STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205070	A. BUILDING _____ B. WING _____	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE POINT CENTER	67 PINE POINT RD SCARBOROUGH, ME 04074

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F 000	INITIAL COMMENTS From 3/3/2024 to 3/6/2024, on-site visits were conducted at Pine Point Center to complete the annual Long Term Care Survey Process for Federal Recertification and investigating complaints #ME00041769, #ME00044053, #ME00044713, #ME00044763, #ME00045063, #ME00045452, #ME00045652, #ME00047174, #ME00046341, and #ME000465589. It was determined that Pine Point Center is not in compliance with 42 CFR Part 483, Subpart B-Requirements for Long Term Care Facilities.	F 000	Pine Point provides this plan of correction without admitting or denying the validity or existence of the alleged defecienciew. The plan of correction is prepared and executed as evidence of the facility's continued compliance with state and federal regulations.	
F 550 SS=D	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.	F 550	Resident Rights/ Exercise of Rights The administrator met with Resident #17 and their family to review the plan of care and address any concerns.	4/5/24

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

RN-C RNHA | Administrator | 3/27/2024

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 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her 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 ensure a resident was treated with dignity and respect for 1 out of 14 residents reviewed during survey. (Resident #17) On 3/3/24 at 12:10 p.m., a surveyor observed a loud confrontation among a staff member, a family member, and Resident #17 in the Oak Hill Dining Room. The staff member was seen and heard yelling to the family member "I need to talk to you". The staff member was observed pointing their finger at the family member. At this time, the staff member was escorted out of the room by another staff member. On 3/3/24 at 12:45 p.m., during an interview with the family member and Resident #17, they stated the family member had entered the facility and heard 3 staff members talking about Resident #17 in the lobby. The family member overheard one staff member say in an "angry manner"; "I'll	F 550	The facility ensures that each resident is treated with respect and dignity and care for each resident in a manner and in an enviroment that promotes maintenance of enhancement of self-esteem and self-worth. This is inclusive of HIPAA information not being discussed in public areas as well as engagement with residents in a manner free of discrimination and reprisal. All staff will be re-educated to this process. Administrator/ Designee will complete random weekly audits x4 weeks then monthly x3 weeks The audits will include confirming patients concerns are being addressed in a private area and with respect. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	

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F 550	Continued From page 2 take care of this." The family member observed this staff member go directly to Resident #17 in the dining room and move his/her plate and loudly scold Resident #17. The family member and Resident #17 expressed feeling upset hearing staff talk that way. The resident stated, "I'm not surprised, she doesn't like me." On 3/3/24 at 1:00 p.m., in an interview with the Administrator and Director of Nursing about the findings, the surveyor confirmed that it was not appropriate for staff to be talking about a resident in a public area.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews,record reviews, the facility's bathing schedule and facility's bathing documentation, the facility failed to ensure that resident's preferences were being followed in the area of bathing for 2 of 6 residents reviewed. (Resident #14 and Resident #17) Findings: 1. On 3/3/24 at 8:58 a.m., during an obervation of Resident #14, the resident overheard asking a Certified Nurses Aide (CNA) for a shower. Resident #14 said, "I was supposed to get a shower on Friday, but they told me they didn't	F 558	Reasonable Accomadations Needs/ Preferences Resident #14 and #17 were given showers and continue to be given assistance with ADL's inclusive of showers/ whirlpools and the staff accurately documenting in accordance with accepted professional standards and practices.	4/5/24

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F 558	Continued From page 3 have enough staff." "I didn't get one last week either." During a review of the CNA bathing schedule indicated that the resident's scheduled weekly shower was on Thursdays. 2. On 3/4/24 at 9:15 a.m., during an interview with Resident #17, stated had not ever received a shower at the facility. A review of the admission record for Resident #17 showed an admission to the facility on 6/23/23. She/He stated, "They said I am getting dandruff. I need a shower." A review of the CNA bathing schedule indicated that Resident #17's scheduled bathing day was Sunday. On 3/5/24, a surveyor reviewed the facility's bathing documentation for a 9-week period from 1/1/24 to 3/5/24. Resident #14 received one shower during this period on 2/18/24. There were no documented showers for Resident #17. On 3/6/24 at approximately 10:00 a.m., during an interview with a CNA, Resident #17 needs 2 staff members for bathing as well as a mechanical lift for transferring. On 3/6/24 at 10:15 a.m., a surveyor met with the Director of Nursing and shared the above findings.	F 558	A facility-wide audit of shower/ whirlpool schedule and completion was conducted to validated all residents' shower needs are being met . The facility ensures that scheduled showers/whirlpools are offered and provided. All direct care staff will be re-educated to this process. DON/ Designee will complete random weekly x4 weeks then monthly x3 months that showers are offered and documented per patients response. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	
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	F 584	Safe/Clean/Confortable/ Home like Enviroment	

