STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205121	A. BUILDING _____ B. WING _____	R-C 09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE HEALTH & REHAB AT SOUTH PORTLAND	42 ANTHOINE ST SO PORTLAND, ME 04106

(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 On 9/25/24, an unannounced on-site visit was conducted at Pinnacle of South Portland to follow up on the deficiencies cited at the complaint investigation for 7/30/24. It was determined that Pinnacle of South Portland was not in compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	{F 000}	This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited on 9/25/2024. However, the submission of this plan is not an admission that a deficiency exist, The Plan of Correction is prepared and executed solely because it is required by the Federal and State Law. This response and plan of correction does not constitute an admission or agreement by the provider of the facts alleged, or conclusions set forth in the statement of deficiencies.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators,	F 867	F 867 QAPI/QAA Improvement Activities: A. This requirement was not met as evidenced by: the facility's Quality Assurance Committee failed to ensure that the Plan of Correction (POC) for an identified deficiency from the complaint survey process date 7/30/24 was effective. B. Corrective Action: #1. Corrective action for those residents found to have been affected by the deficient practice: Please note that there were no apparent adverse effects either reported or observed resulting from this alleged deficiency for resident identity. #2. Identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken: There were no identified residents affected by the alleged cited deficiency after 9/25/24 #3. Systems and measures to ensure that the alleged deficient practice do/does not reoccur: A root cause analysis will be conducted to determine why the POC failed and identify any systemic issues that contributed to the lack of follow-through. We will Enhance the POC Monitoring Process, develop a robust tracking system to monitor all POCs, including: Specific corrective actions, Responsible parties, Implementation timelines, Monitoring frequencies and methods.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jeff Ketchum	Administrator	10/11/24

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 867	Continued From page 1 including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas;	F 867	#4 Monitoring compliance of the alleged deficient practice: There will be an additional agenda item added to the monthly QAPI committee meeting for responsible parties to report the status of the corrections and results. We will strengthen the QAA Committee oversight revise the QAA committee's policies and procedures to include: 1. More frequent review of open POCs. 2. A process for escalating concerns when POCs are not progressing as planned. 3. Clear accountability measures for staff responsible for POC implementation. 4. Provide additional training to QAA committee members on their roles and responsibilities in overseeing POC implementation and sustainability. #5 How the facility will develop a plan to monitor its performance to make sure that corrections are sustained Schedule quarterly reviews of the enhanced POC monitoring system to ensure it remains effective and make improvements as needed. #6 How the plan will be implemented, and the corrective action evaluated for its effectiveness. Implement a "Plan-Do-Study-Act" (PDSA) cycle for each POC to continuously evaluate effectiveness and make necessary adjustments. #7 How the plan of correction is integrated into the quality assurance system. Develop key performance indicators (KPIs) to measure the overall effectiveness of the facility's POC process and QAPI program. #8 Dates when the proposed corrective actions will be completed. Completion date of November 9th, 2024	

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F 867	Continued From page 2 consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;	F 867		

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F 867	Continued From page 3 (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews, the facility's Quality Assurance Committee failed to ensure that the Plan of Correction (POC) for an identified deficiency from the Complaint Survey Process dated 7/30/24, was effective. The federal citation F880 was cited again during the re-visit to the Complaint Survey, dated 9/25/24. Finding: At the Complaint Survey Process, the following deficiency was cited, F880. During the follow up survey on 9/25/24, it was determined the F880 would be recited for the same issue: failure to maintain and implement an infection control program to help prevent the development and transmission of disease and infection. On 9/25/24 at approx. 1:30 p.m., during and interview, the above was confirmed with the Administrator and Director of Nursing.	F 867		
{F 880} SS=D	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	{F 880}		

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{F 880}	Continued From page 4 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) 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.	{F 880}	F 880 Infection Prevention & Control Response: A. Findings: This tag was recited for failure to maintain and implement an infection control program to help prevent the development and transmission of disease and infection. B. Corrective Action: #1. Corrective action for those residents found to have been affected by the deficient practice: Please note that there were no apparent adverse effects either reported or observed resulting from this alleged deficiency for resident identity. #2. Identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken: There were no identified residents affected by the alleged cited deficiency after 09/25/24 regarding Infection Prevention & Control practices. #3. Systems and measures to ensure that the alleged deficient practice do/does not reoccur: Effective immediately, the facility has enhanced development of our Infection Prevention and Control policies/ procedure understanding and adherence. Mandatory staff education on Standard Precautions still applies while using EBP and the proper Donning/Doffing of required PPE initiated. Education formats include: one to one staff education, staff knowledge quiz and audits that include staff competency demonstrations. Specific focus on effectiveness of training and staff competencies. The Infection Preventionist Nurse, Director of Nurses, ADON and Unit managers will continue ongoing staff education/communication regarding Infection Control Prevention Practices. #4 Monitoring compliance of the alleged deficient practice: The Infection Preventionist Nurse/DNS/ADNS or designee will audit the use of Standard Precautions and proper PPE as required and identified to promote a compliant practice that is sustainable and effective. Ongoing monitoring of changes to determine if intervention/trainings changes have worked or are needed through completion date of November 9h, 2024 and ongoing.	

