

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/16/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205063	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/09/2024
NAME OF PROVIDER OR SUPPLIER CLOVER HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 440 MINOT AVE AUBURN, ME 04210		
(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	F 000			
F 550 SS=D	From 2/5/2024 through 2/9/2024, on-site visits were conducted at Clover Health Care to complete the annual Long Term Care Survey Process for Federal Recertification and investigating complaints #ME00045912 & #ME00046316. It was determined that Clover Health Care was not in compliance with 42 CFR Part 483, Subpart B-Requirements for Long Term Care Facilities. Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her	F 550	All Clover residents are treated with respect and dignity. Dining and nursing staff will be re-educated on ensuring appropriate dining service that conveys respect and maintains dignity, including serving all residents seated at a table at the same time. Meal Service will be audited by Dining Services Director or their designee and a social services representative weekly x 4 weeks, every other week x 8 weeks and monthly x 2 months. The Dining Services Director will review the results of the audits at the monthly Quality Assurance Committee Meeting. The QAC committee will make any additional recommendations it deems necessary to ensure compliance.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Christine F. [Signature] *Administrator* *3/5/2024*

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 550	Continued From page 1 rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to promote care for residents in a manner that maintains each resident's dignity and respect when staff failed to serve all residents seated at the same table at the same time for 1 of 4 meals observed (2/5/24 lunch). Findings: On 2/5/24 from 12:04 p.m. through 1:07 p.m., on the Dublin House, two surveyors observed the lunch meal pass. 4 residents were seated at the table near the television area. The first 2 residents at this table were served at 12:22 p.m. and 12:26 p.m. At 1:02 p.m., 36 minutes later, the other 2 residents were served their lunch. During these 36 minutes, surveyors observed staffing serving the additional 4 tables in their entirety, delivering meals to residents who remained in their rooms for lunch and collecting up dirty plates and clearing off tables from the residents who were finished with their lunch.	F 550			

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F 550	Continued From page 2 On 2/9/24 at 11:16 a.m., during an interview with the Director of Clinical Operations the surveyor discussed the above concerns that the residents were not all served at the same time while at the same table and these 2 residents sat watching their tablemates eat for 36 minutes before being served.	F 550			3/25/24
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to make reasonable accommodations to bed side rails and a bed extender for 1 of 1 resident (#449) reviewed for accommodations on 3 of 5 days of survey. Findings: Resident #449 was admitted on 1/25/24 with diagnosis of cervical and lumbar abscess resulting in quadriplegia. On 2/6/24 at 9:07 a.m., observation of Resident #449 in bed with his/her head at the very top of the bed and feet off the end of the bed. At this time, during an interview, Resident #449 stated, "I've been complaining of it since I got here" and "I have no guard rails on this bed, I asked for them the first day I got here."	F 558	Resident #449 had quarter rails added to his bed on 2/7/24 and a bed extender was added to his bed frame on 2/8/24. An audit will be done to verify current residents bed length is appropriate. Any found not to be of appropriate length will be adjusted. Staff will be educated on bed safety and comfort and reporting of resident needs and requests to the appropriate Department Manager for review and action. Audits related to the bed environment will be conducted by the Plant Operations Director and the Director of Nursing or their designees weekly x 4, then monthly x 2 The Plant Operations Director and/or Director of Nursing will review the results of the audits during the		

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F 558	Continued From page 3 On 2/7/24 at 10:13 a.m., observation of Resident #449 lying flat in bed with his/her head at the top of bed and feet just shy of end. On 2/7/24 at 10:15 a.m., during an interview with the Director of Rehabilitation, she stated Resident #449 was evaluated on 1/26/24 for bed mobility which resulted in a request for side rails sent to nursing. Both the surveyor and Rehab Director observed Resident #449 in bed and discussed his/her positioning in the bed. At this time, the Rehab Director stated, the width of the bed is appropriate, but he/she might benefit from a bed extender. Surveyor noted a bed extender behind the residents recliner. Rehab Director confirmed it was a bed extender but smaller in width than what she is used to. On 2/7/24 at 10:19 a.m., surveyor was provided with therapy's request for Resident #449 to have side rails however, the form was not dated. The Rehab Director confirmed the request was submitted on 1/26/24, day of the evaluation and dated the form. At this time, during an interview with the Belfast unit Registered Nurse (RN) Manager, the surveyor asked how long it takes for side rails to be instituted after therapies request. She stated, "usually 3 days at best, I sign it and review with the Director of Nursing, decide of its appropriate ... then it goes to maintenance. It depends on when maintenance puts them on" and "we very rarely refuse side rails". Surveyor discussed the request date was on 1/26/24 and asked why hasn't the request been reviewed or completed? She stated, "I probably looked at it and didn't see a date, my fault, hit the bottom of the pile". On 2/8/24 at 8:47 a.m., observation of Resident	F 558	monthly Quality Assurance Committee Meeting. The QA committee will make any additional recommendations it deems necessary to ensure compliance.		

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F 558	Continued From page 4 #449 in bed now with bilateral side rails in place however, with his/her head was above the top of the bed with feet approx. 6 inches from the end of the bed. At this time, he/she again stated, if he/she wasn't sitting so high up in the bed his/her feet would be on the edge. On 2/8/24 at 8:57 a.m., both the surveyor and the Belfast RN Manager observed resident #449 in bed with his/her head above the top of the bed and feet approx. 6 inches from end of bed. At this time, RN Manager confirmed if he/she wasn't up so high, she could see his/her feet would be at the bottom of the bed. She's not sure if the bed can extend but if it can't she will get another bed.	F 558			3/25/24
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services	F 582	All Clover residents will receive accurate and timely Medicaid/Medicare coverage and liability notices as appropriate. Re-education regarding NOMNC and SNFABN requirements has been provided to the appropriate staff. Social Services, therapy, and nursing staff will communicate daily during morning meeting regarding upcoming changes necessitating NOMNC or SNFABN notice to facilitate timely completion. The Social Service Director or their designee will audit all NOMNC and SNFABN for accurate and timely completion weekly x 4 then monthly x 2		

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F 582	Continued From page 5 available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure the Notice of Medicare Provider Non-Coverage (NOMNC) form was provided at least two days prior to end of Skilled services for 2 of 4 residents whose Medicare Part A Skilled services were discontinued (Residents #66 and #450). In addition, the facility failed to	F 582	Social Services Director will review the results of the audits at the monthly Quality Assurance Committee meeting. The QA committee will make any additional recommendations it deems necessary to ensure compliance.		

