This plan of correction constitutes my written allegation of compliance for deficiencies during the recent survey on February 10, 2025. However, submission of this plan of correction is not the admission that a deficiency exists or that was cited correctly. This plan of correction is submitted to meet the requirement established by State and Federal Law.

F655

1.
    - Baseline care plan was updated to incorporate each problem listed when the comprehensive care plan was completed on day 3 after admission by the MDS Coordinator on 12/3/24.
    - All baseline and comprehensive care plans will be reviewed by the MDS Nurse and/or DON to ensure no other resident was affected by the alleged deficient practice. If there are any errors, they will be corrected upon review. No negative outcomes were identified from this alleged deficient practice.
    - Any new admissions will have an appropriate baseline care plan completed within forty-eight hours by Charge Nurse, MDS Nurse, or DON
    - Weekly audits will be done by the MDS Nurse and/or DON to confirm that baseline care plans are being completed properly and on time. Audit results will be reported to QAPI monthly for three months.
    - Corrective date for updating care plans with appropriate care areas will be by 3/29/25 and ongoing.
2.
    - Baseline care plan was updated to incorporate each care area by the MDS Nurse when the comprehensive care plan was completed on 11/1/24.
    - All baseline and comprehensive care plans will be reviewed by the MDS nurse and/or the DON to ensure no other resident has been affected by this alleged deficient practice. If there are any errors, they will be corrected upon review immediately. No other negative outcomes were identified from this alleged deficient practice.
    - New admissions that are admitted on Hospice will have an appropriate baseline care plan completed within forty-eight hours by the Charge Nurse, MDS Nurse, and/or DON.
    - Weekly audits will be done by the MDS Nurse and/or DON to confirm an appropriate baseline care plan has been completed within the forty-eight-hour window. Audit results will be brought to QAPI monthly for three months.
    - Corrective date for care plans will be by 3/29/25 and ongoing.

3.

- Baseline and comprehensive care plans for R31 were updated to include appropriate care areas by the MDS nurse on 1/20/25.
- All baseline and comprehensive care plans will be reviewed by the MDS nurse and/or DON to ensure no other resident was affected by this alleged deficient practice. If there are any errors found, they will be corrected immediately. No other negative outcomes identified.
- New admissions that are admitted on hospice, will have an appropriate baseline care plan completed within the first forty-eight hours by the Charge Nurse, MDS Nurse, or DON.
- Weekly audits will be done by the MDS nurse and/or DON to confirm that an appropriate baseline care plan has been completed within the forty-eight-hour window. Audit results will be brought to QAPI monthly for three months.
- Corrective date for baseline care plans, including residents' immediate needs, will be by 3/29/25 and ongoing.

4.

- Baseline and comprehensive care plans for R37 were updated to include appropriate care areas by the MDS nurse on 11/1/24.
- While all residents could be affected by this alleged deficient practice, no other negative outcomes were identified.
- New admissions will have an appropriate baseline care plan completed within the 48-hour window by the charge nurse, MDS nurse and/or DON.
- Audits will be completed weekly by MDS nurse and/or DON to ensure that all new admissions have an appropriate baseline care plan that was completed within the 48-hour window. Audit results will be brought to QAPI monthly for three months.
- Correction date for reviewing care plans will be by 3/29/25 and ongoing.

F656

- Comprehensive care plan was updated to incorporate appropriate care areas by the MDS Nurse when she was reviewing for the admission MDS. This was completed on 2/10/25.
- All comprehensive care plans will be reviewed by the MDS Nurse and/or the DON to ensure no other residents were affected by this alleged deficient practice. No other negative outcomes were identified.
- All residents will have an appropriate comprehensive care plan, including all pertinent areas of care, which will be completed within the seven day window by Charge Nurse, MDS Nurse, and/or DON.
- Weekly audits will be done by the MDS Nurse and/or DON to confirm that all residents have an appropriate comprehensive care plan that includes all pertinent areas of care. Results will be brought to QAPI monthly for three months.
- Corrective date for updating comprehensive care plans will be by 3/29/25 and ongoing.

F657

- Comprehensive care plan was updated for R16 on 2/10/25 to incorporate appropriate care areas by the MDS Nurse.
- All comprehensive care plans will be reviewed by the MDS Nurse and/or DON to ensure no other residents have been affected by this alleged deficient practice. No other negative outcomes were identified.
- All residents will have an appropriate comprehensive care plan completed within the seven-day window by the Charge Nurse, MDS Nurse, and /or DON.
- Weekly audits will be done by the MDS Nurse and/or DON to confirm that an appropriate comprehensive care plan has been completed on time. Audit results will be brought to QAPI monthly for three months.
- Corrective date for updating comprehensive care plans will be by 3/29/25 and ongoing.

684

1.

- R3's discharge instructions were reviewed with the Medical Director on 2/11/25, and an order was received to return all medications to the previously ordered meds before hospital admission.
- While all residents have the potential to be affected by the alleged deficient practice, no other negative outcomes were identified.
- All discharge instructions on new admissions and/or return transfers, will be reviewed by the Clinical Supervisor and/or DON and compared to the orders in Point Click Care (PCC). If any orders have errors, they will be clarified and fixed immediately. Education will be provided to Licensed Staff regarding negative findings of reviews.
- Audits will be completed on admissions and weekly by the Clinical Supervisor and/or the DON. The audits will consist of checking all discharge instructions and admission orders for residents coming into the facility, to make sure they are entered correctly. Audit results will be brought to QAPI monthly for 3 months.
- Corrective date for review of discharge instructions and admission orders will be completed by 3/29/25 and ongoing.

