STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. BUILDING: _____ B. WING _____	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REH	7 HIGHWOOD ST WATERVILLE, ME 04901

(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) COMPLETE DATE
T 001	Initial Comments From 9/9/24 through 9/13/24, and on 9/17/24 on-site visits were conducted at Waterville Center for Health and Rehabilitation for the purpose of conducting the annual Long Term Care Survey Process for Federal Recertification, facility reported incidents #ME00048842, and complaints #ME00048683, #ME00048363, #ME00047975, #ME00047617, #ME00047498, #ME00047476, and #ME00046903. It was determined that Waterville Center for Health and Rehabilitation was not in substantial compliance with 10-144 CMR Chapter 110-Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities.	T 001	Waterville Center for Rehab provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed as evidence of the facility's continued compliance with state and federal regulations	
T 098	4.J.1. Reports of Abuse, Neglect or Misappropriation The facility must ensure that all staff are knowledgeable of the Adult Protective Services Act and that all alleged violations involving mistreatment, neglect, and abuse, including injuries of unknown source and/or misappropriation of resident property, are reported immediately, through established procedures, to the administrator of the facility and to other officials in accordance with State law. This Regulation is not met as evidenced by: Based on interviews, facility policy review, and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime, resulting in failure to protect the resident from further potential harm from the perpetrator. In addition, the facility failed to report to law enforcement or the State Survey Agency (SA) an incident of possible abuse including the violation of a resident's right to be free from a physical restraint which kept the resident from ambulating	T 098	1.Resident #99 is no longer a resident at the facility as of July 26, 2024. 2.The Social Service department will interview all residents regarding resident rights and physical restraint use. Residents that are not able to be interviewed will be observed to ensure no restraints are in use. Any resident identified with restraint use will be evaluated to ensure restraint use policy has been followed, if not in compliance the facility will complete a reportable incident report and initiate a full investigation by September 17, 2024. The resident interviews and observations of resident was completed on September 13, 2024, residents reported understanding of their resident rights, and none reported being restrained, residents who were not able to be interviewed were observed to be restraint free.	9/17/2024

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T 098	Continued From page 1 from a wheelchair [Resident #99 (R99)]. Findings: The facility's "Abuse, Neglect and/or Misappropriation of Resident Funds or Property Prohibition Policy" last revised on April 21, 2023 indicated under the Definitions heading: "Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish." It also states "Timing: incidents and/or allegations of abuse ... should be reported to the Administrator and/or his/her designee immediately. The Administrator or his/her designee will notify the State Agency of alleged violations involving abuse, neglect ... and injuries of unknown source as soon as possible, but in no event later than 24 hours from the time the incident/allegation was made known to them." The "Restraint Use" Policy dated 6/24/2014 states "The resident has the right to be kept from any chemical/physical restraint imposed for discipline or convenience and not requested to treat his/her medical condition." On 7/31/24 at 12:35 p.m., the State of Maine, Division of Licensing and Certification received an anonymous complaint alleging the facility was short staffed and CNAs (Certified Nursing Assistants) were tying residents to chairs. On 9/10/24 at 10:45 a.m. in an interview with a surveyor the Life Enrichment and Pastoral Care staff member stated, "I have never seen or noticed a resident tied to their chairs, but I think I know what you're talking about. That resident passed away. I can't remember what staff or what resident were involved but they were on	T 098	3.The Administrator and/or designee will review the last three months of facility incident reports to ensure reportable incidents indicating use of restraints have been reported, fully investigated and corrective actions taken. Any identified to not be in compliance will be reported and a full investigation will be completed by September 17, 2024. 4.The Director of Clinical Services and/or designee will provide re-education to all staff regarding resident rights, abuse, restraint use, incident reporting. Initiated on September 13, 2024, to be completed by September 17, 2024. 5.The Regional Director of Clinical Services will provide education to the current administrative team regarding reporting and investigation of reportable incidents.(The Interim Director of Clinical Services) and Interim Administrator who had not fully investigated and reported the incident are no longer at the facility) Initiated on September 13, 2024, was completed on September 17, 2024. 6.The Administrator and Director of Clinical Services completed reportable incident report, sent to DHHS-Licensing and Regulatory Services and Adult Protective Services and notified resident's responsible party on September 13, 2024.	9/17/2024