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F 582	Continued From page 6 ensure the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) form 10055, which included appeal rights and liability of payment was provided at least two days prior to a resident's last covered day and with the correct date of services ending for 3 of 4 sampled residents (#91, #349 and #450) whose Medicare Part A services were discontinued. Findings: 1. Resident #66's NOMNC indicated that the resident's Medicare Part A services would end on 12/19/23 and was verbally consented by Power of Attorney on the same day. The resident remained living in the facility. 2. Resident #450's NOMNC indicated that the resident's Medicare Part A services would end on 1/23/24 and was verbally consented by Power of Attorney on 1/22/24. In addition, the SNFABN notice that was provided to Resident #450's legal representative had the incorrect date of 2/4/23 for services ending. 3. Resident #91's Medicare Part A coverage for skilled services ended on 1/29/24. The medical record contained a SNFABN notice that was provided to Resident #91's legal representative with the incorrect date of 2/4/23 for services ending. The resident remained living in the facility. 4. Resident #349's Medicare Part A coverage for skilled services ended on 12/11/23. The medical record contained a SNFABN notice that was provided to Resident #349's legal representative with the incorrect date of 2/4/23 for services ending. The resident remained living in the	F 582			

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F 582	Continued From page 7 facility. On 2/8/24 at 2:22 p.m., during an interview, the Licensed Social Worker (LSW) #1 at 12:00 p.m., confirmed the NOMNC were not provided timely and was unsure why the SNFABN notices had the date of 2/4/23. On 2/8/24 at 2:40 p.m., during an interview, the Regional Director of Operations confirmed the SNFABN notices were a template, and the date was not changed to represent when each residents skilled services would end.	F 582			3/25/24
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(I) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.	F 583	Resident #302 was moved to a private room with access to the bathroom on 2/6/24. The Privacy curtain that was missing was replaced. All semi-private resident rooms were audited to verify there are privacy curtains in place. Any curtains found missing were replaced. Staff were re-educated on the use of privacy curtains to maintain resident privacy and the reporting procedures if a curtain is missing or not properly aligned to ensure privacy. Audits of privacy curtains will be conducted by the Director of Nursing or her designee weekly x 4 then monthly x 2 The Director of Nursing will discuss the		

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F 583	Continued From page 8 §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure a resident's privacy during his stay on the Clare Unit. (Resident #303). Finding: On 2/6/2024, observation of Resident #303s room found that there was no bed curtain that separated his/her bed area from the door to the room. The only curtain in the room separated the other resident in the room from him/her. Additionally, the resident can not get his/her wheelchair into the bathroom and the staff does not move the commode out of the bathroom and if the did there would be no way to provide privacy for the resident. On 2/6/2024 at 1:09 p.m. during an interview, Resident #303 stated "There is no privacy. I have been waiting 3-4 weeks to get usable commode. They make me use a bedpan, and it is depressing." On 2/6/2024 at 3:00p.m the Administrator and the	F 583	results of the audits at the monthly Quality Assurance Committee meeting. The QA committee will make any additional recommendations it deems necessary to ensure compliance.		

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F 583	Continued From page 9 Director of Nursing confirmed the above finding.	F 583			3/25/24
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1,	F 584	There is no resident #74 on the resident list provided to Clover by licensing. Resident Rooms # [REDACTED] [REDACTED] privacy curtains were rehung or replaced. Dublin Place An Order has been placed for new upholstered chairs to replace the 3 chairs near rooms [REDACTED] and [REDACTED] and 2 chairs in the common area. The Purple wheelchair's arm rest was not missing but was in the down position so appeared to not have an arm on the left side. Resident #82's wheelchair left armrest has been repaired. Resident room # [REDACTED] was thoroughly cleaned and urine odor resolved. Resident room # [REDACTED] had the bathroom floor cleaned; bed pans were covered, and toiletries were labeled. Resident room # [REDACTED] had both bedpans replaced and covered. The Sit to Stand Lift near room # [REDACTED] was cleaned and the missing hook was replaced. Room # [REDACTED] had the window shade replaced; the heater was repaired; the bedpan was covered, and the soiled plunger was cleaned and covered.		

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F 584	Continued From page 10 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in good repair and in a sanitary condition for 3 of 4 Units (Dublin Place, Clare Place and Galway Place) and the Laundry room. Findings: On 2/9/24, from 10:16 a.m. to 11:05 a.m., a surveyor did an environmental tour with the Maintenance Director, the Administrator, the Director of Nursing and the Regional Director of Clinical Operations in which the following findings were was observed: Dublin Place: > There were 3 chairs near rooms #34 and #35, and 2 chairs in common area near the unit entrance door with torn/ripped cushions. > Resident Room # - The privacy curtain was missing hooks, hanging down and in disrepair. Resident #82's wheelchair had a left armrest that was ripped/ torn. > Resident Room # - The room had a strong odor of urine. > Resident Room # - The privacy curtains were missing hooks, hanging down and in disrepair. The bathroom floor was dirty. There were 2 bedpans hanging on the wall that were uncovered and there were unlabeled toiletries on a shelf. > Resident Room # - There were 2 bed pans	F 584	Room #4's soiled plunger was cleaned and covered. The Whirlpool room had the transition strip to the toilet area replaced; the room was thoroughly cleaned and had all trash removed and odor issues have been resolved. Clare Place (left side) Walls area under hand sanitizers outside rooms # and # have been repaired/repainted; floor under desk in hallway has been cleaned; linen closet untreated wood has been treated; rust has been removed from exit door and window frame and repainted. Walls have been repaired and repainted in room # Resident # had both armrests repaired. Resident #302 wheelchair arm rests have been repaired. Resident room # baseboard heater was cleaned and re-painted. The untreated board in the linen closet was removed. Hallway by room # spare wheelchair was removed from service; soiled wheelchair was cleaned; and Sit to Stand lift was cleaned. Clare Place (right side) Sit to Stand lift was cleaned and re-painted. The exit door and window frame had rust		

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F 584	Continued From page 11 on the floor next to the toilet. > Hallway by room #■■■ - The sit-to-stand resident lift had food and dirt/debris in the foot base area and was missing a safety hook. The purple wheelchair had a missing left armrest. > Resident Room #■■■ - The privacy curtain was missing hooks, hanging down and in disrepair. The window shade was broken. The heater was rusty. The bathroom has an uncovered bed pan hanging behind the toilet. There was a visibly soiled plunger sitting on the floor. > Resident Room #■■■3 - The privacy curtain was missing hooks, hanging down and in disrepair. > Resident Room #■■■ - There was a visibly soiled plunger sitting on the floor. > Resident Room #■■■ - Resident #74's wheelchair had a left armrest that was ripped/torn. The privacy curtains were missing hooks, hanging down and in disrepair. > Whirlpool room -- The floor transition strip to toilet area was missing. The room had a strong odor of urine and feces. There was trash on the floor and full bags of trash stored on a cart. > Resident room #■■■ - The privacy curtain to the bathroom had a dried brown substance on it. Clare Place(left side): > Hallway outside room #■■■-- The wall had chipped/missing paint, exposing sheetrock, under the sanitizer dispenser creating an uncleanable surface. > Hallway outside room #■■■-- The wall had chipped/missing paint, exposing sheetrock, under the sanitizer dispenser creating an uncleanable surface. > The hallway floor, under the desk in the middle of hallway, was heavily soiled with dirt/debris. > Resident Room #■■■- Resident #47's wheelchair had both left and right side armrests	F 584	removed and re-painted. Invacare SX5 wheelchair had both armrests replaced. Resident room #■■■ walls were cleaned and repainted. Galway Place Room #■■■s broken wardrobe drawer was repaired. Sit to Stand lift was cleaned. The whirlpool tub stain was removed. The shower room floor and transition strip were cleaned. Laundry room The cement floor was repainted in the chemical room and behind the washing and machine and dryer. The missing and stained ceiling tiles were replaced. The Administrator, Director of Plant Operations, Housekeeping Supervisor and the Director of Nursing or their designees will complete walking rounds 3x weekly for 4 weeks, then 2x weekly for 4 weeks, then 1x weekly for 4 weeks or until compliance is established, to verify that the environment is safe, clean, comfortable, and homelike without recurrence of the findings in F584. Any additional environmental issue will be addressed promptly. Staff will be re-educated regarding maintaining a safe, clean, homelike environment. Education will include the		

