STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205115	A. BUILDING _____ B. WING _____	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEXTER HEALTH CARE	64 PARK STREET DEXTER, ME 04930

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F 000	INITIAL COMMENTS From 10/28/24 through 10/31/24, unannounced on-site visits were conducted at Dexter Health Care for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification and to investigate complaint #ME00048945. It is determined that Dexter Health Care is not in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social,	F 561		

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

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religious, and community activities that do not interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on record review and interviews, the facility failed to ensure that a resident's choice in the area of bathing was being followed for 1 of 1 sampled resident (Resident #3 [R3]).

Finding:

On 10/28/24 at 12:30 p.m., during an interview with a surveyor and a resident representative, he/she stated that one of their concerns is that R3 does not always get his/her scheduled showers, and that staff tell them that because R3 was already washed he/she did not need a shower. The resident representative stated that R3 likes his/her showers and only gets one once a week.

On 10/30/24, R3's electronic clinical record was reviewed which indicated that R3 was to receive a shower on Saturdays day shift. Review of the electronic clinical records electronic charting System (ECS) (facility was transitioning from one electronic system to another and went live with the new system on October 1, 2024) ECS shows documentation that for the Months of August and September R3 missed 5 showers. For the month of October, the new electronic charting Point Click Care system (PCC) lacks evidence that R3 received any showers in the month of October.

On 10/30/24 at 10:08 a.m., a surveyor and the Director of Nursing (DON) reviewed R3's bathing documentation for the months of August through October 2024, which noted missing/incomplete documentation in regard to showers. The

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F 561	Continued From page 2 surveyor confirmed there is no evidence that R3's choices were being honored for bathing.	F 561		
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; §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	F 584		

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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, resident equipment in good repair and in a sanitary condition for 2 of 2 environmental tours.

On 10/30/24 at 1:35 p.m. through 1:55 p.m., and at 2:45 p.m., environmental tours were conducted with the Administrator. Findings were confirmed at the time of the observations.

- Room 29, the veneer on the dresser drawers was faded and had blotches of missing veneer, chipped wood and scratched.
- Room 31B, the right upper corner of the dresser drawer was missing, chipped areas and a handle was askew.
- Resident #11's wheelchair was observed to be dirty, the left armrest cushion was missing foam pieces, and the left leg/foot rest was taped creating an uncleanable surface.

- Room 20, the second drawer of the three drawer dresser was missing a piece of wood on one corner.

- Resident #27's wheelchair was dirty and the left armrest was cracked creating an uncleanable surface.

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F 584	Continued From page 4 - Room 22's bathroom ceiling light was flickering when on. - Resident #9's bedside table surface was chipped creating an uncleanable surface.	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 resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656		

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F 656	Continued From page 5 (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 review and interview, the facility failed to implement a care plan intervention for 1 of 1 residents reviewed for nutrition (Resident #27 [R27}). Finding: On 10/30/24, R27's care plan was reviewed and included an intervention added on 7/13/23 under the care area of Nutrition, to weigh the resident every week. On 10/30/24 at 9:32 a.m., a surveyor and Resident Assessment Instrument (RAI) Coordinator reviewed R27's weights documented in the electronic system for the month of October and noted that it lacked evidence of weekly weights from 9/29/24 - 10/5/24 and 10/13/24 - 10/19/24; the surveyor confirmed weights were not documented weekly during this review.	F 656		
F 684 SS=E	Quality of Care CFR(s): 483.25	F 684		

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F 684	Continued From page 6 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that physician orders for medications and treatments were followed for 6 of 25 sampled residents medications reviewed (Resident #11 [R11]), R14, R15, R27, R30, R144,). Findings: 1. On 10/30/24, a review of R15's clinical record was completed. Documentation in R15's nurse's notes indicated that on 10/9/24, R15 was sent to the Emergency Department due to respiratory concerns. On 10/11/24, R15 returned from the hospital with an order for Levaquin (an antibiotic) 750 milligrams (mgs) by mouth everyday for 7 days to treat pneumonia. On 10/13/24, a nurse's note indicated R15 returned from the hospital with an order for Levaquin and this facility was notified by pharmacy that they sent a note to R15's physician regarding prior authorization for it's use and that the medication may be contraindicated with R15's other medicines. There has been no update from the physician. The nurse note indicated that R15 had not received the antibiotic.	F 684		

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On 10/17/24, a nurse's note indicated that on 10/16/24, R15 was started on Levaquin.
On 10/30/24 at 2:00 p.m., in an interview with the Director of Nursing, the surveyor discussed and confirmed that R15 did not receive the antibiotic Levaquin until 5 days after the physician ordered the Levaquin.

