STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205060	A. BUILDING _____ B. WING _____	C 09/03/2024

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CEDAR RIDGE CENTER	23 CEDAR RIDGE DRIVE SKOWHEGAN, ME 04976

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F 000	INITIAL COMMENTS On 9/3/24, unannounced on-site visit were conducted at Cedar Ridge Center for the purpose of investigating complaints #ME00048451, #ME00048539, #ME00048576, #ME00048615 and #ME00048644. It was determined that Cedar Ridge Center was not in substantial compliance with 42 CFR Part 483, Subpart B - Requirements for Long Term Care Facilities.	F 000	Please note the filing of this plan of correction does not constitute an admission of the allegations set forth in the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws.	
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	F 580	The event happened in the past and cannot be corrected. A facility-wide audit of falls within the past 30 days was conducted to review if provider and/or resident representative was notified. The facility ensures that both a provider and resident representative are notified at the time of change in condition, which is inclusive of falls. Licensed staff will be re-educated to this process. DON/Designee will conduct audits weekly x 4, then monthly x 2 to ensure all falls are inclusive of timely notification to both a provider and the resident's representative. Results of these audits will be brought to the monthly QAA Committee for further review and recommendations. Re-education: Fall Management policy: all nurses	10/18/2024

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

Nina Hume | CEO | 9/26/24

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 580	Continued From page 1 resident and the resident representative, if any, 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 the facility's "Falls Management" policy, interviews and record review the facility failed to ensure that a resident's physician and/or representative were notified immediately of an unwitnessed fall and failed to follow its own policy and procedure for unwitnessed falls for 1 of 9 residents reviewed for falls. (#1) Findings: Cedar Ridge's "Falls Management" Policy and Procedure, revised 3/15/24 states under, 5. Post-Fall Management: 5.1 Evaluate the patient for injury. 5.1.1 First aid will be provided for minor cuts and abrasions.	F 580		

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F 580	Continued From page 2 5.2 Notify the physician / advanced practice provider (APP) of the fall, report physical findings and extent of injuries, and obtain orders if indicated. 5.2.1 If the injury is of an emergent nature, the patient will be transported to the hospital. 5.2.2 If the extent of injuries cannot be determined, the nurse will notify emergency medical services (EMS) for evaluation and transport to the hospital. 5.4 The patients representative will be notified of the fall and any follow up treatment needed. On 9/3/24 at 3:35 p.m., in an interview, Resident #1's [representative] stated that on 8/30/24, [Resident #1] had a fall and they did not notify [representative]. When [representative] came in the next day at approximately 1:30 p.m. which was 8/31/24, a Certified Nurses Aide (CNA) told [representative] about [representative][Resident #1] falling the day before. The [representative]wanted [Resident #1] shipped to the hospital immediately. The facility shipped him/her and found out from the hospital he/she had a fractured leg. Review of Resident #1's medical record indicated a nurses note dated 8/31/24 at 4:16 p.m. stated, "CNA and [Resident #1's] [family member] came to this nurse stating res had fallen out of bed last night, and CNA reported to charge nurse on duty ..... Left knee is slightly swollen, painful to touch. Resident unable to use pain scale appropriately. Facial grimacing and protective body movements observed. Light range of motion (ROM) was completed on left ankle, no pain noted. Pain appears to be on left knee radiating to left hip only. Neurological assessment completed, no abnormal findings. Scheduled and PRN pain	F 580		

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F 580	Continued From page 3 medication given prior to [family member] coming in. [family member] requested resident be transported to [hospital] for x-ray/evaluation of left knee and hip. This nurse called 911, res was transported to [hospital] via [ambulance]. His/her [family member]went with him/her. On call provider notified of situation, received order for transport ... . On call nurse manager notified of situation ....". Additionally, Resident #1's medical record lacked evidence that the physician and/or resident representative were notified on 8/30/24 of the resident fall. On 9/3/24 at 3:55 p.m., in an interview, the Director of Nursing (DON) told a surveyor that her understanding was that the resident fell out of bed on 8/30/24 sometime in the late afternoon or early evening and the [resident representative], who is the Power of Attorney (POA), was not notified until 8/31/24 when he/she was told by a CNA about the fall. The DON stated a CNA did not tell the nurse on 8/30/24 until about 9:00 p.m. or 10:00 p.m. in the evening about the resident fall. The DON stated she is not sure why a nurse did not call and notify the physician and the resident's POA. The [resident representative] stated [Resident #1] was obviously in pain and [resident representative] wanted him/her shipped out to the hospital. It was found out at the hospital he/she had a fracture of his/her lower left leg. At this time, the DON confirmed that the resident's physician and [resident representative] were not notified of the fall on 8/30/24 and that the [resident representative] had to find out from a staff member on 8/31/24 and that is when an order from an on call physician was received to transport the resident to a hospital for evaluation.	F 580		
F 655 SS=D	Baseline Care Plan	**F 655**	The event occurred in the past and cannot be corrected.	10/18/2024