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F 584	Continued From page 12 that were ripped/ torn. > Resident Room # [REDACTED] - The privacy curtains don't give privacy to resident bed 2. Both privacy curtains were missing hooks, hanging down and in disrepair. The baseboard heater was marred with black marks and had chipped/missing paint. Resident #302's wheelchair had a right side armrest that was ripped/ torn. > The linen closet had an untreated wood board secured to the floor behind the linen cart. > Hallway by room # [REDACTED] - There was an electric wheelchair that had a ripped/torn left armrest. There was a wheelchair that was heavily soiled with food and dirt. The sit-to-stand resident lift had food and dirt/debris in the foot base area. Clare Place(right side): > The sit-to-stand resident lift had food and dirt/debris in the foot base area. Additionally, there was missing/chipped paint creating an uncleanable surface. > The exit door and window frame were rusty and had chipped/missing paint creating an uncleanable surface. > The black Invacare tracer SX5 wheelchair, by the exit door, had both left and right armrests that were ripped/torn. > Resident Room # [REDACTED] -- The room walls were marred and had missing/chipped paint. The privacy curtains were missing hooks, hanging down and in disrepair. >Resident Room # [REDACTED] -- The privacy curtains were missing hooks, hanging down and in disrepair. Galway Place > Resident Room # [REDACTED] -- The privacy curtain was missing hooks, hanging down and in disrepair. > Resident Room # [REDACTED] - The wardrobe bottom drawer was missing the front face and broken.		F 584 process for initiating a work order for any repairs needed. The Administrator will review the results of the audits during the monthly Quality Assurance Committee meeting. The QA committee will make any additional recommendations it deems necessary to ensure compliance.		

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F 584	Continued From page 13 > Resident Room # [REDACTED] - There was a brown substance dried on the curtain to the resident's bathroom. > The sit-to-stand resident lift had food and dirt/debris in the foot base area. > The whirlpool tub had a large brownish stain inside the bathing area. > The shower had blackish and brownish build up around the floor edges and along the transition strip. Laundry Room: > The cement floor had chipped/missing paint in the chemical room and behind 1 washing machine and behind the dryers creating uncleanable surfaces. > There were 13 missing ceiling tiles and 5 ceiling tiles stained with brownish stains. On 2/9/24 at 11:05 a.m., in an interview, the Maintenance Director, the Administrator, the Director of Nursing and the Regional Director of Clinical Operations confirmed the findings.	F 584			
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610	Clover ensures allegations are investigated and reported timely. Licensed nursing staff were re-educated regarding timeframes for reporting a suspicion of drug diversion and elements of conducting a thorough investigation. Incidents requiring investigation will be discussed in the daily weekday morning meeting to include verifying reporting time frames are met, the current status of the investigation, items still outstanding and		3/25/24

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F 610	Continued From page 14 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based in interviews, record review and facility policy review, the facility failed to thoroughly investigate an allegation of medication diversion for 1 of 1 misappropriation of medication allegation investigated. Findings: A review of the facility's "Management of Controlled Substances Policy revision" effective date: 3/3/23, under Policy states, The facility will manage controlled substances in a manner to prevent drug diversion and maintain safety. Section: 5.11 states, "The facility Administrator or Director of Nursing Services shall be notified by the designated supervisor immediately upon suspicion of drug diversion. Division of Licensing and Regulatory Services (DLRS) and the Attorney General's office will be notified within 72 hours ... An internal investigation will be conducted. Staff interviews will be conducted ... A written report will be submitted to DLS within five business days. On 2/1/24 the Division of Licensing & Certification received a faxed Reportable Incident Form, dated 2/1/24 from Clover Health Care indicating that on 1/24/24, two Gabapentin (Schedule V controlled medication) 400 milligram (mg) capsules were missing from the controlled medication count.	F 610	who is responsible for completion. The Administrator will review all investigations prior to submission to the appropriate agencies to verify thoroughness of investigations and discuss the results of all investigations during the monthly Quality Assurance Committee meeting. The QA committee will make any additional recommendations it deems necessary to ensure compliance.		

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F 610	Continued From page 15 During the facility's recertification survey and this investigation, the facility provided the following as the completed investigation: On 1/29/24 the facility reported to the Attorneys Generals office, local police department, reviewed the controlled substance medication card for Resident #14 and requested the Licensed Practical Nurse to be removed from agency contract. The investigation lacked evidence of staff interviews and reporting in 72 hours. On 2/8/24 at 11:36 a.m., during an interview, the Director of Nursing (DON) confirmed she did not thoroughly investigate the alleged misappropriation of medication by failing to document whether staff interviews were completed. DON stated, initially she did not believe that there was a discrepancy and did not discover there was until 1/27/24, stating, "It was absolutely me, I'm going to own this".	F 610			3/25/24
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;	F 625	Clover provides the residents with bed hold information upon admission and at the time of transfer to a hospital or beginning of therapeutic leave. Licensed nursing staff will be re-educated on the bed hold and transfer notice process. Clover has developed an addendum that outlines bed hold specific costs that will be provided to the resident or responsible party at the time of transfer. The Social Services Director will audit hospital transfer records to verify a bed hold notice, including cost was provided at the		

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F 625	Continued From page 16 (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to issue a bed hold notice which included the daily bed hold cost, to a resident, known family member or legal representative for 1 of 4 sampled residents who had been transferred to the hospital (#55). Finding: 1. Resident #55's clinical record revealed the resident was transferred to an acute care hospital on 1/24/24. The clinical record contained an incomplete bed-hold notice for the transfer, which did not include the daily bed hold cost. On 2/8/24 at 2:32 p.m., during an interview, the Regional Director of Operations the above was confirmed the facility's current forms do not meet the requirements of the regulation for bed hold notices, including information for daily bed hold costs.	F 625	time of transfer. Audits will be conducted weekly x 4 weeks then monthly x 2 months. The Social Services Director will review the results of the audits during the monthly Quality Assurance Committee meeting. The QA committee will make any additional recommendations it deems necessary to ensure compliance.		
F 656 SS=E	Develop/Implement Comprehensive Care Plan	F 656	Residents #36 and #62 are not on Enhanced Barrier Precautions (EBP).		

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F 656	Continued From page 17 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 local contact agencies and/or other appropriate entities, for this purpose.	F 656	Resident #56 care plan was updated to include Enhanced Barrier Precautions on 2/9/24. Current residents on EBP will have their charts/care plans reviewed to ensure rationale is documented and the care plan reflects EBP status. The Infection Preventionist will be responsible for updating the resident record and care plan for any residents newly placed on EBP. The Director of Nursing or designee will Audit resident records/care plans to verify EBP rationale has been added as needed. Audits will be conducted weekly x 4 then monthly x 2 The Director of Nursing will review the results of the EBP audits at the Quality Assurance Committee meeting. The QA committee will make any additional recommendations it deems necessary to ensure compliance.		

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F 656	Continued From page 18 (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 observations, record review and interviews, the facility failed to ensure documentation of Enhanced Barrier Precautions (EBP) in the clinical record for 3 of 3 residents sampled from a list of residents on EBP. (Resident #36, Resident #56 and Resident #62) Findings: On 2/8/24 at 1:40 p.m. a surveyor reviewed the clinical records of Resident #36, Resident #56 and Resident #62. No documentation was found in the clinical record to support or rationalize usage of EBP for any of the sampled Residents. Review of CDC definition of Enhance Barrier Precautions states: "Enhanced Barrier Precautions are an infection Control intervention designed to reduce transmission of multidrug resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices)." Enhanced Barrier Precautions are not used instead of Standard or Transmission based precautions but in conjunction with Standard and Transmission based precautions.	F 656			

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F 656	Continued From page 19 On 2/8/24 at 3:48 p.m. during an interview with the Infection Preventionist, a surveyor confirmed that EBP usage was not documented in the clinical records including the care plans for any of the Residents on EBP and it should be part of the clinical record.	F 656			3/25/24
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined 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	F 657	The Social Services Department will be educated on the requirement of inviting residents/authorized representatives to participate in the review and update of the resident care plan as well as the documentation of attendance required. Social Services will ensure residents and their families are invited to participate in care plan meetings. Resident #10's care plan was revised to reflect current transfer and mobility needs. A care plan tool has been initiated in the electronic healthcare record (EHR). The Social Services Director or designee will document resident and family attendance or declination via this tool. Staff responsible for the development and revision of resident care plans were re-educated on proper care planning. Current resident care plans were reviewed to verify the current transfer and mobility status were present with no contradictions, and any needed corrections were made promptly.		

