STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205101	A. BUILDING ______ B. WING ______	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE HEALTH & REHAB CANTON	26 PLEASANT ST CANTON, ME 04221

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F 000	INITIAL COMMENTS From 7/29/2024 through 7/31/2024, on-site visits were conducted at Pinnacle Health and Rehab Canton for the purpose conducting the annual Long Term Care Survey Process and investigating facility reported incident #ME00048280. It was determined that Pinnacle Canton was not in substantial compliance with 42 CFR 483, Sub-part B Requirements for Long Term Care Facilities.	F 000	**F000** Pinnacle Health & Rehab provides this Plan of Correction without admitting or denying the validity or existence of the alleged deficiencies. The Plan of Correction is prepared and executed as evidence of the facility's continued compliance with State and Federal regulations.	
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 8/22/2024

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 550 Continued From page 1

rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observations and interviews the facility failed to promote care for a resident in a manner that maintains dignity and respect when staff failed to groom a resident on 3 of 3 survey days (Resident #31). In addition, the facility failed to identify a medication correctly to 1 of 1 resident observed for medication pass (Resident #242).

Findings:

1. Resident #31 was admitted on 12/2/22 and has diagnosis of dementia and is dependent on staff for all of his/her activities of daily living needs.

During observations on 7/29/24 at 11:01 a.m., 7/30/24 at 9:39 a.m., and 12:26 p.m., 7/31/24 at 8:21 a.m., Resident #31 was noted to have long facial/chin hair.

Review of Resident #31's "Task-Personal Hygiene-Support Provided - How resident maintains personal hygiene, including... shaving, .." revealed Resident #31 received 1-2 person

F 550

F 550
Resident #31 was shaved on 7/31/24. Staff did document her refusal of care under Behaviors.

Staff were educated on documenting resident's refusal of care on 8/14/24.

Clinical documentation will be reviewed to determine compliance with documentation. Results of these reviews will be shared with the QAA committee monthly x3.

Resident #242 was informed of the medication he takes. He was provided with a medication list on and again on 8/15/24.

Clinical staff were educated on the resident having a right to know what they are taking for medications.

Observations of medication administration will be done with all clinical staff in the first month and then annually during the clinician's competency.

Results of these observations will be shared with the QA committee to determine ongoing observations.

Completion date: September 7, 2024

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F 550	Continued From page 2 hygiene assistance on 7/26/24 at 11:04 a.m., and 22:05 [10:05 p.m.], on 7/27/24 at 10:14 a.m., and 21:11 [10:11 p.m.], on 7/28/24 at 10:03 a.m., and 17:48 [5:48 p.m.] on 7/29/24 at 10:22 a.m., and 21:52 [10:52 p.m.], on 7/30/24 at 11:04 a.m., and 22:36 [11:36 p.m.] and 7/31/24 at 10:00 a.m. During an interview on 7/30/24 at 12:26 p.m., Certified Nursing Assistant (CNA)#1 indicated residents should be shaved every day and if they refuse, it should be documented, but staff should go back and try again. During an interview on 7/30/24 at 2:48 p.m., CNA#2 indicated all residents should be shaved daily and if they refuse it should be documented in the clinical record, the nurse should be notified, and the resident should be re-approached later or by another staff member. During an observation on 7/31/24 at 9:32 a.m., with Director of Nursing (DON), the DON confirmed Resident #31 had obvious facial/chin hair and stated it should be shaved daily. 2. During observation on 7/30/24 at 9:39 a.m., Registered Nurse (RN) #2 was observed handing Resident #242 a medication cup containing 1 tablet. Resident #242 asked what the medication was, and RN #2 replied it was a "TUMS." At this time Resident #242 took the medication. Review of Resident #242's clinical record revealed medication order with start date of 4/26/24 for "PreserVision ARDES 2 chewable tablet. Give 1 tablet by mouth one time a day for supplement eye health at 8:00 a.m." During an interview on 7/30/24 at 9:49 a.m., RN #2 confirmed the medication she gave Resident	F 550		

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F 550	Continued From page 3 #242 was not TUMS, but a PreserVision ARDES 2 chewable tablet. When asked why she had told Resident #242 it was TUMS, RN #2 stated that the resident was "Persnickety" about taking medications. During an interview on 7/30/24 at 10:02 a.m., Director of Nursing confirmed with 2 surveyors that failing to accurately answer Resident #242's question was not acceptable practice.	F 550		
F 584 SS=E	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	**F 584** The Woodside Bathroom floor was cleaned on 7/31/24. The floor tiles surrounding the base of the toilet were replaced on 8/5/24. The ceiling tile outside RM 110 was replaced on 7/31/24. The base of the toilet in resident RM 109 was cleaned 7/31/24. The dust/debris & bugs in bathroom light were cleaned on 7/31/24. The base around the toilet in RM 112 was cleaned 7/31. During the monthly sanitizing of rooms, the ceiling tiles will be inspected for any stains and maintenance will be notified if found. Staff to inspect/sanitize lights during monthly room and sanitizing as well as retraining staff proper cleaning around base of toilet daily or as needed. 1:1 Training will be provided. Staff were educated on checking ceiling tiles, the cleaning around the bases of toilets and cleaning dust/debris and bugs on 8/21/24.	

