STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205174	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFIELD REHAB & LIVING CENTER	95 MAIN STREET PO BOX 489, HARTLAND, Maine, 04943

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F0000	INITIAL COMMENTS From 7/21/25 through 7/23/25, unannounced on-site visits were conducted at Sanfield Rehabilitation and Living Center for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification and to investigate complaints #221042 and #221052. It is determined that Sanfield Rehabilitation and Living Center is not in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F0000		
F0582 SS = A	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 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.	F0582		

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F0582 SS = A	Continued from page 1 (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 review and interview, the facility failed to ensure the Skilled Nursing Facility Advance Beneficiary Notices (SNFABN) Form 10055, which included appeal rights and liability of payment, were provided at least 2 days prior to the resident's last covered day, for 1 of 1 residents whose Medicare Part A services were discontinued, and remained in the facility (Resident #15 [R15]). R15's Medicare Part A coverage for skilled services ended on 5/28/26. The cliical record lacked evidence that R15 or his/her legal representative was provided a SNFABN when the Medicare A coverage for skilled services was discontinued and the resident remained living in the facility. On 7/21/2025 at 2:35 p.m., during an interview with a surveyor, the Social Services Director stated that R15 was not provided the SNFABN Form 10055 when the Medicare A coverage for skilled services was discontinued but R15 should have received one. The surveyor confirmed this finding at this time.	F0582	Medicaid/Medicare Coverage/Liability Notice Resident # R15 did not receive SNFABN Form 10055 2 days prior to their last covered Med A stay. •Resident #R15 was not negatively impacted by this finding; other residents have the potential to be minimally affected by the same or similar issue. •No other residents were affected by this deficient practice. •The facility has implemented a new process on tracking Med A discharges in order to issue timely SNFABN notices. •The Administrator and/or designee(s) will conduct routine/random audits to ensure the timely issuing of SNFABN notices are completed. •The results of audit will be reported to the facility Quality Assurance Committee for the next 3 months, as indicated	9.30.25
F0636 SS = D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment	F0636		

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F0636 SS = D	Continued from page 2 The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation	F0636		

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F0636 SS = D	Continued from page 3 and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to complete an annual Comprehensive Minimum Data Set (MDS) 3.0 with Care Area Assessments timely for 1 of 1 resident reviewed for Accident Hazards (Resident #17 [R17]). The Long Term Care Facility Resident Assessment Instrument (RAI) User's Manual, Version 1.19.1, dated October 2024, on page 2-16, Section 2.6 Required OBRA Assessments for the MDS provided a table "RAI OBRA-required Assessment Summary required assessments" that directs when assessments are due to be completed. Annual MDS are due to be completed 14 days from the ARD date. On 7/22/25, a review of R17's clinical record was completed. R17's annual MDS with an Assessment Reference Date (ARD) of 4/2/25 was due to be completed by 4/16/25, 14 days from the ARD date. The CAA completion date was 4/28/25, 12 days late. On 7/23/25 at 10:48 a.m., a surveyor confirmed this finding with the Director of Nursing.	F0636	Comprehensive Assessments & Timing Resident 17 did not have their Care Area Assessment (CAA) completed within 14 days of the Assessment Reference Date (ARD) on their MDS. •Resident#R17 was not negatively impacted by this finding; other residents have the potential to be minimally affected by the same issue. •No other residents were affected by this deficient practice. •The MDS Coordinator was provided education regarding the timely completion of the CAAs. •The Director or Nursing Services, and/or designee(s) will conduct routine and random audits to ensure the timely completion of CAAs and to ensure the plan of correction improves the areas of concern and sustains compliant practice(s). •The results of the audit will be reported to the facility's Quality Assurance Committee for 3 months, as indicated	9.30.25
F0637 SS = E	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or	F0637		

