STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205086	A. BUILDING: _____ B. WING _____	08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE HEALTH & REHAB AT N BERWICK	47 ELM ST NORTH BERWICK, ME 03906

(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) COMPLETE DATE
T 001	Initial Comments From 8/21/23 through 8/23/23 , on-site visits were conducted at Pinnacle Health & Rehabilitation in North Berwick for the purpose of completing the annual Long Term Care Survey Process for Recertification. It was determined that Pinnacle Health & Rehabilitation in North Berwick was not in substantial compliance with 10-144 Chapter 110-Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities.	T 001		
T 400	16.A.5. Physician Services The physician must visit the resident and review the resident's total program of care including medications and treatments as needed, at least once every thirty (30) days for the first ninety (90) days and every sixty (60) days thereafter. A grace period of ten (10) days may be allowed for the resident whose condition during this period of time did not require medical attention. This Regulation is not met as evidenced by: Based on record review and interview, the facility failed to ensure the physician reviewed the resident's total program of care, which included signing orders for medications and treatments listed on the Physician Orders (block orders) in a timely manner for 1 of 5 sampled residents reviewed for unnecessary medications. (Resident #5). Finding: On 8/23/23, Resident #5's clinical record was reviewed. Documentation in Resident #5's clinical record indicated that the Physician signed	T 400	*On 8/23/23; resident #5's Physician Orders were reviewed and signed.* *By 9/29/23; all resident Physician orders were reviewed for signature dates that are current.* *The medical director was educated on; 9/14/23, on the procedure for recert orders* *5 Random resident Physician Orders will be audited by the DNS or designee weekly for 4 weeks and monthly for 3 months thereafter to assure Physician Orders are current.*	

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T 400	Continued From page 1 the Physician Orders Sheet on 3/30/23. These orders were good for 60 days with the next Physician Order Sheet to be signed due by 5/30/23 (including 10 day grace period), The next Physician Orders sheet was signed on 7/5/23, which were 36 days late including the grace period. On 8/23/23 at 3:09 p.m., during an interview with a surveyor, the Director of Nursing confirmed the finding above.	T 400	*Audit results will be reviewed at QAPI meetings 9/29/23 & next QAPI meeting will be; 10/25/23*	
T 487	18.F.1. Food Supplies Supplies of staple foods for a minimum of a one-week period and of perishable foods for a minimum of 48 hours to meet the requirements of the planned menu shall be kept on the premises at all times. This Regulation is not met as evidenced by: Based on an interview, observations, and review of the facility's "Procedure for Emergency Action," last revised 3/17/22, the facility failed to have on hand enough food supplies for 56 residents. Finding: On 8/21/23, during the initial kitchen tour and interview with the Food Service Director (FSD), it was determined the facility failed to have on hand the 7 days' worth of food as depicted in their Procedure for Emergency Action. The facility policy had an inventory list with 21 specific food/beverage items that were always to be on hand in case of a disaster. On 8/21/23, the surveyor observed with the FSD,	T 487	*7-day emergency food supplies was replenished on; 8/22/23. All residents have the potential to be affected by this deficient practice. By 9/22/23; education will be provided to all dietary staff related to the policy and procedure for Emergency Food and Supplies. Weekly audits will be conducted for 4 weeks, then monthly for 3 months by the FSD or designee to assure a 7-day supply of emergency food supplies are on hand.*	

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T 487	Continued From page 2 the facility had on hand only partial amounts of items listed. The FSD stated that most of the supply had been significantly outdated and had been removed. The FSD stated he had been in the process of re-establishing the emergency supply at the time of survey, and had been sure to remain stocked up on perishable foods, but confirmed the facility had insufficient quantities of canned foods.	T 487	*Audits will be reviewed at QAPI Meetings* *Next QAPI meeting; 10/25/23*	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 000	INITIAL COMMENTS From 8/21/23 through 8/23/23, on-site visits were conducted at Pinnacle Health & Rehab at North Berwick for the purpose of conducting the annual Long Term Care Survey Process. It was determined that Pinnacle Health & Rehab at North Berwick was not in substantial compliance wtih 42 CFR 483, Sub-part B Requirements for Long Term Care Facilities.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §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;	F 584	*On 8/23/23; the 2 fracture bedpans and pink basin were removed from the shared bathrooms rooms 23 & 24, plunger was removed from room 15. On 8/29/23; the laminate around the sink was repaired in room 23, caulking around toilet in room 26 was replaced, tile was replaced behind the toilet in room 27, the loose and chipped laminate was repaired in room 28, the caulking around the toilet in room 30 was replaced.*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9/15/23