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T 098	Continued From page 2 Cove [Unit]." The surveyor was directed to ask Registered Nurse #1 (RN1). On 9/10/24 at 11:15 a.m., in an interview with the surveyor, RN1 stated she did not remember who the resident was or when the incident happened, but did remember she last saw the resident in bed around 5:00p.m.-5:30p.m., at which time the resident had visitors who were preparing to leave. RN1 stated she remembers the prior Interim Director of Nursing (IDON) asked about the resident being tied to a wheel chair in the days following the incident, RN1 told the prior IDON that she believed the family had restrained the resident. On 9/10/24 at 12:47 p.m., in an interview with a surveyor, the Certified Nursing Assistant -Medications #2 (CNA-M2) stated that she was aware of the possibility of someone having been tied to the bed or chair, and that CNA3 had been placed on administrative leave because of that, but that CNA3 returned quickly, and heard it was the family that had restrained the resident. On 9/12/24 at 2:22 p.m., in an interview, CNA3 stated she last saw R99 in bed around 5:30 p.m., there were no visitors in the room at that time. CNA3 stated she was investigated for 1 to 2 days but was told it wasn't her fault. On 9/12/24 at 8:52 a.m., in an interview with a surveyor the Director of Nursing (DON) stated she knows of the incident but was not here at the time. The DON provided the surveyor with the name of the resident and a folder containing the facility's handwritten notes regarding the incident. The folder lacked evidence that the facility reported the incident to law enforcement agencies or to the SA .	T 098	Upon the investigation's completion, the facility was able to verify that the resident's niece, per her report, placed the sheet around the resident and tied it to the back of her wheelchair. A follow up report, as required, was faxed to DHHS-Licensing and Regulatory Services on September 15, 2024. 7.The Director of Clinical Services and/or Administrator will review staff and resident concerns/reports and incident reports of alleged reportable violations to ensure it has been reported timely and fully investigated. A report of the findings will be submitted monthly, for two quarters, to the facility Quality Assurance Performance Improvement Committee for further review and recommendations.	9/17/2024

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T 098	Continued From page 3 On 9/12/24 from 8:58 a.m.- 9:40 a.m., interviews were completed with a surveyor and the DON. During the interview: The Director of Clinical and Quality Assurance confirmed she did not report this incident to law enforcement or the SA. The IDON at the time of the incident joined the interview by phone, and confirmed she did not report this incident to law enforcement or the SA. The Interim Administrator at the time of the incident joined the interview by phone and confirmed she did not report this incident to law enforcement or the SA. On 9/12/24 at 9:40 a.m., in an interview with the DON a surveyor confirmed that the facility failed to report the incident to law enforcement or the SA within 24 hours and failed to report a Follow-Up Investigation within 5 working days	T 098		
T 099	4.J.2. Report of Abuse, Neglect and Misappropriation The facility must have evidence that all alleged violations are thoroughly investigated and in a timely manner. Policies must address administrative procedures to be implemented to prevent further potential abuse while the investigation is in progress. This Regulation is not met as evidenced by: Based on interviews, record review, and policy review, the facility failed to fully investigate an incident involving possible abuse including the use of an unnecessary physical restraint on a resident, which kept the resident from ambulating from a wheelchair (Resident #99 (R99).	T 099	1. Resident #99 is no longer a resident at the facility as of July 26, 2024. 2.The Social Service Department will interview all residents regarding resident rights and physical restraint use. Residents unable to be interviewed will be observed to ensure no restraints are in use. Any resident identified with restraint use will be evaluated to ensure restraint use policy has been followed, if not in compliance the resident will be evaluated for physical or psychological harm and the facility will complete a reportable incident report and initiate a full investigation by September 17, 2024. The interviews and observations of residents was completed on September 13, 2024, residents reported understanding of their resident rights, and none reported being restrained, residents who were not able to be interviewed were observed to be restraint free	9/17/2024

