10:06 a.m., Activity Director indicated that all residents should be asked if they want to attend activities and if they refuse it should be documented in their chart. Bed bound residents and residents that don't like group activities should get a 1:1. Care plans should reflect residents' choices appropriately and be updated quarterly. Review of Resident #10's activity participation logs lacked evidence that 1:1 activities were offered or refused.

During an interview on 7/10/24 at 2:17 p.m., Activity Assistant (AA) indicated that she goes in every room and asks every resident if they want to attend the activity. AA further indicated she did go in Residents #10's room but didn't ask if he/she wanted to attend because he/she was in bed. At this time AA confirmed Resident #10 was not invited to attend music activity.

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F 689	Continued From page 19	F 689		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the resident's safety when the residents wander guard was expired for 1 of 1 resident reviewed for elopement (#13). In addition, the facility failed to a blocked fire door on 1 of 3 units (Seguin Unit), on 2 of 3 survey days. Findings: 1. Resident #13 was admitted on 8/2/21 and has diagnoses to include dementia, anxiety, and is legally blind. Review of significant change Minimum Data Set (MDS) dated 6/21/24 revealed Resident #13 had a Brief Interview for Mental Status of 4 of 15 indicating he/she is not cognitively intact. Review of Resident #13's care plan updated 5/21/24 states "[Resident #13] is at a High Risk for Elopement r/t wandering risk scale, wandering behavior pattern, attempts at opening doors to outside [Resident #13] demands to be brought to store at times with difficulty redirecting-.."	F 689	Resident #13's wander guard was replaced immediately, the fan was removed from in front of fire door. A house audit of residents with wander guards was completed to ensure no other residents were affected by this practice. House audit of fire doors to ensure no other items were obstructing the fire doors. The SDC/designee has educated the nursing staff on monitoring expiration dates on wander guards. The facility staff by the SDC/ designee have been educated on not placing items in front of fire doors. The DNS/ designee will complete random weekly audits x 60 days at standards of care meeting on wander guard expiration dates. The DNS/designee will complete random daily audits x 30 days on fire doors free from item obstruction. The results of these audits will be reviewed with the QAPI committee to ensure compliance is maintained. The DNS is responsible for compliance.	8/15/24

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Observations of Resident #13 between 7/8/24 at 7:49 p.m., 7/9/24 at 9:53 a.m., and 7/10/24 at 10:01 a.m., revealed Resident #13's self propelling wheelchair in halls.

Observation of Resident #13's wander guard located under his/her wheelchair was noted to have expiration date of 3/5/24.

During an interview on 7/11/24 at 10:16 a.m., Licensed Practical Nurse (LPN1) indicated it was nursing's responsibility to check wander guard expiration date and at this time LPN1 confirmed Resident #13's wander guard was expired.

On 7/11/24 at 11:31 p.m., the above concerns were discussed with Director of Nursing.

2. On 7/8/24 at 6:15 p.m., a surveyor observed a standing fan obstructing an open fire door in the Seguin Hallway. The fan was moved without surveyor intervention by 7:00 p.m.

On 7/10/24 at 9:19 a.m., a surveyor observed a standing fan obstructing an open fire door in the Seguin Hallway. Staff was alerted by the surveyor and the fan was moved.

On 7/11/24 at 11:26 a.m., the fan obstructing the fire door was discussed with the Regional Director of Operations.

