STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205176	A. BUILDING _____ B. WING _____	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILL MANOR	25 BOLDUC AVE FORT KENT, ME 04743

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F 000	INITIAL COMMENTS From 2/18/25 through 2/20/25, on-site visits were conducted at Forest Hill Manor for the purpose of completing the annual Survey Process for Federal Recertification. It was determined that Forest Hill Manor is not in compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any,	F 580		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: AL·B·

TITLE: COO

(X6) DATE: 3/14/2025

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 580	Continued From page 1 when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to notify timely the Medical Provider of abnormal laboratory results that required further tests to determine cause and the Resident Representative (RR) with results of abnormal labs when results were requested, for 1 of 1 residents reviewed for hospitalization (Resident # [R42]). Findings: 1. On 2/20/25, R42's clinical record was reviewed and indicated that on 1/21/25, R42 had blood work, which included a Comprehensive Metabolic Panel (CMP) and Complete Blood Count (CBC), that were sent to the hospital for analysis and were resulted at 9:06 a.m. (CBC) and 9:23 a.m. (CMP) on 1/21/25.	F 580	1. Education to all RN Staff to update PCP of all abnormal lab results. 2. Checklist created for RN Staff to utilize to update PCP and resident representative of abnormal lab results. 3. KPI created to verify PCP and resident representative made aware of lab results. Results presented at next scheduled QAPI Meeting. 4. Updating PCP and resident representative on abnormal lab results added to RN Orientation Checklist.	03/31/25 03/31/25 03/31/25 03/31/25

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F 580	Continued From page 2 R42's abnormal lab results were as follows: White blood cell count was high at 14.6 with a normal reference range of 4.0-10.0; Sodium level was high at 158, with a normal reference range of 136-145; and Potassium level was high at 5.3, with a normal reference range of 3.5-5.1. On 1/22/25 at 1:44 p.m., the facility's documentation indicated that the (abnormal) blood work was reviewed by Nurse Practitioner (NP), 28 hours after resulted. The NP ordered a STAT (to be completed immediately) urinalysis. On 2/20/25 at 1:24 p.m., during an interview with a surveyor, the Director of Nursing (DON) stated that the Medical Provider should have been made aware of the abnormal lab results by telephone when they were resulted. 2. Review of R42's clinical record indicated on 1/21/25 at 5:30 p.m., documentation indicated that R42's RR requested an update on the blood work results. The RR was told that the results were in the chart and would be reviewed by the doctor tomorrow and that RR would be called tomorrow after that review. On 2/20/25 at 1:24 p.m., during an interview with multiple surveyors present, the DON stated that he saw the note that was written about not giving the RR the information regarding the lab results and making the RR wait until the following day and that the RR should have been given the information (as the RR could have requested transfer to the hospital for further workup).	F 580		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment	F 584		

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F 584	Continued From page 3 CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584	1. All resident rooms floor care completed with buffer. Ongoing PM entered to have each room buffed quarterly. 2. Floor thresholds cleaned and dirt buildup removed. 3. Room 6 door frame and sink trim repaired. 4. Floor mat cleaned. 5. Floor mat cleaning added to daily cleaning checklist. 6. PM created for monthly review of each resident room to inspect for environmental of care cleanliness and damage. Corrective work completed as needed. 7. KPI of review of environment of care rounds and actions required for each room. Results presented at next scheduled QAPI Meeting. 8. Weekly wheelchair cleaning schedule created for C.N.A. Staff to complete.	03/31/25 03/21/25 03/14/25 02/20/25 03/14/25 03/21/25 03/31/25 03/21/25

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F 584	Continued From page 4 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain resident equipment and the building in good repair, homelike, and in a sanitary condition on 2 of 2 units (Skilled Nursing Unit [SNF] and Long Term Care Unit [LTC]). Findings: 1. On 2/19/25 at 10:30 a.m., the Administrator, Housekeeping/laundry Manager (HLM) and a surveyor observed multiple areas of the building that included floors in resident rooms, the Skilled Unit dining room, common areas, and hallways on both units. The flooring was observed to have discolored areas that created a soiled and/or worn appearance and cracked floor coverings, which created uncleanable surfaces. The HLM stated that the floors are down to the last layers, they are so worn and that is why the floors look the way they do; the surveyor also noted that some of the thresholds between the hallway and resident rooms on the LTC Unit had dirt buildup along the cracks. On 2/19/25 at 3:30 p.m., during the end of day conference with the Administrator, the surveyors reviewed other areas of concern with the environment to include chipped paint along a door frame and the trim that was broken on the edge of a sink in Room 6 and a soiled floor mat in Room 14.	F 584		