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T 099	Continued From page 4 Findings: On 7/31/24 at 12:35 p.m., the State of Maine, Division of Licensing and Certification received an anonymous complaint alleging the facility was short staffed and CNAs (Certified Nursing Assistants) were tying residents to chairs. On 9/10/24 at 10:45 a.m., in an interview with a surveyor, the Life Enrichment and Pastoral Care staff member stated, "I have never seen or noticed a resident tied to their chairs, but I think I know what you're talking about. That resident passed away. I can't remember what staff or what resident was involved but they were on Cove." The surveyor was directed to ask Registered Nurse #1 (RN1). On 9/10/24 at 11:15 a.m., in an interview with the surveyor, RN1 stated she did not remember who the resident was or when the incident happened, but did remember she last saw the resident in bed around 5:00p.m.-5:30p.m., at which time the resident had visitors who were preparing to leave. RN1 stated she remembers the prior Interim Director of Nursing (IDON) asked about the resident being tied to a wheel chair in the days following the incident, RN1 told the prior IDON that she believed the family had restrained the resident. On 9/10/24 at 12:47 p.m., in an interview with a surveyor, the Certified Nursing Assistant -Medications #2 (CNA-M2) stated that she was aware of the possibility of someone having been tied to the bed or chair, and that CNA3 had been placed on administrative leave because of that, but that CNA3 returned quickly, and heard it was the family that had restrained the resident.	T 099	3. The Director of Clinical Services and/or designee will provide re-education to all staff regarding resident rights, abuse, restraint use, and incident reporting. Initiated September 13, 2024, will be completed by September 17, 2024. 4.The Regional Director of Clinical Services will provide education to the current administrative team regarding reporting and investigation of reportable incidents. (The interim Director of Clinical Services and the interim Administrator who had not fully investigated and reported the incident are no longer at the facility) Initiated on September 13, 2024, to be completed by September 17, 2024. 5.The Administrator and Director of Clinical Services completed reportable incident report, which was sent to DHHS-Licensing and Regulatory Services and Adult Protective Services and notified resident's responsible party on September 13, 2024. Upon the investigation's completion, the facility was able to verify that the resident's niece, per her report, placed the sheet around the resident and tied it to the back of her wheelchair. A follow up report, as required, was faxed to DHHS-Licensing and Regulatory Services on September 15, 2024.	9/17/24

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T 099	Continued From page 5 On 9/12/24 at 2:22 p.m., in an interview, CNA3 stated she last saw R99 in bed around 5:30 p.m., there were no visitors in the room at that time, she believed the visitors had gone home. CNA3 stated she was investigated for 1 to 2 days but was told it wasn't her fault. The facility's "Abuse, Neglect and/or Misappropriation of Resident Funds or Property Prohibition Policy" last revised on April 21, 2023 indicates under the Investigation heading it states: "As part of the investigation, the Administrator or his/her designee, shall coordinate the investigative process ...and take the following action(s): Interview the resident, the accused, and potential witnesses. Witnesses may include anyone who: Witnessed or heard the incident; Came in close contact with either the resident the day of the incident (including other residents, family members, etc.); and Colleagues who worked closely with the accused colleague(s) and/or alleged victim the day of the incident. To the extent possible, all interviews should be summarized into a written statement, which is signed and dated." On 9/12/24 at 8:52 a.m., in an interview the Director of Nursing (DON) stated she knows of the incident but was not here at the time. The DON provided the surveyor with a folder containing partial notes that appeared as a timeline . The notes did not indicate who wrote them or when. The folder also contained a copy of the visitor log on the day of the incident, and 2 witness statements from facility employees CNA6 and CNA7 both dated 7/25/24. Review of the documents indicated: - the resident was able to independently transfer from her bed to her chair .	T 099	6. A Root Cause Analysis (RCA) which was initiated on 9/13/24, will be developed to identify potential contributing/causal factors and implement measures to prevent further incidents and will be completed by 9/16/2024 at which time the findings will be reviewed by an Ad Hoc Quality Assurance and Performance Improvement Committee. 7. The Director of Clinical Services and/or designee will review staff and resident reports and/or grievances of alleged reportable violations to ensure it has been reported timely, fully investigated and a root cause analysis has been completed to identify potential contributing/causal factors and implement measures to prevent incident from reoccurring. A report of the findings will be submitted monthly, for two quarters, to the facility Quality Assurance Performance Improvement Committee for further review and recommendations.	9/17/24