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{F 880}	Continued From page 5 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on Centers for Disease Control and Prevention, facility policy, record reviews and interviews, the facility failed to maintain and implement an infection control program to help prevent the development and transmission of disease and infection related to indwelling medical devices for a 2 of 2 sampled residents (Resident #7 and #8) reviewed for Enhanced Barrier Precautions. Findings: The Centers for Disease Control and prevention "Definition and Scope of Enhanced Barrier Precautions": dated 6/23/24 states, Enhanced Barrier Precautions (EBP) involve gown and glove use during high-contact resident care	{F 880}	#5 How the facility will develop a plan to monitor its performance to make sure that corrections are sustained. Root cause analysis completed on existing Infection Control and Prevention/PPE training process to help identify contributing factors that focus on improvements. New audits are designed to focus on staff knowledge, competencies, demonstrations of Infection control/prevention skills to prevent transmission of communicable diseases and infections. Staff knowledge to include when and how precautions are used dependent upon the infectious agent or infection control circumstance for risk. #6 How the plan will be implemented, and the corrective action evaluated for its effectiveness. Various methods of adult learning and multiple training opportunities provided for staff convenience and deliberate repetition of information provided. Continued audits on Infection Control/Prevention and PPE usage will be combined with feedback on learning throughout the staff. Audits will focus on appropriate precautions, the proper type and usage of available PPE. #7 How the plan of correction is integrated into the quality assurance system. Results of Infection Control/Prevention enhancements on training will be reported/ reviewed through the facility Quality Assurance and Performance Improvement Process until compliance is achieved and maintained for a period of six months and ongoing. #8 Dates when the proposed corrective actions will be completed. Completion date of November 9th, 2024	

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{F 880}	Continued From page 6 activities for residents known to be colonized or infected with a multi-drug resistant organisms (MDRO) as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). EBP expand the use of gown and gloves beyond anticipated blood and body fluid exposures ... Standard Precautions still apply while using EBP. For example, if splashes and sprays are anticipated during the high-contact care activity, face protection should be used in addition to the gown and gloves. Facilities "Enhanced Barrier Precautions" revised 3/7/24 states: "Overview: Enhanced Barrier Precautions will not only focus on residents with infection or colonization with MDRO's but will also address residents at risk for developing or becoming colonized. Enhanced barrier precautions are precautions that are between standard precautions and contact precautions." "Procedure: precautions should be applied to all residents at all times ...Enhanced barrier precautions are to be implemented in addition to standard precautions when other transmission-based precautions do not apply, when the facility identifies any resident with: ... any indwelling medical device, for example urinary catheters." 1. Resident #7 has a diagnosis of obstructive and reflux uropathy, urogenital implants and atresia and stenosis of urethra and bladder neck requiring a suprapubic indwelling catheter. The most recent care plan for, "Enhanced Barrier Precaution. Indwelling Catheter. Staff have agreed on precautions due to catheter change splash back", initiated 4/2/24 has nursing interventions of "EBP supplies will be readily	{F 880}		

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{F 880}	Continued From page 7 available" and "staff will maintain EBP measures during the following care ...caring for indwelling device." The care plan for "frequent history Urinary Tract Infection catheter and poor fluid intake", initiated 3/11/24 has nursing interventions of "we will follow Enhanced Barrier Precautions as recommended by CMS". On 9/25/24 at 9:06 a.m., during an interview, Resident #7 confirmed he/she has a suprapubic catheter, that requires staff assistance with care and emptying of his/her urine. Resident #7 confirmed staff does not wear a face shield or goggles but will "sometimes" wear a mask while providing this care. 2. Resident #8 was admitted on 9/4/24 with a dx cellulitis of the lower extremity and urinary retention requiring an indwelling foley catheter. Review of the care plan states, Resident #8 is on "Enhanced Barrier Precaution. Chronic wounds or skin openings requiring dressing (on lower extremity), Indwelling Catheter", initiated 9/5/24 has nursing interventions of "staff will maintain EBP measures during the following care ... caring for indwelling device, Performing wound care". On 9/25/24 at 9:14 a.m., during a brief interview, Resident #8 confirmed he/she does have a catheter that requires staff assistance with care and emptying of his/her urine. The Surveyor asked if staff wear gloves and a gown when providing this care, he/ she stated "yes, I think so". When asked if staff use a face shield during this care, he/she stated, "No". 3. On 9/25/24 at 8:30 a.m., during an interview, the Licensed Practical Nurse (LPN), stated EBP are for residents with history of Methicillin-resistant Staphylococcus aureus (MRSA) or have a foley and you only need to gown and glove when preforming personal care.	{F 880}		

