Plan of Correction – Mid Coast Senior Health Center

Sent to DHHS on: June 28, 2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	DATE
K L Watson	Administrator	06/28/2024

To be acceptable, a POC must include the following elements:

1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice;
2. How the facility will identify other residents having the potential to be affected by the same deficient practice;
3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur;
4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur; and
5. The date that each deficiency will be corrected. Corrections must be made no later than July 27, 2024

ID PREFIX TAG	DEFICIENCIES & FINDINGS	PLAN OF CORRECTION (Including elements 1- 5 as stated above)
F 582 Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)	**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 1 of 3 residents whose Medicare Part A skilled services were discontinued (Residents #26). In addition, the facility failed to 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 for 2 of 3 residents whose Medicare Part A services were discontinued and remained in the facility (#26 and #32).** 1. Resident #26's NOMNC indicated that the resident's Medicare Part A services would end on 1/25/24 and was signed by residents Guardian on 1/24/24, one day prior to end of skilled services. The medical record lacked evidence that Resident #28's legal guardian was provided a SNFABN when the Medicare A coverage for skilled services was discontinued. The resident	1. N/A – Patient/representative were informed of liabilities using a facility-created form when NOMNC was issued although it was not the formal CMS SNF-ABN form. 2. We will audit and identify other residents in-house who should have received a SNF-ABN. 3. Add SNF-ABN to standard forms used by the facility. Skilled Social Worker will issue it for any skilled patient with Medicare A who is remaining at the facility. 4. Skilled Social Worker will use a tracking spreadsheet to ensure provision of SNF-ABN for any patient that meets criteria. The completed SNF-ABN will also be scanned to the Business Office as a secondary cross-checking system. The Business Office will scan the SNF-ABN into patient EMR. 5. Will be completed by July 24, 2024

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	remained living in the facility. 2. Resident #32's Medicare Part A coverage for skilled services ended on 5/16/24. The medical record lacked evidence that Resident #32 or his/her legal representative was provided a SNFABN when the Medicare A coverage for skilled services was discontinued. The resident remained living in the facility.	
F 584 Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	**Based on observation and interview the facility failed to provide maintenance services necessary to maintain a sanitary and comfortable interior on 2 of 3 units observed (100 and 200 units).** 100 Unit the following was observed: -Room 109 the bathroom had dead bugs/debris in the light fixture -Room 112 entrance was missing the threshold -Room 114 had approximately 4 feet section of baseboard trim missing left of the window 200 Unit the following was observed: -Room 201 the sink was dripping and plugged up causing pooling water in the sink. -Room 202 the sink had a steady leak.	1.Room 109 light fixtures have been cleaned. Room 112 threshold was replaced. Room 114 has had the baseboard replaced. The sinks are being fixed as part of our renovation process. 2.Housekeeping and Maintenance will monitor rooms during their daily routine to ensure rooms are clean and safe. 3.We have added columns to our deep clean checklist (see Attached Forms) 4.Forms will be turned into the Housekeeping Supervisor. He will review them and perform any required corrective action. 5. Will be completed by July 27, 2024
F 623 Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	**Based on facility policy, record reviews and interview the facility failed to provide a written Notice of Transfer or Discharge to resident and/or resident representatives for 1 of 6 residents reviewed for hospitalization (Resident #28). In addition, the facility failed to notify the Office of the State Long-Term Care Ombudsman of hospital transfers for 2 of 6 residents reviewed for hospitalizations (Resident's #28 and #2).** 1. Resident #28 was admitted on 5/20/24 with diagnoses to include stage 3 chronic kidney disease. On 6/11/24 Resident #28 was transferred to an acute care hospital for evaluation and was subsequently admitted.	1. N/A – The patient/family was notified of the discharge to ED/hospital according to our internal records, but the Notice of Transfer/Discharge form (with date of transfer, reason for transfer checked) was not signed by patient/family. Our monthly transfer/discharge notification reports for May 2024 were sent to the Ombudsman on 6/11/2024. 2. We will audit and identify other residents in-house who should have received a Notice of Transfer/Discharge form due to a recent ED transfer. 3. Educate and reinforce current process of nurse initiating a Notice of Transfer/Discharge form when transferring a patient to ED/hospital. This form is already in the ED/hospital transfer packet and nursing already has it on the discharge checklist. Skilled Social Worker will then cross-check to ensure the accurate and timely completion/provision of the form to family. The Skilled Social Worker is responsible for sending