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F 584	Continued From page 5 2. On 2/20/25 at 1:54 p.m., in an observation and interview with Registered Nurse #2, a surveyor confirmed that R15's wheelchair had dirt and dried debris on both arms, and wheels of his/her wheelchair.	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656	1. Care Plan created for diabetes. 2. Checklist created for careplan completion for all careplan reviews. Audit to be completed by RCC/RCC Assistant to ensure careplan coincides with current diagnoses. 3. Review of all current resident careplans compared to diagnosis list to verify accuracy. 4. KPI of review and audit of all careplans compared to diagnosis list. Results presented at next scheduled QAPI Meeting.	02/20/25 03/12/25 03/21/25 03/31/25

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F 656	Continued From page 6 (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 a person-centered comprehensive care plan was developed in the area of Diabetes for 1 of 13 residents reviewed (Resident #13 [R13]) Findings: Review of Resident #13's clinical record revealed that he/she was admitted to the facility on 8/13/15. Review of the current physician order for Novolin R insulin sliding scale. Resident #13's current care plan was reviewed, and it lacked evidence that the care plan included goals and interventions for the care area of Diabetes and use of insulin. On 2/20/25 at 8:27 a.m. During a review of R13's care plan with the Residential Care Coordinator, the surveyor confirmed that the treatment of R13's Diabetes was not addressed in his/her care plan.	F 656		

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F 657	Continued From page 7	F 657		
F 657 SS=E	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 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 observations, record reviews and interviews, the facility failed to update/revise care plans for the use of Enhanced Barrier Precautions (EBP) for 2 of 3 residents reviewed (Resident #26 [R26] and [R27]) Findings:	F 657	1. Careplan created for any resident on precautions. 2. Infection control RN to update RCC when any resident is placed on or removed from precautions to ensure careplan creation and/or review. 3. KPI of all careplans to review precautions have been added to careplan. Results presented at next scheduled QAPI Meeting.	03/14/25 03/07/25 03/31/25

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F 657	Continued From page 8 1. On 2/19/25 at 7:55 a.m., a surveyor observed an EBP sign on the outside of the door of R26's room. Record review showed that R26 has wounds on both heels with daily dressing changes. The care plan was reviewed and lacked evidence of addressing the need for the EBP while providing care to R26. On 2/20/25 at 1:30 p.m., during an interview with a surveyor and the Residential Care Coordinator, the surveyor confirmed that R26's care plan had not been updated to include the required EBP. 2. On 2/18/25 at 1:01 p.m., a surveyor observed an EBP sign displayed outside the door of R27's room. On 2/20/25, the Director of Nursing provided orders, dated 8/8/24, for R27 that indicated that the resident was on precautions due to Vancomycin-resistant Enterococci (VRE) in the urine. The care plan was reviewed but lacked evidence of the resident needing EBP continuously, with no end date, for this diagnosis. At 1:45 p.m., during an interview with a surveyor, the Resident Care Coordinator stated that this had not been added to R27's care plan.	F 657		
F 684 SS=D	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.	F 684		