F 727 SS=D RN 8 Hrs/7 days/Wk, Full Time DON
CFR(s): 483.35(b)(1)-(3) F 727

§483.35(b) Registered nurse
§483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at

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F 727	Continued From page 21 least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to use the services of a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week, for 2 of 190 days reviewed for RN coverage. Findings: On 7/10/24 a surveyor reviewed the nursing working schedules from 1/1/24-7/8/24 and found that on Sunday 2/4/24 and Friday 7/5/24 the facility did not have a Registered Nurse (RN) on duty for at least 8 consecutive hours. On 7/10/24 at 10:39 a.m. a surveyor met with the Administrator about the days listed above with no RN on duty.	F 727	An RN 8Hrs/ days / week is in place. All residents have the potential to be affected by this practice. The DNS/ designee has educated the nurse leadership team and the scheduler on the regulatory requirement of RN 8 hours/7 days/week. The DNS/designee will audit the staffing daily monday -friday to ensure there is an RN 8 hrs / day 7 days per week x 3 months. The results of these audits will be reviewed with the QAPI committee to ensure compliance is maintained. The DNS is responsible for compliance.	8/15/24
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761		

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F 761	Continued From page 22 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy, the facility failed to ensure an outdated vaccine was removed from the supply available for use in medication refrigerator in 1 of 1 medication storage rooms reviewed for 1 of 4 days of survey. Finding: On 7/10/24 at 8:49 a.m., a surveyor observed the medication refrigerator in the medication storage room with Registered Nurse (RN) #2. The Surveyor observed a Covid-19 vaccine with and expiration date of 6/28/24. The RN confirmed the vaccine was expired and disposed of the vaccine immediately. The facilities policy titled "Medication Storage	F 761	The expired vaccine was removed and discarded. A house audit was completed to ensure there were no other vaccines expired in med storage areas. The SDC/designee has re-educated nursing staff on facility vaccine medication storage policy. The DNS/designee will complete random vaccine medication storage audits twice a week x 60 days. The results of these audits will be reviewed with the QAPI committee to ensure compliance is maintained. The DNS is responsible for compliance.	8/15/24

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F 761	Continued From page 23 Regulation" states, " ...Facility must have a system in place to regularly check the entire Medication Refrigerator for ...expired medications which includes the removal of these medications from the regular stock PRIOR to the expiration date ..."	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner, failed to ensure foods were dated/ labeled and stored appropriately for 2 of 3 survey days (kitchen and Pemaquid dining room), failed to ensure that the freezers and refrigerator's temperatures were monitored	F 812	The facility immediately discarded all food that was not: sealed, dated, labeled and did not have a used by date. (3 door refrigerator, dry storage area, large walk-in refrigerator/freezer, nourishment room refrigerators). The refrigerator temperature logs are all in place and being documented per policy/procedure. The Floors in the kitchen, dry storeroom and freezer have been cleaned. The flour bin scoop has been implemented. The standing mixer has been cleaned and the surface area behind mixer. The dirty trash buckets have been cleaned. All residents have the potential to be affected by this practice. The FSD/ designee has educated dietary staff on food storage, kitchen sanitation policy/procedures. The FSD/designee will complete audits 3x/week for 1 month the weekly for 2 months on; • food storage (food dated, labeled, used by date, covered/sealed within food safety temperatures/policy food storage. • The kitchen cleanliness including mixer, food storage refrigerators, refrigerators floors/freezer floor and kitchen floor, trash receptacles and the flour bin scoop in place per policy • The results of these audits will be reviewed with the QAPI committee monthly for 3 months to ensure compliance is maintained. The FSD/ administrator is responsible for compliance.	8/15/24

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appropriately. This has the potential to affect all residents that eat food prepared by kitchen staff.

Findings:

1. On 7/8/24 between 6:04 p.m., and 6:21 p.m., a surveyor and the cook completed an initial tour of the kitchen which revealed the following:

Observation of 3 door refrigerator noted the following:
- Individual sliced yellow cheese wrapped in saran wrap, undated, unlabeled and available for use.
-clear squeeze bottle of yellow substance, undated, unlabeled and available for use.
-plastic container of chopped red chili peppers, undated, unlabeled and available for use.
-Clear plastic container containing biscuits covered with saran wrap unlabeled, undated and available for use.
-Gallon jar of ranch dressing undated and available for use.
-Gallon jar containing "relish" undated and available for use.
- Jar of "chopped garlic", undated and available for use.
-Gallon jug of "cole slaw" 1/4 full, undated and available for use.
-1/2 gallon whole milk, undated and available for use.
-1 pitcher of orange juice; 1 pitcher of apple juice; 1 pitcher of tomato juice; and 1 pitcher of purple juice undated and available for use.
- large gray dish basin containing 14, 8 oz cups full of fluid, undated, unlabeled and available for use.
-large gray dish basin containing 12, 8 oz cups full of liquid, undated, unlabeled and available for

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use. The bottom of bottom of the basin contains obvious spilled liquid.
- Plastic container of what was identified as tuna salad, undated, unlabeled and available for use.