	Review of Resident #28's clinical record lacked evidence that a written notice of transfer/discharge was provided to the resident and/or resident representative. Further review lacked evidence the facility provided notice of this discharge to Office of the State Long-Term Care Ombudsman. 2. Resident #2 was admitted to facility on 5/9/24 with diagnoses to include acute respiratory failure with hypoxia, chronic systolic heart failure, and atrial fibrillation. On 6/1/24 Resident #2 was transferred to an acute care hospital and subsequently admitted. Review of Resident #2's clinical record lacked evidence that a written notice of transfer/discharge was provided to Office of the State Long-Term Care Ombudsman.	transfer/discharge notifications to the Ombudsman but we will determine a more effective process with checks and balances (including coverage backup) to ensure that it is done in a timely manner. 4. Skilled Social Worker will use a tracking spreadsheet to audit the completion of the Notice of Transfer/Discharge form as soon as they learn of someone transferring out. The completed Notice of Transfer/Discharge form will be scanned to the Business Office as a secondary cross-checking system. The Business Office will then scan the Notice of Transfer/Discharge form into patient EMR. 5. Will be completed by July 27, 2024
F 625 Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)	**Based on facility policy, record review and interview, the facility failed to issue a bed hold notice which included the daily cost of care, to a resident, known family member or legal representative for 1 of 6 sampled residents who had been transferred to the hospital (Residents #28).** Review of facility policy "Resident Bed Hold Policy for Hospitalizations" undated, states "Prior to and upon a transfer, written information will be given to the residents and/or the resident representatives that explains in detail: the rights and limitations of the resident regarding bed-holds, The reserve bed payment policy as indicated by the state plan, the facility per diem rate required to hold a bed (non-Medicaid resident), or to hold a bed beyond the state bed-hold period (Medicaid residents)." Resident #28 was admitted on 5/20/24 with diagnoses to include stage 3 chronic kidney disease. On 6/11/24 Resident #28 was	1. N/A – The patient/family was notified of the bed hold, but our current form did not have a signature line. 2. We will audit and identify other residents in-house who should have received a Bed Hold Notification. 3. Revise Bed Hold Notification form to have a place indicating who was notified, their signature if in person or, if done by phone or email, the specific date, who was notified, and reason. Nursing to initiate Bed Hold Notification when someone discharges to hospital or goes on LOA. Social Work will cross-check to ensure accurate completion of form and that the patient/family has received a copy. 4. Skilled Social Worker will use a tracking spreadsheet to audit the completion of the Bed Hold Notification form as soon as they learn of someone transferring out. The completed Bed Hold Notification form will be scanned to the Business Office as a secondary cross-checking system. The Business Office will scan the Bed Hold Notification form into patient EMR. 5. Will be completed by July 27, 2024

	transferred to an acute care hospital for evaluation and was subsequently admitted. Review of Resident #28's clinical record lacked evidence that a written notice bed hold was provided to the resident and/or resident representative.	
F 655 Baseline Care Plan CFR(s): 483.21(a)(1)-(3)	**Based on interviews and record reviews, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours that included the problems, interventions, and initial goals needed to provide minimum healthcare information necessary to properly care for 4 of 14 residents that were reviewed for new admissions. (#190, #196, #2 and #28)** 1. Resident #190 was admitted to the facility on 5/29/24. The hospital discharge summary included information that the resident was admitted with diagnosis of COVID-19, Atrial flutter requiring anticoagulant medication and a Coronary Artery Bypass Graft (CABG) on 5/24/24 which required Epicardial pacing wires. The discharge instructions stated, "Epicardial pacing wires: prepped and cut on day of discharge. Instructions: you had temporary epicardial pacing wires placed during surgery and utilized in the post-operative period. These rest on the surface of your heart and allowed us to temporarily control your heart rate. These wires exited the skin just below your ribcage and were cut at the time of discharge. These wires should no longer be visible... Do NOT pull these wires. Incision: Keep your incision dry. No bathing, whirlpool tub, or swimming for 3 weeks. Review of the clinical record lacked evidence of a baseline care plan completed within 48 hours to include the instructions necessary to properly care for	1. Resident #190 and Resident #2 have been discharged. Resident #196 remains skilled and a person-centered comprehensive care plan has been developed and includes measurable objectives and timeframes to meet his medical, nursing, mental and psychosocial needs. Resident #28 has transitioned to LTC and a person center comprehensive care plan has been developed with the same criteria as above. 2. We will audit and identify other residents in-house who need their baseline care plans updated to meet the requirements. 3.We are updating our electronic medical record to include goals and interventions that will populate the baseline care plan for person-centered care. 4. Upon completion of the updates to our EMR, we will review all baseline care plans of in-house residents to ensure requirements are met and revise as needed. Ongoing, the RN care coordinator will be responsible for monitoring and updating care plans as needed. 5. Will be completed by July 27, 2024