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F 657	Continued From page 20 by: Based on interviews and record review, the facility failed to review and revise the care plan by an interdisciplinary team (IDT), that included, to the extent possible, participation of the resident and/or his/her representative, Resident #67) and the facility failed to ensure a care plan was updated in the areas of Activities of Daily Living for Resident (#10) to increase independent activity/mobility for 2 of 36 sampled residents. Findings: 1. On 2/5/24 at 12:28 p.m., during an interview with resident #67 he/she stated, "I don't recall" when asked if he/she had been invited and/or attended IDT meetings. Upon review, the resident's medical record lacked documentation of the resident's participation in the last four IDT meetings dated, 4/27/23, 7/27/23, 11/15/23, and 1/26/24. Further review indicated that resident #67's family representative was invited but did not attend the IDT dated 11/15/23. On 2/8/24 at 11:02 a.m., during an interview the Licensed Social Worker (LSCW) #1 stated, the facility remains unable to produce any documentation that the resident or the family was invited to the above IDT meetings and the facility does not have a system to document the invite and that they typically inform the family via phone. 2. On 2/7/2024 at 1:00p.m. during a review of the resident's clinical record, the Activities Care Plan states:	F 657	The IDT team will meet weekly to discuss any residents experiencing a change of condition, including transfer status. The MDS Coordinator or Nurse Manager will update the care plan accordingly with any changes. The Director of Nursing or designee will complete an audit of 10% of resident charts quarterly to verify documentation is present that the resident and/or their authorized representative were invited to participate in the care plan review and either their attendance or declination is also documented. This audit will be completed for a minimum of 3 quarters or until compliance is established. The Director of Nursing will discuss the results of the quarterly audit at the next scheduled monthly Quality Assurance Committee meeting following the completion of the audit. The QA committee will make any additional recommendations it deems necessary to ensure compliance.		

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F 657	Continued From page 21 "Resident has an ADL self-care performance deficit r/t weakness, chronic pain in right shoulder, deconditioning, acute pain to abdomen. Resident will improve current level of function in all ADLs through the review date. TRANSFER: Resident requires stand and pivot transferring by (2) staff to move between surfaces as necessary. Resident uses a walker to maximize independence with transferring." In the next line the Activities Care Plan states: "Resident has limited physical mobility r/t acute and chronic pain, weakness, deconditioning Resident will demonstrate the appropriate use of walker and wheelchair to increase mobility through the review date. " The resident's Nursing Care Plan states: Resident has an ADL self-care performance deficit r/t weakness, chronic pain in right shoulder, deconditioning, acute pain to abdomen. Resident will improve current level of function in all ADLs through the review date. TRANSFER: Resident requires stand and pivot transferring by (2) staff to move between surfaces as necessary. Resident uses a walker to maximize independence with transferring. In the next line the Nursing Care Plan States: Resident has limited physical mobility r/t acute and chronic pain, weakness, deconditioning Resident will demonstrate the appropriate use of walker and wheelchair to increase mobility through the review date. On 2/7/2024 at 3:00p.m. the Director of Nursing was informed, and she confirmed the contradiction in both the Activities and Nursing	F 657			

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F 657	Continued From page 22 Care Plans.	F 657			3/25/24
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to maintain respiratory equipment consistent with the facility's Respiratory Therapy instructions for 3 of 3 residents reviewed that were receiving respiratory services (#22, #21, #26). Findings: Review for the facilities Policy and Procedure for "Respiratory Therapy", revised November 2011, states: "Steps in the procedure, Infection control considerations related to Oxygen Administration." 7. Change Oxygen cannula and tubing every seven (7) days, or as needed. 8. Keep Oxygen cannula and tubing used PRN in a plastic bag when not in use. 9. Wash filters from Oxygen concentrators every seven days with soap and water. Rinse and Squeeze dry. 1. On 2/5/24 at 11:23 a.m., observation of	F 695	Residents #21, #22, and #26 had new nasal cannulas placed and oxygen filters were cleaned. Plastic bags were secured to oxygen concentrators/tanks for staff to place nasal cannulas/masks in when not being used. Orders for changing cannulas and cleaning filters have been added to the treatment administration record for all current residents with oxygen. Staff were re-educated regarding the proper care and storage of oxygen related supplies. The Director of Nursing or their designee will audit current residents using oxygen to verify oxygen tubing is clean and stored properly, filters are cleaned, and these tasks are documented as being complete on the treatment administration record. Audits will be conducted weekly x 4 weeks, then monthly x 2 months. The Director of Nursing will discuss the results of the audits at the Quality Assurance Committee meeting. The QA committee will make any additional recommendations it deems necessary to ensure compliance.		

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F 695	Continued From page 23 resident #22's oxygen concentrator with an unlabeled nasal cannula lying on the floor. At this time in a brief interview, Resident #22 stated, "I use it sometimes at night if I need it." Additional observation on 2/6/24 at 11:04 a.m., of resident #22's oxygen tubing with an unlabeled nasal cannula lying on the floor. On 2/6/24 review of resident #22's medical record states he/she was admitted on 12/14/24 with diagnosis of Hypoxemia requiring Oxygen while sleeping. The medical lacked evidence of oxygen tubing change weekly. 2. On 2/7/24 at 10:07 a.m., observation for resident #21's oxygen nasal cannula tubing wrapped around the side rail of the bed. On 2/7/24 at 3:50 p.m., during an interview resident #21 stated, he/she puts the oxygen on when he/she gets into bed just in case he/she falls asleep because he/she stops breathing when he/she is sleeping. An additional observation on 2/8/24 at 8:09 a.m., of Resident #21's oxygen nasal tubing wrapped up and stored under the oxygen concentrator handle. 3. On 2/8/24 at 8:10 a.m., observation of Resident #26 oxygen nasal cannula stored on bed side table. On 2/8/24 at 10:35 a.m., the Surveyor, Assistant Director of Nursing and Director of Clinical Operations observed Resident #21 and #26's Oxygen nasal cannula tubing stored as above and both oxygen concentrator filters coated with a layer of dust and discussed Resident #22's observations of the nasal cannula resting on the floor.	F 695			
F 732 SS=B	Posted Nurse Staffing Information	F 732	Clover's staffing information has been relocated to the lobby of the main entrance		

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F 732	Continued From page 24 CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 732	to provide a more prominent location for viewing. Personnel responsible for posting staffing information were re-educated on the requirement to post the information in a prominent location. The Administrator or designee will audit the staffing posting to verify it is in place daily x 7 days, weekly x 3 weeks then at randomly twice a month x 2 months. The Administrator will discuss the results of the audits at the monthly Quality Assurance Committee meeting. The QA committee will make any additional recommendations it deems necessary to ensure compliance.		