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{F 880}	Continued From page 8 The Surveyor asked if face shields/protection is available for staff. The LPN stated, "they all have their own". The surveyor asked were the staff store their face protection, he stated, "I'm not sure". He then stated, the Certified Nursing Assistants (CNA)'s can get them at the nurse's station, both the surveyor and the LPN looked behind the nurse's station, where a tote was stored on the floor. He opened the tote, which only had masks and gowns. He then went into the locked medication room where there were 2 face shields stored above the sink. In an additional interview at 10:55 a.m., the LPN confirmed the medication room is always locked and only nurses have access to the medication room. 4. On 9/25/24 at 8:35 a.m., during an interview, CNA #1 confirmed Resident #7 and Resident #8 both have indwelling catheters and are on EBP. The Surveyor asked what Personal Protective Equipment (PPE) you would utilize while caring for the resident's catheters and/or emptying there urine. CNA #1 stated "gloves and gown". The surveyor then asked, if she would wear eye/face protection. CNA #1 stated, "No". 5. On 9/25/24 at 8:38 a.m., observation of Resident #7's room with EBP posted and a 3-drawer cart outside of the bedroom door containing gloves, and gowns, no face protection available. At this time the Nurse Practice Educator approached the surveyor, in a brief interview, she stated the EBP were initiated on Resident #7 due to his/her suprapubic catheter stating, "there's lots of splashing. Just this morning we had spillage." 6. On 9/25/24 at 8:43 a.m., during an interview, CNA #2 was asked what PPE she would use	{F 880}		

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{F 880}	Continued From page 9 while caring for a resident's catheters and/or emptying the urine. She stated "Gown and gloves". The surveyor then asked if she would use face protection. She stated, "You could, there would be some in the cart or we have our own. I have mine in my car". At this time, she stated she would sanitize her face shield with alcohol or soap and water. 7. On 9/25/24 at 8:55 a.m., during an interview, CNA #3 stated, "with EBP you would use mask, gloves and a gown for direct care". The surveyor asked if this were what she would wear when emptying a foley or providing catheter care. CNA #3 responded, "Yeah I do". Surveyor asked, would you wear eye protection, she stated, "No, I don't think so". At this time CNA #3 confirmed knowledge of Resident #7 and Resident #8 and why EBP are in place. Surveyor again asked if while providing catheter care and/or emptying urine for either resident, what do you wear. CNA#3 stated, "basically gloves, I walk [him/her] into the bathroom, then empty the foley catheter into the container to measure it ..." Surveyor asked, would you wear a gown while preforming catheter care. CNA #3 stated, "I think that would be a good idea, then wash hands". CNA #3 confirmed she had not received standard precautions and/or Transmission Based Precaution education through the facility but has received it in other facilities. 8. On 9/25/24 at 9:00 a.m., during an interview with CNA #4, She confirmed she is familiar and has worked with both Resident #7 and Resident #8. The Surveyor asked what PPE is worn while providing catheter care and/or emptying the urine, she stated, "gown and gloves, I empty the urine into a container then take the cc's and dump it	{F 880}		

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{F 880}	Continued From page 10 into the toilet." Surveyor asked if she has face/eye protection available, she stated, "Yes, there are some shields in the draw". Finally, surveyor asked if she uses the face shield when emptying Resident #7 or #8's catheter bag, she stated, "I haven't". On 9/25/24 at 9:21 a.m., during an interview, the Nurse Practice Educator (NPE) confirmed the facility follows CDC recommendations for standard precautions and TBP. At this time, the Surveyor discussed the ongoing concerns regarding the use of appropriate PPE while providing direct care with anticipation of splashes and sprays and the lack of available face shields for the CNA's. The NPE stated, she has ongoing education for staff on gloves and gown usage but has not considered the use of face/eye protection during catheter care.	{F 880}		