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F 584	Continued From page 4 §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 a sanitary, orderly, and comfortable interior for bathrooms, a ceiling tile, a patient lift, lights, floors and wheelchairs for 1 of 1 facility tour (7/31/24). Findings: A surveyor conducted a facility Environment tour on 7/31/24 from 12:05 p.m. to 12:30 p.m. with the Maintenance Director and the Administrator in which the following findings were observed: > The bathroom, located across from the nurse's station, had a dirty floor around base of the toilet and stained floor tiles. > The hallway ceiling tile, by resident room 110, had a large brown stain on it. > The sit-to-stand patient lift, in the hallway by resident room 114, had chipped/missing paint on the foot base creating an uncleanable surface.	F 584	The Environmental services Director and/or designee will perform random room checks to monitor the cleaning practices. The results of these checks will be shared with the QAA committee to determine the need for ongoing audits. The sit to stand lift was removed from the floor and thoroughly cleaned on 7/31/24. The base was painted on . The bedpan was disposed of. Resident #17's wheelchair was cleaned on 8/1/24. Resident #30's wheelchair was cleaned on 8/1/24. Resident #7 has a new wheelchair. There are no rips or black tape present on her foot cradle, the protective covering is worn with some peeling. Per therapy manager, resident refused to have the new footrests placed on her chair, preferring her old ones. A new cradle was purchased with the consent of the resident. All floors surrounding the toilets were cleaned. All wheelchairs were cleaned with a brush in the shower. Nursing staff were educated on cleaning wheelchairs, lifts and disposing of bedpans on 8/14/24. Walkthroughs of the unit will be done weekly to inspect all floors, wheelchairs and patient lifts to ensure they are clean. Results of these walkthroughs will be shared with the QAA committee monthly x3 who will then determine the need for ongoing compliance. Completion date: September 7, 2024	

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F 584	Continued From page 5	F 584		

Additionally, there was dirt and food debris in the foot base area.
> Resident Room 109 - There was dust/debris in the bathroom light and the floor was dirty around the base of the toilet.
> Resident Room 112 - The bathroom floor was dirty around the base of the toilet and there was a bedpan sitting on the bathroom floor. Resident #17's wheelchair was dusty and soiled with food debris.
> Resident Room 120 - Resident #30's wheelchair was soiled with food debris and had dried liquid residue on the right side of the chair.
> Resident Room 126 - Resident #7's reclining wheelchair had a footrest with material that was ripped/torn, with ripped black tape on it and in disrepair, creating an uncleanable surface.

On 7/31/24 at 12:05 p.m., in an interview, the Maintenance Director and the Administrator confirmed the findings.

F 645 SS=D — PASARR Screening for MD & ID — CFR(s): 483.20(k)(1)-(3) — F 645

§483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.

§483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:
(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,
(A) That, because of the physical and mental condition of the individual, the individual requires

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F 645	Continued From page 6 the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing	F 645	**F 645** Resident #10 had been discharged from Pinnacle Health & Rehab at the time of the survey. Resident #15: a new PASRR Level I Screen was submitted on Assessment Pro on 7/30/24 Review of all residents PASRR Level I Screens was conducted on 7/30/24. No other residents possessed a PASRR Level I Screen outcome consisting of a Convalescence Categorial determination. Prior to and on admission all PASRR Level I Screens will be reviewed for outcome. If a resident is admitted with a convalescence categorial determination a 30-day count will be started so that a new PASRR Level I Screen can be submitted prior to their 30th day. The Social Services Director or designee will perform monthly audits to ensure there are no PASRR Level I Screens with a convalescence categorial determination that are not being tracked. Results of monthly audits will be shared with the QAPI committee who will determine the need for ongoing audits. Completion date: 8/07/2024	

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F 645	Continued From page 7	F 645		

facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and interview, the facility failed to ensure that 2 of 2 residents reviewed with a specialized mental health diagnosis, whose stay went beyond the expected 30 days, had been referred to the appropriate state-designated authority for Pre-Admission Screening & Resident Review Level II (PASRR) evaluation and determination (Resident #10 and Resident #15).