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F 732	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to post the nurse staffing information in a prominent place readily accessible and visible to all residents and all visitors for 5 of 5 days of survey. Finding: On 2/5/24 through 2/9/23, the surveyor observed that the nurse staffing information was not posted in an prominent place readily accessible and visible to residents and visitors. On 2/9/24 at 12:30 p.m., in an interview with the surveyor, the Area Director of Clinical Operations and the Area Manager of Clinical Reimbursement confirmed that the nurse staffing information was not posted in an area that was readily accessible and visible to all residents and all visitors.	F 732			3/25/24
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755	Clover has an established system for receiving, logging, documenting, and reconciling controlled substances. The controlled substance book was reviewed and updated for accuracy by the nurse manager on 2/6/24 with verification completed by the Director of Nursing. Licensed/authorized staff who manage, count, or administer medications were re- educated on proper controlled substance management. The Director of Nursing or their designee will audit the controlled substance books to		

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F 755	Continued From page 26 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation, failed to determine that drug records are in order and that an account of all controlled drugs is maintained, failed to ensure that two people who are authorized to administer medications signed the Shift Count page indicating that they counted all controlled substances at the change of shift for multiple shifts between 1/15/24 through 2/6/24 and failed to ensure that the nurse receiving a pharmacy delivery of controlled substance had two signatures confirming entry to bound book for 1 of 1 deliveries reviewed on 1 of 4 units (Clare Place). Findings:	F 755	verify proper entry on index, newly delivered controlled substances are signed in by two authorized staff, and the narcotic count is appropriately signed off weekly x 4 weeks then monthly x 2 months or until compliance is established. The Director of Nursing will discuss the results of the audits at the Quality Assurance Committee meeting. The QA committee will make any additional recommendations it deems necessary to ensure compliance.		

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F 755	Continued From page 27 A review of the facility's "Management of Controlled Substances Policy revision" effective date: 3/3/23, under Policy states, The facility will manage controlled substances in a manner to prevent drug diversion and maintain safety. Section: 5.3.1 states, "when a schedule II-V drug is delivered to the facility, a facility licensed nurse will review the pharmacy delivery sheets, count the medication, date and sign the delivery sheet verifying accuracy of the delivery. The controlled substance must be entered into the bound book after receipt by two staff members. One of the two must be the licensed nurse who received the controlled substance and signed the delivery sheet." 5.3.3 states, "Receipt of Schedule II-V drugs will be entered into a bound book from which no pages will be removed. Receipt of the medication will be entered on the index page and the specific bound book page ...The date received will be entered on the first line of the bound book page along with the quantity received and two signatures including the person who received the drug and the person confirming entry into the bound book, one of whom must be a licensed nurse." 5.4.1 states, "A count of all schedule II-V drugs will be done at the change of each shift by two people who are authorized to administer medications, one of whom must be a licensed nurse, utilizing the bound book from which no pages are removed and referencing the index page. Accuracy of the count will be acknowledged with the two signatures of the staff members who performed the count on the shift count page." 5.8.2 states, "All narcotic keys must be kept on the staff member administering medications during that shift ... Keys cannot be given to	F 755			

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F 755	Continued From page 28 anyone else to use unless reconciliation of the controlled medications is performed before and after. Once a staff member has signed that the oncoming shift count is correct, that person is responsible for the medications in that cart until they complete the outgoing shift count & that it is correct. 1. On 2/6/24 at 1:29 p.m., during the medication administration observation on Clare Place, 2 surveyors observed the Licensed Practical Nurse (LPN) #2 requesting Gabapentin from the locked medication cart. The Nurse Manager stated, the Registered Nurse (RN) #2 (RN who counted the narcotic draw and obtained the keys for the shift) was currently at break but she does have the key for the narcotic drawer. Nurse Manager opened the narcotic draw and provided the LPN with the needed Gabapentin and documented the removal in the Controlled Substances Book (bound book). Surveyors noted the index which requires the patient's name, drug, page number and signature of person responsible for removing drug from count. The index lacked the following: 13 entries with only a page number (79, 85, 86, 88, 89, 90, 91, 92, 93, 98, 99, 100, 101). On page's #73, 104, 105, 106, 107 was documentation of residents drug delivery and use however, these pages were not indicated on the index. Surveyor asked why the index was lacking the needed information for reconciliation. The Nurse Manager stated, "I don't know, I honestly didn't realize these weren't filled out, it should be." At this time, RN #2 returned from her break. Surveyors asked how shift change count is preformed. RN# 2 stated, 2 staff would count, the, oncoming staff would stand at cart and the outgoing would stand with the bound book. She then showed the process of looking at the individual narcotic cards, with the page	F 755			

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F 755	Continued From page 29 number of the narcotic book written on the top of the card, stating, she would say the page number , the other staff would turn to that page and verify the number of medications are correct. Surveyor asked if she would follow the index during this process. She was taught to count using the card and page numbers on the card. She was unaware to use the index. On 2/7/24 at 12:57 p.m., during an interview with the Nurse Manager, she confirmed the controlled substance count was not completed for reconciliation prior to her taking the keys on 2/6/24 while RN #2 went on break. 2. On 2/8/24, during review of the Pharmacy delivery sheets on 1/20/24, the Clare Place unit received 90 capsules of Gabapentin 400mg tabs for Resident #14, the pharmacy delivery sheet was signed and dated by a nurse. Review of the controlled substance bound book, pg 70 for Resident #14 indicated on 1/20/24, the amount 90 capsules was received and added to the 7 remaining capsules, this was signed by 1 nurse. 3. Upon review of the Controlled Substances Book and Shift Count pages 273 and 274 from 1/15/24 through 2/6/24. The surveyor observed that the facility counts at the change of each shift, approx. 3 times a day. The licensed nursing staff coming on duty and the licensed nursing staff nurse going off duty both failed to sign the Shift Count page of the Controlled Substances Book that indicated the controlled substances count was done on the following dates: 1/25/24, 1/30/24 and 2/2/24. The licensed nursing staff nurse coming on duty failed to sign the Shift Count page of the Controlled Substances Book that indicated the controlled substances count was done, twice on 2/5/24 and the licensed nursing staff nurse	F 755			

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F 755	Continued From page 30 going off duty failed to sign the Shift Count page of the Controlled Substances Book that indicated the controlled substances count was done on the following dates: 1/24/24, 1/25/24, 1/26/24, 1/30/24, 2/2/24 and 2/4/24. On 2/8/24 at 11:36 a.m., during an interview, the Director of Nursing (DON) the above concerns were discussed, the facilities policy and procedure for management of Controlled Substances and pages of the bound book were reviewed. The DON confirmed she was unaware of the lack of reconciliation and documentation in the bound book.	F 755			3/25/24
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761	Clover ensures appropriate labeling and storage of medications. All expired items were discarded at the time of discovery, and the unlabeled Basaglar insulin pen was discarded. Medication carts and medication storage rooms were checked to verify no other expired or unlabeled medications were present. Any expired or unlabeled medications were removed immediately. Staff responsible for medications were re-educated regarding removal of expired medications and the requirement of labeling and dating all insulin vials and pens. The 7a-7p med technician will check and remove any expired medication or treatment weekly.		