2.

- R 17's discharge orders were clarified and re-written by the doctor on 2/12/25.
- While all residents have the potential to be affected by the alleged deficient practice, no other negative outcomes were identified.
- Staff will be educated on proper chart checks. Chart checks will be completed by licensed staff on each shift, and all new orders for each day will be identified and compared to orders in Point

Click Care (PCC) to ensure orders have been entered properly by being signed off by three licensed staff.

- Audits will be completed every other day by clinical supervisor and/or DON to ensure all new orders are being checked by three nurses and are entered properly. Audits will be brought to QAPI monthly for three months.
- Corrections for double checking orders will be ongoing.

3.

- Physician order for gradual dose reduction was clarified with the doctor and corrected in Point Click Care (PCC) on 2/12/25.
- While all residents have the potential to be affected by this alleged deficient practice, no other negative outcomes were identified.
- Staff will be educated on proper chart checks. Chart checks will be completed on each shift by licensed staff, and all new orders for each day will be identified and compared to the orders in PCC to ensure the orders have been entered properly. Orders must be signed off by staff for three shifts to ensure the orders were entered properly.
- Audits will be completed every other day by Clinical Supervisor and/or DON to ensure all new orders are being checked by three nurses and are entered properly. Audits will be brought to QAPI monthly for 3 months.
- Corrections for checking new orders will be by 3/29/25 and ongoing.

F 695

- The only oxygen concentrator in use at the time of inspection was checked, and the filter in the back was taken out, then rinsed in water, air dried and replaced on 2/11/25.
- While all residents have the potential to be affected by the alleged deficient practice, no other negative outcomes were identified.
- A reminder was placed on the Licensed TAR to check oxygen concentrators that are in use to clean the filter weekly. The Clinical Supervisor and/ or DON will check to make sure the reminder is being signed off and completed.
- Audits will be completed by the Clinical Supervisor and/ or the DON on any resident's TAR who is on oxygen weekly. If the reminder is signed off, the concentrator will be checked to confirm it has been done. Audit results will be brought to QAPI monthly for three months.
- Corrective date for review of dusty filter in O2 concentrator is 2/11/25 and ongoing.

F 711

- Block orders for R31 were signed by medical director on 2/9/25.
- While all residents have the potential to be affected by this alleged deficient practice, no other negative outcomes were identified.
- All block orders will be signed on admissions or checked monthly by the clinical supervisor and/or the DON to ensure each resident has signed updated orders.
- Monthly checks will be completed by clinical supervisor and/or the DON to check all residents' charts for signed updated block orders. If there are any negative findings, this will be fixed immediately. Audit results will be brought to QAPI every month for three months.
- Correction of updated signed block orders will be by 3/29/25 and ongoing.

F 712

- Notified Medical Director of late doctor visit for R 31. An appointment was made for the visit right then and the resident was seen on 2/18/25.
- While all residents have the potential to be affected by this alleged deficient practice, no other negative outcomes were identified.
- All new admissions will be placed on the communication board in PCC with the estimated date for a 30 day visit as a reminder. The Clinical Supervisor and/ or the DON will continue to check the communication board daily.
- Audits on each new admission will be done weekly to ensure the doctor visits have been scheduled for the proper time frame. If they are not, the Clinical Supervisor and/or the DON will make the appointment at that time to ensure the resident will be seen by the doctor on time.
- Correction for timely doctor visits will be by 3/29/25 and ongoing.

F761

- The medication storage room refrigerator is still being used, however, we added a separate fridge without a freezer for the vaccinations to be stored on 2/12/24. We have ordered a new dormitory-style fridge without freezer that we will replace both with when it arrives.
- The refrigerator in the medication storage room, holding/storing vaccines, will be changed out for a regular dormitory refrigerator without freezer when it is delivered. This will remain moving forward for vaccine storage.
- While all residents have the potential to be affected by the alleged deficient practice, no other negative outcomes were identified.
- Refrigerator in the medication storage room will be changed out for the proper refrigerator to store vaccines when it arrives at the facility.
- Deficient practice was fixed on 2/12/25 and will be ongoing.

F812

1.

- When vital cuisine nutritional drinks come from the freezer to the walk-in refrigerator, they need to have a thaw date written on them.
- Staff will be in-serviced on the proper way to remove the vital cuisine nutritional drinks from the freezer to the walk-in, and that a thaw date needs to be put on them.
- Residents who drink supplemental juices have the potential to be affected by the alleged deficient practice, no other negative outcomes have been identified.
- Nutritional drinks will be audited to ensure they have a thaw date when they come out of the freezer to the refrigerator. These audits will be conducted monthly and reported to QAPI for three months.
- Correction date for proper removal of nutritional drinks will be completed by 3/14/25 and ongoing.

2.