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F 684	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, the facility failed to ensure physician orders were followed for 1 of 5 sampled residents for unnecessary medications (Resident #13 [R13]). Finding: On 2/19/25 at 3:05 p.m., during a clinical record review for R13, the electronic Medication Administration Record (MAR) showed that R13's blood sugars (BS) were checked 4 times a day and the sliding scale insulin would provide coverage as indicted per the sliding scale. Review of the physician order indicated the use of Novolin R insulin for sliding scale insulin coverage. Sliding scale coverage was ordered for BS starting at 150, coverage would be provided using the following sliding scale: 150-200 = 2 units of Novolin R 201-250 = 4 units of Novolin R 251-300 = 6 units of Novolin R 301-350 = 8 units of Novolin R 351-400 = 10 units of Novolin R On 2/6/25 at 7:47 p.m., R13's BS was 175, R13's sliding scale indicates that he/she should have received 2 units. Documentation on the MAR shows that R13 received 1 unit of Novolin R insulin. On 2/9/25 at 10:44 a.m., R13's BS was 153, R13's sliding scale indicates that he/she should have received 2 units. Documentation on the MAR shows that R13 received 1 unit of Novolin R insulin.	F 684	1. Education to all RN's on correct dosing of insulin per sliding scale. 2. Education on correct documentation within EMR of sliding scale insulin to all RN's. 3. KPI completed by DON on correct compliance of sliding scale dosage. Results presented at next scheduled QAPI Meeting.	03/21/25 03/21/25 03/31/25

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F 684	Continued From page 10 On 2/10/25 at 3:35 p.m., R13's BS was 228, R13's sliding scale indicates that he/she should have received 4 units. Documentation on the MAR shows that R13 received 1 unit of Novolin R insulin. On 2/11/25 at 5:21 a.m., R13's BS was 151, R13's sliding scale indicates that he/she should have received 2 units. Documentation on the MAR shows that R13 received 1 unit of Novolin R insulin. On 2/11/25 at 10:50 a.m., R13's BS was 162, R13's sliding scale indicates that he/she should have received 2 units. Documentation on the MAR shows that R13 received 1 unit of Novolin R insulin. On 2/13/25 at 5:09 a.m., R13's BS was 161, R13's sliding scale indicates that he/she should have received 2 units. Documentation on the MAR shows that R13 received 1 unit of Novolin R insulin. On 2/13/25 at 10:48 a.m., R13's BS was 205, R13's sliding scale indicates that he/she should have received 4 units. Documentation on the MAR shows that R13 received 1 unit of Novolin R insulin. On 2/13/25 at 3:38 p.m., R13's BS was 240, R13's sliding scale indicates that he/she should have received 4 units. Documentation on the MAR shows that R13 received 1 unit of Novolin R insulin. On 2/13/25 at 7:59 p.m., R13's BS was 157, R13's sliding scale indicates that he/she should	F 684		

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F 684	Continued From page 11 have received 2 units. Documentation on the MAR does not show how much insulin coverage he/she received. On 2/20/25 at 8:15 a.m., during an interview with the Resident Care Coordinator, R13's MAR was reviewed The surveyor confirmed that on several days R13 had BS that would have required coverage from sliding scale and he/she did not receive the correct dose.	F 684		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that hot water temperatures in resident rooms did not exceed 120 degrees Fahrenheit and that blue floor tiles in the Skilled Unit hallway were completely glued to the floor creating a possible trip hazard, on 2 of 3 days of survey (2/18-2/19/25). Findings: 1. On 2/18/25 between 11:25 a.m. - 11:46 a.m., two surveyors observed the following hot water temperatures: Room 38, the hot water temperature was 124.8;	F 689	1. Hot water mixing valve found to be faulty and replaced by facility Maintenance Staff. 2. Maintenance daily rounds check list updated to include randomly checking water temps in 3 resident rooms daily. 3. KPI of checklist to verify completion and temperatures less than 120 degrees. Results presented at next QAPI Meeting. 4. Floor tiles which were identified were replaced.	02/19/25 02/21/25 03/31/25 02/20/25

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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 689	Continued From page 12 Room 39, the hot water temperature was 122.1; Room 37, the hot water temperature was 124.5; Room 36, the hot water temperature was 124.8; Room 35, the hot water temperature was 122.5; Room 34, the hot water temperature was 120.9; and Room 1, the hot water temperature was 120.8. At 11:48 a.m., two surveyors discussed with the Administrator that there were hot water temperatures above 120 degrees in some of the rooms. Room 38 was rechecked at this time and was not above 120 degrees. On 2/18/25 between 1:38 p.m.- 1:46 p.m., surveyors observed the following hot water temperatures: Room 38, the hot water temperature was 121.2; Room 1, the hot water temperature was 122.1; Room 24, the hot water temperature was 121.5; and Room 6, the hot water temperature was 120.4. At 2:02 p.m., during an interview with a surveyor, the Administrator stated that the water temperatures were adjusted this morning after the first report, but they will make another one. They will continue to check rooms today and continue to make adjustments. On 2/19/25 at 11:32 a.m., in Room 4, the hot water temperature was 120.3. On 2/19/25 at 12:20 p.m., the Administrator stated that the mixing valve was found to be faulty was changed this morning and they are continuing to make adjustments. 2. On 2/19/25 at 9:09 a.m., two surveyors	F 689		