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F0637 SS = E	Continued from page 4 mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is NOT MET as evidenced by: Based on interview and record reviews, the facility failed to complete a significant change in status Minimum Data Set 3.0 (MDS 3.0) assessment within 14 days of a resident's admission to hospice services, for 2 of 3 sampled residents (Resident #10 [R10] and R9). 1.Review of the RAI (Resident Assessment instrument) manual directs that a significant change MDS ARD (assessment reference date) date is no later than 14th calendar day after determination that significant change occurred. Completion is the 14th calendar day after determination. On 7/22/25 at 12:16 p.m., a review of R10's clinical record was completed. R10 was admitted to Hospice on 6/27/25 and a Significant Change MDS was initiated with an Assessment Reference Date (ARD) of 7/3/25 but was not completed. The completion date should have been 7/11/25 and as of 7/22/25 the MDS was not completed. On 7/22/25 at 1:52 p.m., during an interview with a surveyor, The Vice President of clinical Services reviewed the clinical records and stated the MDS's had not been completed timely. 2. On 7/21/25, R9's clinical record was reviewed and indicated that R9 entered Hospice on 6/22/25. A significant change MDS was due to be completed by 7/6/25, within 14 days after the entrance into Hospice. R9's significant change MDS was not signed by the Registered Nurse, indicating completion until 7/17/25, 11 days late. On 7/22/2025 at 1:52 p.m., during an interview with the Vice President of Clinical Services, a surveyor confirmed this finding.	F0637	Comprehensive Assessment after a significant change Residents R10 and R9 did not have their Significant Change MDS completed within 14 days of initiation. •Residents' #R10 and #R9 were not negatively impacted by not having the significant MDSs completed within 14 days of initiation. •No other residents were impacted by this deficient practice. •The MDS Coordinator was provided education regarding the timely completion of a significant change MDS once it is initiated. •The Director of Nursing Services, and/or designee(s) will conduct routine and random audits to ensure timely completion of significant change MDSs and to ensure the plan of correction improves the areas of concern and sustains compliant practices(s). •The results of the audit will be reported to the facility's Quality Assurance committee for 3 months, as indicated.	9.30.25
F0638 SS = D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment	F0638		

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F0638 SS = D	Continued from page 5 A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews and interviews, the facility failed to complete a quarterly Minimum Data Set (MDS) 3.0 in a timely manner for 2 of 12 sampled residents (Resident #11 [R11] and R7). The Long Term Care Facility Resident Assessment Instrument (RAI) User's Manual, Version 1.19.1, dated October 2024, on page 2-16, Section 2.6 Required OBRA Assessments for the MDS provided a table "RAI OBRA-required Assessment Summary required assessments" that directs when assessments are due to be completed. Quarterly MDS are due to be completed 14 days from the ARD date. 1. On 7/21/25, R11's clinical record was reviewed. R11's Quarterly MDS had an Assessment Reference Date (ARD) of 7/3/25 and was due to be completed by 7/17/25, which is the ARD plus 14 calendar days. The assessment was not completed at time of review. On 7/22/2025 at 2:37 p.m., during an interview with the Vice President of Clinical Services, a surveyor confirmed that R11's quarterly MDS was late. 2. On 7/22/25, R7's clinical record was reviewed. R7's Quarterly MDS had an Assessment Reference Date (ARD) of 7/8/25 and was due to be completed by 7/22/25, which is the ARD plus 14 calendar days. The assessment was not completed at time of review. On 7/23/2025 at 10:46 a.m., during an interview with the Director of Nursing, a surveyor confirmed that R7's quarterly MDS was now late.	F0638	Qrtly Assessment at Least Every 3 Months Residents R11 and R7 Quarterly MDS did not have their MDS completed timely (Assessment Reference Date plus 14 days.) •Resident's #R11 and #R7 were not negatively impacted by not having their quarterly MDS completed timely. •No other residents were impacted by this deficient practice. •The MDS Coordinator was provided education regarding the timely completion of a quarterly MDS once it is initiated. •The Director of Nursing Services, and/or designee will conduct routine and random audits to ensure timely completion of quarterly MDS and to ensure the plan of correction improves the areas of concerns and sustains compliant practice(s). •The results of the audits will be reported to the facilities Quality Assurance Committee for the next 3 months, as indicated	9.30.25
F0640 SS = E	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments.	F0640		

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F0640 SS = E	Continued from page 6 (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews, Minimum Data Set 3.0 (MDS)	F0640		