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 584	Continued From page 1 §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 §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 provide housekeeping and maintenance services necessary to maintain the building in good repair and in a sanitary condition, for 1 of 1 environmental tour. Findings: On 8/21/23 at 2:30 p.m., a surveyor observed 2 fracture bedpans and a pink wash basin on the floor next to the toilet in the shared bathroom for resident rooms 23 and 24. At this time, the B Unit charge nurse confirmed the finding and asked staff to remove the items. The charge nurse stated the items "should not be stored like that." On 8/23/23 at 10:00 a.m., during an observational environment tour with the Administrator, the following were observed: Resident Rooms: Room 15 - Observed plunger in resident bathroom next to the toilet. Room 23 - Observed the laminate around sink	F 584	*The laundry room was dusted on; 8/23/23.* *A walkthrough of all resident rooms/bathrooms was conducted by the maintenance department on; 9/11/23. To identify and remove/repair any bedpans, wash basins on floors, plungers in resident bathrooms, laminate repair, discolored or peeling caulking and chipped tiles.* *The laundry room dusting has been added to the weekly cleaning list assignment* *Weekly resident room audits will be conducted by the maintenance department or designee for 4 weeks and then monthly for 3 months to identify and remove/repair any bedpans, wash basins on floors, plungers*	

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F 584	Continued From page 2 and on front of sink is chipped and has a sharp edge. Room 26 - Observed in bathroom - toilet base caulking is discolored. Room 27 - Observed in bathroom - floor tile chipped behind toilet. Room 28 - Observed in bathroom - loose & chipped laminate on bathroom sink. Room 30 bathroom - caulking around toilet peeling away from base. Laundry Room: Observed a moderate to large amount of dust on all flat surfaces of dryers and shelves in room. All the above findings were confirmed with the Administrator aon 8/23/23 at 10:45 a.m.	F 584	*in resident bathrooms, laminate repair, discolored or peeling caulking and chipped tiles. Audit results will be reported at QAPI meetings. Weekly laundry room dusting audits will be conducted by the Housekeeping/ Laundry supervisor or designee for 4 weeks then monthly for 3 months. Results of audits will be reviewed at quarterly QAPI meetings* 9/11/23, *QAPI meeting; 10/25/23*	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services.	F 655		

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F 655	Continued From page 3 (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours that included the minimum health care information needed to properly provide care for a newly admitted resident. In addition, the facility failed to ensure the resident, and/or resident representative, was involved in the development of the resident's baseline care plan and was provided a summary of the care plan for 1 of 1 residents sampled for new admissions (#158). Finding:	F 655	*On 9/5/23 resident #158's care plan meeting was held. The resident's family member participated in the care plan meeting and was offered a copy of the care plan.* *Effective 9/7/23; all new admissions will have a baseline care plan meeting within 48 hours of admission, they (or representative) will be offered to participate in their meeting and offered a copy of their baseline care plan.* *On 9/19/23 education will be provided to care plan team members on procedure for 48-hour meetings.*	

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F 655	Continued From page 4 On 8/21/23 at 2:37 p.m., Resident #158 stated no one had met with him/her since admission to discuss care planning, and he/she had not been provided a copy of the initial care plan. A review of Resident #158's clinical record indicated he/she was admitted to the facility on 8/14/23. The baseline care plan was initiated on 8/15/23 and was noted to lack any interventions to address the problem areas of Impaired Mobility, Activities of Daily Living Self-Care Performance, and Alteration in Thought Processes. The clinical record lacked evidence that the resident, and/or resident representative, were provided a summary of Resident #158's baseline care plan. On 8/23/23 at 10:30 a.m., in an interview with the Director of Nursing (DON), Infection Preventionist, and Assistant Director of Nursing, the surveyor discussed Resident #158 had stated he/she had not been included in development of the baseline care plan and had not received a copy. The surveyor also discussed the record lacked evidence that Resident #158's representative had been included in the development of the care plan and had been provided a copy. Additionally, the baseline care plan had not been completed 9 days after Resident #158's admission. The DON confirmed the findings.	F 655	*Audits will be conducted by the DNS or designee, for all new admissions once a week for 4 weeks and monthly thereafter for 3 months to assure baseline care plans are complete, residents (representatives) were involved and a copy of their plan was offered to them.* *Audits will be reviewed at QAPI Meetings* *9/19/23, QAPI meeting will be held on; 10/25/23*	
F 657 SS=D	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-	F 657		