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F 689	Continued From page 13 observed areas of blue floor tiles in the Skilled Unit hallway that were starting to lift because they were becoming unglued in areas, presenting a possible trip hazard. On 2/19/25 at 10:30 a.m., during an interview with a surveyor, the Administrator stated that the blue tiles are downstairs, and they had plans to replace them.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to recognize a potential significant weight loss for 1 of 5 sampled residents reviewed for	F 692	1. Checklist for RN's to complete when entering orders and verification of accuracy. 2. Education to nursing staff of documentation of dietary supplement within EMR. 3. KPI completed by dietician on residents experiencing excessive weight loss. Results reported at next scheduled QAPI Meeting.	03/21/25 03/31/25 03/31/25

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F 692	Continued From page 14 nutrition (Resident #30 [R30]). Finding: On 2/19/25, R30's clinical record was reviewed. R30's care plan, revised on 11/29/24, indicated R30 "lost weight and will now get a nutritional supplement once a day". R30's care plan indicated a goal to maintain a body weight within 3 lbs of 179 lbs. R30's weights were as follows: On 9/5/24, R30 weighed 184 lbs. On 10/18/24, R30 weighed 175 lbs. On 11/19/24, R30 weighed 168 lbs. On 1/7/25, R30 weighed 160 lbs. On 2/13/25, R30 weighed 155 lbs. On 2/20/25 at 9:40 a.m., during an interview with a surveyor, the Director of Nursing stated the dietician had ordered a supplement, but the order had dropped off. At this time, the surveyor confirmed R30's clinical record lacked evidence that nursing staff had not notified the medical provider or the registered dietitian, and had not initiated nutritional interventions, such as requesting additional supplements to address the weight loss.	F 692		
F 695 SS=E	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.	F 695		

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F 695	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to maintain respiratory equipment in a sanitary manner to help prevent the development and transmission of disease and infection related to respiratory care for 3 of 5 residents reviewed for respiratory care (Resident #11 [R11], [R27] and [R33]). Findings: 1. On 2/18/25 at 11:35 a.m., a surveyor observed R11's oxygen tubing, dated 1/20/25, resting on the floor. The oxygen concentrator filters were observed to be heavily soiled with dust / debris. On 2/19/25 at 8:07 a.m., a surveyor observed R11's oxygen concentrator filters to be heavily soiled with dust / debris. On 2/19/25 at 12:28 p.m., during an interview, a surveyor and the Director of Nursing (DON), observed R11's oxygen concentrator filters to be heavily soiled with dust/debris. The DON stated the tubing should be changed every 2 weeks unless otherwise directed by the provider. At this time the surveyor confirmed the tubing had not been changed per protocol and the concentrator was not maintained in a manner to prevent the development and/or transmission of disease. 2. On 2/18/25 at 1:01 p.m., a surveyor observed R27's oxygen tubing, dated 1/7/25, and the INVACARE oxygen concentrator was missing both side filters. On 2/19/25 at 8:45 a.m., a surveyor observed the oxygen tubing, dated 1/7/25, and the oxygen	F 695	1. Nursing staff educated regarding requirements of labeling and changing of oxygen tubing. 2. Nursing staff educated regarding requirements of cleaning and presence of oxygen concentrator filters. 3. Treatment entered into electronic medical record requiring RN Staff to change and date all oxygen tubing and cleaning of all oxygen concentrator filters. 4. Bi-weekly audit of all residents with oxygen tubing to verify labels applied with date of last tubing change completed by Director of Nursing, results reported at next scheduled QAPI Meeting. 5. All oxygen tubing changed and dated.	03/21/25 03/21/25 03/21/25 03/31/25 02/20/25