2. On 10/29/24 at 10:51 a.m., during a record review for R144, a written order was noted to change Macrobid (an antibiotic) to be given for 5 days not 14 days. On 10/15/24 the order was changed to 5 days, the Medication Administration Record (MAR) indicates he/she received a morning dose on 10/15/24. The order was changed and reentered at 8:00 p.m. and the evening dose was not signed off as given. On 10/16/24, the morning dose and the evening dose were not signed off as being given resulting in R144 missing 3 doses of his/her antibiotic treatment.

3. On 10/28/24 1:35 p.m., during an interview with the surveyor, R14 stated that he/she has a rash on his/her stomach that staff are supposed to clean and put a cream on every day and they are not doing it.

On 10/28/24, R14's clinical record and orders were reviewed. R14 had a written order dated 10/15/24, "regarding moderate to severe yeast under pannus (excess skin hangs over genitals and or thighs) area: Not healing well cleanse under pannus fold twice a day (BID) dry. Apply nystatin powder well, keep folded towel under pannus to air. And to assess for possible ringworm to bilateral lower extremities". On 10/15/24, another written order was for

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ketoconazole (antifungal) 2% cream, apply daily for 4 weeks to both legs and feet in morning".

During the record review the Treatment Administration Record (TAR) shows that the order was put in the system as an as needed treatment and had not been done daily as ordered by the Provider since ordered on 10/15/24 (15 days of treatments missed). The TAR shows that the ketoconazole cream order was not followed on 4 days since the order was written on 10/15/24 (4 days of treatments missed)

On 10/29/24 at 2:30 p.m., during an interview with the Nurse Manager, the orders for R144 and R14 were reviewed and the surveyor confirmed R144's and R14's orders were not followed as outlined above.

4. On 10/30/24, R11's clinical record was reviewed and included an order, dated 3/3/24, for Protonix (reduces acid in the stomach), 40 mgs twice a day. The clinical record lacked evidence of a change of this order until the Physician signed a new set of block orders on 10/22/24, decreasing this order to once a day beginning 10/1/24. A review of the Medication Administration Record (MAR) for October indicated that R11 received Protonix only once a day. On 10/30/24 at 3:30 p.m., the Director of Nursing and surveyor reviewed R11's clinical record. It was noted that during transfer of the orders from the previous electronic charting system to the current electronic system, the frequency was incorrectly entered, which reduced the administration from twice a day to once a day without a physician order until 10/22/24, the Physician signed the physician orders which were entered into the new system which included the reduced frequency. The DON notified the

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Physician after this interview to notify of the error on the transfer of the orders. The surveyor confirmed that from 10/1/24 - 10/21/24, R11's physician order was not followed which was to receive the medication twice a day.

5. On 10/30/24, R27's clinical record was reviewed and included the following:

R27 had an unwitnessed fall in their room on 8/19/24 at 4:30 pm. The documentation indicated that neuros were initiated. The surveyor reviewed the "Neurological Flow Sheet" and noted there there was 7 assessments missing from 8/19/24 9:15 a.m. to 8/20/24 1:15 p.m., were there was nothing documented. On 10/30/24 at 10:07 a.m., during an interview with a surveyor, the Nurse Manager and Licensed Practical Nurse (LPN) #1 both stated that neuros are to be completed for unwitnessed falls. During this interview, the surveyor confirmed that neuros were not completed as indicated.

R27's physician orders included a medication order, dated 12/6/22, for Trazodone (anti-depressant) 50 mgs to be administered once a day; the clinical record lacked evidence of an order to discontinue this medication. A review of the Medication Administration Record (MAR) for October 2024 did not include this medication. On 10/30/24 at 2:14 p.m., during an interview with a surveyor, the Director of Nursing was unable to find an order to discontinue this medication and confirmed that R27 had not received this medication from 10/1/24 - 10/29/24.