Findings:

1. Resident #10 was admitted to the facility on 6/14/24 with diagnosis of Schizophrenia. Resident #10's clinical record contained a PASRR Level I determination letter dated 6/12/24 that stated further PASRR evaluation was not required due to Resident #10 met the criteria for a short-term convalescence admission. Resident #10 was not discharged after a short stay and was assessed to be Nursing Facility level of care and continued to reside in the facility. The clinical record lacked evidence to indicate that the PASRR Level I was forwarded again to the State Mental Health Authority to determine if a PASRR Level II

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F 645	Continued From page 8 evaluation and determination was needed after Resident #10's stay changed from short-term to long-term. 2. Resident #15 was admitted to the facility on 5/20/24 with diagnosis of Schizophrenia and Bipolar Disorder. Resident #15's clinical record contained a PASRR Level I determination letter dated 5/24/24 that stated further PASRR evaluation was not required due to Resident #15 met the criteria for a short-term convalescence admission. Resident #15 was not discharged after a short stay and was assessed to be Nursing Facility level of care and continued to reside in the facility. The clinical record lacked evidence to indicate that the PASRR Level I was forwarded again to the State Mental Health Authority to determine if a PASRR Level II evaluation and determination was needed after Resident #15's stay changed from short-term to long-term. On 7/30/24 at 3:00 p.m., in an interview, the Social Service Director confirmed the finding. On 7/30/24 at 3:30 p.m., in an interview, the surveyor discussed the finding with the Director of Nursing.	F 645		
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	F 655		

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F 655	Continued From page 9 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. (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 interviews and record reviews, the facility failed to ensure a baseline care plan was	F 655		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 655	Continued From page 10 developed and implemented within 48 hours that included the problems, interventions, and initial goals needed to provide minimum healthcare information necessary to properly care for 1 of 2 residents reviewed for baseline care plans. (#190). Findings: Resident #190 was admitted on 7/23/24 with diagnoses to include chronic obstructive pulmonary disease (COPD). Review of Resident #190 active orders July 2024 revealed the following: -Order with start date of 7/23/24 for "Advair HFA Inhalation Aerosol 115-21 MCG/ACT (Fluticasone-Salmeterol) 2 puff inhale orally two times a day related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE." -Order with start date of 7/24/24 for "Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML 3 ml inhale orally every 6 hours as needed for SOB or Wheezing via nebulizer and 3 ml inhale orally two times a day for copd." -Order with start date of 7/24/24 for "Prednisone Oral Tablet 10 MG (Prednisone). Give 3 tablet by mouth one time a day related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE ..." -Order with start date of 7/23/24 for "ProAir HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate)2 puff inhale orally every 4 hours as needed for wheezing." Review of Resident #190's care plan initiated 7/23/24 lacked evidence that a baseline care plan was initiated within 48 hours to include goals and interventions for his/her respiratory concerns.	F 655	655 Resident 190's care plan was updated for his diagnosis of COPD on 7/31/24. All care plans of the other residents with a diagnosis of COPD to ensure they reflect the goal of care. 3 care plans will be reviewed on a weekly basis until all care plans are reviewed to ensure they accurately reflect the resident's goals of care. The results of these reviews will be shared with the QAA committee monthly x3 who will then determine the ongoing needs. Completion date: September 7, 2024	

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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 655	Continued From page 11 On 7/31/24 at 10:53 a.m., during a review of Resident #190's entire clinical record with a surveyor, the Licensed Social Worker confirmed Resident 190's care plan did not include goals and interventions for his/her respiratory diagnoses.	F 655		
F 656 SS=E	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)-	F 656		

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F 656 Continued From page 12

(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 observations, interviews, record reviews, and facility policy, the facility failed to update/implement a care plan in the area of falls for 2 of 2 sampled residents (#30 and #80, in the area of Post Traumatic Stress Disorder (PTSD) for 1 of 1 resident (Resident #9), and in the area of mood and behaviors for 1 of 1 residents reviewed for behaviors (Resident #31).