Observation of dry storage room revealed the following items on shelving units:
-Box of cream of wheat undated, opened to air and available for use.
-Bag of sliced almonds undated, opened to air and available for use.
-Small bag of peanut butter crackers opened, individual crackers directly on shelf, open and available for use.
-8 ox plastic glass 1/4 full of a brown liquid, uncovered, unlabeled and available for use.
-Bag of vanilla cake mix dated 5/15, opened to air and available for use.
-Bag of plain breadcrumbs, undated, open to air, and available for use
-Bag of mashed potatoes undated, open to air and available for use.
-Floor had obviously soiled grout, obvious debris. Surveyor and cooks shoes sticking to ground.

Observation of walk in refrigerator revealed the following:
-Large plastic gray basin on refrigerator shelf with 8 plastic containers of unknown substance, undated, unlabeled and available for use.
-Large metal tray approximately 11x14 inches in diameter, covered with foil, undated, unlabeled and available for use. Note on top states "leftovers please use"
-Block of yellow sliced cheese wrapped in saran wrap, undated and available for use.
-Unknown white substance wrapped in saran wrap undated, unlabeled and available for use.

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Observation of walk in freezer revealed:
-Box of pork sausage patties undated, opened to air and available for use.
-Box of frozen pizza dough undated, opened to air, and available for use.
-Box of frozen broccoli with obvious freezer burn undated, open to air and available for use.
-Floor in freezer, had obvious stains on grout between tiles, obvious debris.

Review of policy "Food Storage" dated" 9/19" states "It is the policy of this facility that food will be stored in a manner so as to maintain high quality, avoid spoilage and prevent contamination. All perishable foods will be stored at proper temperatures, refrigerated at 35º to 41º degrees and frozen at 0º to -10º degrees F ... All food will be dated upon stocking if taken out of its original packaging and re-wrapped or secured in containers with tightly fitted lids. If not in the original packaging, all food items must be covered, dated and labeled with the name of the contained food.. All food will be stored in areas protected from contamination by condensation, leakage, drainage, rodents or vermin"

During an interview on 7/11/24 at 8:02 a.m., (DA#2) indicated when food is opened for the first time you are supposed to document an opening date and make sure it's properly sealed and stored.

2. On 7/8/24 at 6:04 p.m., an initial tour of the kitchen revealed the following:
-Stand mixer with black cover over it had visible debris. During an interview on 6/8/24 at 6:05 p.m., Cook indicated that the mixing bowl is cleaned after every use and if it is covered it means that it's been thoroughly cleaned and is

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ready to be used again. At this time the cook confirmed the area behind and above mixing bowl had obvious debris.
-2 large flour containers noted to have visible caked on debris on top. There is a brown soup bowl located on top of one flour container, visibly soiled. At this time cook confirmed dietary staff use the soup bowl to take flour out of the container and is not sure why they don't use a scoop.

Observation of dishwashing room on 7/8/24 revealed the following:
-30 gallon trashcan noted next to counter with obvious caked on, dried on debris on top and outside surfaces.
-All 4 walls and baseboards are visibly dirty.
-Dishwasher top and sides had visibly caked on debris.
-Pipes directly under sink have obvious dust and debris.