6. On 10/29/24, R30's clinical record was reviewed and indicated that R30 had an ileostomy as of March 2024 but the surveyor could not find

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F 684	Continued From page 10 any active orders for the care of it. On 10/29/24 at 9:35 a.m., during an interview with a surveyor, R30 stated that he/she does have an ileostomy. On 10/29/24 at 1:53 p.m., during an interview with a surveyor, the Resident Assessment Instrument (RAI) Coordinator stated she was unable to unable to find orders for the care of the ileostomy in the current electronic orders.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that a physician order was followed for a pressure ulcer dressing change for 1 of 1 observation for Resident #11 [R11]. Finding: On 10/29/24, a surveyor reviewed R11's clinical record and noted that there was documentation of measurements on 10/7/24, 10/8/24, 10/23/24, 10/25/24 and 10/26/24 for R11's right 3rd toe	F 686		

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F 686	Continued From page 11 pressure injury. On 10/29/24 at 2:25 p.m., a surveyor observed Licensed Practical Nurse #1 (LPN1) complete a pressure ulcer dressing change for R11. The physician order directed staff to change the dressing to R11's Stage II, right third toe daily. The surveyor observed LPN1 remove the old dressing, cleanse the area, and apply the dressing to R11's second toe of the right foot. Upon exit of the room, the surveyor asked LPN1 to review the physician order and stated to LPN1 that she dressed the second toe. LPN1 went back to the room, removed R11's sock and LPN1, R11, and the surveyor noted the second toe was dressed and not the third. R11 stated, "right foot, wrong toe." The surveyor confirmed that she had completed the pressure ulcer dressing change to the wrong toe. LPN1 then changed the dressing to the third toe.	F 686		
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per	F 711		

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F 711	Continued From page 12 physician-approved facility policy after an assessment for contraindications. This REQUIREMENT 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 11 residents reviewed (Residents #6 [R6]). Finding: On 10/28/24, R6's clinical record was reviewed and included block orders (60 day) signed by the physician on 7/11/24. The next block orders), including a 10-day grace period, needed review and the Physician's signature by 9/19/24; the Physician visited on 9/9/24 but failed to sign the block orders. On 10/30/24 at 11:29 a.m., during an interview with the Director of Nursing, a surveyor confirmed that the last block orders were signed were 7/11/24, making them now 41 days late.	F 711		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §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 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.	F 727		

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F 727	Continued From page 13 §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 daily schedules review and interview, 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 7 weekend shifts reviewed for RN coverage. Findings: On 10/31/24 at 10:00 a.m., a surveyor reviewed the daily staffing schedules with the Administrator and Operations Consultant with the following confirmed: 1. On 10/13/24, there was no evidence of a RN in the building working 8 consecutive hours. 2. On 10/20/24, there was no evidence of a RN in the building working 8 consecutive hours.	F 727		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a	F 758		

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resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure there was a physician ordered renewal for an as needed (PRN) psychotropic

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F 758	Continued From page 15 medication before entering into the new electronic charting system (PCC)'s current physician orders and entered this order without a stop date, making it available for administration for 1 of 5 residents reviewed for unnecessary medications (Resident #9 [R9]). Finding: On 10/31/24 at 8:40 a.m., R9's clinical record was reviewed with the Director of Nursing (DON). The surveyor noted that the physician orders in the old electronic charting system (ECS), included Lorazepam (anti-anxiety) that was to be administered as needed at bedtime thru 9/23/24. The DON was unable to find a new physician order to renew this medication in R9's clinical record. This Lorazepam PRN medication order was entered into the new electronic charting system (PCC) with a start date of 10/1/24 (the date PCC went into effect) without a physician order for the renewal and entered the medication order with no end date, making this medication available to be used greater than 14 days. The surveyor confirmed that there was no renewal order for this PRN Lorazepam and that the medication order was still available for use during this review.	F 758		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on a complaint report, clinical record	F 760		

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reviews, and interviews, the facility neglected to protect a resident from receiving another residents medications resulting in the resident being transported to an Acute Care Emergency Department and later admitted to the hospital for evaluation, monitoring and treatment of low blood pressure and syncope episodes. (Resident #31 [R31]).

Finding:

During a recertification survey surveyors were made aware that R31 received another residents medications the morning of 10/28/24 which resulted in R31 having to be transported to the Emergency department for evaluation and treatment.

A review of R31's clinical record, in the nurse's notes, a nurse's note dated 10/28/24 at 6:30 a.m., documents that a medication was held due to an error in medication given, the night nurse was made aware and was told to wait for the day nurse of the incident.