- When Health Shakes are removed from the freezer and put in the reach-in refrigerator, they need to have a thaw date written on them.
- Staff will be in-serviced on the proper way to remove health shakes from the freezer to the reach-in refrigerator, and that a thaw date needs to be put on them.
- Residents who drink supplemental milk shakes have the potential to be affected by the alleged deficient practice, no other negative outcomes were identified.
- Health shakes will be audited to ensure they have a thaw date when they come out of the freezer, to the reach-in refrigerator, they have a thaw date. These audits will be conducted monthly and reported to QAPI monthly for three months.
- Correction date for proper removal of health shakes will be completed by 3/14/25 and ongoing.

3.

- When removing bags of cereal from their original packages, they will be labeled and have an expiration date on them.
- Residents who eat cereal have the potential to be affected by the alleged deficient practice, no other negative outcomes were identified.
- Staff will be in-serviced on proper ways of removing bags of cereal from their original packages, and labeling them, and including an expiration date.
- Cereal bags that are removed from their original packages will be audited monthly. Audit results will be brought to QAPI monthly for three months.
- Correction date for proper removal of and labeling of cereals will be by 3/14/25 and ongoing.

4.

- All kitchen staff will wear hair nets when cooking, preparing or assembling food.
- All resident food has the potential to be affected by this alleged deficient practice, no other negative outcomes were identified.
- Staff will be in-serviced on when a hair net is required and being worn properly.
- Kitchen staff will be audited monthly to ensure proper use of a hair net is being followed. These findings will be reported to QAPI monthly for three months.
- Correction date for proper use of a hair net will be completed by 3/14/25, ongoing.

F842

1.

- On 2/12/25 R6's code status was updated in the electronic record by the DON after verifying with the resident/POA. A red sticker will be placed on the outside of the chart to make it easier for staff to determine a code status on a resident.
- While all residents have the potential to be affected by the alleged deficient practice, no other negative outcomes were identified.
- All residents' charts will be reviewed to ensure code status is readily available to staff. Any resident that has a code status of DNR, will have a bright red sticker placed on the outside of the chart for easy access to staff.
- Audits will be completed weekly by the Clinical Supervisor and/or the DON to make sure each resident has an updated code status visible for staff. Audit results will be brought to QAPI monthly for three months.
- Corrective date for code status will be fixed by 3/29/25 and ongoing.

2.

- R23's Acknowledgement of Important Information and Policies Form was reviewed and updated with POA on 2/12/25. The resident does not have an advanced directive and chooses to use the POLST Form in place of an advanced directive.
- All residents have the potential to be affected by this alleged deficient practice, no other negative outcomes were identified.
- The Social Worker will review all Acknowledgement of Important Information and Policies Forms in resident records to ensure they reflect the residents' wishes. Social Worker will educate new residents and their families on the difference between the POLST and advanced directives.
- Social Worker will audit all new admissions to ensure the Acknowledgement of Important Information and Policies form is completed. Audits will be completed monthly by the Social Worker and the results will be brought to QAPI monthly for three months.
- Corrective Date: 3/14/25 and ongoing.

3.

- On 3/6/25 R15's code status was updated in the electronic record by the DON after verifying with the resident/POA. A red sticker will be placed on the outside of the chart to make it easier for staff to identify code status of a resident.
- While all residents have the potential to be affected by the alleged deficient practice, no other negative outcomes were identified.
- All residents' charts will be reviewed to ensure code status is readily available to staff. Any resident that has a code status of DNR, will have a bright red sticker placed on the outside of the chart for easy access to staff.
- Audits will be completed weekly by the Clinical Supervisor and/or the DON to make sure each resident has an updated code status visible for staff. Audit results will be brought to QAPI monthly for three months.
- Corrective date for code status will be fixed by 3/29/25 and ongoing.

4.

- R25's orders were clarified and updated for code status on 2/13/25.
- While all residents have the potential to be affected by this alleged deficient practice, no other negative outcomes were identified.
- All resident charts will be reviewed to ensure code status is added to Physician orders under the MAR/TAR. Any resident admitted on Hospice has updated orders to reflect this by MD.
- Audits will be completed weekly on any new admissions to ensure all admission orders have a code, a status signed by the doctor, and the order is placed on the MAR/TAR.
- Audits will be completed weekly by Clinical Supervisor and/or the DON. Audit results will be brought to QAPI monthly for three months.
- Corrective date for completion of code status updates will be done by 3/29/25 and ongoing.

5.

- Orders for R16 were updated with proper date by the doctor on 2/12/25.
- While all residents have the potential to be affected by this alleged deficient practice, no other negative outcomes were identified.
- All new orders will be reviewed by the DON and or Clinical Supervisor upon filing to ensure the dates are correct on orders signed by the doctor.
- All orders given to the doctor for signature and date will be reviewed immediately to ensure proper date is being used. This will be reviewed by the Charge Nurses, Clinical Supervisor, and/ or the DON.
- Audits for proper dating to the doctor orders will be done weekly. Audits will be completed by the DON and/or the Clinical Supervisor and results brought to QAPI monthly for three months.
- Corrections to order dates review will be completed by 3/29/25 and ongoing.

F880

1.