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F 761	Continued From page 31 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews, facility failed to adequately date and properly dispose of open medications according to manufacturer specifications and failed to ensure expired medications were removed from the supply available for use on 3 of 4 units observed (Belfast Place, Clare Place and Dublin Place). Findings: Facilities Policy and Procedure: Storage of Medications, revised November 2020 states: #4 Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. 1. On 2/5/24 at 9:31 a.m., observation of Belfast Place medication room and Treatment cart with the Registered Nurse (RN) Manager the following was observed: the medication room contained one box of Earwax Removal drops with expiration date of 1/24. The treatment cart contained an opened and unlabeled Basaglar insulin pen and a Humalog Insulin pen both with manufacturer's directions to use within 28 days after initial use. 2. On 2/5/24 at 9:42 a.m., observation of Clare Place medication cart with the Certified Medication Technician (CNA-M) #2, the following was observed: one box of Earwax Removal Drops with an expiration date of 1/24, an opened bottle of Ferrous sulfate 325mg with expiration	F 761	The Director of Nursing or their designee will audit the medication room and medication and treatment carts once a week x 4 weeks then monthly x 2 months. The Director of Nursing will discuss the results of the audits during the monthly Quality Assurance Committee meeting. The QA committee will make any additional recommendations it deems necessary to ensure compliance.		

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OMB NO. 0938-0391

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F 761	Continued From page 32 date of 1/24 and an open bottle of Centrum Silver multivitamin with an expiration date of 1/24. 3. On 2/5/24 at 9:57 a.m., observation of Dublin Place medication storage room with RN #1 the following was observed: 2 unopened bottles of Loratadine 10 milligram tablets with expiration date of 1/24 available for use. 4. On 2/5/24 at approx. 10:00 a.m., observation of Dublin Place treatment cart with CNA-M #1, the following was observed: one opened bottle of allergy relief 10 milligram tabs with an expiration date of 1/24 and 2 boxes of Earwax Removal drops, one with expiration date of 12/23 and the other with a date of 1/24. On 2/9/24 at approx. 1:00 p.m., the above concerns were discussed during the exit conference with the Administrator and Director of Nursing	F 761			3/25/24
F 790 SS=D	Routine/Emergency Dental Svcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an	F 790	Clover provides routine and emergency dental services for all its residents. Resident #3 is currently declining to be fitted for dentures. This has been documented in the medical record. Nursing staff were re-educated regarding managing and reporting lost, missing, or damaged dentures. Social Services or their-designee will make all dental referrals (if resident/authorized representative agrees) within 3 days of notification of need and document all pertinent information in the resident's		

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F 790	Continued From page 33 additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews, the facility failed to assist the resident in obtaining routine and emergency dental care within 3 days, after lost of dentures for 1 of 1 resident reviewed for dental (#3). Findings: Facility policy and procedure for "Dental Services", revised 2016 states: 6. Direct care staff will assist residents with denture care, including removing, cleaning and storing dentures.	F 790	electronic medical record including any refusals. Any residents missing dentures or needing emergency dental services will be discussed during the weekday morning meeting to ensure timely referrals are made and documentation has been completed in the resident chart. Social Services Director will discuss any resident emergency dental services during the monthly Quality Assurance Committee meeting if applicable. After the review, the QA committee will make any additional recommendations it deems necessary to ensure compliance.		

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F 790	Continued From page 34 7. Dentures will be protected from loss or damage, to the extent practicable, while being stored. 8. Lost or damaged dentures will be replaced at the resident's expense unless an employee or contractor of the facility is responsible for accidentally or intentionally damaging the dentures. 9. If dentures are damaged or lost, residents will be referred for dental services within 3 days. If the referral is not made within 3 days, documentation will be provided regarding what is being done to ensure that the resident is able to eat and drink adequately while awaiting the dental services; and the reason for the delay. 10. All dental services provided are recorded in the resident's medical record On 2/5/24 at 2:11 p.m., during the interview with Resident #3, it was observed he/she had no dentures in place. At this time, he/she stated that they were accidentally throw away by staff and he/she has been unable to get new ones but would like to have teeth again. On 2/7/24 at 1:02 p.m., during an interview with the Licensed Practical Nurse (#3), he was asked about Resident #3's dentures. He stated that resident did at one time have dentures, last seen "months ago" which he/she would frequently refuse to wear. The LPN #3 stated this caused the dentures to be ill fitting, but the resident did not get them replaced. On 2/7/24 at approx. 1:10 p.m., In an additional interview with Resident #3, he/she reiterated that the dentures were thrown away by staff but he/she is able to eat without dentures due to a puree diet.	F 790			

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F 790	Continued From page 35 Resident #3's medical record, lacked evidence regarding dentures, dental services, replacement and/or refusal of dental care. On 2/7/24 at 1:46 p.m., during an interview with the Director of Nursing (DON) and Administrator, both confirmed that they were aware he/she did have dentures but are unaware of how and when they went missing. On 2/7/24 at 3:11 p.m., During interview with Licensed Social Worker #1, she confirmed that the facility has no record of the dentures or where they are but that the resident has not had them for some time, in addition there is no record of if the resident has been offered dental services.	F 790			3/25/24
F 800 SS=D	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on Medical Record review, menu review and interviews Resident (#303), Assistant Dietary Manager, and Charge Nurse on Belfast Unity, the facility diet ordered for Resident 303 with increased protein requirement. Findings: On 2/6/2024 at 1:09p.m. during an interview with Resident #303, He/She stated that, "I am not	F 800	Resident #302's meal ticket was updated to include providing extra protein on 2/7/24. Current resident diet orders were reviewed and compared to the meal tracking tickets to verify they were correct, and any corrections needed were made promptly. For newly admitted residents or residents experiencing a diet change, nursing staff shall complete a Diet Communication Form to be given to the Dining Services department. The Director of Nursing or designee shall run a Diet Report every week x 4 weeks then every other week x 4 weeks, then monthly thereafter and provide the Dining Services Director with a copy.		

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F 800	Continued From page 36 getting the protein I need." A review of Resident #303's Clinical Record under Physician's Orders it states that the Resident will have a diet of Increased Protein portions for all meals. A review of the Dietitian's Plan for Resident #303 indicates that Resident #303 will have increased protein portions for all meals. Observation of Resident #303 meal ticket for 2/7/2024 Lunch, it states that the diet is Regular and does not mention any increased protein requirement. On 2/7/2024 at 2:00p.m. in an interview with the Assistant Dietary Manager, he stated that the computer program that the facility had been using has been changed to a different program and that information must not have been transferred. The above findings were confirmed with the Assistant Dietary Manager at that time and with the Administrator and the Director of Nursing On 2/7/2024 at 3:00p.m.	F 800	The Dining Services Director shall review the Diet Report and compare it against the meal ticket system to verify the correct diet orders are being followed. The Dining Services Director will review results of the audits at the Quality Assurance Committee meeting. After the review, the QA committee will make any additional recommendations it deems necessary to ensure compliance.		3/25/24
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812	Clover ensures that food is procured, stored, prepared, and served in a sanitary manner. Dietary staff were instructed at the time of survey to don hair nets/coverings. The container of fruit was opened on the morning of 2/5/24 as verified by the Assistant Director of Dining Services. The fruit was labeled and dated at that time.. The pan of hot dogs was discarded at the		

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F 812	Continued From page 37 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to serve and store food in a sanitary manner on 3 of 5 survey days. Also the facility failed to keep accurate and complete temperature logs in the main kitchen and unit kitchens. Findings: 1. On 2/5/2024 at 7:56a.m. during the initial observation of the kitchen with the Assist Dietary Manager, it was observed that 2 of the 6 kitchen staff were not wearing hair coverings. -Observation of the reach-in-prep-fridge found two large containers of fruit and undated and unlabeled. Also, a pan of hotdogs that were unlabeled and undated. -When asked to see the temp logs for the breakfast cooking the cook provided a Hot/cold food log showing breakfast lunch and dinner. There was no recording for the dinner column for any of the days on the sheet. -The survey team entered on 2/5/2024 and the temperature in the breakfast column were already filled in thru 2/7/2024. -When asked if there was a cleaning schedule,	F 812	time of discovery on 2/5/24. Dining staff were re-educated regarding proper kitchen storage, appropriate logging of food temperatures, documentation of refrigerator temperatures, and sanitation. Resident food items were removed from the recreation room refrigerator. This refrigerator is for staff use only and is therefore exempt from temperature monitoring and documentation. This refrigerator is now labeled "staff use only". A second refrigerator in the activities room will be labeled, "Resident use only". The February temperature log was filled in beginning February 9 th , 2024. The Dining Services Director reviewed the Sanitation/Cleaning schedule with Dining Services Staff. The Dining Services Director or their designee will audit the refrigerator temperature logs, food temperature logs, cleaning schedules, staff hair net use, and reach in refrigerator for proper dating and labeling daily x 7 days then twice weekly x 3 weeks then monthly x 2 months The Dining Services Director will review the results of the audits at the monthly Quality Assurance Committee meeting.		