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F 655	Continued From page 4 CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and	F 655	-cont- Resident #7 was discharged on 8/16/2024. A facility-wide audit was conducted on all admissions from last 14 days to ensure baseline care plans were completed within 48 hours of admission. The facility ensures the center must develop and implement a baseline person-centered care plan within 48 hours of admission/readmission for each patient/ resident (hereinafter "patient") that includes the instructions needed to provide effective and person-centered care that meet professional standards of quality care. Licensed staff will be re-educated to this process. DON/Designee will conduct audits weekly x 4 weeks, then monthly x 2 to ensure baseline care plans are completed within 48 hours of admission that are complete, person-centered, and include instructions needed to provided effective care. Results of these audits will be brought to the monthly QAA Committee for further review and recommendations. Re-education: OPS416: all nurses	

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F 655	Continued From page 5 dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours that included the instructions needed to provide minimum healthcare information necessary to properly care for 1 of 9 residents reviewed. (#7) Finding: 1. Resident #7 was admitted to the facility 8/5/24 with diagnosis of cardiovascular accident with left side hemiparesis requiring anticoagulant treatment, dysarthria with modified diet texture, thrombocytopenia, depression, anxiety with ordered antianxiety medications and neurogenic bladder with indwelling supra-pubic catheter. On 9/3/24 resident #7's clinical record was reviewed and revealed that it lacked evidence of a base line care plan that included the instructions necessary to properly care for Resident #7's immediate health and safety needs for the use of an anticoagulant and antianxiety. In addition, a care plan for Activities of Daily Living, impaired swallowing, cognitive loss, chronic pain, indwelling supra- pubic catheter and risk of falls were not initiated until 8/13/24, eight days after admission. On 9/3/24 at 2:25 p.m., during interview with interim Director of Nursing the above was	F 655		

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F 655	Continued From page 6 confirmed.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	**F 656**	The event occurred in the past and cannot be corrected. Resident #7 was discharged on 8/16/2024. A facility-wide audit was conducted to ensure all care plans' code status and transfer status are correct. A facility-wide observation audit was conducted to ensure residents are being transferred correctly and per the care plan. The facility ensures that comprehensive care plans are created to promote positive communication between patient, patient representative, and team to obtain the patient's and resident representative input into the plan of care, ensure effective communication, and optimize clinical outcomes. This is inclusive of accurate code status and following the care plan to mitigate poor outcomes, like falls. Licensed staff will be re-educated to this process. DON/Designee will conduct weekly audits x 4, then monthly audits x 2 to ensure care plan code status are accurate and that resident transfers are being conducted as care planned. Results of these audits will be brought to the monthly QAA Committee for review and further recommendations. Re-education: OPS416: nurses	10/18/2024

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F 656	Continued From page 7 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 interviews, the facility failed to ensure that a care plan was followed for a 2 assist transfer for 1 of 4 sampled residents requiring a mechanical device use for a transfer and failed to ensure the care plan was accurate to reflect the residents advanced directive code status. (Resident #7) Findings: 1. On 8/30/24 at 9:24 a.m. during an interview with Resident #7's representative, [he/she] stated Resident #7 fell on 8/7/24 due to only one staff assisting (him/her) during a transfer when there should have been 2 staff. Review of Resident #7's medical record contained an e-Interact note dated 8/7/24 stating, "The resident in [room] had a fall today. The CNA (Certified Nurses Aide) was helping the resident to transfer to the commode. While standing pivoting to the commode, (he/she) lost (his/her) balance. And The CNA tried to catch the resident but the resident was moving too fast and ended up on the floor. The Nurse went to [room] and saw the resident was on the floor and the CNA tried to help and comfort at that moment."	F 656		