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F 657	Continued From page 5 (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. (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 interview and record review, the facility failed to include the resident and/or resident's representative, in the development of the resident's care plan, for 1 of 23 residents whose care plans were reviewed. (Resident #30). Finding: 8/21/23 at 1:28 p.m., in an interview with Resident #30, a surveyor asked if the facility invited him/her, or the Power of Attorney (POA), to attend a meeting and participate in the development of the resident's care plan.	F 657		

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F 657	Continued From page 6 Resident #30 stated "They've never had one for me. If they had one, I would want to go." A review of Resident #30's clinical record noted the most recent Minimum Data Set (MDS) 3.0 Quarterly Assessment was dated 6/12/23. The surveyor noted several progress notes from members of the interdisciplinary team completed on 6/22/23. Resident #30's care plan was noted with a revision date of 6/22/23. The record lacked evidence that a care plan meeting had been held and that the resident and/or her representative had been invited to attend. On 8/23/23 at 9:30 a.m., in an interview with a surveyor, the facility's Director of Social Services stated the MDS Coordinator schedules care plan meetings and sends out invitations. The Director of Social Services stated the MDS Coordinator completes an attendance form at the time of the meeting and confirmed that a care plan meeting was held on 6/27/23, but was unable to say if the resident and/or the representative was invited or attended. On 8/23/23 at 10:10 a.m., in an interview with a surveyor, the facility's MDS Coordinator stated he/she develops the care plan schedule but does not attend care plan meetings. The MDS Coordinator stated he/she schedules the team meetings based on the MDS Assessment Reference Dates and then distributes the schedule to the Interdisciplinary Team. He/she stated the facility's secretary then sends out invitations to resident families for the care plan meetings. The MDS Coordinator stated a care planning meeting was held on 6/27/23 and was attended	F 657	*A care plan meeting will be held for Resident #30 on; 9/19/23. The resident and POA have been invited to their meeting.* *On 9/19/23 education will be provided to the Care Planning Team on the procedure for inviting residents/POA's to meetings and the timeline for Care Plan meetings.* *The DNS or designee will audit care plan resident charts to assure residents (POA) were invited to their meeting and that meetings were held timely.* *Audits will be conducted weekly for 4 weeks, and then monthly thereafter.* *Audits will be reviewed at QAPI meetings*	

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F 657	Continued From page 7 by the nurse, social worker, activities, and therapy staff. The MDS Coordinator stated Resident #30's POA did not attend the meeting and that copies of the care plan are not sent to the family or resident representative that he/she is aware of. The MDS Coordinator stated if a family member wanted to know the details of the care plan meeting, the social worker would call them and discuss over the phone. On 8/23/23 at 10:30 a.m., in an interview with the Director of Nursing (DON), Infection Preventionist, and Assistant Director of Nursing, the surveyor discussed Resident #30 had stated he/she had not been included in development of the care plan and would like to be included. The surveyor also discussed the record lacked evidence that Resident #30's POA had been invited to participate in the development of the care plan. The DON confirmed the findings.	F 657	*9/19/23, QAPI meeting will be; 10/25/23*	
F 761 SS=E	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 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.	F 761	*On 8/21/23, Tubersol vial open with no date and 2 expired vials were disposed.* *On 9/13/23 an audit of refrigerated medications was conducted to determine medications where within parameters of expirations date.*	

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F 761	Continued From page 8 §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 observations and interviews, Pinnacle - North Berwick failed to label and/or dispose of opened vials of Tuberculin purified protein derivative (Tubersol), available for resident and staff tuberculosis screenings, in 1 out of 2 medication storage refridgerators . Finding: Observed on 8/21/23 at 11:05 a.m. in the AB unit medication room refrigerator: - Tubersol vial with no open date - Tubersol vial opened date7/16/23 - Tubersol vial opened date 7/17/23 Package Insert located in the box for Tubersol states, "A vial of Tubersol which has been entered in use for 30 days should be discarded" and "Do not use after expiration date." On 8/22/23 9:20 a.m. this surveyor confirmed with Registered Nurse #3 the above findings and she/he removed and disposed of them immediately.	F 761	*By 9/23/23; all nurses will be educated on the procedure for dating refrigerated medications. Weekly audits for 4 weeks and monthly thereafter for 3 months of all refrigerated medications will be conducted by the DNS or designee to determine that medications are within parameters of expiration dates. Results will be reviewed quarterly at QAPI Meetings 9/13/23, QAPI Meeting; 10/25/23*	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		