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T 099	Continued From page 6 -The visitor log showed only one person had signed in to visit R99 on 7/25/24. The visitor returned the visitor's badge at 2:02 p.m. - CNA3 last saw the resident in a wheelchair between 4:30-5:30 p.m. when CNA3 went into R99's room to pick up a meal tray . There is no mention in the documents of R99 being restrained at this time. - RN1 last saw R99 in bed between 5-5:30 p.m., when R99 received their evening meal tray. There is no mention in the documents of R99 being restrained at this time. -RN3 was notified at approximately 6:30 p.m. that R99 was trying to stand up while restrained to a wheelchair. The evening meal tray was observed on the floor. -There was a change for the worse in the resident's condition at 6:30 p.m., for which hospice was notified. - The resident was resisting the restraint but unable to get out of it. - The facility notes have no information about any visitors other than the one who returned the visitor's badge at 2:02p.m., when R99 transferred from the bed to the wheelchair, or who restrained R99 to the wheelchair. On 9/12/24 from 8:58 a.m.- 9:40 a.m., interviews were completed with a surveyor and the DON. During the interview: -The Unit Manager denied investigating the incident. She stated RN3 had texted her at 6:41 p.m. to inform her that R99 was found "in the chair tied with the sheet behind it and like a double knot, that they had let [him/her] out". The UM notified the prior IDON and from there the Director of Clinical and Quality Assurance and the prior IDON took control of the incident. -The Director of Clinical and Quality Assurance denied investigating this incident.	T 099		

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T 099	Continued From page 7 -The IDON at the time of the incident joined the interview by phone and confirmed that she had not spoken with the family or fully investigated this incident. -The Interim Administrator at the time of the incident joined the interview by phone and confirmed she had not spoken with the family or full investigated this incident. - The resident had a Brief Interview for Mental Status (BIMS) which indicated severe cognitive impairment; and was thus unable to be interviewed at the time of the incident. The resident died on 7/26/24 and was not available to be interviewed by surveyors. On 9/12/24 at 9:40 a.m., in an interview with the DON, a surveyor confirmed that the facility failed to fully investigate this incident, and at the time it was still unknown who had restrained R99 to the wheelchair. A surveyor requested the Incident Policy, and the DON provided the "Accidents/Incidents Involving Residents" policy dated 7/1/2021 which requires "each incident or accident must be detailed in the medical record of the resident," and "each incident, accident, or medication error must be investigated immediately for determination of root cause." Review of the facility Incident Report #1944 dated 7/25/24 and timed as having been written at 8:38 p.m., states " [6:30 p.m.]- [Certified Nursing Assistants] called nurse into [patient's] room where [he/she] was found restrained to [his/her] wheelchair by wrapping a bedsheet around [his/her] waist and the wheelchair ending with a double knot. Resident unable to give Description ." There was no documentation in the medical record to indicated this incident occurred or was	T 099		

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T 099	Continued From page 8 fully investigated.	T 099		
T 222	9.A.4. Minimum Staffing Rules The nursing staff-to-resident ratio is the number of nursing staff to the number of occupied beds. Nursing assistants in training shall not be counted in the ratios. The minimum nursing staff-to-resident ratio shall not be less than the following: a. On the day shift, one direct-care provider for every 5 residents; b. On the evening shift, one direct-care provider for every 10 residents; and c. On the night shift, one direct-care provider for every 15 residents The definition of direct care providers and direct care is found in Chapter 1 of these Regulations. This Regulation is not met as evidenced by: Based on review of the staffing schedules, daily resident census, and interview, the facility failed to ensure staffing minimums were met in accordance with the "State of Maine Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities," Chapter 9.A.4.A., 5 days out of 35 days reviewed for minimum staffing (7/22/24, 7/26/24, 8/29/24,	T 222	The facility will continue to schedule direct care staff to meet the care needs of the residents. This includes meeting the State of Maine minimums (day shift 1:5) evening shift (1:10) and Night (1:15) The days that staff call out, on-call nursing management staff will be available to cover direct care staff shifts to meet the need of the facility while meeting the staff to resident ratios outlined for the state of Maine minimum staffing requirements. The facility will also utilize non-nursing managerial staff to assist in tasks, that are within their scope of practice, to adjunct the needs of residents. The facility secures sufficient staffing with the appropriate competencies and skill 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. The minimum nursing staff to resident ratio shall not be less than the following:	11/5/2024