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F 656	Continued From page 8 Resident #7's care plan dated 8/5/24 states, "[Resident] requires assistance for mobility related to: deconditioning r/t recent hospitalization" ...Intervention: "Provide [Resident] with sit to stand Med size total assist two assistance transfer ..." 2. Review of Resident #7's medical record contained the hospital history and physical dated 7/31/24 stating, "[Resident] is a Do not resuscitate (DNR)." The hospital discharge summary dated 8/5/24 states, "Code Status: Allow Natural Death, DNR" and the "Treatment Directives" signed by the physician on 8/5/24 states the resident is a "Do not resuscitate (DNR)." Review Resident #7's care plan initiated on 8/6/24 states, "[Resident] has an established advanced directive code status: Full Code." On 9/3/24 at 2:25 p.m., during interview, the interim Director of Nursing confirmed the CNA did not follow the plan of care which resulted in the residents fall and confirmed the plan of care was not accurate in the area of advanced directives.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 657	The event happened in the past and cannot be corrected. Resident #1 is no longer on precautions as Covid infection has resolved. A facility-wide audit was conducted to ensure any resident on transmission based precautions has this included in their care plan. The facility ensures that care plans are reviewed and revised by the interdisciplinary team after each	10/18/2024

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F 657	Continued From page 9 (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 interview, observation and record review, the facility failed to revise the care plan to reflect a resident's current status for 1 of 2 residents reviewed for infection prevention and control (#1). Findings: On 9/3/24, review of Resident #1's electronic medical record, on the front page stated, "Infection Prevention and Control Covid 19(Coronavirus) Onset Date 8/24/2024 Infection Status Confirmed (D) Isolation Precautions Airborne, Contact Isolation Start Date 8/24/2024 - Expected End Date 9/4/2024 PPE Requirements - Gloves, Gown, N95 Respirator, Eye Protection (Face Shield or Goggles)	F 657	-cont- assessment, and as needed to reflect the response to care and changing needs and goals of the resident, inclusive of changes in transmission based precautions. Licensed nurses will be re-educated to this process. DON/Designee will conduct audits weekly x 4, then monthly x 2 to ensure changes in transmission based precautions are being updated in the care plan. Results of these audits will be brought to the monthly QAA meeting for review and further recommendations. Re-education: OPS416: nurses	

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F 657	Continued From page 10 On 9/3/24 at 9:00 a.m., a surveyor observed signage on the Resident #1's room door which stated Airborne and contact precautions N95 mask, a gown, a face shield, and gloves. There was a wheeled cart outside the residence door with personal protective equipment in it. Review of Resident #1's current care plan lacked evidence of updating and revised to reflect the current status of the resident. On 9/3/24 at 10:20 a.m., in an interview, the Director of Nursing confirmed that Resident #1's current care plan lacked evidence of updating and revision to include COVID to reflect the current status of the resident.	F 657		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on facility policy, observations, record reviews, and interviews, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to oxygen and nebulizer use for 2 of 2 residents reviewed for respiratory care. (Resident #4 and #6) Findings:	**F 695**	Resident #4's nebulizer equipment was removed from the room on as there is no longer an order for nebulized medication. Resident #6's oxygen concentrator filter was cleaned. A facility-wide audit was conducted to validate that all residents utilizing a nebulizer have a bag to place tubing/ mouthpiece equipment in when not in use as well all oxygen concentrator filters have been cleaned. The facility ensures residents with nebulizers have bags to place mouthpiece equipment and tubing in when not in use. The facility ensures that oxygen concentrator filters are cleaned weekly. Nursing staff will be re-educated to this process.	10/18/2024