Nursing note dated 10/28/24 at 7:51 a.m., documents that R31 was given the wrong medication (another residents). he/she was given Gabapentin (anticonvulsant medication) 400 milligram (mg) Hydroxyzine (antihistamine) 25 mg, Metoprolol succinate (beta blocker, heart medication) 100 mg, Protonix 40 mg, Spironolactone (diuretic) 25 mg, and that R31 reported nausea. On call provider was notified and received new orders to hold Lasix, Bupropion, Finasteride, Tamsulosin for 24 hours, and to hold morning Oxycodone. Vital signs at that time were listed as Blood pressure (BP) was 138/70, pulse was 71, temperature was 97.2, and

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oxygen saturation was 94% on room air (RA).

On 10/28/24, a third eye provider note was entered at 8:49 a.m., addressing the incident with wrong medications being received by R31. The note documents the most concerning medications given in error are Gabapentin in combination with Hydroxyzine which can be sedating. The provider notes the Metoprolol will drop his/her BP and pulse significantly in the next 24 hours.

On 10/28/24 at 9:09 a.m., a nursing note was entered that at 8:35 a.m. R31 was assisted to the bathroom and reported more nausea, he/she then slumped down. Staff called for assistance the nurse found resident to have had a syncope episode, he/she was lowered to the floor, and when R31 was arousable he/she yelled "what is going on" vital signs were taken with BP at 120/70, pulse at 70. resident was upset, 911 was called, MD was made aware, BP retaken and dropped to 90/70 with pulse between 70-72. BP then returned to 120's over 70's per the nursing note. R31 was then sent to the emergency room.

On 10/31/24 during an interview with the facility staff (CNA-M), who was working on the day of the medication error and who's log on was used for the medication pass. She stated that all of the other residents morning medications were given to R31. The list of medications received by R31 is Lisinopril 20 mg, Metoprolol 100 mg, Clopidogrel 75 mg, Jardiance 25 mg, Sertraline 100 mg, Omeprazole 20 mg, Glipizide 10 mg, Eliquis 5 mg, Bumetanide 2 mg, Preservision 1 capsule, Gabapentin 400 mg, Hydroxyzine 25 mg and Trelegy inhaler 2000-62-5.25 1 inhale. Two of the medications were for high blood pressure (Lisinopril and Metoprolol), one was an

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anticoagulant (Eliquis), one antiplatelet (Clopidogrel) two were antidiabetic (Jardiance and Glipizide), one was a Diuretic (Bumetanide) one is an anticonvulsant (Gabapentin), and one was an antihistamine (Hydroxyzine), and the other medications had less serious potential for side effects. R31 was not allergic to any of the incorrect medications received.

Documentation in the facility's Administering oral medications policy, dated 2/2022: on page 2 of 2, under steps in the procedure #10 stated, confirm the identity of the resident.

On 10/30/24 at 1:36 p.m., in an interview with the surveyor, Certified Nursing Assistant-Medication Aide (C.N.A.-M) stated she was passing medications on B. The Adult Education CNA-M instructor, and her student came down to B wing, they let her know they would be passing medications on the A wing. They went to the A wing and the CNA-M logged into the computer for them for the medication pass and the Adult Education CNA-M instructor and the student took over passing the medications. They came out to confirm the resident they had the medications for was on the outside of the room (near the door) and the CNA-M said no he/she was on the inside (by the window). And they said that they just gave medication to the wrong resident. The CNA-M then proceeded to notify the nurses on duty.

On 10/30/24 at 2:00 p.m. in an interview with the surveyor, the Adult Education CNA-M instructor stated that on 10/28/24 they arrived at 6:00 a.m. The Adult Education CNA-M instructor stated she did not have her own log in for the computer system Point Click Care (PCC). The CNA-M logged onto the computer, we looked up the

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F 760	Continued From page 19 medications and diagnosis and prepared the residents medications this was around 6:30 a.m. The student said good morning (using the other residents name) and R31 said "what can I do for you", the student then stated she had (the other residents name) medications and R31 stated "right here" when we gave R31 his/her medication cup he/she did say "that was quiet a few meds this morning" the Adult Education CNA-M instructor and her student then went to the CNA-M and told her that R31 said he/she was the other resident name and that was when we knew we gave the wrong medications to the wrong resident. The CNA-M told the charge nurse, and we took R31's vital signs (blood pressure, pulse, respirations) R31 came out to the cart and asked why everyone was after him/her. We told him/her they received the wrong medications, and he/she then stated his/her stomach was hurting (nausea). It was explained that we would be checking him/her every hour. We went back to do vital signs, and he/she became very lethargic and faint and was in bed. The ambulance was called, and he/she was taken to the hospital within an hour or two of receiving the wrong medications. On 10/30/24 at 2:00 p.m., in an interview with the surveyor, the Adult Education CNA-M instructor it was confirmed that on the morning of 10/28/24, the wrong medications were given to R31, and that they did not confirm the residents identity before giving the medications. On 10/31/24 R31 remained at the hospital being treated for receiving the wrong medications.	F 760		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		