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F 812	Continued From page 38 he said that there is one on the wall, but there are no dates and no documentation anywhere that the tasks are ever done. The above findings were confirmed with the Assistant Dietary Manager at that time, and with the Administrator at 3:00p.m. 2. On 2/7/2024 at 11:00a.m. this surveyor observed the Temp Log for the Unit Fridge - Clare Unit. It lacked documentation for 2/4/2024 and 2/5/2024. 3. On 2/8/2024 at 8:40a.m. - Belfast Unit Fridge Temp Log lacked documentation for 2/3/2024. 4. On 2/8/2024 at 2:30p.m. this surveyor observed the Temp Log for the Recreation Room, and it lacked documentation for the month of February 2024. The Activities Coordinator was asked if he/she ever used that fridge and he/she stated that they did whenever the needed to store drinks, food, or ice cream for the residents during activities. On 2/9/2024 at 12:45p.m. all of the kitchen finding were confirmed with the Administrator.	F 812	After the review, the QA committee will make any additional recommendations it deems necessary to ensure compliance.		3/25/24
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(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	F 842	Resident# 36 and 62 are not on Enhanced Barrier Precautions (EBP). #56 is now d/c but had EBP added to their care plan on 2/9/24. Residents currently on EBP will be audited by the Infection Preventionist to verify there is documentation in the medical record regarding the clinical rationale for EBP use.		

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F 842	Continued From page 39 to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(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(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or	F 842	Licensed nursing staff will be educated regarding the requirement of documentation for the use of Enhanced Barrier precautions. The Infection Preventionist will be responsible for updating the resident record and care plan for any residents newly placed on EBP. The Director of Nursing or designee will Audit resident records/care plans to verify EBP rationale has been added as needed. Audits will be conducted weekly x 4 weeks then monthly x 2 months. The Director of Nursing or Infection Preventionist will review the results of the EBP audits at the quarterly Quality Assurance Committee meeting. After the review, the QA committee will make any additional recommendations it deems necessary to ensure compliance.		

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F 842	Continued From page 40 (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(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure documentation for Enhanced Barrier Precautions (EBP) in the clinical record for 3 of 3 residents sampled from a list of residents on EBP. (Resident #36, Resident #56 and Resident #62) Finding: On 2/8/24 at 1:40 p.m. a surveyor reviewed the clinical records of Resident #36, Resident #56 and Resident #62 following observation of EBP signage at their doors. No documentation was found in the clinical record to support or explain usage of EBP for any of the sampled residents. Review of CDC definition of Enhance Barrier Precautions states: "Enhanced Barrier Precautions are an infection Control intervention designed to reduce transmission of multidrug resistant organisms	F 842			

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F 842	Continued From page 41 (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices)." Enhanced Barrier Precautions are not used instead of Standard or Transmission based precautions but in conjunction with Standard and Transmission based precautions. On 2/8/24 at 3:48 p.m. during an interview with the Infection Preventionist, a surveyor confirmed that EBP usage was not documented in the clinical records, including the care plan, for any of the residents on EBP and it should be part of the clinical record.	F 842			
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880	Clover has an Infection Prevention Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections. Dublin Place The bed pans in the shared bathroom for rooms #34 and 35, the salad tongs were removed, the personal items labeled, and the plunger was bagged. Room #33's commode bucket was cleaned and placed in the commode and the towel was removed from the back of the commode. Room #32's urinal was labeled and stored properly. Room #38's shared bathroom had the seat		3/25/24

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F 880	Continued From page 42 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. (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.	F 880	cushion cleaned and stored properly. Room #41 had the bedpans cleaned and bagged/stored properly; the brief disposed of, and the plunger bagged. The shared bathroom between room #42 and #43 had the bedpans properly labeled and stored. Clare Place: Room #19 had the bed pans properly stored/bagged, the urinary collection device labeled and bagged/stored properly, and the urinal labeled and stored properly. Galway Place: The shared bathroom between Rooms #50 and 51 had the bedpan labeled and bagged/stored properly. Laundry cart: Laundry aide #3 was educated at the time of survey of the need to keep the clean linen on the cart covered while transporting/delivering laundry. Dining: The dietary staff member was re-educated at the time of survey when to perform appropriate handwashing, glove changing and tongs. Resident #6 had the appropriate isolation precaution sign placed at the time of survey. The Whirlpool room on Dublin was thoroughly cleaned, trash bags removed, cardboard boxes removed, toilet brush		

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F 880	Continued From page 43 §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 observations, interviews and record reviews the facility failed to maintain an Infection Control Program designed to help prevent cross contamination and/or development of infection by maintaining a safe and sanitary environment related to personal toileting items, Transmission Based Precautions (TBP) and linen handling for 3 of 5 days of survey on 3 of 4 units. (Clare Place, Dublin Place and Galway Place) Finding: Review for the facilities Policy and Procedure for Infection Prevention and Control Program, revised May 2023 states: An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. 1. Dublin Place: On 2/5/24 at 11:34 a.m. and 2/6/24 at 8:06 a.m., observations of [REDACTED] shared bathroom with 2 unlabeled and uncovered bed pans and a pair of salad tongs hanging on the wall behind the toilet on hooks, a shelf with multiple personal care items not labeled and a plunger next to toilet not	F 880	covered, missing tile repaired, soap container stored properly, personal care items labeled, plastic drawer unit removed, and laundry carts cleaned. The Whirlpool room on Galway had the tub faucet leak repaired and rust stain removed, room was thoroughly cleaned, trash bags removed, soap container stored properly, and slippers were removed. Isolation signage for rooms for residents with active COVID-19 will be updated to not say "airborne" but will specify use of N-95 mask. The Infection Preventionist will monitor isolation signage as part of her daily walking rounds. Laundry, Housekeeping, Dietary and Nursing staff were re-educated regarding their role in Infection Prevention and Control. The Dining Services Director or designee will audit staff serving food daily x 7 days then weekly x 3 weeks then monthly x 2 months. The Administrator, Director of Plant Operations, Housekeeping Supervisor and the Director of Nursing or their designees will complete walking rounds: 3x weekly for 4 weeks, then 2x weekly for 4 weeks, then 1x weekly for 4 weeks or until compliance is established, to verify cleanliness of whirlpool rooms, linen carts are covered while transporting/storing clean		