- Facility reviewed and is updating procedures to control and monitor areas where legionella can grow and spread.
- All residents have the potential to be affected by this alleged deficient practice, but no other negative outcomes were identified.
- Water samples will be sent out every 6 months and randomly to monitor the water quality and testing reliability.
- Audits will be done every 6 months by sending a water sample out for testing. This will be done randomly as well, and when pneumonia is present, to make sure water quality and testing reliability is acceptable. The results of these audits will be brought to QAPI monthly for 6 months.
- Corrective date for updating procedures on legionella monitoring will be completed by 3/29/25 and ongoing.

F883

1.

- R20 received PCV20 on 2/20/25 per the doctor and POA consent.
- While all residents have the potential to be affected by the alleged deficient practice, no negative outcomes have been identified.
- All residents that are currently present in the facility will be reviewed to ensure they are up to date on pneumonia vaccines. If they are not, they will receive an acceptance or declination for the option to have it or refuse it.
- Audits will be completed weekly by ICP and/or the DON to ensure all current residents are up to date or have been offered and refused the PCV 20 and/or PCV 21. Audit results will be brought to QAPI monthly for three months.
- Corrections for updating residents' pneumonia vaccinations will be completed by 3/29/25 and ongoing.

2.

- R12 was offered PCV 20 on 2/17/25 and POA verbally refused over the phone for her mother to be given the PCV20 or PCV21.
- While all residents have the potential to be affected by the alleged deficient practice, no other negative outcomes have been found.
- All residents that are currently in the facility will be reviewed to ensure they are up to date on the pneumonia vaccines. If they are not up to date, they will receive an acceptance and declination for the option to have it or refuse it.
- Audits will be completed weekly by ICP and/or DON to ensure all current residents are up to date or have been offered and declined the PCV 20 or PCV 21. Audits will be brought to QAPI monthly for three months.
- Corrections for updating residents' pneumonia vaccinations will be completed by 3/29/25 and ongoing.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205149	A. BUILDING ______ B. WING ______	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KATAHDIN HEALTH CARE LLC	22 WALNUT STREET MILLINOCKET, ME 04462

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS From 2/10/25 through 2/12/25, unannounced on-site visits were conducted at Katahdin Health Care for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification. It was determined that Katahdin Health Care is not in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (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.	F 655		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer Brown
TITLE: administrator
(X6) DATE: 3/7/2025

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 655	Continued From page 1	F 655		

(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 record reviews and interviews, the facility failed to ensure that baseline care plans were completely developed and implemented within 48 hours that included health care instructions needed to provide minimum healthcare for 4 of 4 residents reviewed that were admitted in the last 30 days (Resident #16 [R16], [R25], [R31], R37]).

Findings:

1. On 2/10/25, R16's clinical record was reviewed which indicated that R16 was admitted to the facility on 11/30/24. R16 was admitted with the diagnosis of diabetes mellitus receiving oral medication, heart failure and receiving a diuretic medication and blood thinner, oxygen dependent, limited physical mobility requiring activities of daily living assistant and was to receive therapy, and received a psychotropic medication for depression. These care areas were not added to

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F 655	Continued From page 2	F 655		

the baseline care plan until after 48 hours of admission.

On 02/11/25 at 1:19 p.m., during an interview with the Minimum data Set (MDS) nurse, a surveyor confirmed that this finding.

2. On 2/10/25, R25's clinical record was reviewed which indicated that R25 was admitted to the facility on 1/17/25. R25 was admitted already receiving Hospice services due to cancer, with the diagnosis of type 2 diabetes mellitus receiving insulin medication and blood glucose monitoring, Chronic obstructive pulmonary disease (COPD) with as needed nebulizer medications, psychotropic medication use, and pain medications in addition to limited physical mobility needing activities of daily living assistance.
On 02/11/25 at 10:38 a.m., during an interview with the Minimum data Set (MDS) nurse, a surveyor confirmed that this finding.
3. On 2/12/25, R31's clinical record was reviewed which indicated that R31 was admitted to the facility on 12/18/24. R31 was admitted with the diagnoses of insulin dependant diabetes, which requires monitoring, physical weakness requiring activities of daily living assistance and depression. These care areas were not added to the baseline care plan until after 48 hours of admission.

On 2/12/25 at 7:10 a.m., in an interview with the surveyor, the Director of Nursing confirmed that there was not a complete baseline care plan developed addressing the resident's immediate needs to monitor diabetes, activities of daily living assistance and depression.

4. On 2/12/25, R37's clinical record was reviewed

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F 655	Continued From page 3 which indicated that R37 was admitted to the facility on 10/29/24. R37 was admitted with the diagnoses of acute and chronic respiratory failure requiring oxygen treatment, Chronic Obstructive Pulmonary Disease, Opioid abuse-requiring suboxone (used to treat narcotic addiction) and a Stage 2 pressure ulcer on the left gluteal fold. These care areas were not added to the baseline care plan until after 48 hours of admission. On 2/12/25 at 10:45 a.m., in an interview with the surveyor, the Director of Nursing confirmed that there was not a complete baseline care plan developed addressing the resident immediate needs: suboxone use due to opioid addiction, activity of daily living assistance due to shortness of breath, and skin care, wound prevention, monitoring and caring for a Stage 2 pressure ulcer on the left gluteal fold.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F 656		

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F 656	Continued From page 4 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that a care plan was created after a comprehensive assessment in the area of diabetes and pain for 1 of 1 resident received for Hospice (Resident #25 [R25]). Finding: On 2/10/25, R25's clinical record was reviewed	F 656		