Findings:

1. On 7/29/24 at 11:08 a.m., two surveyors observed Resident #30 in a wheelchair with his/her feet on the wheelchair pedals. The call bell was attached to the bed, outside of the resident's reach. The Surveyor asked the resident if he/she could reach the call bell, he/she attempted but could not reach. At this time, Certified Nurse Aide (CNA) #4 confirmed Resident #30 cannot propel independently in his/her wheelchair and would not be able to move

F 656

F656
Resident #30 was given his call bell on 7/29/24.
Resident #8 was given his call bell on 7/29/24.
Staff were educated of the resident having the right to have their call light within reach at all times on 8/14/24.
Nursing management will perform daily rounds at various times of the day for 2 weeks to determine ongoing compliance.
Results of these rounds will be shared with the QAA committee to determine the ongoing need for monitoring.

Resident #9s care plan was updated to include her diagnosis of PTSD, the triggers she identified that may case her re-traumatization, and interventions staff can utilize to keep her safe and healthy on 7/31/24.

A chart audit was conducted to see if any other residents possessed the diagnosis of PTSD. There were 2 other residents who possessed this diagnosis in their history. Both were seen by the Tapestry Geropsych NP on 8/7/24 and after gathering evidence that this diagnosis no longer pertained to them the NP had the diagnosis removed from both residents' diagnosis lists.

The Social Services Director or designee will perform monthly audits to ensure there are no new diagnoses of PTSD for any resident that has not already been identified.

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F 656 Continued From page 13

the wheelchair to reach the call bell. Review of Resident #30's care plan for falls initiated on 1/5/23 instructs nursing to "Be sure [his/her] call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all request for assistance."

2. On 7/29/24 at 11:10 a.m., two surveyors observed Resident #8 lying in bed. The foot of the bed was against the wall next to the call bell, which was coiled up and hanging on the wall, not within reach for the resident. At this time, CNA #4 confirmed Resident #8 requires a hoyer lift for transfers and would not be able to reach his/her call bell. Review of Residents #8's care plan for frequent falls related to impaired mobility, last revised on 6/08/20 instructs nursing to, "Be sure [his/her] call light is within reach and encourage [him/her] to use it for assistance as needed. [He/she] needs prompt response to all requests for assistance. [He/she] needs reminding to use the call light when [he/she] needs assist." In addition the care plan for activities of daily living , transfers revised on 6/15/20 instructs nursing to, "mechanical lift for transfers" and "Encourage [him/her] to use bell to call for assistance."

On 7/30/24 at 3:44 p.m., the above care plan concerns were discussed with the Director of Nursing.

3. Review of policy "Trauma Informed Care" undated states "...The resident, responsible party, and multidisciplinary team will develop a resident centered care plan the will include triggers that may [case] re-traumatization, as well as [anu] holistic interventions that may keep the resident safe and healthy..."

F 656

Results of monthly audits will be shared with the QAPI committee who will determine the need for ongoing audits.

Resident 31's care plan was updated for her verbal and physical behaviors towards staff on 8/14/24.
The care plans of other residents with known negative behaviors were reviewed to ensure they reflect the resident's goals of care.
The results of the reviews will be shared with the QAA committee monthly x3 to determine the need for ongoing compliance.

Completion date: September 7, 2024

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Resident #9 was admitted on 1/17/19 with diagnoses to include paranoid schizophrenia, anxiety disorder, post-traumatic stress disorder (PTSD), bipolar disorder, and major depressive disorder

During an interview on 7/31/24 at 9:18 a.m., Licensed Social Worker (LSW) indicated that residents with PTSD should have a care plan that includes their triggers, how they cope, and how facility can help them. During a follow up interview on 7/31/24 at 10:49 a.m., LSW and a surveyor reviewed Resident #9's entire care plan and confirmed Resident #9 was admitted with diagnoses of PTSD and the facility did not update care plan as required for trauma informed care. At this time LSW indicated that when trauma informed care came out, she made sure all the new people had it in their care plans but didn't go back to the ones that have been here long term.

During an interview on 7/31/24 at 11:04 a.m. the above was discussed with DON

4. Resident #31 was admitted to facility on 12/2/22 and has diagnoses to include dementia.

Review of quarterly Minimum Data Set (MDS) dated 6/5/24 revealed Resident #31 had a Brief Interview for Mental Status (BIMS) of 8 of 15 indicating moderate cognitive impairment. Further review of Resident #31's MDS revealed he/she has physical and verbal behaviors directed towards others.

Review of Resident #31's clinical record revealed he/she refuses care often and has verbal and physical behaviors towards staff.

