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F 000	INITIAL COMMENTS	F 000		

(Census 35, Capacity 51)

From 3/31/25 through 4/3/25, and on 4/9/25, the Division of Licensing and Certification conducted on-site visits at High View Rehabilitation and Living Center for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification. It was determined High View Rehabilitation and Living Center was not in compliance with 22 Code of Federal Regulations, Part 483, Subpart B - Requirements for Long Term Care Facilities.

Non-compliance with 42 CFR Part 483, Subpart §483.25(d) F689 - Free of Accident Hazards, was determined to constitute an immediate jeopardy ("IJ") situation beginning on 3/31/25 and ending on 4/9/25. The facility failed to provide the correct size mattresses for the bed frames resulting in the exposed metal bed frame, sharp metal edges where plastic pieces were missing, exposure to movable mechanical hinges, and risk for entrapment of body parts for 2 of 35 residents. See §483.25(d) F689 for details.

Non-compliance with 42 CFR Part 483, Subpart §483.25(n) F700 - Bedrails, was determined to constitute an immediate jeopardy ("IJ") situation beginning on 3/31/25 and ending on 4/9/25. The facility failed to regularly inspect mattresses and bed rails, and/or identify areas of possible entrapment. This failure had the potential to effect 35 out of 35 residents with bed rails. See §483.25(n) F700 for details.

Non-compliance with 42 CFR Part 483, Subpart §483.90(d)(3) F909 - Resident Bed, was

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F 000	Continued From page 1 determined to constitute an immediate jeopardy ("IJ") situation beginning on 3/31/25 and ending on 4/9/25. The facility failed to identify the potential for entrapment through regular inspections of all bed frames, mattresses and bed rails. This had the potential to effect 35 out of 35 residents. See §483.90(d)(3) F909 for details. Immediate jeopardy is defined as a situation in which a recipient of care has suffered or is likely to suffer serious injury, harm, impairment, or death as a result of a provider's noncompliance with one or more health and safety requirements. On 4/1/25 at 12:25 p.m., the Administrator was provided with written notification (IJ templates F689, F700, and F909) related to the IJ situation and a removal plan was requested. On 4/1/25 at 3:50 p.m., the facility submitted an acceptable removal plan. The removal plan was reviewed and approved by the State Agency on 4/1/25 at 4:05 p.m. This removal plan indicated the following: F689 -Free of Accident Hazards - Resident #3 sustained a minor skin tear injury due to this. - Resident #3's bed was immediately replaced to avoid further injury. - [High View Manor (HVM)]'s Maintenance, Housekeeping, and Laundry Supervisor was educated in the use of the Bionix Bed System Measurement Device that HVM has owned. - The facility has implemented the utilization of the Bed System Measurement Device Test tool method and will have completed measuring the remaining 34 beds by the end of today, April 1, 2025.	F 000		

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- All scheduled employees, inclusive of Nurses, [Certified Medication Aide (C.M.A.)]'s, [Certified Nursing Assistant (C.N.A.)]'s, and housekeepers are going to be educated on bed gap awareness by Friday, April 4, 2025. Per Diem staff will be trained prior to working their next shift.

F700 - Bedrails
- Resident #26 has not incurred injury due to lack of using the Bed System Measurement Device Test.
- Resident #26 was immediately placed in a bed that was tested using the Bed System Measuring Device.
- HVM's Maintenance, Housekeeping, and Laundry Supervisor was educated in the use of the Bionix Bed System Measurement Device that HVM has owned.
- The facility has implemented the utilization of the Bed System Measurement Device Test tool method and will have completed measuring the remaining 34 beds by the end of today, April 1, 2025.
- All scheduled employees, inclusive of Nurses, [Certified Medication Aide (C.M.A.)]'s, [Certified Nursing Assistant (C.N.A.)]'s, and housekeepers are going to be educated on bed gap awareness by Friday, April 4, 2025. Per Diem staff will be trained prior to working their next shift.