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F0640 SS = E	Continued from page 7 reviews and interviews, the facility failed to electronically submit discharge MDS data to the State MDS database within 14 days after completion for 4 of 12 residents MDS's reviewed (Resident #2 [R2], R3, R19, R21). 1. On 7/21/25, a review of R2's clinical record indicated that R2 was discharged on 6/5/25. A review of R2's discharge MDS with an ARD date of 6/5/25 indicated that assessment was due to be completed by 6/19/25 and was required to be electronically submitted to the State MDS database within 14 days after completion (7/3/25) but had not been submitted at time of review. 2, On 7/21/25, a review of R3's clinical record indicated that R3 was discharged on 6/6/25. A review of R3's discharge MDS with an ARD date of 6/6/25 indicated that assessment was due to be completed by 6/20/25 and was required to be electronically submitted to the State MDS database within 14 days after completion (7/4/25) but had not been submitted at time of review. On 7/22/2025 at 1:52 p.m., during an interview with the Vice President of Clinical Services, a surveyor confirmed these findings 3. On 7/22/25, a review of R19's clinical record and discharge MDS was completed. Documentation on R19's MDS indicated that the resident's discharge date was 6/4/25 and the MDS was completed on 6/5/26. This MDS was required to be electronically submitted to the State MDS database within 14 days (6/19/25), but was not submitted until 7/22/25 (33 days late). On 7/23/25 at 9:00 a.m., in an interview with the surveyor, the Director of Nursing (DON) confirmed the MDS's were not submitted timely. 4. On 7/22/25, a review of R21's clinical record and discharge MDS was completed. Documentation on R21's MDS indicated that the resident's discharge date was 4/9/25 and the MDS was not completed until 7/14/26 (82 days late). This MDS was required to be electronically submitted to the State MDS database within 14 days (4/23/25), but was not submitted until 7/22/25 (90 days late). On 7/23/25 at 9:00 a.m., in an interview with the surveyor, the Director of Nursing (DON) confirmed the MDS's were not submitted timely.	F0640	Encoding/Transmitting Resident Assessment 1 & 2) Resident's #R2 and #R3 MDSs were submitted on July 23rd. 3 & 4) Resident's #R19 and #R21 were submitted late. •No residents were affected by these findings; other residents have a minimal risk of being affected by these finding. •The MDS Coordinator was provided education regarding the timely submission completed MDSs. •The Director of Nursing Services, and/or designee will conduct routine and random audits to ensure timely submission of completed MDSs and to ensure the plan of correction improves the areas of concerns and sustains compliant practice(s). •The results of the audits will be reported to the facilities Quality Assurance Committee for the next 3 months, as indicated 9.30.25	

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F0640 ~~F0656~~ SS = E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F0640 F0656		

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F0656 SS = E	Continued from page 9 (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and interview, the facility failed to ensure that a care plan was developed in the area of Hospice care for 2 of 3 residents reviewed for Hospice (Resident #10 [R10] and R9). 1. Review of R10's clinical record stated he/she was admitted into Hospice on 6/27/25. The clinical record lacked evidence that a comprehensive care plan had been developed in the area of Hospice care that included goals and interventions. On 7/22/25 at 12:30 p.m., during an interview with the Director of Nursing the surveyor confirmed the above finding. 2. On 7/22/25, R9's clinical record was reviewed indicated R9 was admitted on Hospice on 6/22/25. The clinical record lacked evidence that a comprehensive care plan had been developed in the area of Hospice care that included goals and interventions. On 7/22/25 at 12:31 p.m., during an interview with the Director of Nursing, the surveyor confirmed the above finding.	F0656	Development /Implement Comprehensive Care Plan 1 & 2) Resident #R10 and #R9 now have comprehensive care plans which include hospice. •No other residents were affected by these findings; other residents have a minimal risk of being affected by these finding. •The facility implemented a new scanning process to ensure hospice care plans are attached the hospice residents EHR. •The Director of Nursing Services, and/or designee will conduct routine and random audits to ensure hospice care plans are scanned and attached to hospice residents EHR and to further ensure the plan of correction improves the areas of concerns an sustains compliant practice(s). •The results of the audits will be reported to the facilities Quality Assurance Committee for the next 3 months, as indicated.	9.30.25
F0730 SS = D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(e)(7) §483.35(e)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is NOT MET as evidenced by: Based on performance evaluation review and interview, the facility failed to complete annual performance evaluations at least every 12 months for 1 of 5 sampled employees (Certified Nursing Assistant #1 [CNA1]). 1. CNA1 was hired on 8/3/2004. The facility was unable to provide evidence of a completed annual performance evaluations for 2024.	F0730	Nurse Aide Perform Review-12 hr/yr In Service 1) Evaluation for C.N.A 1 has been combined into 2024/2025 review since the evaluation is due to be completed in August. •Personal files for C.N.A staff will be reviewed to identify dates evaluations are due – out of date evaluations will be completed, as soon as able. •The facility implemented a monitoring system to ensure performance reviews are up to date and evaluations will be completed as timely as able, going forward. •The Business Office Manager/DNS, and/or designee(s) will complete routine and random audits of C.N.A personnel files for timely completion of performance evaluations and to further ensure the plan of correction improves the areas of concerns and sustains compliant practice(s). • The results of the audits will be reported to the facility's Quality Assurance Committee x3 months, as indicated.	9.30.25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205174	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFIELD REHAB & LIVING CENTER	95 MAIN STREET PO BOX 489, HARTLAND, Maine, 04943