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F 656	Continued From page 15 Review of Resident #31's care plan most recently updated 7/11/24 lacked evidence of goals and interventions for mood/behaviors. During an interview 7/30/24 12:26 p.m., Certified Nursing Assistant (CNA)#1 indicated Resident #31 refuses care often and refuses to have his/her hair washed at any time and will not always let you shave his/her face and has been both physically and verbally aggressive toward staff. During an interview on 7/31/24 at 10:51 a.m., LSW confirmed Resident #31's refuses care often and has both verbal and physical behaviors. At this time, a surveyor and LSW reviewed Resident #31's entire care plan and confirmed Resident #9's care plan did not include goals and interventions for mood and behaviors/refusal of care.	F 656		
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- (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	F 657		

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F 657	Continued From page 16 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 record review and interviews, the facility failed to ensure that a care plan was updated to reflect the resident's current needs for range of motion for 1 of 1 residents reviewed for range of motion (ROM) (Resident #4). Finding: Resident #4 was most recently admitted 9/5/23 with diagnosis of Cerebral Palsy with muscle wasting and atrophy. Observations of Resident #4 on 7/29/24 at 11:56 a.m., and 7/30/24 at 1:15 p.m., revealed he/she has bilateral hand/arm contractures. At this time Resident #4 indicated that he/she did not have a hand brace and did not want one. Review of Resident #4's clinical record revealed order with start date of 12/22/17 states "BRACE MAY WEAR PRN as needed for POSITIONING HAND/WRIST FOR NEUTRAL POSITION" Further review of Resident #4's clinical record revealed order was discontinued on 9/5/23.	F 657	F657 Resident's 4's care plan had been updated on September 2023 when the braces were no longer to be sued. The one line in the resident's care plan that mentioned the brace was removed on 7/29/24. No other residents currently utilize braces. Clinical staff were educated of the importance of updated care plans when there are changes in the resident's care on 8/14/24. Completion date 9/7/24.	

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F 657	Continued From page 17	F 657		

Review of Resident #4's entire clinical record revealed that care plan meetings were held on 1/25/2024, 4/18/2024, 7/18/2024, and 10/26/2023.

Review of Resident #4's Care Plan most recently updated 7/18/24 states " [Resident #4] has cerebral palsy; Use braces and splints as ordered. Has a left elbow splint to be worn except for R.O.M and care and to remove at HS. ... OT to monitor/document and treat as indicated. Encourage resident/caregivers to use and correctly apply all splints, and braces. Use assistive devices recommended by OT for grooming, and other activities in order to facilitate independence." Further review of Resident #4's care plan lacked evidence that the care plan was updated after the wrist brace was discontinued.

During an interview on 7/30/24 at 12:43 p.m., Occupational Therapist (OT) revealed Resident #4 was discharged from OT on 1/5/22 and has not had a left arm brace for at least a year to her knowledge.

During an interview on 7/30/24 at 1:17 p.m., Certified Nursing Assistant (CNA)#3 indicated she has been at the facility since 10/23 and has never seen Resident #4 with any kind of brace and has never known him/her to use one.

During an interview on 7/30/24 at 1:21 p.m., with Registered Nurse (RN) #4 confirmed Resident #4 Care Plan was incorrect and was not updated after the splints were discontinued.

During an interview on 7/30/24 at 1:27 p.m. the Director of Nursing (DON) confirmed the above

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F 657	Continued From page 18 findings.	F 657		
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 observations and interview, the facility failed to ensure that the resident's environment was free of accident hazards relating to a patient lift for 1 of 4 days of survey. (7/29/24) Finding: On 7/29/24 at 9:35 a.m., two surveyors observed a patient lift, available for use in the hallway by resident room 127, that was missing a sling bar safety clip that would prevent the sling strap from potentially coming off during a lift/transfer. On 7/29/24 at 10:15 a.m., the Director of Nursing confirmed a patient lift, available for use in the hallway by resident room 127, was missing a sling bar safety clip at the time of the surveyor's observations. The Director of Nursing stated that the lift has since been removed from the floor.	F 689	**F689** The hoyer was removed from the floor on 7/29/24 to have the clip replaced. The hoyers will be checked weekly to ensure all safety clips are in place. Clinical staff were educated to make sure the clips are in place prior to using the lifts on 8/14/24. The results of these checked will be shared with the QAA committee monthly x3 who will then determine the need for ongoing compliance. Completion date: September 7, 2024	
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are	F 699		