	Resident #190's immediate health and safety needs for the above concerns. 2. Resident #196 was admitted to the facility on 6/4/24. The hospital discharge summary included information that the resident was admitted with diagnosis of left hip prosthetic joint infection requiring intravenous antibiotics via a peripherally inserted central catheter line. Review of the clinical record lacked evidence of a baseline care plan completed within 48 hours to include the instructions necessary to properly care for Resident #160's immediate health and safety needs for the above concerns. On 6/12/24 at approx. 10:55 a.m., during an interview, the above was discussed with the Registered Nurse Admission Coordinator. 3. Resident #2 was admitted to facility on 5/9/24 with diagnoses to include acute respiratory failure with hypoxia, type 2 diabetes mellitus, chronic systolic heart failure, atrial fibrillation, and malnutrition. Review of the clinical record lacked evidence of a baseline care plan completed within 48 hours to include the instructions necessary to properly care for Resident #2's immediate health and safety needs for the above concerns. 4. Resident #28 was admitted on 5/20/24 with diagnoses to include chronic kidney disease stage 3, benign prostatic hyperplasia with lower urinary tract symptoms and history of multiple urinary tract infections requiring use of prophylactic antibiotics. Review of the clinical record lacked evidence of a baseline care plan completed within 48 hours to include the instructions necessary to properly care for Resident #28's immediate health and safety	

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	needs for the above concerns.	
F 656 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	**Based on facility policy, record reviews and interviews the facility failed to update and/or implement goals and interventions for 2 of 14 care plans reviewed. (Resident's #12 and #29).** 1. Resident #12 was admitted on 9/29/22 and has diagnoses to include chronic kidney disease stage 2, congestive heart failure [CHF], Diabetes Mellitus II[DMII], right leg above knee amputation and atrial fibrillation. Review of Resident #12's clinical record revealed his/her last quarterly Minimum Data Set [MDS] was completed on 3/7/24. The most recently signed provider orders dated 4/26/24 revealed the flowing: -Order with start date of 1/18/23 for "Blood glucose checks fasting and pm qid [4 times daily]-call provider if BG above 400." -Order with start date of 5/17/23 for "insulin Aspart 100 unit/ml solution injection sub-q 8units tid [three times daily] for DMII." -Order with start date of 10/1/22 for " insulin Aspart 100 unit/ml solution sub q tid per sliding scale 0730/730 am 1130/1130 am, 1630/430pm sliding scale: 70-150=0 units, 151-199=1 units 200-249=2 units, 250-299=3 units 300-349= 4 units, 350-399=5 units >400 call MD/provider for DMII." -Order with a start date of 1/21/23 for apixaban 5mg tablet by mouth 1 tab bid for DVT [deep vein thrombosis] prophylaxis -Order with start date of 3/22/24 for torsemide 20 mg tablet by mouth ...2 tablet/40mg 8am for CHF." -Order with start date of 4/4/24 for "ipratropium-albuterol 0.5mg/3ml -2.5 mg/3ml solution inhalation 1 vail tid prn for dyspnea."	1. Resident # 12 and resident #29's person centered comprehensive care plan has been updated, consistent with the resident's rights and includes measurable objectives and timeframes to meet his medical, nursing and mental and psychosocial needs. 2. We will audit and identify other residents in-house who need their comprehensive care plans updated to meet the requirements. 3.We are updating our electronic medical record to include goals and interventions that will populate the comprehensive care plan for person-centered care. 4. Upon completion of the updates to our EMR, we will review all comprehensive care plans of in-house residents to ensure requirements are met and revise as needed. Ongoing, the RN care coordinator will be responsible for monitoring and updating care plans as needed. 5. Will be completed by July 27, 2024