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F 656	Continued From page 5 which indicated that R25 was admitted to the facility, already receiving Hospice services for a terminal illness. Review of the admission orders indicated that R25 was admitted with physician orders for an Opioid pain medication for chronic pain and required pain monitoring and was receiving insulin for diabetes. R25's Admission Minimum Data Set (MDS), dated 1/23/25, was coded under section I2900 to indicate R25 had a diagnosis of diabetes mellitus and under section J0100A to indicate that the Resident was receiving scheduled pain medication. R25's care plan as of 2/10/25, lacked evidence of chronic pain or diabetes being addressed in the comprehensive care plan. On 2/11/25 at 10:45 a.m., during an interview with the MDS nurse, a surveyor confirmed this finding.	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 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	F 657		

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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 interview, the facility failed to review, revise and update a care plan in the area for a pressure ulcer 1 of 1 resident reviewed for pressure ulcer (Resident #16 [R16]).

Finding:

On 2/10/25, R16's clinical record was reviewed and included a physician order for a treatment for a pressure ulcer to the left lateral 5th digit toe (pinky toe). The surveyor reviewed the care plan but could not find a pressure ulcer care area.

On 2/11/25 at 11:09 a.m., during an interview with a surveyor, the Director of Nursing (DON) stated that R16's Stage II pressure ulcer to the pinky toe started on 12/12/24 and resolved on 1/15/25. R16 went to the hospital and was admitted on 1/31/25 and returned on 2/4/25 with the pressure ulcer reopened to the same area. The Minimum Data Set (MDS) Nurse updated R16's care plan late yesterday afternoon for the pressure ulcer. The surveyor confirmed the care plan had not been updated to reflect that R16 had a pressure ulcer when it first started 12/12/24 and the care plan was not updated when R16 was re-admitted with an open pressure ulcer on 2/4/25, until 6 days after re-admission.

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F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews the facility failed to verify/clarify admission orders when residents returned from an Acute Care Hospital stay, the facility failed to get an order for the use of a Foley catheter and failed to follow a Physicians order for 3 of 4 Residents who returned from the hospital (Resident #3, [R3, R17 and R16]). Findings: 1. On 2/11/25, R3's clinical record was reviewed, documentation showed that R3 was sent to the hospital on 2/4/25 and returned to the facility on 2/6/25. The discharge orders from the hospital were not clarified with a Provider and did not match the current medications R3 was currently receiving. The following medications and treatments on R3's discharge orders were not on the active Medication Administration Record (MAR) or Treatment Administration Record (TAR): albuterol sulfate 2 inhalation 6 hours as needed (PRN), Foley catheter, and trolamine salicylate 10% cream. The following medications were not clarified for	F 684		

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F 684	Continued From page 8 the frequency of the doses, R3's MAR indicates that R3 was receiving the following: Flonase allergy relief nasal suspension 2 spray in both nostrils daily in the am and the discharge orders are written for PRN use. R3 received 5 doses, Lactulose oral solution 20 grams(gm)/30 milliliters (ml) give 20gm, 20 ml every other day. The concentration being used 20gm/30ml, the facility was giving 20 ml which is less than the 20gm ordered for 2 doses, Eliquis 5 (milligram) mg twice a day and the discharge orders did not specify the frequency, R3 received Eliquis twice a day for 4 days before clarification. Metoprolol 25 mg ½ tablet twice a day when the discharge orders did not specify the frequency, potassium citrate-citric acid oral solution 110-334 mg/5ml give 5 ml by mouth two times a day, the discharge orders did not specify the frequency, refresh tears 0.5% instill 1 drop in both eyes two times a day the discharge orders did not specify the frequency. Senna oral tablets give 2 tablets by mouth two times a day the discharge orders did not specify the frequency. Tylenol extra strength 500 mg tablets- 2 tables by mouth three times a day, the discharge order was for Tylenol extra strength 1,000mg every 6 hours as needed. The following medications were received by R3 without a physician order: Vitamin D 25 microgram (mcg) by mouth one time a day was being received for 5 days without a Physician order. ProAir inhalation aerosol solution 2 puffs inhale orally three times a day and received 14 doses, sucralfate oral tablet 1 tablet by mouth four times a day, received 16 doses without a physicians order. On 12/12/24, a physicians order was written for a dose reduction of Risperidone of 0.25 mg every	F 684		

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week and to inform if it's not tolerated. The clinical record lacks evidence that this reduction was followed. The facility discontinued R3's morning 0.25mg dose and decreased the bedtime dose from 1 mg to 0.5mg and did not continue with the 0.25mg weekly reduction.

On 2/12/25 at 4:00 p.m., during an interview with the Director of Nursing (DON), the surveyor confirmed that the discharge orders were not verified/clarified with the Provider and that the facility assumed they were to continue R3's medications as previously ordered. She did not get clarification orders for the medications listed in the discharge and did not get an order for the use of the Foley catheter. The discharge orders for R3 and R17 were not clarified with a provider upon their returns to the facility.