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	205086	A. BUILDING _____ B. WING _____	08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE HEALTH & REHAB AT N BERWICK	47 ELM ST NORTH BERWICK, ME 03906

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F 812	Continued From page 9 §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, and record reviews, the facility failed to ensure food is stored, served and prepared in a safe, sanitary manner as evidenced by improper food storage in the dry storage area, and failure of staff to utilize beard restraints on 1 of 2 days of kitchen observations (8/21/23). In addition, the facility failed to maintain evidence of: temperature monitoring of food temperatures for 6 meals served in June and July, 2023; monitoring for sanitizer solution levels in sanitizing buckets; and maintain proper temperature ranges for the dishwasher machine, and refrigerators in 2 of 2 nursing unit kitchenettes. This has the potential to affect all residents. Findings:	F 812	*1. Unlabeled food items were discarded immediately* *2. A log was created to track sanitizer solution in buckets on; 9/12/23* *3. Beard and hair nets were provided to dietary staff on; 8/21/23* *4. Glove education was provided to cook; on; 8/21/23* *5. The cook on shift was educated on checking meal temperatures on; 8/21/23* *6. The dietary aides and cooks on shift were educated on temperature logs for the refrigerators in the kitchenettes on; 8/21/23.* *7. The dietary aides and cooks on shift were educated on logging wash and rinse cycles*	

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F 812	Continued From page 10 On 8/21/23 at 9:30 a.m., a surveyor completed the initial tour of the kitchen with the Food Service Director (FSD) and observed: 1. Several undated and open bags of rice, tri-color rotini, dry beans, and panko in the dry storage area. The FSD removed the items from stock. 2. The FSD confirmed that the facility does not maintain records of results of sanitizer solution checks of the sanitizing buckets (to ensure correct levels in parts per million [ppm] for proper sanitizing). On 8/21/23 at approximately 11:30 a.m., a surveyor observed the noon meal service and noted the following: 3. Three male staff with beards and mustaches were without beard restraints. 4. One staff donned gloves, picked up a bag of hamburger buns, removed a bun and carried it in his/her open hand to the stove. The staff then placed a hamburger patty, which was cooking on the stove, onto the bun, which remained in his/her hand, and then placed the hamburger onto a plate. At the time of the observations, the surveyor brought the findings to the attention of the FSD, who confirmed beards should be covered and food should not be handled in such a manner. A review of the facility's, "Policy/Procedure: Food Preparation and Serving," for the Dietary Department, last revised 3/18/22, stated "10. A hairnet or baseball cap is to be worn by all kitchen employees at all times when in the kitchen, all hair must be covered with no hair dangling (including bangs and facial hair)." And, the facility's "Procedure and Policy for Taking Food,	F 812	*of the dishwasher on; 8/21/23* All residents have the potential to affected by this deficient practice. The following education will be provided to all dietary staff by; 9/22/23: The policy and procedures for labeling of foods, procedure for tracking sanitizer solutions in buckets, policy and procedure for beard/hair nets use, safe food preparation/handling/glove use, policy and procedure on meal temperature checks, *procedure for temperature logs for kitchenette refrigerators, logging wash machine and rinse cycles for the dishwasher temps.*	

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F 812	Continued From page 11 Freezer, Refrigerator and Dish Machine Temperatures, Times for Meals and Left Over Foods," last revised 6/20/23, stated "All food temperatures will be taken 10 minutes before serving and written down on temperature sheet." "11. Freezer 0 or lower. 12. Diet kitchen, bayview refrigerator 41 or lower." "Dish machine temps taken by person that is washing dishes for each meal. If not at proper temps, reset booster, put dishes through again, if still not at temps, make note and notify Food Service Director (FSD) and call Ecolab to put in a call for service for the dish machine. Morning cook takes temps of the walk-in and freezer and puts out the sanitizer container for cleaning on cook's side and tray side. AM tray side that stocks the kitchen takes temps for the country kitchens." 5. On 8/22/23, a surveyor reviewed the kitchen temperature logs. The logs lacked evidence that temperatures for meals were tested prior to being served to residents at the following times: 6/5/23: supper 6/19/23: supper 6/21/23: lunch 6/22/23: breakfast and lunch 7/23/23: lunch 8/1/23: lunch 6. A review of temperature logs for refrigerators in the nursing unit kitchenettes noted the following: In May, 2023, there were 11 out of 31 days with out of range temperatures (5/5/23, 5/9/23, 5/11/23, 5/12/23, 5/14/23, 5/17/23, 5/23/26, 5/26/23, 5/27/23, 5/30/23, 5/31/23). In June, 2023, there were 7 out of 30 days with out of range temperatures (6/8/23, 6/11/23, 6/17/23, 6/20/23, 6/21/23, 6/22/23, 6/28/23).	F 812	*The following weekly audits will be conducted by the Director of Food Service or designee 4 times a week for 6 weeks and then monthly for 3 months: Inspection for unlabeled food items, review of sanitizer solution logs, inspection for beard/hair net usage, inspections for appropriate usage of gloves, review of logs for refrigerator temps in the kitchenettes, review of logs for wash and rinse cycles of the dishwasher.* *Audit results will be reviewed at QAPI Meetings.* *9/22/23, QAPI Meeting is:* *10/25/23*	