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F 699	Continued From page 19 trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to identify a resident's current diagnosis of Post-Traumatic Stress Disorder (PTSD)/trauma to determine what trigger(s) might cause re-traumatization for 1 of 1 sampled resident reviewed with a current diagnosis of PTSD (Resident #9]. Findings: Review of policy "Trauma Informed Care" undated states "...The resident, responsible party, and multidisciplinary team will develop a resident centered care plan the will include triggers that may [case] re-traumatization, as well as [anu] holistic interventions that may keep the resident safe and healthy..." Resident #9 was admitted on 1/17/19 with diagnoses to include paranoid schizophrenia, anxiety disorder, Post traumatic stress disorder, bipolar, and major depressive disorder. Review of quarterly Minimum Data Set (MDS) dated 7/3/24 revealed Resident #9 had a brief interview for mental status score of 15 of 15 indicating he/she is cognitively intact. Further review of MDS revealed resident had diagnoses to include PTSD, schizophrenia, bipolar, depression and anxiety.	F 699	**F699** Resident #9s care plan was updated to include her diagnosis of PTSD, the triggers she identified that may case her re-traumatization, and interventions staff can utilize to keep her safe and healthy on 7/31/24. A chart audit was conducted to see if any other residents possessed the diagnosis of PTSD. There were 2 other residents who possessed this diagnosis in their history. Both were seen by the Tapestry Geropsych NP on 8/7/24 and after gathering evidence that this diagnosis no longer pertained to them the NP had the diagnosis removed from both residents' diagnosis lists. The Social Services Director or designee will perform monthly audits to ensure there are no new diagnoses of PTSD for any resident that has not already been identified. Results of monthly audits will be shared with the QAPI committee who will determine the need for ongoing audits. Completion date: 8/14/2024	

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F 699	Continued From page 20 During an interview on 7/29/24 at 11:58 a.m., Resident #9 indicated that "loud noises and stuff really bother [him/her]," but no one has ever asked [him/her] what [him/her] triggers are or how they would be able to help [him/her]. During an interview on 7/31/24 at 9:18 a.m., Licensed Social Worker (LSW) indicated that residents with PTSD should have a care plan that includes triggers and how they cope and how facility can help them. A follow up interview on 7/31/24 at 10:49 a.m., LSW reviewed Resident #9's entire care plan with a surveyor and confirmed Resident #9 was admitted with diagnoses of PTSD and the facility did not take the necessary measures required for trauma informed care. LSW indicated that when Trauma Informed Care came out, she made sure all the new residents had it in their care plans but didn't go back to the ones that have been here long term. During an interview on 7/31/24 at 11:04 a.m. the above was discussed with DON.	F 699		
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	F 761		

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

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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, record review and facility policy the facility failed to adequately date and ensure expired medications were removed from the supply available for use in 1 of 2 medication carts observed (nurse medication cart) and failed to ensure biologicals were stored at appropriate temperatures in 2 of 3 refrigerators observed (medication room top and bottom refrigerators).

Findings:

Facilities "Storage of Medications" policy and procedure, effective July 2020 states, "All medications are maintained within the temperature ranges ... refrigerated 36°F to 46°F with a thermometer to allow temperature monitoring ...The facility should maintain a temperature log in the storage area to record temperatures at least once a day ... The facility should check the refrigerator or freezer in which vaccines are stored, at least two times a day, per CDC guidelines ...When the original seal of the

F 761

F761

The Aspart insulin pen was disposed of on 7/29/24. The Basaglar Kwik pen was disposed of on 7/29/24. The Lantus Solastar pen was disposed of on 7/29/24. The Lispro Kwik pen was disposed of on 7/29/24.

All insulin pens that were delivered prior to the days when the low temperature was recorded were removed for the refrigerators. The COVID vaccine was moved to the immunizations refrigerator that has no freezer on 7/30/24.

The tuberculin solution was disposed of. All other tuberculin solutions were checked to ensure they had been delivered after the last low temperature recording.

The bottom refrigerator was defrosted on 8/1/24. The top refrigerator was defrosted on 8/4/24.

The task of defrosting the refrigerators has been placed on the night nurse duties.

Clinical staff were educated of dating insulin pens and tuberculin solutions when opened. They were also educated on the proper storage of vaccines when delivered form the pharmacy on 8/14/24.

The temperatures of the refrigerators are being checked daily.

The dates of the opened insulin pens are checked weekly to ensure they are not older than 30 days

The results of these checks will be shared with the QAPI committee who will determine the need for ongoing audits.

Completion date: September 7, 2024

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manufacturers container or vial is initially broken, that container or vial will be dated. The nurse shall place a date opened sticker on the medication and enter the date opened ... The nurse will check the expiration date of each medication before administrating it. No expired medication will be administered to a resident. All expired medications will be removed from the active supply and destroyed in the facility, regardless of the amount remaining."