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T 222	Continued From page 9 8/31/24, and 9/4/24). Findings: The "State of Maine Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities," Chapter 9.A.4.A., indicates the minimum nursing staff-to-resident ratio shall not be less than one direct care provider for every 5 residents on the day shift; not be less than one direct care provider for every 10 residents on the evening shift, and not be less than one direct care provider for every 15 residents on the night shift. "Direct Care" means hands-on care provided to residents, including, but not limited to feeding, bathing, toileting, dressing, lifting, moving residents, treatments, and medication administration per the definition in Chapter 1 of the regulations. 1. On 722/24, the facility had a census of 92 residents which required no less than 19 direct care staff to be on duty. The facility's schedule indicated that only 15 direct care staff were working the day shift. 2. On 7/26/24, the facility had a census of 89 residents which required no less than 18 direct care staff to be on duty. The facility's schedule indicated that only 14 direct care staff were working on the day shift. 3. On 8/29/24, the facility had a census of 94 residents which required no less than 19 direct care staff to be on duty. The facility's schedule indicated that only 16 direct care staff were working the day shift. 4. On 8/31/24, the facility had a census of 95	T 222	On day shift, 1 direct care provider for every 5 residents, 1 direct care provider for every 10 residents, and 1 direct care provider for every 15 residents. There will be 1 nursing staff on call each day to assist with any call outs that may occur and staff may be mandated from the prior shift to ensure staffing meets the minimum requirement. In extraordinary circumstances where there's potential for staffing concerns the facility would limit admissions. Facility staff responsible for the scheduling of direct care staff will be re-educated to this process. The Don/designee will audit staffing sheets daily to validate sufficient direct care staff are scheduled to meet the needs of the residents and the State of Maine minimum nursing staff to resident ratios	11/5/2024

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T 222	Continued From page 10 residents which required no less than 19 direct care staff to be on duty. The facility's schedule indicated that only 17 direct care staff were working the day shift. 5. On 9/04/24, the facility had a census of 90 residents which required no less than 18 direct care staff to be on duty. The facility's schedule indicated that only 17 direct care staff were working the day shift. On 9/12/24 at 8:51 a.m., during an interview with the Scheduler and the Director of Nursing, staffing schedules were reviewed with a surveyor. At this time a surveyor confirmed the facility did not meet minimum staffing ratios on 7/22/24, 7/26/24, 8/29/24, 8/31/24, and 9/4/24.	T 222		
T 323	11.A. Physical Restraints The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. "Physical Restraints" are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. "Discipline" is any action taken by the facility for the purpose of punishing or penalizing residents. "Convenience" is any action taken by the facility to control resident behavior or maintain residents with a lesser amount of effort by the facility and not in the residents' best interest.	T 323	Resident #99 is no longer a resident at the facility as of July 26, 2024. 1.The Social Service department interviewed all residents regarding resident rights and physical restraint use. Residents that were not able to be interviewed were observed to ensure no restraints were in use. Any resident identified with restraint use would be evaluated to ensure restraint use policy has been followed, if not in compliance the resident will be evaluated for physical or psychological harm, the facility will complete a reportable incident report, a full investigation completed by September 16, 2024.	9/17/2024