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F 812	Continued From page 12 In July, 2023, there were 3 out of 31 days with out of range temperatures (7/4/23, 7/10/23, 7/24/23). 7. A review of temperature logs for the wash and rinse cycles of the dishwasher machine noted the following out of range temperatures (in degrees Fahrenheit [F]), or lack of evidence of temperature monitoring: 5/2/23 - No temperatures Recorded for Lunch and Dinner 5/7/23 - Supper Rinse Temperature = 179 F 5/8/23 - Lunch Wash Temperature = 140 F 5/22/23 - Breakfast Wash Temperatures = 140, 157 F; Rinse = 160 F 5/24/23 - Supper Rinse Temperature = 170 F 5/30/23 - No Supper Wash or Rinse Temperatures Recorded 5/31/23 - No Lunch & Supper Wash or Rinse Temperatures Recorded 6/12/23 - Breakfast Rinse Temperature = 175 F 6/19/23 - Lunch Rinse Temperature = 175 F 6/27/23 - Breakfast Rinse Temperature = 174 F 7/9/23 - No lunch Rinse Temperature Recorded 7/16/23 - Lunch Rinse Temperature = 175 F 7/17/23 - Lunch Rinse Temperature = 170 F 7/24/23 - Lunch Rinse Temperature = 175 F 8/8/23 - Breakfast Rinse Temperature = 170 F 8/19/23 - Breakfast Rinse Temperature = 175 F On 8/22/23 at 2:00p.m., in an interview with a surveyor, the FSD confirmed the logs lacked evidence of consistent temperature monitoring for meals and equipment, as required per facility policy, and stated that out of range refrigerator and dishwashing machine temperatures should have been rechecked and reported.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		

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F 842	Continued From page 13 §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 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	F 842		

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F 842	Continued From page 14 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. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that clinical records were complete and contained accurate information for 1 of 23 sampled residents (#158). Finding: 1. A review of the clinical record of Resident #158 noted an admission date of 8/14/23. The baseline care plan included the following focus area: (Resident #158) "has an established	F 842	On *8/23/23 Resident #158's code status was reviewed and signed on the physician's orders.* *By 9/29/23; all resident Physician Orders will be reviewed for code status and physician signature.* *All residents have the potential to be affected by this deficient practice. By 9/29/23; education will be provided to nurses and medical providers related to requirements of code status on residents signed physician orders.* *The DNS or designee will audit 5 resident physician orders assuring signed code status, weekly for 4 weeks and then monthly for 3 months.*	

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F 842	Continued From page 15 advanced directive order in place. Resident is a Do Not Resuscitate, Do Not Intubate, Do Not Hospitalize (DNR/DNI/DNH)." The most recent physician's progress note, dated 8/18/23, stated "Code Status: DNR, DNI, DNH, Beacon Hospice." A review of the physician's orders since admission could not locate a signed order addressing the resident's code status. On 8/23/23 at 10:30 a.m., in an interview with the Director of Nursing (DON), the Infection Preventionist, and the Assistant Director of Nursing, the surveyor discussed that Resident #158's clinical record noted he/she was a hospice patient, however the record lacked a physician's order specifying the resident's wish to be a DNR, DNI, DNH. The DON reviewed Resident #158's record and noted that the care plan addressed Resident #158's Advanced Directive, but confirmed the Physician Orders did not specify a code status.	F 842	*Audits will be reviewed at quarterly QAPI meetings 9/29/23, QAPI meeting is scheduled for; 10/25/23*	