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F 695	Continued From page 11 The facilities procedure on "Nebulizer: Small Volume" last revised on 11/1/2023, section 21 states to "rinse small volume nebulizer, mouthpiece, and "T" piece with sterile water and dry". In subsection 21.1 the procedure states to "place in treatment bag labeled with patient name and date". Subsection 21.2 the procedure then states to "replace and date the setup daily, if used". The facilities "Oxygen Nasal Cannula" procedure dated 8/7/23 instructs nursing to, "replace disposable set-up every seven days. Date and store cannula in treatment bag when not in use." 1. On 9/4/2024 at 9:00 a.m., observation of Resident #4's unlabeled nebulizer tubing and mouthpiece stored on bedside table with other personal belongings. No treatment bag was observed in the resident's room. Review of Resident #4's medical record, the last documented nebulizer treatment was administered on 8/30/24. In addition, the medical record lacked evidence of a provider's order to change nebulizer tubing or when the nebulizer tubing was last changed. 2. On 9/3/24 at 9:08 a.m. and 11:06 a.m., observation of Resident #6 with Oxygen (O2) nasal cannula tubing labeled with a date of 8/25/24, the oxygen concentrator filter was coated with thick layer of dust. On 9/3/24 at 12:07 p.m., both the surveyor and Registered Nurse (RN) #2 observed Resident #6's O2 tubing dated 8/25/24 with the filter coated with dust. At this time, the RN stated the tubing	F 695	-cont- DON/Designee will conduct audits weekly x 4, then monthly x 2 to ensure nebulizers have a bag to put tubing and mouthpieces in when not in use, and that oxygen concentrator filters are cleaned weekly. Results of these audits will be brought to the monthly QAA Committee for further review and recommendations.	

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F 695	Continued From page 12 should have been changed and the filter cleaned weekly on Sunday nights. On 9/3/24 at 12:45 p.m., during an interview, the Director of Nursing confirmed the above.	F 695		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on facility policy review, interview and record review the facility failed to ensure that a resident's drug regimen was free from unnecessary drugs by administering excessive doses of Ativan in less than 7 hours and failed to monitor of psychotropic medication side effects	**F 757**	Resident #7's Ativan dosing was clarified and updated during resident's stay in facility. An order for monitoring of psychotropic medication side effects was added to the plan of care. A facility-wide audit was conducted to ensure PRN psychotropic medications have specific time parameters for administration as well as monitoring for side effects. The facility ensures that residents on psychotropic medications are monitored for side effects and will have appropriate time parameters for medication administration. Licensed staff will be re-educated to this process. DON/Designee will conduct weekly audits x 4, then monthly audits x 2 to ensure all residents with psychotropic medications are monitored for side effects and PRN administration has specific time parameters. Results of these audits will be brought to the QAA Committee for further review and recommendations. Re-education: psychotropic med policy from PharMerica	10/18/2024

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F 757	Continued From page 13 for 1 of 9 sampled residents (#7). Findings: The facility's policy, Behaviors: Management of Symptoms, revised on 7/1/24 states, "Staff will use non-pharmacological interventions as the first line of approach to managing challenging behaviors. The facility's policy, "Medication Monitoring" dated 1/24 under "Guidelines For Psychotropic Medication Monitoring" states, "When monitoring a resident receiving psychotropic medications, the facility must evaluate the effectiveness of the medications as well as look for potential adverse consequences" and under section "Chemical Restraints" states, "When any medication restricts the resident's movement or cognition, or sedates or subdues the resident, and is not an accepted standard of practices for a resident's medical or psychiatric condition, the medication may be a chemical restraint." On 8/30/24 at 9:24 a.m., during a telephone interview, Resident #7's [representative] stated when [he/she] had visited [Resident #7] on 8/13/24, [he/she] had concerns about [his/her] parent status, and noticed [his/her] parent was "out of it, [Resident #7] was not making any sense" and "[Resident #7] couldn't open his/her eyes". Resident #7s respresentative then stated [he/she] was told by the nurse they were giving (Resident #7) Ativan overnight, but they gave (him/her) too much, stating "they snowed (him/her)" and "they gave (him/her) 3 mg Ativan overnight to basically make (him/her) sleep." Resident #7 was admitted to the facility on 8/5/24	F 757		