F909 - Resident Bed
- Resident #13 and Resident #26 have not incurred injury and Resident #3 sustained a minor skin injury due to the lack of using the Bed System Measurement Device Test.
- Resident #3's bed was immediately replaced to avoid further injury. Resident #26 was immediately placed in a bed that was tested using the Bed System Measurement Device. A new

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F 000	Continued From page 3 mattress has been ordered for Resident #13. The Bed System Measurement Device tools will be used to assess the proper fit to the current bed frame upon delivery. - The facility has implemented the utilization of the Bed System Measurement Device Test tool method and will have completed measuring the remaining 34 beds by the end of today, April 1, 2025. - All scheduled employees, inclusive of Nurses, [Certified Medication Aide (C.M.A.)]'s, [Certified Nursing Assistant (C.N.A.)]'s, and housekeepers are going to be educated on bed gap awareness by Friday, April 4, 2025. Per Diem staff will be trained prior to working their next shift. On 4/9/25, surveyors verified that the facility's plan to remove the IJ(s) was implemented and was effective by observations of residents; interviews with staff; and document review of policies and education content including sign-in sheets. The surveyors determined the removal of the IJ(s) on 4/9/25.	F 000		
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 interviews and observations, the facility failed to meet the reasonable needs of residents in the area of bed size for 1 of 35 residents reviewed for accommodation of needs (Resident	F 558		

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F 558	Continued From page 4 #13 ["R13"]) Finding: On 3/31/25 at 2:00 p.m., a surveyor spoke to R13, he/she stated that his/her bed is too short for them and was told by the facility they would get a bed to fit him/her. R13 stated that it has not happened. Observation of the bed shows there is a 3-inch gap from the end of the mattress to the footboard with a rolled-up blanket to fill the gap. R13 is over 6 feet tall and the mattress on the bed is not long enough leaving a gap at the foot of the mattress where his/her feet hang over the edge of the mattress. On 3/31/25 at 2:19 p.m., a surveyor confirmed this finding during an interview with the Maintenance/Housekeeping/Laundry Supervisor and was told the facility has ordered R13 a longer mattress on this date.	F 558		
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	F 584		

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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, 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 maintain the building in good repair for 4 of 4 days of survey (3/31/25, 4/1/25, 4/2/25, and 4/3/25).

Findings:

On 3/31/25 at 11:22 a.m., a surveyor observed chipped paint around the room 200 placard, and the wall next to the nurse station door had a large un-painted area around a camera installation.

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On 4/1/25 at 8:08 a.m., during an interview with a surveyor and the Administrator, Resident #26's (R26) bathroom was observed. The bathroom had a large trash bag taped to the ceiling directing a steady leak of water into a trash barrel. Paint chips and insulation debris was observed in the standing water of the trash barrel. The Administrator stated it has been like that over the winter and will not be repaired until it is warmer outside. The Maintenance, Housekeeping, and Laundry Supervisor was able to redirect all the water into R26's bathroom (R26 does not use the bathroom).

On 4/2/25 at 7:30 a.m., a surveyor observed the ceiling outside room 200 to be discolored, and large pieces of peeling paint were observed hanging down and an out of order sign was observed on the bathroom door in room 203. At 7:51 a.m., during an interview with 2 surveyors, the Maintenance, Housekeeping, and Laundry Supervisor stated the resident in room 203 does not use the toilet, and the toilet has been out of order for 2 weeks due to a leaking seal.

On 4/3/25 at 9:00 a.m., during a facility tour with a surveyor and the Maintenance, Housekeeping, and Laundry Supervisor, the following were observed and confirmed:
-the transition strip, connecting the hall to the sitting area created uncleanable surfaces at the wall, and had accumulations of dirt /debris along the strip border;
-the wall next to the nurse station door had a large un-painted area around a camera installation;
-the wall around the room number placard for room 200 had chipped paint;
-the ceiling outside of room 200 is discolored, and