2. On 2/12/25, R17's clinical record was reviewed, documentation indicated that R17 went to the hospital on 1/6/25 and returned to the facility on 1/10/25. Hospital discharge orders were reviewed and compared to current MAR/TAR.
Upon discharge the following medications were discontinued:
Fluticasone furoate-vilanterol 200-25 mcg/dose inhalation the facility failed to follow this order and R17 continued to receive a daily dose from 1/11/25 to 2/11/25 when it was brought to the DON's attention who then discontinued the medication.
Januvia 100 mg tablet was not discontinued and received 33 doses after discontinuation order.

The following medications were ordered to be held until resumed by usual care Providers or as directed on discharge orders:
Cephalexin 250 mg by mouth daily was ordered

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to be held until 1/15/25, R17 received 5 doses, and medication was not held as ordered.
Furosemide 40 mg daily was ordered to be held until restarted at the discretion of primary provider. This medication was not held and order to restart was not received.
Tamsulosin 0.4 mg daily was held until reviewed by primary providers since suprapubic catheter in place. This medication was not held as ordered and an order to restart was not received.

The following orders were reviewed and R17 received incorrect doses of the following medications:
Metformin HCl ER was ordered for 500 mg ER 1,000 mg twice a day and R17's MAR indicates that R17 has received Metformin 1,000 mg once a day.
Vitamin C 500mg is ordered once a day and R17 has been receiving 1,000 mg a day.
Pantoprazole sodium 40 mg by mouth daily, MAR indicates R17 has been receiving 40mg twice a day.
Potassium chloride ER 20 Meq (milliequivalent) by mouth once a day, R17's MAR indicates that he/she has been receiving 20 Meq twice a day.
Bisacodyl 5 mg tablet was ordered three times a day as needed, R17's MAR indicates that R17 has been receiving this medication three times a day.

Discharge orders dated 1/10/25 have orders for the following:
acetaminophen-codeine 300-30 mg twice a day as needed for pain. R17's MAR/TAR does not have this order and R17 reported pain 7 times and was given regular strength acetaminophen 650 mg for his/her discomfort instead of the acetaminophen-codeine as ordered for pain.

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Aspirin 81 mg daily, this order is not on the MAR/TAR and R17 has not received this medication since 1/10/25 when ordered.

R17's TAR was reviewed and indicates the following treatments are being used without a current physician orders.
Lidocaine external patch apply one time a day and remove per schedule. R17 does not have a current order for this treatment. Treatment for blood glucose monitoring is being done 4 times a day, R17 does not have an order for this treatment.
Insulin sliding scale using Humalog insulin has been used with no active order, R17 received 53 doses of Humalog insulin.

On 2/12/25 at 20:28 a.m., during an interview with the DON the above findings were reviewed and confirmed. She stated the discharge orders were not verified/clarified with the Provider. The facility just continued all previously ordered medications without getting them reordered by the physician.

3. On 2/11/25, R16's clinical record was reviewed and indicated R16 was admitted to the facility on 11/30/24. R16 was sent to the hospital and admitted on 1/31/25 and returned to the facility on 2/4/25. The admitting orders from the hospital included Amiodarone 200 milligrams (mg) daily and sucralfate 1 gram tablet four times a day. A review of the orders entered into R16's electronic record upon re-admission to the facility did not include Amiodarone 200 mg daily (heart arrhythmia medication) and the frequency of the sucralfate (ulcer treatment medication) was three times a day and not the ordered four times a day. In addition, ferrous sulfate 325 mg (iron medication) and folic acid 0.8 mg (vitamin B

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F 684	Continued From page 12 medication) were added to the facility's physician orders but were not on the orders from the hospital. On 2/11/25 at 4:00 p.m., the surveyor reviewed R16's current orders and hospital discharge orders with the DON. The hospital orders had not been signed by the facility's Medical Provider and there were no progress notes or written physician orders that indicated the hospital discharge orders were changed. At the time of this review, R16 was receiving the folic acid, ferrous sulfate, and sucralfate three times a day, but was not receiving the Amiodarone. On 2/12/25 at 7:06 a.m., during an interview with a surveyor, the DON stated she confirmed with the Medical Provider last night that the Amiodarone, ferrous sulfate and folic acid should have been on the physician orders and clarified the that the sucralfate was to be three times a day. When asked if the orders were reviewed or clarified with the Medical Provider at time of readmission from the hospital, the DON stated that was done last night, 7 days after admission.	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced	F 695		

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F 695	Continued From page 13 by: Based on observations and interviews, the facility failed to provide oxygen therapy in a sanitary manner for 2 of 3 days of survey (2/10/25 and 2/11/25) for Resident #16 (R16). Finding: The manufacturer's instructions for DeVilbiss 5 Liter Oxygen Concentrator indicated that the air filter should be inspected periodically and cleaned as needed by the user or caregiver. On 2/10/25 at 11:00 a.m. and 2/11/25 at 12:15 p.m., a surveyor observed R16 wearing oxygen via nasal cannula that was attached to a DeVilbiss oxygen concentrator and observed the filter on the back of the concentrator to be dusty. The surveyor confirmed this finding with the Director of Nursing (DON) after the second observation. The DON stated she never thought of cleaning the filter and will add that to the orders when they change the tubing.	F 695		
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the	F 711		