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F 757	Continued From page 14 with diagnosis of cardiovascular accident (CVA) with left side hemiparesis (L Hemi), depression and anxiety. Review of resident #7's medical record contained a Providers Admission History and Physical dated 8/6/24 under "Assessment Plan" stated, Hx CVA: w/L Hemi, dysarthria, spastic bladder. Continue with ASA, Plavix and Statin therapy. Supportive care and monitor", and Anxiety: (He/she) admitted with Ativan TID (three times daily) PRN (as Necessary)." Physician order dated 8/5/24 for Lorazepam (Ativan) oral tablet 1 milligram (mg), give 1mg by mouth as needed for anxiety x3 daily PRN. The Medication Administration Record for August 2024 showed, Resident #7 received 3 mg of Ativan within 7 hours. On 8/12/24 he/she received Ativan 1mg at 8:00 p.m. another 1mg at 10:27 p.m., then the 3rd mg at 3:00 a.m., on 8/13/24. The medical record lacked evidence of behavioral symptoms warranting the PRN or non-pharmacological interventions attempted prior to the 8:00 p.m., dose. The medical record also lacked documentation of non-pharmacological interventions attempted prior to the resident receiving the second dose at 10:27 p.m., or the third dose at 3:00 a.m. Further review of Resident #7's clinical record, the medical record lacked evidence of monitoring for potential adverse consequences for the use of Ativan. A providers note dated 8/13/24 under "Assessment Plan" stated, "Anxiety: Patient currently with Ativan 1 milligram three times daily as needed. Nursing notes that they used all three doses in a short time. Family left concerns with nursing staff about decreasing overall dosing of	F 757		

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F 757	Continued From page 15 Ativan. In discussion with nursing on day shift will change Ativan to 1 milligram scheduled at bedtime and half a milligram every eight hours as needed for severe anxiety." On 9/3/24 at 2:25 p.m., during an interview, the Interim Director of Nursing (DON) reviewed the Ativan administration times and documentation stating, nursing expectation for an order for 3x daily should be every 8 hours. On 9/5/24 at 1:25 p.m., during an interview, the PharMerica pharmacists (pharmacy utilized at the facility) stated if an order is written to administer a medication 3x daily or TID (three times daily), it's the expectation or standard of every 8 hours, it's the expected practice.	F 757		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	**F 842**	Resident #6's oxygen tubing was labeled and filter was cleaned on 9/3/2024. A facility wide audit was conducted to ensure oxygen tubing sticker dates aligned with the date of the change in the TAR and that filters were cleaned as indicated in the TAR. The facility ensures documentation of nursing care is recorded in the medical record and is reflective of the care provided by nursing staff. The patient's record specifies what nursing interventions were performed by whom, when, and where. Licensed staff will be re-educated to this process.	10/18/2024

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F 842	Continued From page 16 (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided;	**F 842**	-cont- DON/Designee will conduct weekly audits x 4, then monthly audits x 2 to ensure oxygen concentrator filters are cleaned and oxygen tubing is dated the same day it was signed off as being completed in the TAR. Results of these audits will be brought to the monthly QAA Committee for review and further recommendations. Re-education: NSG113: nurses	

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F 842	Continued From page 17 (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and observation, the facility failed to ensure the Treatment Administration Record (TAR) was accurately documented for changing of oxygen tubing for 1 of 2 residents reviewed for oxygen use (#6). Finding: On 9/3/24 at 9:08 a.m., and at 11:06 a.m., a surveyor observed Resident #6 using Oxygen (O2), via nasal cannula with the tubing dated for Sunday 8/25/24 and the filter located on the back of the concentrator coated with a layer of dust. Review of the residents TAR, nursing documented the oxygen tubing was changed and the filter was cleaned on 9/1/24. On 9/3/24 at 12:07 p.m., both the surveyor and the registered Nurse (RN) #2 observed resident #6's O2 tubing dated 8/25/24 and the filter coated with dust. RN #2 stated the tubing should be changed on Sunday nights. On 9/3/24 at 12:12 p.m., during an interview, the above was discussed with the Director of Nursing	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	**F 880**	The event occurred in the past and cannot be corrected.	10/18/2024

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F 880	Continued From page 18 §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 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,	**F 880**	A facility-wide audit was conducted to ensure that any resident that needs to be on precautions has the correct signage and PPE set-up. The facility ensures the prevention of transmission of infectious disease via transmission based precautions when the route(s) of transmission is (are) not completely interrupted using Standard Precautions alone. The type of PPE and precautions used depends on the potential for exposure, route of transmission, and infectious organism/pathogen (or clinical syndrome if an organism is not yet identified). Nursing staff will be re-educated to this process. DON/Designee will conduct audits of PPE donning for those residents on transmission based precautions, weekly x 4 weeks, then monthly x 2 month. Results of these audits will be brought to the monthly QAA Committee for further review and recommendations. Re-education: IC306, plus other precaution policies– with donning/doffing competencies for all CNAs/nurses	