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T 323	Continued From page 11 This Regulation is not met as evidenced by: Based on interviews, policy review and record review, the facility failed to ensure a resident's right to remain free from a physical restraint. (Resident #99 [R99]). Findings: On 7/31/24 at 12:35 p.m., the State of Maine's Division of Licensing and Certification received an anonymous complaint alleging the facility was short staffed and CNAs (Certified Nursing Assistants) were tying residents to chairs. On 9/10/24 at 10:45 a.m., in an interview with a surveyor, the Life Enrichment and Pastoral Care staff member stated, "I have never seen or noticed a resident tied to their chairs, but I think I know what you're talking about. That resident passed away. I can't remember what staff or what resident were involved but they were on Cove [Unit]." The surveyor was directed to ask Registered Nurse #1 (RN1). On 9/10/24 at 11:15 a.m., in an interview with the surveyor, RN1 stated she did not remember who the resident was or when the incident happened, but did remember she last saw the resident in bed around 5:00p.m.-5:30p.m., at which time the resident had visitors who were preparing to leave. RN1 stated she remembers the prior Interim Director of Nursing (IDON) asked about the resident being tied to a wheel chair in the days following the incident, RN1 told the prior IDON that she believed the family had restrained the resident. On 9/10/24 at 12:47 p.m., in an interview with a	T 323	2. The resident interviews and observations of residents was completed on September 13, 2024, residents reported understanding of their resident rights, and none reported being restrained, residents who were not able to be interviewed were observed to be restraint free. 3.The Director of Clinical Services and/or designee will conduct two interviews and two observations of residents, including new admissions, that are not able to be interviewed, weekly alternating 6a-2p, 2p-10p and 10p-6a times four weeks, then monthly times eight weeks. A report of findings will be submitted to the Quality Assurance Performance Improvement Committee for further review and recommendations. 4.The Director of Clinical Services and /or designee provided re-education to staff regarding resident rights, abuse, restraint use and incident reporting. Initiated on September 13, 2024, and completed on September 17, 2024. It is facility policy that all staff receive education regarding resident rights, abuse, restraint use, and incident reporting on hire and annually. Administrator and/or designee will conduct weekly audits times four weeks, monthly times eight weeks to ensure compliance. Results will be reviewed QAPI committee for further recommendations	9/17/2024

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T 323	Continued From page 12 surveyor, the Certified Nursing Assistant -Medications #2 (CNA-M2) stated that she was aware of the possibility of someone having been tied to the bed or chair, and that CNA3 had been placed on administrative leave because of that, but that CNA3 returned quickly, and heard it was the family that had restrained the resident. On 9/12/24 at 8:52 a.m., in an interview the Director of Nursing (DON) stated she knows of the incident but was not here at the time. The DON provided the surveyor with a folder containing partial notes that appeared as a timeline . The notes did not indicate who wrote them or when, but did include a copy of the visitor log on the day of the incident, and 2 witness statements from facility employees CNA6 and CNA7 both dated 7/25/24. According to CNA6's witness statement dated "July 25th, 2024", at approximately 6:30 p.m., CNA6 and CNA7 found R99 "sitting in [his/her] wheelchair attempting to get out of it. This was due to a sheet wrapped around [his/her] waist, we witnessed that it was double knotted in the back of [his/her] wheelchair ... The sheet seemed to act as a restraint due to the fact [he/she] couldn't get out of [his/her] wheelchair." According to CNA7's witness statement dated "7-25-24", at approximately 6:30 p.m., CNA7 and CNA6 "found [R99] in [his/her] wheelchair trying to stand up but couldn't because there was a sheet tied around her waist then double knotted to the back of [his/her] wheelchair ... the sheet seemed to act as a restraint." On 9/12/24 at 9:40 a.m., a surveyor confirmed with the DON that a physical restraint was used to confine R99 to a wheelchair without a physician's	T 323		

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T 323	Continued From page 13 order, evaluation/assessment, monitoring or informed consent, and the clinical record lacked documentation regarding the medical need for a physical restraint. On 9/12/24 at 2:22 p.m., in an interview, CNA3 stated R99 was known for getting out of his/her wheelchair and walking from his/her room to the nurse station. CNA3 stated she last saw R99 in bed around 5:30 p.m., there were no visitors in the room at that time. CNA3 stated she was investigated for a day or two but was told it wasn't her fault. The facility's "Restraint Use" policy, dated 6/24/2014, states "the resident has the right to be kept from any chemical/physical restraint imposed for discipline or convenience and not requested to treat his/her medical condition." For residents requiring some level of physical restraint use the following documentation must be in place: -Medical reason or use and type of device with a signed physician order. PRN (as needed) orders are not acceptable. -Documentation indicating the assessment of risk, the interdisciplinary process that determined the least restrictive device, and plan of care for the restrictive device. -Documentation must reflect either the MDS (Minimum Data Set)/Triggers CAA's (Care Area Assessments), continued assessment of the need for, or the medical improvement of the resident that may support a reduction in the means of restraint. -A daily documentation tool indicating the release of the restraint every 2 hours for a minimum of 15 minutes and the type of activity in which the resident participates to enhance mobility. -The resident and/or representative will be	T 323		