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F 584	Continued From page 4 supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §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 maintain a safe, clean, comfortable and	F 584	Findings 1,2,3 Ceiling tiles were ordered to replace all stained tiles. An audit of ceiling tiles through out the facility will be completed and tiles with staining or in need of cleaning will be cleaned or replaced. Administrator/ Designee will complete random weekly x4 and monthly x3 months audits to ensure stained and/or dirty ceiling tiles are replaced and/ or cleaned as needed. Rotating hallway Weekly Quality of Life Rounds to be initiated and Director of Maintenance to attend all rounding and ensure all findings are addressed in a timely manner. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	4/5/24

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F 584	Continued From page 5 homelike environment on 2 of 2 units and in the Kitchen. Findings: 1. On 3/3/24 at 9:10 a.m., during the initial observation of the Kitchen with the cook, it was observed that the ceiling had multiple ceiling tiles that had moderate to heavy amounts of spotting and staining. On 3/6/24 at 11:15 a.m., in an interview with the Director of Maintenance, he stated that the Kitchen ceiling had not been cleaned in the 13 years that he has been here. He stated, "I would not know how you would clean that." 2. On 3/6/24 at 11:20 a.m., during a tour of the Long Term Care Unit with the Director of Maintenance the following were observed: - Pleasant Hill House, resident Room 6, the window curtains were off the track on both sides of the window. One stained ceiling tile at the nurses' station and 1 stained ceiling tile in the resident dining room. 3, On 3/6024 at 11:40 a.m., during a tour of the Short Stay Unit with the Director of Maintenance, the following were observed: - Stained ceiling tiles in resident Room 1, just over the bed. - One stained ceiling tile at the Nurse's station, and one stained ceiling tile in the hallway just outside the dining room. The Director of Maintenance was made aware of the findings at that time and recorded them.	F 584		

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F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews and observations, the facility failed to provide sufficient staffing to meet the acuity level and resident needs in a timely manner for 3 out of 3 units surveyed. (Pleasant Hill House, Dunston House and Oak Hill House) Findings:	F 725	Sufficient Nursing Staff The events happened in the past and cannot be corrected. Residents #14, #17, #12, #18 are currently receiving assistance with ADL's inclusive of showers/ whirlpools. These residents needs are being met with staff's prompt response to call bell utilization. A facility wide audit of staffing has been conducted to validated the facility ensures there is sufficient direct care staff to meet the needs of the residents. The facility has moved the shift start times to 7a/3p/11p to better assit with meeting residents needs. An audit of call bell response times was also conducted to validate sufficient direct care staff for meeting residents needs. The facility ensures staff respond to call bells promptly and that scheduled showers/ whirlpools are offered and provided. All direct care staff will be re-educated to this process.	4/5/24

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F 725	Continued From page 7 1. On 3/3/24 at 9:17 a.m.. a surveyor observed Resident #14 asking a CNA #2 for a shower. Resident #14 stated they should have gotten a shower on Friday but was told there wasn't enough staff that day. "And it happened last week too." CNA #2 confirmed the resident's scheduled shower day was Thursday and it hadn't happened yet this week. A record review of Resident #14's bathing documentation revealed only 1 documented shower in the past 63 days. On 3/3/24 9:30 a.m., a surveyor interviewed CNA #5, "There's a lot I can't get to. Changing, repositioning, it doesn't happen. Things we are supposed to do but can't get to it. I spend all my time looking for someone to help me. I find them and then I have to wait because they're busy. We should have 2 people over here." On 3/3/24 at 9:35 a.m., a surveyor interviewed CNA #3 "We can't give the care we need because there isn't enough staff" "It's disruptive to my med pass when I am constantly pulled away from the med cart" When asked if it feels safe to have so many disruptions during a medication pass, CNA #3 replied "No." 2. On 3/3/24 at 9:38 a.m., a surveyor observed a call bell on Oak Hill Unit go unanswered for 40 minutes. 3. On 3/3/24 at 10:10 a.m., a surveyor interviewed Resident #17 and learned that she/he had requested to get up at 6:00 a.m. and wasn't helped up until 10:00 a.m. after being told they didn't have enough staff yet. 4. On 3/4/24 at 9:16 a.m., during an interview	F 725	DON/ Designee will complete daily audits x 3 weeks and weekly x3 months to ensure that the Nurses are assisting the CNA's with direct care and answering call lights in a timely manner and ensure the shift in start times is beneficial in meeting the daily needs and demands of the patients. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendatitions.	