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F 880	Continued From page 19 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 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 record review, interviews and observations the facility failed 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 for 1 of 1 day of survey. Findings: On 9/3/24 at 9:00 a.m., two surveyors observed signage on Resident #1's bedroom door which	F 880		

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F 880	Continued From page 20 stated, contact and airborne precautions. N95 mask, a gown, a face shield, and gloves needed when entering room. There was a wheeled cart outside the resident's door with personal protective equipment in it. On 9/3/24 at 9:10 a.m., in an interview, when asked by a surveyor what precautions were needed to enter Resident #1's room, the Registered Nurse (RN #1) stated that resident #1 is on contact and airborne precautions and a N95 mask, a gown, a face shield, and gloves were needed. On 9/3/24 at 9:13 a.m., two surveyors observed two Certified Nursing Assistants (CNA #2 and CNA #3) go in to Resident #1's room, without donning a N95 mask, a gown, a face shield and gloves. When exiting the room, both CNA #2 and CNA #3 confirmed they did not use required personal protective equipment for Resident #1's room. They stated that they thought the resident was off precautions. At this time, RN #1 confirmed that the two CNAs did not use required personal protective equipment when entering the resident's room and stated the resident was on precautions until 9/4/24. On 9/3/24 at 1:00 p.m., in an interview, a surveyor discussed the infection control findings with the Director of Nursing and the Administrator.	F 880		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced	**F 908**	Resident #1's bed side rail was fixed on 9/3/24. A facility-wide audit was conducted to ensure all bed side rails function properly.	10/18/2024

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F 908	Continued From page 21 by: Based on observation and interviews, the facility failed to ensure that a resident's bed was maintained in good repair and safe operating condition for 2 of 2 observations for 1 of 1 day of survey. (9/3/24) Findings: On 9/3/24 at 3:35 p.m., in an interview with Resident #1's representative [RR], [he/she] stated that the bed rail had been broken for a long time and it was stuck in the up position. Resident #1s representative demonstrated to the surveyor that the side rail would not function properly on the right side of the bed as you're looking at it from the foot of the bed. The surveyor observed [RR] trying to put the railing down and it would not go down as it was stuck in the up position. The [RR] then went around to the other side of the bed and easily put down the left side rail. [RR] stated [RR] had reported this to the nursing staff many times over the past few weeks and no one had done anything about it. On 9/3/24 at 4:20 p.m., in an interview, Certified Nursing Assistant/Medication Tech(CNA/M) told the surveyor that when the ambulance brought Resident #1 back to the facility on 8/31/24 from an evaluation at a hospital emergency room for a fall the resident had on 8/30/24, she nor the ambulance crew could make the right siderail (facing the bed from the foot of the bed) work or function. She stated she does not know how long the side rail had not been working and stuck in the up position. On 9/3/24 at 4:25 p.m., a surveyor observed two maintenance men in Resident #1's room working	F 908	-cont- The facility ensures all medical devices, inclusive of beds, meet its performance specifications or otherwise perform as intended. Staff must report any actual or potential equipment, device or supply malfunction and related incidents to the Risk Management Department. Nursing staff and the maintenance department will be re-educated to this process. NHA/Designee will conduct audits weekly x 4, then monthly x 2 to ensure all equipment audit logs/requests are completed timely. Results of these audits will be brought to the monthly QAA Committee for further review and recommendations. Re-education: maintenance, all CNAs and nurses: SH202	

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F 908	Continued From page 22 on his/her bed side rail for approximately 5 minutes without fixing it. They went around and tried the left side rail and found it to be working properly. They then exited the room and spoke with a surveyor. The surveyor asked if the right side railing was broken and if either maintenance personnel knew how long the railing had been broken. They both stated that it was broken, they did not have a work order on the bed rail and they did not know how long it had been broken. On 9/3/24 at 4:10 p.m., in an interview, the surveyor discussed the finding of the broken bed rail on Resident #1's bed with the Administrator.	F 908		