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F 584	Continued From page 7 peeling paint observed hanging from the ceiling; -the resident bathroom in room 203 is out of order due to a leaking toilet; -the closet door of room 227 is displaced from the track, the track support is broken. The closet ceiling in room 227 is discolored with peeling paint. Paint chips observed on the resident's clothing below the ceiling damage; and -the resident bathroom in room 229 is observed with trash bag funnel taped to ceiling draining water into the trash barrel below. Paint chips and insulation debris observed in the standing water of the collection barrel.	F 584		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interviews, the facility failed to ensure physician orders were followed for 1 of 5 residents reviewed for unnecessary medications (Resident #27, ["R27"]). Finding: On 4/2/25 during a review of R27's clinical record, a telephone order on 3/21/25 at 17:57 (5:57 p.m.) stated, "Eliquis (a blood thinner) oral tablet 2.5 m.g. (milligram) give 1 tablet by mouth two times	F 684		

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F 684	Continued From page 8 a day related to non-ST elevation MI (myocardial infarction [heart attack]) HOLD 3/22/25 06:00 a.m. - 3/24/25 14:00 (2:00 p.m.), Hold Date / Reason: procedure for wart removal on 3/24/25." Review of R27's medication administration record dated March 2025 stated, "on 3/23/25 at 20:00 (8:00 p.m.) H (Hold)". On 4/3/25 at 10:38 a.m. in an interview with a surveyor, the Director of Nursing (DON) stated that the Registered Nurse (RN) gave Eliquis to R27 on the evening of 3/23/25 when it should have been held, and the RN only noticed the hold order when she went to chart medication given. A review of "Resident/Facility Notification Form" to the provider on 3/24/25 stated, "Resident's (R27's) Eliquis was on hold for 3/24/25 appointment to remove lesion. Med tech did not notice the hold on this med, and it was given". On 4/3/25 at 10:39 a.m., during an interview with a surveyor, the DON confirmed that Eliquis was given to R27 on the evening of 3/23/25 when the medication was supposed to be held. The failure to follow the providers orders to hold Eliquis for R27 prior to a medical procedure resulted in the cancellation and rescheduling of the medical procedure and necessity to hold the Eliquis a second time prior to a medical procedure.	F 684		
F 689 SS=K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		

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§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
Based on observations, review of facility's "Bed Safety" policy, clinical record reviews, and interviews, the facility failed to identify hazards in a resident's environment and implement interventions to prevent avoidable accidents/injuries. This failure resulted in Resident #3 ("R3") obtaining a skin tear when hitting his/her right arm on the exposed, uncovered, square tubing on the bed frame that the mattress was not wide enough to cover, and failure to identify exposed areas of a bed frame that created a risk of entrapment for Resident #26 ("R26"). This created an Immediate Jeopardy (IJ) situation for all 35 residents.

Findings:

On 3/31/25, the facility census was 35; all 35 resident bed frames have a mattress, and 2 quarter size bed rails attached to the bed frames.

On 3/31/25, the facility's "Bed Safety" policy, undated, was reviewed. The policy indicated the following:
-To try to prevent deaths/injuries from the beds and related equipment (including the frame, mattress, side rails, headboard, footboard, and bed accessories), the facility shall promote the following approaches:
-Inspection by maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment risks;
- Review that gaps within the bed system are

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within the dimensions established by the Federal and Drug Administration (FDA) (See Bionix Bed System Measurement Device Instructions and www.Bionix.com).
-Ensure that bed side rails are properly installed using the manufacturer's instructions and other pertinent safety guidance to ensure proper fit (e.g., avoid bowing, ensure proper distance from the headboard and footboard etc.); and
- Identify additional safety measures for residents who have been identified as having a higher than usual risk for injury including entrapment (e.g. altered mental status, restlessness, etc.).
-The maintenance department or designee shall provide a copy of inspections to the Administrator and report results to the Quality Assurance (QA) Committee for appropriate action. Copies of the inspection results and QA Committee recommendations shall be maintained by the Administrator and/or Safety Committee.
-The staff shall report to the Director of Nursing and Administrator any deaths, serious illnesses and/or injuries resulting from a problem associated with a bed and related equipment including the bed frame, bed side rails, and mattresses.
-The Administrator shall ensure that reports are made to the Food and Drug Administration (FDA) or other appropriate agencies, in accordance with pertinent laws and regulations including the Safe Medical Devices Act.