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F 695	Continued From page 16 concentrator still was missing both side filters. On 2/19/25 at 12:20 p.m., during an interview with a surveyor, R27 stated that he/she uses oxygen every night. Review of the manual of the INVACARE Platinum Series XL, 5, 10 indicated that the concentrator was not to be operated without the filter. On 2/19/25 at 12:24 p.m., the DON and surveyor observed R27's oxygen concentrator was missing the filters, and the tubing that was dated 1/7/25. The DON stated that all respiratory tubing and respiratory masks were to be changed every 2 weeks. 3. On 2/18/25 at 11:37 a.m., a surveyor observed R33's oxygen tubing with nasal cannula, dated 1/20/25, resting on the floor. On 2/19/25 at 12:28 p.m., during an interview with the DON, a surveyor confirmed the tubing had not been changed timely per protocol.	F 695		
F 725 SS=F	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	F 725		

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F 725	Continued From page 17 at §483.71. §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 record review and interviews, the facility failed to ensure sufficient direct care staff were scheduled and on duty to meet the needs of residents that reside in the facility. This has the potential to affect all residents needing assistance with Activities of Daily Living (ADL's). Findings: Review of Payroll Based Journal staffing report revealed the facility triggered for low weekend staffing during the fourth quarter of 2024 (July 1 - September 30). On 2/20/25 at 9:58 a.m., during an interview with a surveyor and the Administrator, the staffing schedules were reviewed for the fourth quarter of 2024. The Administrator confirmed the facility did not ensure enough staff were on duty to meet resident needs on the weekends.	F 725	1. Education to RN Staff regarding minimum staffing numbers. 2. Daily check in from scheduler to DON on staffing numbers. 3. Minimum staffing requirements added to RN Orientation Checklist. 4. Education to Administrator on-call and nursing supervisors regarding minimum staffing requirements. 5. DON to communicate with Administrator staffing concerns for upcoming 48 hours and plan to address staffing. 6. KPI on weekend staffing to ensure minimum staffing numbers are always met. Results presented at next scheduled QAPI Meeting.	03/31/25 02/24/25 03/31/25 03/31/25 03/14/25 03/31/25

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F 761	Continued From page 18	F 761		
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 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 and interview, the facility failed to ensure all expired drugs and biologicals, available for resident use, had been removed from 1 of 2 medication storage units (skilled nursing unit), and 1 of 1 medication storage refrigerator (medication storage refrigerator long term care unit). Findings:	F 761	1. Outdated medications removed. 2. Checklist created for CNA-M to complete on first Monday of month to verify presence of outdated medications. 3. Random audit of medication carts and storage rooms to check for outdated medications. 4. KPI completed by Director of Nursing regarding findings of outdated medication audit presented at next scheduled QAPI Meeting.	02/20/25 03/21/25 03/24/25 03/31/25

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F 761	Continued From page 19 1. On 2/20/25 at 10:36 a.m., during an inspection of the medication storage room on the skilled unit, a surveyor discovered one box of Ayr Saline Nasal Gel (sinus spray), available for resident use, that had expired on 7/24. 2. On 2/20/25 at 10:55 a.m., during an inspection of the medication storage room refrigerator on the long term care unit, a surveyor discovered one bottle of GI (gastrointestinal) Cocktail (Lidocaine, Banophen, Mylanta) (medication for dyspepsia [upper abdominal pain]) give 15 milliliters (ml) by mouth twice daily as needed, with Resident #15's name on the bottle, which had a discard after 2/2/25 written on the label. R15's current physician's orders, dated 8/17/23, included an order for GI Cocktail 15 ml, solution, oral, twice a day as needed for dyspepsia. The above findings were confirmed with the Certified Nursing Assistant - Medications on 2/20/25 at the time of the observations, and the medications were immediately removed for destruction.	F 761		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance	F 773		