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T 323	Continued From page 14 informed of risk and benefits and possible negative outcomes and a written consent for use will be obtained. -The consent must be signed by a competent resident, responsible party, or legal representative. -The resident / responsible party has the right to refuse a restraint. The medical record had no such documentation.	T 323		
T 480	18.D.6. Menus The current menu plan shall be posted conspicuously and be readable by personnel, residents and dietetic services staff. This Regulation is not met as evidenced by: Based on observations and interviews, the facility failed to have the current menu plan posted and readable for personnel, resident's and dietetic services staff on 5 of 5 Units (Harbor, Cove, Memory Care, Blueberry Hill, and Cranberry Island) for 3 of 5 days of survey (9/9/24, 9/10/24, and 9/11/24). Findings: On 9/09/24 at 11:50 a.m., in an interview with a surveyor, Resident #47 (R47) stated, "We don't get menus, so we don't get to choose any more. We just get to know what the main meal is. We don't know in advance." On 9/09/24 at 12:29 p.m., a surveyor observation by the nurse station on the Mountain Top Unit revealed menus were not posted on the labeled menu board or anywhere else on the unit.	T 480	Weekly menus will be posted in an area that is visible and in a print that is large enough for residents to be able to easily read The Food Service Director and/or designee will provide training to staff regarding the posting of weekly menus in an area that is visible and in a print that is large enough for residents to be able to easily read The Food Service Director and/or designee will conduct weekly audits for one (1) month and then random, monthly audit for two (2) months to ensure that the weekly menus are posted in an area visible and in a print that is large enough for residents to be able to read. The results will be reported to the facility's QAPI Committee for review and further recommendation	11/5/2024

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T 480	Continued From page 15 On 9/09/24 at 12:47 p.m., in an interview with a surveyor, Registered Nurse #2 (RN2) states, "I think the kitchen is responsible for menus. I have to call down a million times to request them and they will only send up one or two. It's been a problem." On 9/09/24, 9/10/24, and 9/11/24 from 11:30 a.m. to 12:00 p.m., a surveyor observed no menus posted on all 5 units. On 9/10/24 at 11:40 a.m. in an interview with a surveyor, a family member of R16 states, "My [loved one] never gets a menu for his/her room and that they themself have never seen a menu posted in the dining room or anywhere in the facility." On 9/10/24 at 11:45 a.m., in an interview with a surveyor, Certified Nursing Assistant #1 (CNA1) states, "The CNA's will give a menu to the Resident's at the beginning of the month, they will choose their meals and give the menus back. The menus used to be posted at the facility and given to the Resident's but that doesn't seem to happen anymore." On 9/11/24 at 8:10 a.m., in an interview with a surveyor, Certified Nursing Assistant-Medications (CNA-M1) states, "Resident's get to view the menu for the week on Thursdays and decide what they want and then the menus go back to the kitchen. The Resident's do not get a copy of the weekly menus for themselves and don't get a monthly menu for their rooms. It has been a very long time since any menu has been posted here in the dining room." On 9/11/24 at 8:15 a.m., in an interview with a	T 480		

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T 480	Continued From page 16 surveyor while on Harbor Unit, the Interim Food Service Director confirmed that the menus were not posted for the staff and Resident's or for anyone to see on any of the Units. He states that he was under the impression that the resident's got a monthly menu and that the weekly menus were posted on all the Units. Review of the Facility's Resident Council minute meetings reveal the following: 8/6/24 at 2:00 p.m. - The majority states: 1. they are still not getting menus choose alternate dishes. Would like to see a variety of meals and not just sandwiches. 2. Meals are still being served cold. 7/9/24 - [Resident] had mentioned, [he/she] has not been receiving menus to fill out and receiving cold meals daily. Majority states not given menus weekly, not offered, no menus to fill out. Majority states portions are too small a lot of the time. On 9/11/24 at 8:30 a.m., in an interview, the surveyor discussed the findings with the Administrator.	T 480		