According to the "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment" document, published by the FDA on March 10, 2006, the FDA is recommending a dimensional limit of less than 120 millimeters (4 ¾ inches) for the area between the inside surface of the (bed) rail and

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the compressed mattress.

1. On 3/31/25 at 10:58 a.m., a surveyor observed a skin tear on R3's right arm. R3 stated that he/she fell on Saturday (3/29) and hit their arm on the bed frame as R3 pointed to an area of the bed frame; the surveyor observed that R3's mattress did not cover the bed frame, exposing a mechanical hinge, a screw, and sharp metal edges where plastic caps were missing. Review of R3's clinical record indicated that R3 self-reported to nursing that he/she had fallen in his/her room and hit the bed frame.

On 3/31/25 at 11:44 a.m., a surveyor and the Director of Nursing (DON) observed R3's skin tear and the area of the bedframe that R3 hit their arm on. R3 stated to the DON that the bed frame was harder than his/her arm. The DON stated to R3 that someone would be in to clean up the injury and started treatment for R3's skin tear.

On 3/31/25 at 1:10 p.m., the Maintenance/Housekeeping/Laundry Supervisor stated that the Administrator brought down a tool (Bionix Bed System Measurement Device) from the third floor, but he doesn't know how to use it or what the proper measurements are supposed to be (between mattress and bed side rail). The surveyor shared photos of R3 and R29's bed frames and mattresses with the Maintenance/Housekeeping/Laundry Supervisor at this time and confirmed the mattresses did not fit the bed frames.

On 3/31/25 at 1:18 p.m., during an interview with the DON, a surveyor confirmed that R3's mattress does not fit the bed frame which allowed R3's arm to strike the square tubing on the bed

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frame that was not covered.

On 3/31/25 at 2:19 p.m., two surveyors observed Maintenance/Housekeeping/Laundry Supervisor in the process of changing R3's bedframe. He stated it was one of the last beds in the facility this way and that the mattress was a 36 inch mattress on a 39 inch bed frame.

On 4/2/25, R3's clinical record was reviewed; on 4/1/25 at 4:57 p.m., it was documented that R3's right forearm skin tear dressing was changed. There was serous drainage and during the wound dressing change, R3 reported pain 3/10. At 7:20 p.m., the skin tear measurements were documented as follows: the top measures 1.2 centimeters (cm) length (L) x 0.8 cm width (W), the middle skin tear measured 1.5 cm L x 0.7 cm W, and the bottom skin tear measured 0.5 cm L x 0.5 cm W and was superficial. The length of all 3 areas together measured 4 cm L x 0.8 cm W.

2. On 3/31/25 at 11:32 a.m., 2 surveyors observed R26 lying in bed leaning toward his/her left side. The mattress did not appear to be compatible with the bed frame as several inches of bed frame was observed exposed on both sides of the mattress creating multiple areas for possible entrapment of body parts (See F909 for details). The bed rail at the height of the resident's head measured 10 inches from the mattress, this had the potential to cause death as a result of entrapment of body parts (See F700 for details).

On 4/1/25 at 8:30 a.m., during an interview with 2 surveyors and the Maintenance/Housekeeping/Laundry Supervisor, R26's bed frame was observed to be wider than

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F 689	Continued From page 13 the mattress by a couple inches (improved compared to observation on 3/31/25). The Maintenance/Housekeeping/Laundry Supervisor stated he had narrowed the width of the bed frame this morning, and staff independently adjust bed equipment, and he doesn't know why. On 4/1/25 at 9:05 a.m., during an interview with a surveyor, the Administrator stated night staff have made changes such as switching out a resident's bed mattress without letting administrative staff know of the changes. At this time the surveyor confirmed that staff did not identify the risk for accidents / injuries associated with exposed bed frames around resident mattresses. The immediate jeopardy that began on 3/31/25 when the facility failed to identify hazards in a resident environment and implement interventions to prevent injury including the risk of death by entrapment of body parts. The Administrator was notified of the immediate jeopardy at 12:25 p.m. on 4/1/25. Please See F-000 Initial Comments related to the IJ removal plan.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.	F 695		