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F 812	Continued From page 20 §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 and interviews, the facility failed to label supplements with a thaw date and failed to remove expired food for 2 of 4 days of survey (10/28/24 and 10/29/24). In addition, the facility failed to ensure the kitchen was maintained in a clean manner for the exhaust fan located in the dishwashing room on the clean dish side for 3 of 4 days of survey (10/28/24 to 10/30/24). Findings: 1. On 10/28/24 at 11:30 a.m., during the initial walk through of the kitchen, a surveyor observed in the walk-in refrigerator, on a shelf was a box with 9 thawed health shakes supplements that were not labeled with a thaw date. Storage and handling instructions on the carton after thawing	F 812		

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keep refrigerated, use within 14 days after thawing.

On 10/28/24 at 11:45 a.m. the surveyor confirmed with the Dietary Manager that the health shakes did not have a thaw date on them or on the box.

2. On 10/28/24 at 11:30 a.m., on a shelf on the left side of the walk-in refrigerator there was a tray that held 6 individual serving cups labeled as coleslaw with a label to use by 10/28/24.
On 10/29/24 at 8:00 a.m. during a second tour of the kitchen, a surveyor observed in the walk-in refrigerator a tray with 3 individual serving cups labeled as coleslaw with a use by date of 10/28/24 that was still available for use and 1 day past expiration.

On 10/29/24 at 8:25 a.m. a surveyor confirmed with the Dietary manager that the 3 expired serving cups of coleslaw were still in the walk-in refrigerator and available for use.

3. On 10/28/24 at 11:30 a.m. during the initial tour of the kitchen, the surveyor observed an exhaust fan in the dishwasher room, the exhaust fan was in the window on the clean dish side. The exhaust fan was heavily covered with dust and an unknown substance, the window casings were also covered with a heavy layer of dust and an unknown substance.

The Dietary Manager was asked to observe the dirty exhaust fan in the window and the soiled window casings. He stated he would add it to their kitchen cleaning list. The surveyor confirmed the above finding at that time.

4. On 10/29/24 a second observation of the

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F 812	Continued From page 22 exhaust fan in the dish room was made, the fan remained heavily covered with dust and an unknown substance. 5. On 10/30/24 a third observation of the exhaust fan in the dish room was made, the fan remained heavily covered with dust and an unknown substance.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(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(h) Medical records. §483.70(h)(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(h)(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;	F 842		

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F 842	Continued From page 23 (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(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(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(h)(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	F 842		

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facility failed to ensure a clinical record contained complete and accurate information for 3 of 7 residents reviewed (Resident #11 [R11], R27, and R9).

Findings:

1. On 10/30/24, R11's clinical record was reviewed and included an order, dated 3/3/24, for Protonix, 40 milligrams (mg) twice a day. On 10/30/24 at 3:30 p.m., during an interview with the Director of Nursing (DON), a surveyor confirmed that during transfer of physician orders from the old electronic charting system (ECS) into the new electronic charting system (PCC) to begin on 10/1/24, this or was entered, in error, to be administered one time a day instead of twice a day.

2. On 10/30/24, R27's clinical record was reviewed and included a physician order, dated 12/6/22, for Trazodone 50 milligrams (mg) to be administered once a day; the clinical record lacked evidence of an order to discontinue this medication. On 10/30/24 at 2:14 p.m., during an interview with the DON, a surveyor confirmed that during transfer of physician orders from ECS to PCC to begin on 10/1/24, this medication order was omitted.