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F 725	Continued From page 8 with CNA #2 and was told there is "no support from licensed staff" and that "most wait for the CNAs to answer the call bells." 5. On 3/5/24 at 9:00 a.m., a surveyor interviewed Resident #12 after observing a 40 minute wait for the call bell to be answered. The resident stated it usually takes 30-45 minutes for someone to answer the call bell. "That is not unusual." 6. On 3/5/24 at 9:05 a.m., a surveyor interviewed Resident #18 who said staffing was a problem, especially on the weekends; "My roommate and I have talked and we feel like if we died on a Friday afternoon, that no one would find us until Monday morning" 7. On 3/5/24 at 10:35 a.m., a surveyor interviewed Resident #14 who stated that the food was frequently cold by the time it was passed and the CNAs had to waste time heating up the food because it was always cold. 8. On 3/6/24 at 9:45 a.m., a surveyor interviewed CNA #1 and learned that 11 out of 39 residents on Pleasant Hill, Dunston House and Oak Hill Units always need 2 staff members for care but sometimes it's more. "It's hard to find someone to help" explaining they get stuck in a room with a resident and can't get to the lights or they are waiting for someone to come help. 9. On 3/6/24 at 10:54 a.m., a surveyor observed CNA #1 come to the nursing station to request assistance and the licensed staff replied, "Ok but this is why I don't get my dressings done." During an interview with the CNA #1 afterwards, she/he revealed that "That nurse is one of the first ones to help when we ask but most don't."	F 725		

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F 725	Continued From page 9 On 3/6/24 at 1:00 p.m., a surveyor brought the above findings to the attention of the Director of Nursing.	F 725		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on review of annual evaluations and interviews, the facility failed to complete an annual performance evaluation for a nurse aide at least every 12 months, for 2 of 5 sampled Certified Nursing Assistants (CNA) employed greater than 1 year (CNA1, CNA3). Findings: On 3/6/24, a surveyor reviewed the following employee files: 1. CNA1 was hired 12/13/16. The last annual evaluation was completed and signed on 10/21/2020. The next annual evaluation was dated for December for 2021-2022 year however, was not signed until 4/18/23. 2. CNA3 was hired 12/23/19. The last annual evaluation was completed and signed on 1/2/2020. The next annual evaluation was dated for 2021-2022 however, was not signed until	F 730	Nurse Aide Perform Review- 12 hr/yr In-Service CNA #1 and CNA#3 have received their annual performance review. An audit of annual performance reviews for all current CNA's has been conducted. The facility ensures that all CNA's receive a performance appraisal at least once every twelve months. Leadership staff will be re-educated to this process. DON/ Designee will complete random weekly audits x 4weeks and then monthly x3 months to ensure annual performance appraisals are administer. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations	4/5/24

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F 730	Continued From page 10 4/7/23. On 3/6/24 at 9:51 a.m., during an interview with a surveyor, the Administrative Assistant stated she was unable to find one for both CNA 1 and CNA 3 for 2023. At this time, the Administrative Assistant stated she was aware of the lack of annual evaluations at the end of 2023 and has not completed any of the past due evaluations at this time.	F 730		
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 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 observation and interview, the facility failed to ensure that food was stored in the walk-in fridge correctly and that the kitchen was maintained in a clean and sanitary manner for 2	F 812	Food Procurement, Store/ Prepare/ Serve-Sanitary Finding 1. All desserts are covered dated, and marked. All wall mounted fans and ceiling vents were cleaned of dirt, dust, and debris. Ceiling tiles where ordered to replace stained tiles. Finding 2. Meat slicer was cleaned at that time. Finding 3. Unit refrigerators on all 3 hallways have been cleaned.	4/5/24