On 7/8/24 at 6:21 p.m., Cook indicated kitchen staff have stickers that they are supposed to be putting on all items they place in refrigerator which should be dated and labeled when they are put in refrigerator, but no one really does; Refrigerator and freezer temperatures are supposed to be taken twice daily; staff sweep the floors, but don't usually wash them at the end of each shift; and staff are supposed to ensure entire kitchen in clean before the end of their shift.

During follow-up kitchen observation on 6/10/24 at 7:05 a.m., with Food Service Director (FSD), the following was observed:

-Observation of walk in refrigerator contained

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block of yellow sliced cheese wrapped in saran wrap undated, and available for use. White substance covered in saran wrap, undated, unlabeled available for use.
-Observation of Dish Room revealed trash can in dish room top and sides had obvious debris. Top and sides of dishwasher visibly soiled and All 4 walls of dish room visibly soiled with obvious debris.
-Observation of food preparation area revealed that the top and sides of trash can visibly soiled.
-Observation of dry storage room reveled bag of vanilla cake mix dated 5/15 on shelf open to air and available for use. At this time FSD confirmed above concerns.

During an interview on 7/10/24 at 8:43 the above concerns were discussed with the Administrator in the presence of 2 surveyors.

Review of temperature logs reveled the flowing:
Review of "Main Dining Room temperature Log" dated "June 2024" lacked evidence of documented temperature on 6/10/24 during the PM shift.
Review of "Walk -In Temperature Log/refrigerator-freezer" dated "July 2024" lacked evidence of documented temperatures on 6//3/24, 6/4/24, 6/5/24, and 6/6/24 during the PM shift.
Review of "3 Door Refrigerator Temperature Log" dated "July 2024" lacked evidence of documented temperatures on 6/3/24, 6/4/24, 6/5/24, 6/6/24 or 6/7/24 during the PM shift.
Review of Walk-In temperature logs dated "July 2024" lacked evidence of documented temperatures on 6/3/24, 6/4/24, 6/5/24, 6/6/24, 6/7/24 and 6/8/24 during the PM shift.
Review of "Pemaquid Dining Room Temperature

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F 812	Continued From page 29 Log dated "June 2024" revealed documented temperature of 42 degrees on 6/6/24, 6/8/24, 6/14/24, 6/17/24, 6/21/24 and 6/27/24 during the AM shift. Further review of refrigerator temperature log lacked evidence of any follow -up regarding these temperatures. Review of "Pemaquid Dining Room Temperature Log" dated "April 2024" revealed documented refrigerator temperature of 43 degrees on 4/18/24, and 42 degrees on 4/19/24 during the PM shift. Further review of refrigerator temperature log lacked evidence of any follow -up regarding these temperatures. Review of facility policy "Kitchen Sanitation" dated 1/20 states "Cleaning will be done daily, weekly, monthly, or as needed within the Kitchen. All assignments will follow the proper procedures listed in this manual and will be reviewed by the food Service Manager or Designee... All food contact surfaces shall be cleaned with detergent and sanitized with an approved food safe sanitizer and allowed to air dry. The Manager is responsible for assigning the cleaning duties to the appropriate staff and to ensure that appropriate safety equipment is available. Utilizing a checklist for the tasks assigned the kitchen is to be clean at the end of the shift. In the absence of the Food Service Manager, Cook or designee is responsible to ensure that cleaning responsibilities have been completed at the end of the shift. .." During an interview on 7/11/24 at 7:59 a.m., Dietary Aide (DA#1) indicated that if a refrigerator temperature is too high or too low, he just documents the temp on the page because he figures the Dietary Manager reviews it anyway and has no idea what else is supposed to be	F 812		

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done.

During an interview on 7/11/24 at 8:02 a.m., DA#2 indicated if a refrigerator temperature were out of range, he would notify Dietary Manager and get his guidance.

During an interview on 7/11/24 at 8:07 a.m., DM indicated if temps are off staff are to notify him or the maintenance staff. If there is a problem, they will attempt to fix it and take the temperature again.