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F 695	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observations, manufacturer's instructions, facility policy review, and interview, the facility failed to provide oxygen therapy in a sanitary manner for 2 of 4 days of survey (2/10/25 and 2/11/25) for Resident #19 (R19). Finding: The manufacturer's instructions for Invacare Perfecto2 indicated that there is one cabinet filter located on the back of the cabinet; environmental conditions that may require more frequent inspection and cleaning of the filter include, but are not limited to: high dust, air pollutants, etc and to remove the filter and clean as needed. The facility's policy, "Departmental (Respiratory Therapy)-Prevention of Infection, revised 3/2025, directed staff to wash filters from oxygen concentrators every seven days with soap and water. 1. On 4/01/25 at 10:21 a.m., a surveyor observed R19 wearing oxygen via nasal cannula and that the oxygen concentrator filter on the back of the machine was very dusty. 2. On 4/2/25 at 8:15 a.m., a surveyor observed that the oxygen concentrator filter on the back of the machine was very dusty. At 8:21 a.m., during an observation and interview with the Director of Nursing, a surveyor confirmed this finding.	F 695		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care	F 699		

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F 699	Continued From page 15 The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to identify a resident's current diagnosis of Post-Traumatic Stress Disorder (PTSD) to determine what trigger(s) might cause re-traumatization for 1 of 1 sampled resident reviewed with a current diagnosis of PTSD (Resident #5 ["R5"]). Finding: On 4/2/25 during a clinical record review for R5, it was noted that R5 had a diagnosis of PTSD listed as an active diagnosis. Review of R5's care plan updated on 2/19/25 lacked evidence that a trauma informed care plan was established to include triggers for this resident's PTSD diagnoses. Review of R5's quarterly Minimum Data Set (MDS) 3.0, Section I, Active Diagnoses, Psychiatric/Mood Disorder, I6100 was coded to indicate R5 had an active diagnosis for Post Traumatic Stress Syndrome (PTSD). On 4/2/25 at approximately 1:30 p.m., during an interview with the Director of Nursing the surveyor confirmed that R5 did not have a trauma informed care plan.	F 699		
F 700 SS=K	Bedrails	F 700		

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F 700	Continued From page 16 CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident's bed dimensions were appropriate for a resident resulting in a 10 inch gap between the mattress and the bed rail. This failure created the potential for bodily injury including death by entrapment of body parts, for 1 of 35 residents [Resident #26 (R26]. In addition to the resident in immediate jeopardy, the facility's failure to regularly inspect and monitor bed rails resulted in the potential for harm for 35 out of 35 residents with bed rails. Finding:	F 700		

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According to the "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment" document, published by the FDA on March 10, 2006, the FDA is recommending a dimensional limit of less than 120 millimeters (4 ¾ inches) for the area between the inside surface of the (bed) rail and the compressed mattress.

According to the clinical record, R26 is diagnosed with "HEMIPLEGIA AND HEMIPARESIS" (paralysis or severe loss of motor function on one side of the body) affecting the resident's left side, and osteoporosis (condition where bones become weak and brittle increasing the risk of fractures). The care plan indicates "The resident has limited physical mobility [related to (r/t)] Stroke", and "The resident is at risk for falls r/t Hemiparesis, Confusion Unaware of safety needs". Care plan interventions indicate that R26 is on fall precautions, requires fall mats on the floor beside the bed, R26 will use the bed rails for independent bed mobility, and R26 is dependent on 2 staff for turning and repositioning in bed.

On 3/31/25 at 11:32 a.m., 2 surveyors observed R26 lying in bed leaning toward his/her left side. The mattress was observed to be smaller than the bed frame. The resident's left bed rail measured 10 inches from the mattress at resident's head level. The mattress was off set, creating a wedge shaped gap with the opening wider toward the top of the mattress.