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F 773	Continued From page 20 with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to notify the provider of abnormal laboratory results timely for 1 of 1 residents reviewed for hospitalization (Resident #42 [R42]). Finding: On 2/20/25, R42's clinical record was reviewed and indicated that on 1/21/25, R42 had blood work and a chest x-ray ordered by the doctor (MD). The bloodwork, which included a Comprehensive Metabolic Panel (CMP) and Complete Blood Count (CBC), were obtained by the facility and sent to the hospital for analysis and were resulted at 9:06 a.m. (CBC) and 9:23 a.m. (CMP) on 1/21/25. R42's abnormal lab results were as follows: White blood cell count was high at 14.6 with a normal reference range of 4.0-10.0; Sodium level was high at 158, with a normal reference range of 136-145; and Potassium level was high at 5.3, with a normal reference range of 3.5-5.1. On 1/21/25 at 5:30 p.m., the facility's documentation indicated that the results were in the chart and would be reviewed by MD tomorrow. On 1/22/25 at 1:44 p.m., the facility's documentation indicated that the (abnormal) blood work and chest x-ray results were reviewed by Nurse Practitioner (NP), 28 hours after	F 773	1. Education of all RN Staff to update PCP of all abnormal lab results. 2. Checklist created for RN Staff to utilize to update PCP of abnormal results. 3. KPI created to verify PCP has been made aware of lab results. Results presented at next scheduled QAPI Meeting. 4. Updating PCP on abnormal Lab Results added to RN Orientation Checklist.	03/31/25 03/31/25 03/31/25 03/31/25

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F 773	Continued From page 21 resulted. On 2/20/25 at 12:21 p.m., during an interview with a surveyor, Registered Nurse stated that if a resident has labs that were completed, they have to check the computer for the results unless it is a critical value and then the laboratory would call (the facility is owned by the hospital and share the same electronic medical record). On 2/20/25 at 1:24 p.m., during an interview with a surveyor, the Director of Nursing (DON) stated that the Medical Provider should have been made aware of the abnormal lab results by telephone when they were resulted.	F 773		
F 880 SS=E	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, 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	F 880		

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F 880	Continued From page 22 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 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	F 880	1. Education to all staff regarding proper PPE usage and signage. 2. Orientation check list updated to review PPE usage and precaution signage meaning. 3. KPI completed by infection preventionist on random audits of staff observations entering precaution rooms.Results presented at next scheduled QAPI Meeting. 4. Education to all CNA-M and RN Staff regarding proper administration of Optic Medications. 5. PM entered into facility work order system for all items on water management system.	03/31/25 03/31/25 03/31/25 03/31/25 03/21/25

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F 880	Continued From page 23 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 observations and interviews, the facility failed to implement infection prevention measures for 2 of 3 days of survey (2/18/25 and 2/19/25) and 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 monitoring for control measures for 1 of 1 review of water management program. Findings: The facility's "Enhanced Barrier Precautions" signage directed staff and providers to wear gloves and a gown for the following High-Contact Resident Care Activities: -dressing -bathing/showering -transferring -changing linens -providing hygiene -changing briefs or assisting with toileting -device care or use: central line, urinary catheter, feeding tube, tracheostomy -wound care: any skin opening requiring a dressing 1. On 2/18/25 at 11:28 a.m., a surveyor observed personal protective equipment signage to indicate necessary precautions, to include a gown, needed before entering room. The surveyor observed the Unit Caretaker changing linen and	F 880		

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F 880	Continued From page 24 making Resident 33's (R33's) bed and did not wear a protective gown when handling used linen and bedspread for a resident on enhanced barrier precautions (EBP). On 2/20/25 at 11:28 a.m., in an interview with the Director of Nursing (DON), a surveyor confirmed that the Unit Caretaker did not wear a gown when handling linen and bedspread for R33, on EBP's. 2. On 2/19/25 at 8:20 a.m., a surveyor observed a Certified Nursing Assistant - Medications (CNA-M) administer eye drops in both eyes for R11 without wearing gloves. In an interview with the CNA-M, she stated she probably should have worn gloves. On 2/20/25 at 11:28 a.m., in an interview with the DON, a surveyor confirmed that the CNA-M did not wear gloves when administering eye drops for R33. The DON stated that Lippincott Nursing Procedures are used as guidance for appropriate medication administration, and the CNA-M should have been wearing gloves. On 2/20/25 a surveyor reviewed "Lippincott Nursing Procedures, ninth education, copyright 2023", page 338 stated "perform hand hygiene and then put on gloves", when administering eye drops. 3. On 2/19/25 at 7:55 a.m., a surveyor observed an Enhanced Barrier Precaution sign to indicate necessary precautions be used when assisting R26, to include a gown, and gloves that were needed when providing care. The surveyor observed two certified Nursing Assistants (CNA) assisting R26 to reposition in bed, both CNAs did not wear a protective gown and one CNA did not	F 880		