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F 880	Continued From page 44 bagged. On 2/5/24 at 11:52 a.m., 2/6/24 at 8:08 a.m., and 2/7/24 at 10:02 a.m., observations of [REDACTED]'s bathroom with a commode bucket on the floor next to toilet and a towel taped to the back rail of the over toilet commode seat. On 2/5/24 at 11:53 a.m., and 2/6/24 at 8:09 a.m., observation of room [REDACTED]'s bathroom with an unlabeled urinal stored on handrail. On 2/5/24 at 3:07 p.m. and 2/6/24 at 8:10 a.m., observation of room [REDACTED]'s shared bathroom with a seat cushion on the floor underneath the paper towel dispenser. On 2/5/24 at 3:12 p.m. and 2/6/24 at 8:11 a.m., observation of room [REDACTED]'s bathroom to have 2 bed pans and a brief on the floor behind the toilet and unbagged plunger. On 2/6/24 at 8:04 a.m., observation of room [REDACTED] shared bathroom with 2 unlabeled and unbagged bed pans hanging on wall behind toilet. Clare Place: On 2/7/24 at 11:20 a.m., 2 surveyors observed room 19's bathroom with 2 bed pans labeled, unbagged and stacked together, an unlabeled/unbagged foley drainage bag (urinary collection device) hanging from the shelf and an unlabeled urinal on the shelf. On 2/7/24 at 11:42 a.m., this was confirmed with the Administrator and the Director of Nursing who observed the above.	F 880	linen, proper labeling and storage of bedpans/urinals/commodes, and proper isolation signage is in place. Any additional environmental issues will be addressed promptly. The Administrator will discuss the results of the audits during the monthly Quality Assurance Committee meeting. After the review, the QA committee will make any additional recommendations it deems necessary to ensure compliance.		

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F 880	Continued From page 45 On 2/7/24 at 3:52 p.m., additional observation of room 19's bathroom to again have the an unlabeled/unbagged foley drainage bag hanging from the shelf. Galway Place: On 2/5/24 at 12:00 p.m., observations of room [REDACTED] shared bathroom with an unlabeled / uncovered bed pan hanging by a screw on the wall. On 2/9/24 from 10:16 a.m. - 11:05 a.m., during the environmental tour, a surveyor discussed and confirmed the above infection control concerns with the Administrator. 2. On 2/7/24 at 11:21 a.m., observation of laundry aide #3 delivering clean linens to resident room # 19 and the linen was not covered on the cart. A this time, the laundry aide confirmed the clean linen was not covered. On 2/7/24 at 11:21 a.m., a surveyor observed laundry aide #3 delivering clean linens to resident's rooms and the linen was not covered on the cart. On 2/7/24 at 11:21 a.m., in an interview, laundry aide #3 confirmed she was delivering clean linens to resident's rooms and the linen was not covered on the cart. 3. On 2/5/24 at 9:29 a.m. a surveyor observed a	F 880			

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F 880	Continued From page 46 dietary server perform the following steps without changing gloves or performing hand hygiene between clean and dirty tasks. -transferred and arranged bacon and toast on a resident plate using a gloved hand -handled a dirty plate -reached into a bucket and retrieved a wet towel -wiped down the counter -transferred and arranged bacon and toast on a second resident plate using a gloved hand At this point, a surveyor approached the dietary aide, shared observation, and questioned when they would normally change their gloves and/or perform hand hygiene during food service. I was told they usually use tongs. 4. On 2/5/24 at 10:55 a.m. a surveyor observed a private room (Resident #6) with an open door and "Airborne precautions" signage at the door. Review of facility policy titled "Isolation - Categories of Transmission-Based Precautions" version 2.1 under "Airborne Precautions" states "Preventing the spread of airborne pathogens requires a room with special air handling and ventilation called an airborne infection isolation room (AIIR)." On 2/5/24 at 11:10 a.m. a surveyor during an interview with the Dublin Unit Manager confirmed that Resident #6 was positive for SARS-COV-2 and was not in an AIIR but it was his/her understanding that Airborne Precautions were the correct Transmission Based Precaution to use for SARS-COV-2. A review of facility policy titled "Residents with Confirmed SARS-COV-2 Infection" revised September 2022 states; "Staff who enter the	F 880			

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F 880	Continued From page 47 room of a resident with suspected or confirmed SARS-COV-2 infection will adhere to standard precautions and use a NIOSH-approved particulate respirator with N95 filers or higher, gown, gloves, and eye protection. On 2/6/24 at 2:06 p.m. during an interview with facility Infection preventionist a surveyor confirmed that Airborne Precautions were not being utilized for Resident #6 and the signage did not communicate the precautions to be used for SARS-COV-2 per facility policy. 5. On 2/5/24 at 11:05 a.m. a surveyor toured the whirlpool room on Dublin with LPN#3 and observed the following: - A strong odor of urine and feces upon entering the room - An open wagon filled with full, tied, plastic, trash bags - Flattened cardboard boxes stacked on the floor - A toilet brush uncovered on the floor near the toilet - Missing threshold tile between toilet and room creating a tripping hazard and an uncleanable surface. - Gallon size soap containers with a pump on the floor next to the tub. - A container of used personal care products on the back of the shared toilet with no labels. - 4 white plastic drawer units creating a cluttered environment difficult to clean. 1 was broken and leaning over with the drawer hanging out. - Unzipped rolling laundry carts that were visibly soiled with a dried tan substance on the inside base of the protective cover. - Confirmed with LPN #3 that this room is	F 880			

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F 880	Continued From page 48 being used for resident bathing. On 2/5/24 at 11:20 a.m. a surveyor toured the Galway unit whirlpool room and observed the following: - Tub faucet with continuous leak creating a rust-colored stain on the inside surface of tub from the top to the drain. - Smell of feces and urine prominent upon entering room - Full, tied, plastic, trash bags in an open cart. - Gallon size soap container with pump on the floor - Pair of resident slippers on the floor On 2/8/24 at 10:52 a.m. during a tour of the Dublin Whirlpool room with the Administrator and LPN #3, a surveyor confirmed that the administrator would not bathe in this room, the smell was unacceptable and while this was a known issue "on the list", it was still being utilized for resident care.	F 880			3/25/24
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews	F 947	CNAs # 1, 2, 3,4 and 5 had training related to abuse, resident rights and dementia management. Current CNA training records were reviewed to identify any additional staff that do not have these trainings documented. CNAs that are missing trainings will be scheduled for training related to abuse, resident rights, and dementia management. New Hire and Annual Education will be tracked by the Human Resource Director utilizing the electronic learning		

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F 947	Continued From page 49 and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to implement and maintain an effective training program which includes, at a minimum, training on abuse, resident rights and dementia management by failing to ensure that 5 of 5 Certified Nursing Assistant's (CNA) employed, completed the required annual training (CNA #1, CNA #2, CNA #3, CNA #4 and CNA #5). Findings: On 2/9/24, during a review of employee personnel records, the following was noted: 1. CNA #1's employee personnel record lacks evidence of mandatory abuse, resident rights and dementia training within the last twelve months. 2. CNA #2's employee personnel record lacks evidence of mandatory abuse, resident rights and dementia training within the last twelve months. 3. CNA #3's employee personnel record lacks evidence of mandatory abuse training within the last twelve months. 4. CNA #4's employee personnel record lacks evidence of mandatory abuse, resident rights and dementia training within the last twelve months.	F 947	management system (Relias). Department Heads and Supervisors will be notified of any staff out of compliance with required training. Audits of training records will be completed by the HR Director every two weeks for new hire CNAs and monthly for all other CNAs x 3 months. The HR Director will discuss the results of the audits at the monthly Quality Assurance Committee meeting. The QA committee will make any additional recommendations it deems necessary to ensure compliance.		

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F 947	Continued From page 50 5. CNA #5's employee personnel record lacks evidence of mandatory abuse, resident rights and dementia training within the last twelve months. On 2/9/24 at 11:50 a.m., during an interview with a surveyor, the Director of Nursing confirmed the above findings.	F 947			