On 3/31/25 at 1:10 p.m., during an interview with a surveyor, the Maintenance/Housekeeping/Laundry Supervisor stated the facility has a tool to measure the bed

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F 700	Continued From page 18 rail gaps, but he does not know how to use it, or what the proper measurements are supposed to be (between mattress and bed side rail). At this time, the surveyor confirmed the mattresses did not fit the bed frame creating the potential for entrapment of body parts. The immediate jeopardy that began on 3/31/25 when the facility failed to ensure a resident's bed dimensions were appropriate for a resident resulting in a 10 inch gap between the mattress and the bed rail creating the potential for entrapment of body parts including the risk of death. The Administrator was notified of the immediate jeopardy at 12:25 p.m. on 4/1/25. Please See F-000 Initial Comments related to the IJ removal plan.	F 700		
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. (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	F 812		

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F 812	Continued From page 19	F 812		

serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews and record review, the facility failed to ensure the kitchen was maintained in a clean manner on 4 of 4 days of survey (3/31/25, 4/1/25, 4/2/25, and 4/3/25), the facility failed to label thawed nutritional shakes with a thaw date on 1 of 4 days of survey. (3/31/25), the facility failed to discard expired foods on 1 of 4 days of survey (3/31/25), the facility failed to label, and date opened foods for 1 of 4 days of survey (3/31/25). In addition, the facility failed to consistently monitor and document food temperatures for proper cooked temperatures and proper serving temperatures for 94 of 99 meals reviewed. (Food Temperature Log sheets for March and 2 days in April)

Findings:

On 3/31/25 at 10:50 a.m., during the initial tour of the kitchen a surveyor observed the following areas that were not clean:

Under the dish storage rack there was a seam in the linoleum flooring that was raised and had dirt buildup.

Under the stove there was a seam in the linoleum flooring that was raised and had dirt buildup.

The wall behind the stove was observed to have food splatter and around the pipes on the back wall was a build up of dirt and grime.

The wall behind the meat slicers was observed to have food splatter.

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F 812	Continued From page 20	F 812		

The warewasher room (dishwasher room) on the clean side, the flooring was raised and had dirt build up, the tiles on the dirty side were soiled and had dirt build up in the grout lines.

In the reach in cooler there were 5-6 fluid ounce thawed cartons of Mighty Shakes with directions to store frozen, thaw at or below 40 degrees Fahrenheit and use thawed produce within 14 days. There was a ½ gallon of fat free milk with an expiration date of 3/30/25 that was available for use.

In the walk-in refrigerator there were 5 containers of Yoplait plain yogurt 2 pounds each with a best by date of 3/27/25. There were 3 containers of Ricotta Cheese 48 ounce each with a best by date of 3/24/25.
On the second shelf there was a steamtable pan that contained thawed meat wrapped in plastic with a label identifying the meat as Roast Beef with a use by label of 3/26/25. (Food Service Supervisor (FSS) opened the plastic wrap, and the inner label identified the meat as a Pot Roast.)

In the dry food storage area, there was an unopened bag with a label of 4 Season with a use by date of 3/18/25 (per interview with the FSS this would be the date it should have been discarded).

There were 12 bags of unlabeled/unidentified crumbs with no expiration date, there were 11 assorted bags of cereal that were not labeled or had expiration dates.