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	205176	A. BUILDING _____ B. WING _____	02/20/2025

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F 880	Continued From page 25 wear gloves when assisting R26 with repositioning, they failed to follow the enhanced barrier precautions (EBP) for R26. On 2/19/25 at 9:00 a.m., a surveyor confirmed the above finding with the charge nurse. 4. On 2/19/25 at 8:13 a.m., a surveyor observed CNA take R28 into the bathroom by wheelchair. The surveyor observed an Enhanced Barrier Precaution sign on the doorframe area. CNA was not wearing a gown when entering or exiting the bathroom. At 8:21 a.m., the surveyor observed Registered Nurse (RN) go into R28's bathroom and then observed her transporting R28 in a wheelchair out of the bathroom. At 8:25 a.m., during an interview with a surveyor, RN stated that she assisted R28 with toileting hygiene and transferred R28 to the wheelchair and did not know that R28 was on enhanced barrier precautions, but would check why. On 2/19/25 at 8:50 a.m., during an interview with a surveyor, and with a CNA present, RN stated that R28 tested positive for Vancomycin-Resistant Enterococcus (VRE) and that they should be wearing gowns when providing care to R28. On 2/19/25 at 9:21 a.m., during an interview with a surveyor, Infection Preventionist confirmed that R28 was on EBP for VRE in the urine and that is why the sign is posted outside the door. 5. The facility's "Water Management Program" indicated the individual or team responsible for the Water Management Program manages the following: Documented results of all monitoring activities; Corrective actions and procedures to follow if a test result outside of acceptable limits is obtained;	F 880		

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F 880	Continued From page 26 and Documented corrective actions taken when the control limits are not maintained. The Control Locations Management Log identified areas to monitor (action item), control ranges, and minimum frequency of checks. Further review included multiple action items that included: check hot water temperatures of faucets to ensure proper heating (monthly), clean showerheads and run hoses weekly, ensuring all active outlets are flushed weekly, and cleaning the ice machine at least twice a year, with more items listed. On 2/19/25 at 10:18 a.m., during an interview with a surveyor, the Forest Hill Maintenance Specialist stated that he only checks the water temperatures that comes into the boiler room that is generated by the hospital. He does not check hot water temperatures at faucets to ensure proper heating or any other monitoring that was identified on the Control Locations Management Log. On 2/19/25 at 10:30 a.m., during an interview with a surveyor, the Administrator stated that he would check for further information regarding action items that were to be monitored. On 2/19/25 at 12:20 p.m., during an interview with a surveyor, the Administrator confirmed that the facility is not monitoring the action items identified per Water Management Policy except for the ice machine and boiler room checks.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations	F 883		

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F 883	Continued From page 27 §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 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	F 883	1. Resident received Pneumococcal Vaccine per PCP order. 2. All residents assessed and vaccine administered as recommended. 3. Spreadsheet created and dates of Pneumococcal Vaccine administered logged and monitored by Infection Preventionist. Ongoing recommendations provided to PCP when indicated.	02/20/25 03/21/25 03/21/25

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F 883	Continued From page 28 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 review, facility policy review, and interview, the facility failed to ensure residents were offered pneumococcal immunizations for 1 of 5 residents reviewed for immunizations (Resident #34 [R34]). Finding: The facility's policy, Pneumococcal/Influenza Immunization Policy, last revised 2/12, indicated that "all patients will be offered the vaccine unless contraindicated due to health history. Administration of the vaccine will be in accordance with the Pneumococcal Immunization/Influenza Standing Order. On 2/19/25, R34's clinical record was reviewed. The surveyor could not find evidence that R34 was offered, declined, or had received a Pneumococcal Immunization. On 2/20/25 at 9:31 a.m., during an interview with a surveyor, the Infection Preventionist stated that there was no offering, history of receiving, or declination of a Pneumococcal Immunization in	F 883		

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F 883	Continued From page 29 R34's clinical record and that R34's Resident Representative consented yesterday, after the surveyor asked for further information on R34's vaccination status.	F 883		