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F 812	Continued From page 11 of 2 kitchen tour observations. Findings: 1. On 3/3/24 at 9:10 a.m., during the initial tour of Kitchen, a surveyor observed 2 uncovered, undated, and unmarked trays of deserts. Also observed, 2 wall mounted fans with a light to moderate amount of dirt, a ceiling vent with a small to moderate amount of dust and debris. The entire ceiling has a moderate to heavy amount of staining and spotting. The cook was made aware of the findings at that time. 2. On 3/5/24 at 1:00 p.m., during a return visit to the Kitchen tour with the Food Service Director. She stated that some new ceiling tiles have been ordered and that it is the responsibility of the Facility's Management to clean the ceiling, but it has not been done for the 3 years that she has been here. Inspection of the meat slicer found pieces of meat still on the back side of the slicer, Food Service Director stated that they usually use it only once a week. The Food Service Director was made aware of all the findings at that time. 3. On 3/6/24 at 2:00 p.m., observation of the Unit Refrigerator on the long-term-care Pleasant Hill Unit found that the fridge has Cranberry appearing stains and shelves and the bottom of the Unit. The Freezer unit has a moderate amount of staining. The Dunstan Hill Unit fridge had Cranberry staining on the shelves and the bottom of the unit and onto the floor. The freezer unit had a plate size area of brownish staining and debris on the bottom of freezer around the drain. Oak Hill Unit fridge has dirty stains on the top of	F 812	An audit was completed to validate that all trays of food/ desserts are covered, updated, and marked. An audit was completed to confirm fans and ceiling vents were cleaned and tiles needing replacement have been changed out. An audit was completed to confirm the refrigerators on all 3 hallways have been cleaned entirely. Administrator/ Designee will complete random weekly audits x4 weeks and then monthly x3 months of all food trays to ensure all are covered, updated, and marked, will also confirm wall fans and ceiling vent is cleaned regularly, ceiling tiles replaced as necessary, and all 3 refrigertors on the long term care side are being cleaned regularly and when needed. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	

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F 812	Continued From page 12 the door when opened and on the shelves and the bottom of the unit. These were confirmed with the Charge Nurse on the units.	F 812		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight	F 842	Resident Records- identifiable Information Resident #154 was discharged on 9/29/2023. Resident #111 was discharged on 8/24/2023 An audit of resident records was completed to validate staff have completed documentation that is accurate, organized and readily available inclusive of medication administration. A facility wide audit was completed to validate baseline care plans are completed within 48 hours of a patient admission.	4/5/24

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F 842	Continued From page 13 activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure that the clinical records contained accurate documentation for 1 of 6 residents reviewed for medications (# Resident 154), and for 1 of 22 sampled residents (Resident #111).	F 842	The facility ensures that medical records, in accordance with accepted professional standards and practices, are complete, accurately documented readily accessible, and systematically organized for all residents. The facility ensures a baseline, person- centered baseline care plan is developed and implemented within 48 hours of a patient/ residents's admission. Facility Nursing staff will be re-educated to this process. DON/ Designee will complete audits of MAR documentation to validated the staff completed documentation as provided and that baseline care plans are developed and implemented within 48 hours of admission. The audits will be completed weekly x4 weeks then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	

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F 842	Continued From page 14 Findings: 1. On 9/26/23 the Department of Health received a complaint that Resident #154 was not receiving medications correctly and the residents eye drops were found in another resident's room. During a record review, Resident #154 was admitted on 9/21/23 with physician orders for Ketorolac Tromethamine Ophthalmic Solution Instill 1 drop in left eye two times a day for inflammation. Review of the electronic medication administration record (EMAR), it was noted that the medication was held on the evening of 9/21/23, administered on both day and evening shifts on 9/22/23 and 9/23/23 then held again for both day and evening shifts on 9/24/23 and day sift on 9/25/23. Further review of the medical record showed EMAR notes stating, on 9/21/23, 9/24/23 and 9/25/23 the eye drops were held due to awaiting delivery from pharmacy. A provider order sheet dated 9/25/23 states, "FYI: Patients daughter to bring in Ketorolac ophthalmic drops (0.5%) ... (Omnicare out of this medication)." Additionally, the pharmacy Proof of Delivery" report states Resident #154's eye drops were delivered on 9/25/23. On 3/5/24 at 3:10 p.m., during an interview, the surveyor asked the Director of Nursing (DON) how the eye drops were administered on 9/22/23 and 9/23/23 when they were not delivered until 9/25/23, 4 days after admission. At this time, the DON confirmed inaccurate records. 2. Record review revealed Resident #111 was admitted to the facility on 8/10/23. The baseline	F 842		

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F 842	Continued From page 15 care plan was initiated on 8/8/23, and was revised on 8/11/23 to include activities. On 3/5/24 at 1:20 p.m., in an interview with a surveyor, the Marketing Clinical Advisor confirmed Resident #111 was not admitted until 8/10/23 and that predating a care plan prior to the actual admission was incorrect. On 3/5/24 at 1:30 p.m., the Director of Nursing (DON) stated that staff had anticipated Resident #111 would be admitted on 8/8/23, however, the hospital discharge was delayed. The DON stated staff had initiated the care plan, but the correct date of admission did not carry over. The DON confirmed that staff did not revise the care plan to reflect the correct date of admission.	F 842		
F 868 SS=E	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI	F 868		