On a serving cart, on the second shelf, was a bin containing 8 unlabeled bags of cereals with no

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F 812	Continued From page 21 expiration dates, and 3 opened bags with no labels or expiration dates. On 3/31/25 at 11:30 a.m. during an interview with the FSS the surveyor confirmed the above findings. On 4/1/25 at 11:00 a.m. during a meal prep and meal service observation the surveyor observed the FSS taking the cooked temperatures of the lunch meal. The surveyor asked the FSS for the facilities food temperature logs for previous meals. Upon reviewing the facilities food temperature logs for the month of March, the facility failed to consistently record cooked temperatures and serving temperatures for 94 out of 99 meals. The surveyor confirmed this finding during an interview with the FSS at 2:40 p.m.	F 812		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.	F 867		

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F 867	Continued From page 22 §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or	F 867		

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F 867	Continued From page 23	F 867		

safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

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F 867	Continued From page 24 §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility's Quality Assurance Committee failed to ensure the plan of correction for identified deficiencies from the annual survey dated 5/1/24 was effective. Findings: At the annual recertification survey of 4/29/24 through 5/1/24, the following deficiencies were cited: F812, F880 and F883. During the annual recertification survey of 3/31/25 through 4/2/25, it was determined that F812, F880 and F883 would be cited again for the same issues: F812 was cited again for failure to ensure the kitchen was maintained in a clean and sanitary manner and failure to discard expired foods; F880 was cited again for failure to implement a water management program to monitor for and prevent the growth and spread of Legionella and other water-borne pathogens; and	F 867		

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F 867	Continued From page 25 F883 was cited again for failure to offer the updated Pneumococcal vaccination to 3 of 5 residents. On 4/3/25 at 8:25 a.m., during an interview with a surveyor and the Administrator, repeat deficiencies were reviewed. The Administrator stated the plan of correction from the previous survey indicated monitoring for 3 months, monitoring was not continued beyond that time. At this time the surveyor confirmed the above finding.	F 867		
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, 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;	F 880		

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HIGH VIEW REHABILITATION AND LIVING CENTER	517 RIVERVIEW ST MADAWASKA, ME 04756

(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 880	Continued From page 26 §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. §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.	F 880		

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F 880	Continued From page 27	F 880		

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 facility policy review and interviews, the facility failed to notify the Centers for Disease Control and Prevention (CDC) of an outbreak of Norovirus in the facility. In addition, based on review of the facility's Legionella Water Management Program and interview, the facility failed to fully develop and implement a water management program to monitor for and prevent the growth and spread of Legionella and other water-borne pathogens.

Findings:

The facility's policy, "Reporting Communicable Diseases", revised 3/20/25, indicated that the Infection Preventionist is responsible for notifying the local, district, or state health department of confirmed cases of state-specific reportable diseases. The Maine CDC "Notifiable diseases and Conditions List", dated 2/17/21, indicated that "any cluster/outbreak of illness with potential public health significance needs to be reported.

1. On 3/31/25 at 10:15 a.m., the Administrator stated that the facility is experiencing what was thought to be an outbreak of Norovirus. On 3/31/25 at 3:59 p.m., during an interview with a surveyor, the Director of Nursing (DON) stated the CDC had not been notified of the outbreak. She also stated that they have not tested residents for Norovirus but five (5) residents have symptoms of nausea, vomiting, and diarrhea.

On 4/1/25, the DON provided a statement that she had contacted the CDC and that she was

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F 880	Continued From page 28 advised that they are not required to test symptomatic individuals for Norovirus and to continue precautions per guidance. A line list of affected residents will be sent to the CDC when the outbreak is completed and that an outbreak of unknown etiology is reportable (to the CDC). On 4/2/25 at 2:10 p.m., during an interview with a surveyor, the Nurse Manager-Infection Preventionist stated she was away part of last week and that the DON filled her in on the communication with the CDC. 2. On 4/3/25, a review of the facility's Legionella Water Management Program was completed by the surveyor with the Administrator and Maintenance/Housekeeping/Laundry Supervisor. The program lacked evidence of testing protocols and acceptable ranges for control measures, documentation of the results of testing, and what corrective actions would be taken if control limits are not maintained. The program also lacked evidence of validating the effectiveness of the program by testing the water for Legionella/water pathogens.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31	F 883		

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F 883	Continued From page 29 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and	F 883		

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F 883	Continued From page 30	F 883		

(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on facility policy review, record reviews, Centers for Disease Control and Prevention (CDC) recommendations, and interview, the facility failed to offer the updated Pneumococcal vaccination to 3 of 5 residents (Resident #3 [R3], R22, and R29).

