Plan of Correction
Pinnacle Health & Rehab
North Berwick
Date Survey Completed: October 30, 2024

F 584: Safe/Clean/Comfortable/Homelike Environment

How corrective action will be accomplished for those residents found to have been affected by the deficient practice:

By 11/29/24, the director of maintenance or designee will remove the black tape from the threshold entrance from the hallway in all resident rooms; 19, 20, 21, 22, 23, 25, 27, 28, 31, 32 and 34. Once the tape has been removed the areas will be repaired in a way in which the surface is cleanable. Gaps in flooring at the end of Unit C will be filled by 11/29/24.

How the facility will identify other residents having the potential to be affected by the same deficient practice;

On 11/4/24, the director of maintenance or designee completed a walkthrough of all resident rooms to identify any other resident rooms with black tape.

What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not reoccur;

Beginning 12/2/24; the director of maintenance or designee will perform weekly audits for 4 weeks followed by monthly audits for 3 months to assure black tape is not being used on the floors creating an uncleanable surface and any gaps are identified, filled, and cleanable.

How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur;

Results of the weekly audits will be reported at monthly Safety Meetings and quarterly at QAPI Meetings.

Compliance Date: 11/29/24

F 695: Respiratory/Tracheostomy Care and Suctioning

How corrective action will be accomplished for those residents found to have been affected by the deficient practice:

Concentrator tanks for resident # 29, 9, 22 & 6 were all cleaned on; 10/31/24.

How the facility will identify other residents having the potential to be affected by the same deficient practice;

The DON or designee completed a walkthrough on; 10/31/24, to assess all concentrators in use for filter cleanliness.

On 11/25/24, at the Nurses Meeting, education will be provided to nurses on the policy for cleaning concentrator filters and use of mesh bags for O2 tubing.

What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not reoccur;

Beginning 11/25/24; the DON or designee will perform weekly audits for 4 weeks and monthly audits thereafter, for 3 months to assure concentrator filters are clean and mesh bags are used for O2 tubing sanitation.

Mesh bags for O2 tubing was ordered on; 11/11/24. Once received, will be utilized for each concentrator in use following the policy and procedure.

On 10/31/24, the DON or Designee added to our Respiratory Policy the procedure for cleaning concentrators and use of mesh bags for O2 tubing

How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur;

Results of the weekly audits will be reported a monthly Safety Meetings and quarterly at QAPI Meetings

Compliance Date: 11/25/24

F812: Food Procurement, Store/Prepare/Serve-Sanitary

How corrective action will be accomplished for those residents found to have been affected by the deficient practice:

The food slicer was cleaned on; 10/28/24.

The floor in the dry storage room was swept and cleaned on; 10/28/24

All items identified as being open/undated or expired were thrown away at the time of identification.

North East Flooring was in the facility on; 11/15/24 to make recommendations for flooring and provide a quote by; 11/19/24, a tentative date was set for; 12/2/24 to re-do the kitchen floor.

How the facility will identify other residents having the potential to be affected by the same deficient practice;

On 11/19/24, the Dietician and Food Service Director will provide education to all staff on kitchen cleanliness specifically focusing on; the sanitation of the food slicer and not allowing the build up of crumbs/debris in the dry storage area. Also, reviewed will be the policy for food storage, i.e.; how long items can be stored for and the requirement to label/date items.

What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not reoccur;

The food slicer cleaning has been added to the daily cleaning sheet.

The dry storage room floor cleaning has been added to the daily cleaning sheet.

Beginning 11/19/24; bi-weekly audits will be conducted by the FSD or designee for 6-weeks and then monthly for 3 months thereafter to assure all food is dated and not expired.

How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur;

Results of the audits will be reported at quarterly QAPI meetings

Compliance Date: 11/19/24 (12/2/24-flooring)

F 880: Infection Prevention & Control

How corrective action will be accomplished for those residents found to have been affected by the deficient practice:

A drawing/map was created to identify the piping throughout the facility, including potentially high-risk areas such a as mixing valves, and shower heads.

How the facility will identify other residents having the potential to be affected by the same deficient practice;

Education will be provided to the Safety team at the Safety meeting on; 11/25/24.

What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not reoccur;

Quarterly Legionella testing will be conducted by the director of maintenance or designee.

Legionella test kit was ordered on 11/15/24. Kits will be utilized for testing once received.

How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur;

Results of the testing will be reported at quarterly QAPI meetings.

Compliance Date: 11/25/24

F 883: Influenza and Pneumococcal Immunizations

How corrective action will be accomplished for those residents found to have been affected by the deficient practice:

On 11/22/24 residents #4, 25, & 48 will be offered the Pneumococcal Vaccine (at our annual vaccination clinic).

How the facility will identify other residents having the potential to be affected by the same deficient practice;

On 11/19/24, all resident records were audited to assure they will be offered (at our annual vaccination clinic on; 11/22/24) and documented response of acceptance or declination of the Pneumococcal Vaccine will be charted in the resident record.

What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not reoccur;

On 11/25/24; the DON or designee will provide education to clinical staff at the Nurses Meeting reviewing the policy for documentation of acceptance or declination of the Pneumococcal Vaccine.

Beginning; 11/18/24, the DON or Designee will audit all new admission charts for documentation of acceptance or declination of the Pneumococcal Vaccine for 4 weeks and then monthly for 3 months.

How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur;

Results of audits will be reported at quarterly QAPI meetings.

Compliance Date: 11/25/24