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F0730 SS = D	Continued from page 10 On 7/23/25 at 12:45 p.m., in an interview with a surveyor, the Administrator confirmed that CNA1 had not received an annual performance evaluations in 2024.	F0730		
F0880 SS = D	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, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and	F0880	Infection Prevention & Control 1) Resident #R12 received his insulin injection from a nurse without having the PPE on (gloves). •No other residents were affected by this deficient practice; all other residents had the potential to be affected. •Staff education was provided to all licensed staff regarding appropriate use of PPE. •The DNS and/or designee will complete routine and random audits to ensure gloves are being worn when insulin injections are being administered and also further endure the plan of correction improves the areas of concern and sustains complaint practice(s). •The results of the audits will be reported to the facility's Quality Assurance Committee x3 months, as indicated	9/30/25

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F0880 SS = D	Continued from page 11 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review and interview, the facility failed to maintain an Infection Control Program designed to help prevent the development and transmission of disease and infection by failing to wear gloves during a subcutaneous injection for 1 of 1 resident observed during medication administration. (Resident# 12 [R12]) On 7/22/25 at 7:50 a.m., the Charge Nurse was observed in the nurse's station preparing R12's Lantus insulin dose 25 units with no infection control concerns. The Charge Nurse then entered R12's room and asked him/her where they wanted their injection. The charge nurse then cleaned the abdominal area with an alcohol prep pad and then administered the 25 units of Lantus subcutaneously without wearing gloves. At this time the Charge Nurse acknowledged that she did not wear gloves during this insulin injection and that she should have been wearing gloves, the surveyor confirmed this finding.	F0880		

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F0880 ~~F0909~~ SS = D	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is NOT MET as evidenced by: Based on observations and interview, the facility failed to ensure that a bed gap filler (bumper pad) was in place between the mattress and foot of bed frame to eliminate the potential risk of entrapment of body parts for 1 of 22 resident beds observed (Resident #17 [R17]). On 7/21/2025 at 12:42 p.m., two surveyors observed a gap stuffed with blankets between the foot board of bed frame and mattress of R17's bed. The gap between the end of the mattress and foot board was 5 inches. On 7/21/25 at 2:15 p.m., during an observation of R17's bed, the Administrator stated that there should have been a bumper pad in place and not stuffed with blankets, thinking maybe it was soiled and sent for cleaning. The bumper pad was immediately put in place by the facility.	F0880 F0909	Resident Bed 1) Resident #R17 immediately had the bath blanket removed and a bolster was placed at the foot of the bed for the use of an appropriate gap filler. •No other residents were affected by this deficient practice; all other resident has a potential to be affected. •The facility completed and audit and implemented a monitoring system to ensure all bed gaps are filled with appropriate equipment. •The Maintenance Director and/or designee will complete routine and random audits to ensure there are no potential gaps between bed frames and mattresses and to further ensure the plan of correction improves the areas of concern and sustains complaint practice(s). •The results of the audits will be reported to the facility's Quality Assurance Committee x3 months, as indicated	9.30.25