1. On 7/29/24 at 11:27 a.m., during observation of the nurse medication cart with the Registered Nurse (RN #1), the following was noted by two surveyors:

> One Aspart insulin flex pen labeled with an opened date of 6/7/24. Manufactures instructions of, "Keep in a refrigerator at 36° to 46°F until first use. After first use store out of the refrigerator below 86°F for up to 28 days."
> One Basaglar Kwik Pen (insulin glargine) labeled with an opened dated of 6/01. Manufacture instructions of, "Store unused pens in the refrigerator at 36° to 46°F. Do not freeze Basaglar. Do not use if it has been frozen ...Throw away the pen you are using after 28 days, even if it still has insulin left in it."
> One Lantus SoloStar Pen opened with no date. Manufactures instructions of, Store not in use Lantus refrigerated between 36° to 46°F. Do not freeze Lantus. Discard Lantus if it has frozen. In-use Lantus should be thrown away after 28 days, even if it still has insulin left in it.
> Two Lispro Kwiki pens, one opened without a date and one labeled with an open date of 6/5/24. Manufactures instructions of, Insulin lispro should be stored in the refrigerator 36° to 46°F until it is opened, but do not freeze it. Discard unused

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F 761	Continued From page 23	F 761		

portion of the pen 28 days after first opening. At this time, RN #1 confirmed the medications were expired and removed them for availability.

2. On 7/30/24 at 9:15 a.m., during observation of the medication room with the Registered Nurse (RN #2) the following was noted by 2 surveyors:

>Top dormitory style refrigerator with a freezer compartment had excessive buildup of ice preventing the freezer door from closing. The refrigerator contained a box of Ozempic pens located on the top shelf next to the freezer compartment, several bags containing Trulicity pens on the lower shelf and 5 bottles of Lorazepam concentrated on the door.
Ozempic Manufactures instructions; "Ozempic should be kept in the refrigerator at a temperature ranging from 36° to 46°F prior to first use. However, Ozempic should not be stored in the freezer or close to the refrigerators cooling element."
Trulicity Manufactures instructions; "Store in refrigerator of 36° to 46°F ...Do not freeze."
Lorazepam Manufactures instructions; "Store at 36° to 46°F".
Review of the top medication refrigerator temperatures documented for the month of July stated 2 of 30 days had the appropriate temperatures between 36° to 46°F, all of the other temps were below the recommended temperature.

>Bottom dormitory style refrigerator with a freezer compartment had excessive buildup of ice preventing the freezer door from opening. The refrigerator contained several bags of unused insulin pens stored on the top shelf next to the freezer compartment. The lower shelf had

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F 761	Continued From page 24 additional insulin pens/vials and a bag with 7 vials of the COVID-19 vaccine. The refrigerator door had an opened and unlabeled multi dose vial of Tuberculin purified protein derivative. COVID-19 manufacturer instructions to "store refrigerated between 36°F to 46°F for up to 30 days". Tuberculin purified protein derivative manufacturer instructions to, "store at temperature between 36° to 46°F. Do not freeze." and "Once entered, vial should be discarded after 30 days." Review of the bottom medication room refrigerator temperatures documented daily for the month of July stated 2 of 30 days had the appropriate temperatures between 36° to 46°F, all of the other temps were below the recommended temperature. On 7/30/24 at 1:43 p.m., the Director of Nursing, RN #2 and the surveyor observed both top and bottom refrigerators, the freezer compartments, the temperatures and the medications being stored confirming the above concerns.	F 761		
F 812 SS=D	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	F 812		

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F 812	Continued From page 25 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, interview, the facility's " Refrigeration Policy", and the facility's "Dish Machine Temperature Log", the facility failed to ensure facial hair protection was worn; failed to ensure the walk-in freezer temperatures were monitored; and failed to ensure refrigerator and freezer temperatures were monitored for 1 of 1 kitchen tour for 1 of 3 days of survey.(7/29/24). Findings: On 7/29/24 from 9:40 a.m. to 10:10 a.m., two surveyors conducted an initial kitchen tour with the Food Service Director in which the following findings were observed: Refrigeration Policy Procedure: 2. The morning cook is to read and record the inside thermometer of each refrigerator and freezer and record on the refrigerator/freezer temperature log sheet within 30 minutes of the shift. Procedure: 3. The evening cook is to read and record the inside thermometer of each refrigerator and freezer and record on the refrigerator/freezer temperature log sheet within 60 minutes of the end of the shift. Dish Machine Temperature Log 1. The Kitchen Supervisor will train dishwashing	F 812	F812 The morning male kitchen aide was reminded how to wear the hair net to cover his facial hair on 7/29/24. The afternoon male kitchen aide was told to put on a hair net to cover his facial hair on 7/29/24. The dish machines' temperature was obtained on 7/29/24. The refrigerator/freezer's temperature was obtained on 7/29/24. A sign stating that "hair and facial protection is required beyond this point" was placed on both kitchen entrance doors on 7/29/24, and an in-service was given on 8/13/24. The Food Service Director and/or Food Service Supervisor will monitor staff daily to ensure they are wearing hair coverings if needed. The results of these checks will be shared with the QAA committee who will determine the need for ongoing audits. An in-service was given on the policy of dish machine temperature log on 8/13/24. The Food Service Director and/or Food Service Supervisor will perform random spot check on these temperatures and re-train staff on temperature recording if needed.	