3. On 7/9/24 at 8:23 a.m., Observation of dining room kitchenette refrigerator/freezer revealed the following:

-Refrigerator contained container of sour cream, small glass jar with unknown red substance, ¼ gallon of whole milk, and 1 plastic container of cupcakes undated, unlabeled and available for use.
- Freezer was visibly heavily soiled with a brown substance and contained unlabeled and undated popsicles.

Review of facility policy "Use & Storage of food brought to residents by family and visitors" dated 3/22 states "...Perishable foods must be stored in the nursing unit kitchen nourishment refrigerator and identified with resident's name, food item and "use by date". Facility staff are responsible to discard perishable foods within 72 hours of being brought in from outside...

During an interview on 7/9/24 at 8:23 a.m., Dietary Manager (DM) indicated the refrigerator contains resident's personal food and snacks and it is locked to prevent residents from opening it

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F 812	Continued From page 31 without staff and per policy personal food is to be discarded after 72 hours. DM further indicated that dietary staff are supposed to ensure items are dated, refrigerator is clean, and items are discarded after 72 hours. On 7/9/24 at 8:32 a.m., Administrator indicated that only staff have access to the refrigerators, and it is the dietary staff's responsibility to clean the refrigerator.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident	F 842	The residents medical record has been updated to the updated wander guard expiration date. House audit on residents with wander guards' medical records to ensure not other residents were affected by this practice. The DNS/ designee will complete random weekly audits x 60 days at standards of care meeting on wander guard residents medical records to ensure expiration date is correct. The results of these audits will be reviewed with the QAPI committee to ensure compliance is maintained x 60 days. The DNS is responsible for compliance.	8/15/24

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representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.

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F 842	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that the resident's record contained accurate information (#13). Findings: During a medical record review of Resident #13's "Treatment Administration Record" (TAR) dated July 2024 revealed order with start date of 1/20/23 to "Check [wanderguard] expiration date one time weekly every day shift every Friday for [wanderguard]." Further review of Resident #13's TAR revealed it was checked on 7/5/24 on 7a-3p shift. Review of Resident #13's "care plan" updated 5/21/24 states "[Resident #13] is at a High Risk for Elopement r/t wandering risk scale, wandering behavior pattern, attempts at opening doors to outside (Resident #13) demands to be brought to store at times with difficulty redirecting- Wander guard to wheelchair EXP 10/14/23 9000-0139I." On 7/11/24 at 10:01 a.m., a surveyor observed Resident #13's wander guard located under wheelchair to have expiration date of 3/5/24 9000-01391. Review of Resident #13's "Kardex" revealed "Wander guard to wheelchair EXP 6/14/2025 9800-0-1395." During an interview on 7/11/24 at 10:16 a.m., in presence of 2 surveyors, Licensed Practical Nurse (LPN1) indicated it was nursing's responsibility to check wander guard is working,	F 842		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 34 and to check expiration date. At this time LPN1 confirmed Resident #13's clinical record did not contain accurate information and wander guard is expired. On 7/11/24 at 11:31 p.m., the above concerns were discussed with the Director of Nursing.	F 842		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on interviews and observations, the facility failed to ensure a resident's wheelchair was clean on 2 of 3 survey days (#13). Findings: On 7/08/24 at 7:49 a.m., 7/9/24 at 9:54 a.m., and 7/10/24 at 9:53 a.m., Resident #13 was observed in the hall, sitting in his/her wheelchair. The wheelchair was observed to be soiled on each observation. During an interview on 7/10/24 at 11:21 a.m., Administrator confirmed Resident #13's wheelchair is soiled.	F 921	Resident #13's wheelchair was cleaned and sanitized. A house audit of wheelchairs revealed that no other residents were affected by this practice. The SDC/ designee has provided education on wheelchair cleaning process to housekeeping and nursing staff to ensure ongoing compliance. The administrator/designee will complete weekly wheelchair cleaning audits x 60 days and report findings to the QAPI committee for review and to maintain compliance. The administrator is responsible for compliance	8/15/24