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F 711	Continued From page 14 exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the physician reviewed the resident's total program of care, which included signing orders for medications and treatments listed on the Physician Orders (block orders) in a timely manner for 1 of 12 residents reviewed (Residents #31 [R31]). Finding: On 02/12/25, R31's clinical record was reviewed and included block orders (30 day) signed by the physician on 12/18/24. The next block order, including a 10-day grace period, needed review and the Physician's signature by 1/28/25; there are no further visits from the physician. On 2/12/25 at 7:10 a.m., in an interview with the surveyor, the Director of Nursing, confirmed that the last block order was signed on 12/18/24, making them now 15 days late.	F 711		
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.	F 712		

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F 712	Continued From page 15 §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, the facility failed to ensure the attending physician made required visits, at least every 30 or every 60 days (depending on date of admission) and wrote a progress note for 1 of 12 sampled residents (Resident #31 [R31,]. Findings: On 2/12/25 a review of R31's clinical record indicated that R31 was admitted on 12/18/24 and had a physician visit on 12/18/24. The next 30 day physician visit, including a 10-day grace period, which needed a review and written progress note was due on 1/28/25; there are no further visits from the physician. On 2/12/25 at 7:10 a.m., in an interview with the surveyor, the Director of Nursing, confirmed that the last physician visit and written progress note was signed on 12/18/24, now making the visit 15 days late.	F 712		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals	F 761		

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F 761	Continued From page 16 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §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, interviews, and the Centers for Disease Control (CDC) guidance, the facility failed to ensure vaccines were stored in a refrigerator without a freezer compartment for 1 of 1 medication storage refrigerator. Finding: Review of "United States (U.S.) Centers for Disease Control and Prevention: Vaccine Storage and Handling Toolkit" dated "3/24/24 states" ...Do not store any vaccine in a dormitory-style or bar-style combined refrigerator/freezer unit under	F 761		

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F 761	Continued From page 17 any circumstances." On 2/11/25 at 3:00 p.m., a surveyor and a Licensed Practical Nurse observed in the medication storage room, a dormitory style refrigerator (small combination refrigerator/freezer unit that is outfitted with one exterior door). The refrigerator contained multiple vials of vaccines that included: influenza, Prevnar 20, measles, and Coronavirus (Covid-19). The surveyor confirmed that the vaccines were stored in the combination refrigerator/freezer during this observation. On 2/11/25 at 3:20 p.m., during an interview with the Director of Nursing, the surveyor confirmed that the facility follows CDC recommendations for the administration of vaccines. The surveyor confirmed that the vaccines are being stored in a dormitory style refrigerator with a built-in freezer compartment.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812		

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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 812	Continued From page 18 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to label supplements with a thaw date that were located in the walk-in refrigerator and reach in refrigerator which were located in the kitchen, failed to label and date bags of cereal in the dry food storage area and failed to ensure kitchen staff properly wore hairnets by leaving hair uncovered and unrestrained for 2 of 3 days of survey (2/10/25, 2/11/25). Findings: On 2/10/25 at 10:30 a.m., during the initial kitchen tour, a surveyor observed in the walk-in refrigerator, on a shelf was a carton of 30 Vital Cuisine nutritional juice drinks that were thawed that were not labeled with a thaw date. Storage and handling instructions on the carton "after thawing keep refrigerated, use within 14 days". In the reach in refrigerator there were 6 thawed Healthy shakes with no thaw date with storage and handling instructions on the carton "after thawing keep refrigerated, use within 14 days", there were 4 thawed Vital Cuisine nutritional juice drinks with the same handling instructions. In the dry food storage area, there were bags of cereal that were out of the original packages they were not labeled and did not have an expiration date. (the original packages had expiration dates)	F 812		

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F 812	Continued From page 19 The surveyor confirmed the above findings with the Food Service Director at the time of the observations. On 2/11/25 at 9:00 a.m., during the second tour of the kitchen the surveyor observed the cook with a hat that did not contain all her hair. The surveyor confirmed this finding at the time of the observation.	F 812		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident	F 842		

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

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

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

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

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F 842	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that clinical records were complete and contained accurate information for 4 of 12 sampled residents reviewed for code status or advanced directive for 4 of 12 sampled residents (Resident #6 [R6]), R23, R15, R25) and 1 of 3 reviewed for hospitalization (R16). Findings: 1. On 2/12/25, a reviewed of R6's electronic clinical record was completed. There was no evidence in the electronic record for information regarding R6's code status. A review of R6's current paper chart was completed and there was no evidence of a completed Physician Orders for Life-Sustaining Treatment (POLST) and did not have an Advanced Directive. On 2/12/25 at 9:42 a.m., in an interview with the surveyor, the Administrator presented a paper copy of a signed physician order dated 10/5/24, that indicated R6's code status as 'full code'. This information was not readily available unless you looked through the old filed paper chart. On 12/12/25 at 9:42 a.m., the Administrator confirmed R6's code status was not readily available in their current chart and would immediately be added to the current electronic record. 2. On 2/12/25, a review of R23's electronic clinical record and paper clinical record was completed. In the paper clinical record admission form "acknowledgement of important information and policies" number 6, advanced directives are checked off indicating that R23 had an advanced directive and was provided to the facility. R23's electronic and paper clinical record lacked evidence of R23's advanced directives.	F 842		

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On 2/12/25 7:41 a.m., during a review of clinical records with the Administrator the form is in his/her clinical record, but the advanced directive was not there. During an interview later at approximately 9:00 a.m. the Administrator stated that R23's POA was called and there was a misunderstanding and that the POA stated they thought the POLST was R23's advanced directive, the facility failed to explain the advanced directive, they will review with POA and will put a copy in clinical record when completed.
3. On 2/12/25, a surveyor reviewed R15's electronic clinical record, the surveyor could not find information about R15's code status. The surveyor reviewed the paper chart and noted that R15 did not have a completed Physician Orders for Life-Sustaining Treatment (POLST) and did not have an Advanced Directive. At 10:00 a.m., the Director of Nursing was able to find a signed physician order in the paper chart, dated 9/6/24, that indicated R15's code status was a "full code" but this information was not readily available unless you looked through the paper chart. The DON entered R15's code status into the electronic orders at this time.