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F 812	Continued From page 26 staff to monitor dish machine temperatures throughout the dishwashing process. 3. Staff will be trained to record dish machine temperatures for the wash and rinse cycles at each meal. 4. The Kitchen Supervisor will spot check this log to assure temperatures are appropriate, and staff is actually monitoring dish machine temperature. 1. On 7/29/24 at 9:40 a.m., a kitchen worker with facial hair was observed with facial hair protection pulled down below mouth while working in the kitchen. On 7/29/24 at 10:10 a.m., in an interview, the Food Service Director confirmed the findings. 2. On 7/29/24 at 2:20 p.m. and 2:35 p.m. ,a kitchen worker with facial hair was observed with no facial hair protection while in the kitchen. 3. Dish machine temperatures for high temperature Dish machine missing dates for: April 2024 - 5(breakfast), 19(breakfast), 24(breakfast) 4. Refrigerator/Freezer temperature Log missing dates for: Refrigerator: July 2024 - 4(a.m.), 24(p.m.), 25(a.m. and p.m.) Freezer: July 2024 - 24(p.m.), 25(a.m. and p.m.) On 7/30/24 at 9:00 a.m., in an interview, a surveyor discussed the findings with the Food Service Director.	F 812	The results of these spot checks will be shared with the QAA committee who will determine the need for ongoing audits. An inservice was provided on the policy of temperatures being taken within 30 minutes of the start of shift and within 60 minutes of the end of shift on 8/13/24. The Food Service Director or designee will monitor the temp logs daily to ensure temps are being recorded and taken within the time stated in the refrigeration policy. Completion date: September 7, 2024	
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly.	F 814		

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F 814	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure garbage was properly contained. On 7/29/24 the cart utilized to store garbage was observed to have no lid/cover, leaving the garbage inside the cart exposed, creating the potential for the harborage and feeding of pests for 1 of 3 days of survey. Finding: On 7/29/24 from 9:40 a.m. to 10:10 a.m., two surveyors conducted an initial kitchen tour with the Food Service Director in which the following findings were observed: > Two surveyors observed trash being stored in an open top cart outside the facility next to the kitchen area. On 7/29/24 at 10:10 a.m., in an interview, the Food Service Director confirmed the finding and stated that the trash is kept in the open bin and then wheeled to the large trash trailer later in the day.	F 814	F814 A 96-gallon trash can with a lid was purchased and is now used for trash. An in-service was provided on 8/2/24 on the use of the trash bin. The food service Director and /or Food Service Supervisor will monitor the trash can to ensure it being kept covered. Completion date; September 7, 2024	
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the kitchen walk-in freezer was maintained in good repair and in safe	F 908		

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F 908	Continued From page 28 operating condition for 1 of 1 kitchen tours (7/29/24). Finding: On 7/29/24 from 9:40 a.m. to 10:10 a.m., two surveyors conducted an initial kitchen tour with the Food Service Director in which the following finding were observed: > The walk-in freezer had a large ice build-up keeping the freezing unit left fan from running and the freezing unit right fan made a loud noise while spinning and hitting an ice build-up near it. On 7/29/24 at 10:10 a.m., in an interview with two surveyors, the Food Service Director confirmed that there was a large ice build-up keeping the freezing unit left fan from running and the freezing unit right fan made a loud noise while spinning and hitting an ice build-up near it. The Food Service Director stated that the walk-in freezer had been worked on in February of 2024. The Food Service Director went on to state that it hasn't ran properly since, has been worked on many times and continues to ice up.	F 908	**F908** The refrigeration company freed the unit of ice build-up on 7/29/24 allowing the fans to run properly. The Food Service Director and/or Food Service Supervisor will monitor the freezer unit daily. If ice is preventing proper operation it will be written in the comment section of the temp sheet and maintenance will be notified, and if needed the refrigeration company will be called for repair. The result of this monitoring will be shared with the QAA committee who will then determine the need for ongoing monitoring. Completion date; September 7, 2024	