On 10/30/24, a surveyor reviewed R27's clinical record for nutrition concerns as it was reported that R27 had weight loss. A review of the clinical record for weights included the following documentation:

10/23/24 117.5 pounds (lbs);
10/10/24 117.5 lbs;
10/9/24 218.0 lbs

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F 842	Continued From page 25 9/1/24 218.0 lbs; and 7/1/24 171.75 lbs. On 10/30/24 at 8:18 a.m., during an interview with a surveyor, the Resident Assessment Instrument (RAI) Coordinator stated that the Dietician comes to her often and expresses that the weight is incorrect and it makes it hard to assess. On 10/30/24 at 9:46 a.m., during an interview with a surveyor, the Dietary Manager, stated weights have been an issue since July with being inaccurate. He doesn't know when to notify the dietician or physician because it is hard to determine if it is inaccurate or accurate. 3. On 10/31/24 at 8:40 a.m., R9's clinical record was reviewed with the DON. The surveyor noted that orders transferred from ECS to PCC contained the following data entry errors: The order in ECS for Calcium Carbonate 500 mg was entered in PCC with no dose; the order in ECS for artificial tears (saline Solution) 2 drops each eye was entered in PCC as 1 drop each eye; the order in ECS for Lorazepam as needed with a stop date of 9/23/24 was entered in PCC as an active order; and the order for Miconazole power in ECS was entered twice in PCC. The DON was unable to find an order to renew the Lorazepam as needed.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		

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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
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The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism

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	205115	A. BUILDING _____ B. WING _____	10/31/2024

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F 880	Continued From page 27 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on the Center for Disease Control and Prevention, Enhanced Barrier Precaution policy, Wound Care policy, record reviews, observations, and interviews the facility failed to maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections during pressure ulcer dressing changes for 2 of 2 residents requiring pressure ulcer dressing changes (Resident #17 [R17], and Resident #11 [R11]). In addition, the facility failed to follow Enhanced Barrier Precautions (EBPs) pertaining to a	F 880		

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Resident with an indwelling urinary catheter for 1 of 1 resident observed for urinary catheter care (R17).

Findings:

The Centers for Disease Control and prevention "Definition and Scope of Enhanced Barrier Precautions": dated 6/23/24 states, Enhanced Barrier Precautions (EBP) involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a multi-drug resistant organisms (MDRO) as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).

A review of the facility's Enhanced Barrier Precautions (EBPs) policy and procedure, revised 2/2024, page 1, #5 EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of multi-drug resistant organisms.

A review of the facility's wound care policy and procedure (revised 2/2022) indicated on page 1, under Equipment and Supplies (necessary when performing wound care), #4 Personal Protective Equipment (gowns, gloves, mask, etc. as needed).

On 10/29/24, a review of R17's clinical record was completed. R17 is diagnosed with multiple sclerosis, relative immobility, peripheral neuropathy, a chronic Stage IV pressure ulcer on the right ischial area (lower part of hip bone) and an indwelling urinary catheter due to neuromuscular dysfunction of the bladder.

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A physician order indicated R17's pressure ulcer wound is to be changed every other day on the day shift.
On 10/30/24 at 6:35 a.m., a surveyor went to observe the morning pressure ulcer wound dressing change. Upon entering R17's room, attending to R17 was Licensed Practical Nurse #2 (LPN2), Certified Nurse Assistant #1 (C.N.A.1) and Certified Nurse Assistant #2 (C.N.A.2). LPN2 stated she just finished the dressing change. LPN2 was wearing protective gloves and a protective mask, but was not wearing a protective gown.
C.N.A.1 and C.N.A.2 were finishing R17's morning bathing and urinary catheter care. C.N.A.1 and C.N.A.2 were both wearing protective gloves and mask, but were not wearing a protective gown.

On 10/30/24 at 7:00 a.m., in an interview with the surveyor, LPN2 stated she did not have a gown on and stated she was unaware of the Enhanced Barrier Precautions and stated she should have worn a gown for the dressing change.

On 10/30/24 at 7:45 a.m., in an interview with the surveyor, C.N.A.1 and C.N.A.2 stated they were not wearing a protective gown and knew that they should have been. They stated they were aware of the EBP sign on R17's room entrance door.

2. On 10/29/24, a surveyor reviewed R11's current physician orders and noticed the R11 had an order for a daily pressure ulcer dressing change to the right foot, third toe. The surveyor had observed Enhanced Barrier Precaution signs outside of other resident rooms by the door

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F 880	Continued From page 30 entrance but did not notice one for R11. On 10/29/24 at 2:25 p.m., a surveyor observed Licensed Practical Nurse #1 (LPN1) complete a pressure ulcer dressing change for R11. LPN1 only donned gloves and did not don a gown as directed by the facility "Enhanced Barrier Precautions" and "Wound Care" policies. During this dressing change, a second surveyor walked by the room and noted that LPN1 was not wearing a gown during this procedure.	F 880		