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	Review of Resident #12's care plan updated 5/31/24 lacked evidence of goals and interventions for the above diagnoses. 2. On 6/10/24 at 9:47 a.m., in an interview with the Resident #29's representative, [he/she] stated, "The doctor has told me how to massage [his/her] leg because now that [he/she] is on Hospice they may not cover continued Physical Therapy (PT) for [him/her]."	
F 812 Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	**Based on observations and interviews, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for the floor stand mixer, floor stand fan, and the small countertop mixer. Freezer #7 contained unlabeled and undated items for 2 of 2 observations. Additionally, the dry storage room floor was not maintained in clean and sanitary manner, there is no temperature log for the dish machine, and the Mere Point Unit Freezer contained the ice scoop in with the ice for 1 of 3 days of survey.** 1- Observed that the facility lacks a log for the dish machine. The cook stated, "we are supposed to have a log for that, but I do not know where it is." In an interview, the Kitchen Coordinator and a Diet Aide, that run the dish machine, both stated in the instructions for running the dish machine that they must observe the temperature gauge and see that it rises to the correct temperature. 2- Observation of the dry storage room to have food on the floor i.e. packets of peanut butter, crackers and an energy bar. 3- Observation of the large floor mounted mixer to have stuck on dried food on mixer. At this time, the cook stated that she "had not used the machine for 2 days".	<u>Dish Machine Temperature Log</u> 1. Corrective action accomplished by showing the kitchen coordinator and diet aids where the blank dish machine temperature logs are located and how to read the temperature gauges. 2. N/A 3. In order to ensure consistent compliance with the dish machine temperature logs, the task of checking the temperatures was reassigned to the on duty opening cook. As the kitchen is opened for service, the opening cook will check that the dish machine is operating within temperature guidelines and complete the log. 4. Food and Nutrition Services (FNS) Leadership will audit the logs daily. 5. The correction plan will be put in place completely by July 1, 2024. <u>Dry Storage Sanitation</u> 1. Corrective action accomplished by weekly staff meetings to include discussion and education of importance of maintaining a clean and sanitary kitchen as well as picking up after yourself. We also instituted a new cleaning guide/standard work. 2. N/A 3. Continued discussion, education, and auditing of closing check lists for thoroughness will help ensure compliance. Daily sweeping of dry goods will be reassigned from the cook's closing checklist to wait staff's closing checklist. 4. Food and Nutrition Services (FNS) Leadership will audit the logs daily.

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	4- Observation of the floor mounted fan to have a light to moderate covering of dirt like debris on fan with some long strands of dust like debris blowing in the air. 5- Observation of the small countertop mixer with dried food/debris on the side and the stand. No staff member could say when that machine was last used. 6- Observation of Kitchen Freezer #7 containing a package of Frozen French Fries with no label or date, an open bag of Hash browns with no date, and two packages of log shaped food with no label and no date. On 6/12/24 at 8:35 a.m. in the Mere Point Unit Kitchen, during observation of breakfast, surveyor noted the ice scoop in the ice bin of the freezer compartment of fridge. At this time, the kitchen staff member confirmed the ice scoop should not be stored in the ice bin.	5. The correction plan will be put in place completely by July 8, 2024. <u>Floor Mixer Sanitation and Cleanliness</u> 1. Corrective action accomplished by weekly staff meetings to include discussion and education of importance of maintaining a clean and sanitary kitchen. We also instituted a new cleaning guide/standard work. 2. N/A 3. Equipment cleanliness is part of the closing cook's checklist. The floor mixer will be specifically added to the checklist in order to bring more attention to it. As part of the floor mixer cleanliness guideline, covering the mixer after cleaning with a bag will be instituted. 4. Food and Nutrition Services (FNS) Leadership will do walkthroughs daily and audit the logs daily. 5. The correction plan will be put in place completely by July 8, 2024. <u>Floor-Mounted Fan Cleanliness</u> 1. Corrective action will be accomplished by removing all fans from the kitchen. 2. N/A 3. Fans are removed and not allowed to be in the kitchen moving forward. 4. Daily kitchen walk through by the food and nutrition leadership team will ensure no fans are in the kitchen. 5. This was corrected on June 11, 2024. <u>Cleanliness of Small Countertop Mixer</u> 1. Corrective action accomplished by weekly staff meetings to include discussion and education of importance of maintaining a clean and sanitary kitchen. Also by instituting a new cleaning guideline as detailed below. 2. N/A 3. Equipment cleanliness is part of the closing cook's checklist. The counter mixer will be specifically added to the checklist in order to bring more attention to it. As part of the counter mixer cleanliness guideline, covering the mixer after cleaning with a dated and initialed bag will be instituted. 4. Food and Nutrition Services (FNS) Leadership will do walkthroughs daily and audit the logs daily.