4. On 2/10/25, R25's clinical record was reviewed. The surveyor reviewed the "Acknowledgement of Important Information and Policies", dated 1/17/25, and noted that the Advanced Directives were not checked to indicate whether or not R25 had an Advanced Directive. On 2/10/25 at 10:39 a.m., during an interview with a surveyor, the Beacon Hospice Nurse stated that R25 was admitted to the facility already receiving Hospice services and continued at the nursing facility. On 2/10/25 at 12:59 p.m., during an interview with a surveyor, the Administrator stated

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R25 was asked if he/she wanted an Advance Directive and the information was provided but she forgot to check the form to indicate so. The surveyor reviewed R25's physician orders that were printed on 1/17/25 and signed by the Medical Provider on 1/18/25 and noted that neither a code status or Hospice was included on the physician orders. On 2/12/25 at 10:52 a.m., during an interview with the Director of Nursing (DON), a surveyor confirmed these findings.

5. On 2/10/25, R16's clinical record was reviewed. A review of the signed physician orders that were printed on 12/3/24 indicated that the Medical Provider signed the physician orders but the date signed was 11/23/24, 7 days prior to R16's admission date and 10 days prior to the orders being printed. On 2/11/25 at 1:30 p.m., during an interview with the Director of Nursing, a surveyor confirmed this finding.

F 880 SS=D | F 880

Infection Prevention & Control
CFR(s): 483.80(a)(1)(2)(4)(e)(f)

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

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

§483.80(a)(1) A system for preventing, identifying,

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

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the

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corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on review of the facility's Legionella Water Management Program and interview, the facility failed to fully develop/implement a water management program to prevent the growth and spread of legionella and other water-borne pathogens in the area of testing protocols for 1 of 1 review of water management program.

Finding:

On 2/11/25, a review of the facility's Legionella Water Management Program (revised on 2/2023) was completed.

The facility's program identified areas where Legionella could grow and spread that included: sinks located in resident rooms, kitchen, hair care room, whirlpool room, staff bathroom, visitors bathroom, A-wing day room bathroom, and medication room, showers, water heaters, boiler room, ice machine, medical devices, and water cooler.

Control measures and monitoring included: visual testing of ice machine and water cooler on a scheduled basis, temperature monitoring of water heaters to be maintained at or above 140

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F 880	Continued From page 26 degrees Fahrenheit (F) and chemical analysis of free chlorine when sections of the building have been offline or damage has been found to the water main. The verification process to make sure the program was running as designed and was effective included documentation of process control that would be reviewed monthly and that random testing will also be done to insure testing reliability. On 2/11/25 at 11:05 a.m., during an interview with a surveyor, the Maintenance Supervisor stated that he has no documentation to verify the process for control measures and monitoring in areas that the program identified as areas where Legionella could grow and spread (including monitoring areas that have not been frequently used that included sinks and showers) and the facility does not send water samples out for testing at all.	F 880		
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;	F 883		

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F 883	Continued From page 27 (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 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	F 883		

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F 883	Continued From page 28 contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record reviews, facility policy review, and interviews, the facility failed to ensure residents were offered Pneumococcal vaccinations in accordance with the Centers for Disease and Prevention Control (CDC) recommendations for 2 of 5 residents reviewed for immunizations (Resident #20 ([R20] and R12). Findings: The facility's policy, Pneumococcal Vaccine, last revised 10/2023, indicated that "administration of the pneumococcal vaccines or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations. 1. On 2/11/25, R20's clinical record was reviewed. The surveyor could not find evidence that R20 was offered or had received the PCV20 vaccine, a type of pneumococcal vaccine. The CDC recommendation was based on shared clinical decision-making, decide whether to administer one dose of PCV20 or PCV21 at least 5 years after the last Pneumococcal vaccine dose, which was administered in 2017. 2. On 2/11/25, R12's clinical record was reviewed. The surveyor could not find evidence that R12 was offered or had received the PCV20 vaccine. The CDC recommendation was to give one dose of PCV15, PCV20, or PCV21 at least 1 year after the last dose of PPSV23, a type of pneumococcal vaccine, which was administered in 2017. On 2/11/25 at 1:42 p.m., the Director of Nursing	F 883		

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F 883	Continued From page 29 (DON) stated that the facility does offer the PCV20 and uses the CDC recommendations for offering/administration of the vaccine; she would review R20 and R12's clinical records. On 2/12/25 at 7:03 a.m., the DON stated that both residents will be offered the PCV20 as she found no evidence that they were offered to R20 and R12.	F 883		