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F 868	Continued From page 16 program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on review of the Quality Assessment and Assurance (QAA) attendance sheets and interview, the facility failed to ensure that they held quarterly Meetings. There is documentation of 3 of 4 meetings and that the required members were in attendance. The Administrator attended 3 of 4 quarterly QAA meetings and the Medical Director attended 3 of 4 quarterly QAA meetings. Findings: 1. On 3/4/24 a review of the QAA Agenda/Sign-in pages found that the there was no sheet for April, the month for one of the Quarterly Meetings. 2. Review for October, another of the Quarterly Meetings, the Administrator and the Medical Director were absent. 3. On 3/5/24 at 8:15 a.m., in an interview, the	F 868	Findings 1,2,3 QAA Agenda/ Sign in sheets are to be kept in a binder with all appropriate members present. The facility in accordance with QAA Committee will be scheduled quartlery and sign in sheet is to have Medical Director written in on the sign in sheet as remote zoom in when attending remotely. Administrator/ Designee will complete monthly invitations x12 months to ensure all quarterly's are being completed, also ensure all required staff members are present and signed off on attendance sheet, Medical Director to be written in when zoomed in remotely. All attendance sheets to be kept in a binder for each month meeting the quarterly requirements.	4/5/24

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F 868	Continued From page 17 Administrator stated that the designated months for the Quarterly QAA meetings are January, April, July, and October. He could not account for the lack of April meeting documentation. He was informed of the finding at that time.	F 868		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure	F 883	Influenza and Pneumococcal Immunizations Resident # 14 PPSC23 was in EMR on provider H&P under document tab on 9/6/2023 and was added to EMR Immunization tab. Resident #26 had signed copy of consent with refusal in EMR document tab on 7/27/2021. EMR Immunization tab was updated to reflect refusal. Resident #1 had signed copy of consent with refusal on 7/27/21 uploaded in document tab of EMR added to the EMR Immunization tab.	4/5/24

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F 883	Continued From page 18 that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to perform adequate screening and documentation for the pneumococcal vaccination as required for 3 out of 5 Residents screened for vaccinations. Findings: 1. On 3/5/24, a surveyor reviewed Resident #14's Electronic Medical Record (EMR) and found no pneumococcal vaccinations recorded under Immunizations. A surveyor reviewed the physical medical record and found that Resident #14 had received the PPV13 (A type of	F 883	An audit was completed to validate residents have been offered pneumococcoccal vaccination. These will be offered following the recommended schedule based on the residents Pneumococcal history. The facility offers each resident a pneumococcal Immunization, unless the immunization is medically contraindicated or the resident has already been immunized in accordance with the recommended schedule based on the resident's pneumococcal vaccination history. Facility licensed staff will be re-educated to this process. DON/ Designee will complete random weekly audits x4 weeks and then monthly x3 months of newly admitted residents to validate they are being offered the appropriate vaccination following the recommended schedule and residents pneumococcal vaccination history.	

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F 883	Continued From page 19 pneumococcal vaccine) vaccination on 10/1/15 and the PPSC23 (A type of pneumococcal vaccine) vaccination on 10/31/08. These were not recorded in the EMR. 2. On 3/5/24, a surveyor reviewed Resident #26's EMR and found no pneumococcal vaccinations were recorded. A surveyor reviewed the physical medical record and found a signed undated consent refusing the PPVC 13 vaccination but no documentation showing the PCV 20 (A type of pneumococcal vaccine) vaccination was offered as required by facility policy. 3. On 3/5/24, a surveyor reviewed Resident #1's EMR and found no pneumococcal vaccinations under immunizations. A surveyor reviewed the physical medical record for Resident #1 and found the PCV 13 was given on 12/15/15. This was not recorded in the EMR. No documentation was located that the PCV 20 had been offered as required by facility policy. A surveyor reviewed the facility policy titled "IC601 Pneumococcal vaccination" last revised 11/1/23; "Upon Admission, obtain the pneumococcal vaccination history of all patients. 1.2 Document pneumococcal vaccination history in the electronic medical record." And "2. Based on the patient's pneumococcal vaccination history, offer (unless the vaccination is medically contraindicated, or the patient has already been vaccinated) the appropriate vaccination following the recommended schedule. 2.1 Offer the PCV20 vaccine to adults 19-64 years of age with underlying medical conditions."	F 883	The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	

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F 883	Continued From page 20 On 3/5/24 at 11:14 a.m., a surveyor interviewed the Director of Nursing and notified of the above findings.	F 883		