		5. The correction plan will be put in place completely by July 8, 2024. <u>Freezer Labeling and Dating of Freezer #7</u> 1. Corrective action accomplished by weekly staff meetings to include discussion and education of importance of labeling and dating. Labeling and dating is an ongoing area of improvement and encompasses all staff. 2. N/A 3. Continued discussion, education, and auditing of closing check lists for thoroughness will help ensure compliance. Checking labels and dates is part of the closing cook's checklist. Use of this checklist and the audits that are associated with the checklists will ensure compliance. 4. Food and Nutrition Services (FNS) Leadership will do walkthroughs daily and audit the logs daily. 5. The correction plan will be put in place completely by July 1, 2024. <u>Ice Scoop in Refrigerator Ice Bin on Mere Point</u> 1. Corrective action will be accomplished by eliminating the ice making capabilities of the refrigerator. 2. N/A 3. The ice making capability of the Mere Point kitchen refrigerator will be disabled. Additionally, a laminated sign will be put on all operationing ice makers that have a holding bin stating "do not leave scoops in bin". Where needed, a proper holder for the ice scoop will be created. 4. Food and Nutrition Services (FNS) Leadership will do walkthroughs daily and audit the logs daily. 5. The correction plan will be put in place completely by July 8, 2024.
F 880 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	**Based on observations and interviews 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 urinary collection devices for 3 of 3 days of survey on 2 of 3 units (100 and 200 Units).** Observations of 100 Unit revealed the following:	1. All urinary collection devices in the identified rooms were immediately cleaned, bagged, and hung off the floor. 2. Will identify all in-house residents who use urinary collection devices. 3. Will create a standard work and purchase equipment as needed for the sanitary storage of personal reusable urinary devices in resident rooms to prevent cross-contamination. Will educate all nursing, rehab, activities, housekeeping, and facilities staff on the new process.

	-On 6/10/24 at 9:48 a.m., and 6/11/24 at 7:25 a.m., observations of Room 109 bathroom revealed uncovered commode bucket on floor, available for use. -On 6/10/24 at 9:25 a.m., observation of Room 112 bathroom revealed uncovered commode bucket on the floor with bed pan stored inside, available for use. Observations of 200 unit revealed the following: -On 6/11/24 at 8:14 a.m. and 3:09 p.m., and on 6/12/24 at 8:04 a.m., observations of Room 201 bathroom revealed an uncovered commode bucket on bathroom floor, available for use. - On 6/11/24 at 8:21 a.m., and 3:13 p.m., observations of Room 202 bathroom revealed an uncovered commode bucket on floor, available for use. -On 6/12/24 at 8:16 a.m. 2 surveyors observed Room 202 bathroom containing uncovered commode bucket on floor and urinal drainage bag hanging over the hand railing containing approximately 250 ccs yellow liquid.	4. Will do regular walk-throughs to audit adherence to the new process, adjusting the frequency of audits as needed. 5. Will be completed by July 27, 2024.
F 881 Antibiotic Stewardship Program CFR(s): 483.80(a)(3)	**Based on record review and interviews the facility failed to maintain an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This could affect all residents receiving antibiotics.** Review of facility policy "Antibiotic Stewardship" dated 4/15/24 states "Purpose: to monitor the use of antibiotics in our residents. Promotes the judicious use of antimicrobials in order to optimize the treatment of infections, reduce the risk of adverse events to patients/resident, and minimize the development of antibiotic-resistant organisms ...conduct surveillance and collect data on pathogens related to antibiotic."	**We disagree and are requesting an IDR (Informal Dispute Resolution) regarding this citation of deficiency. Please see IDR Request document.

	On 6/12/24 at 1:04 p.m., during an interview, the Admissions Coordinator, Registered Nurse Care Manger, and Infection Preventionist, confirmed the facility does not track antibiotic use.	