Findings:

The facility's policy, "Pneumococcal Vaccine", revised 3/2025, indicated prior to or upon admission, residents will be assessed for eligibility to receive the Pneumococcal vaccine series and when indicated, are offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has completed the current recommended vaccine series. Assessments of Pneumococcal vaccination status are conducted within five (5) working days of the resident's admission if not conducted prior to admission. Administration of the Pneumococcal vaccines are made in accordance with current CDC recommendations at the time of the vaccination.

On 4/3/25 at 9:10 a.m., during an interview with a surveyor, the Nurse Manager-Infection Preventionist stated she was unable to find information to indicate that R3, R22, and R29 were offered the most recent Pneumococcal vaccination, and that the facility does use the PneumoRecs VaxAdvisor: Vaccine Provider App | CDC" tool to determine Pneumococcal

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F 883	Continued From page 31 vaccination recommendations. The following were confirmed at this time: 1. The documentation in R3's clinical record indicated that R3 received the Pneumococcal Conjugate Vaccine (PCV) 13 in 2019. The CDC recommendation was to give one dose of PCV20 or PCV21 at least 1 year after PCV13. 2. The documentation in R22's clinical record indicated that R22 received the PCV13 in 2015 and the Pneumococcal Polysaccharide Vaccine (PPV) 23 in 2011. The CDC recommendation was based on shared clinical decision-making, decide whether to administer one dose of PCV20 or PCV21 at least 5 years after the last pneumococcal vaccine dose. 3. The documentation in R29's clinical record indicated that R29 received the PCV13 in 2016 and the PPV23 in 2007. The CDC recommendation was based on shared clinical decision-making, decide whether to administer one dose of PCV20 or PCV21 at least 5 years after the last pneumococcal vaccine dose	F 883		
F 909 SS=K	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:	F 909		

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F 909	Continued From page 32	F 909		

Based on observation, interview, and record review, the facility failed to identify the existing risk for entrapment of body parts through bed inspections, this failure created the potential for severe bodily injury including death by entrapment of body parts, for 3 of 35 residents [Resident #26 (R26), (R3) and (R13)]. In addition to the resident in immediate jeopardy, the facility's failure to implement an effective inspection of all resident bed equipment (bed frames, mattresses, and bed rails) to ensure that bed mattresses fit the bed frames to prevent entrapment of body parts, this has the potential to effect 35 out of 35 residents with bed rails.

Findings:

On 3/31/25, the facility's "Bed Safety" policy, undated, was reviewed. The policy indicated, to prevent deaths/injuries, maintenance staff would inspect all beds and related equipment to identify risks and problems including potential entrapment of body parts using the Bionix Bed System Measurement Device (Please see F689).

1. According to the clinical record, R26 is diagnosed with "HEMIPLEGIA AND HEMIPARESIS" (paralysis or severe loss of motor function on one side of the body) affecting the resident's left side, and osteoporosis (condition where bones become weak and brittle increasing the risk of fractures). The care plan indicates "The resident has limited physical mobility [related to (r/t)] Stroke", and "The resident is at risk for falls r/t Hemiparesis, Confusion Unaware of safety needs". Care plan interventions indicate that R26 is on fall precautions, requires fall mats on the floor beside the bed, R26 will use the bed rails for

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F 909	Continued From page 33	F 909		

independent bed mobility, and R26 is dependent on 2 staff for turning and repositioning in bed.

On 3/31/25 at 11:32 a.m., 2 surveyors observed R26 lying in bed leaning toward his/her left side. The mattress did not appear to be compatible with the bed frame. The bed frame had exposed square holes measuring 4 inches by 5 inches along the lower end of the bed frame on both sides of the mattress creating the risk for entrapment of body parts. On R26's left side at his/her waist level, the bed frame had rectangular openings creating risk for entrapment of body parts. The bed rail at the height of the resident's head measured 10 inches from the mattress, creating the risk of entrapment of body parts (See F700 details).

2. On 3/31/25 at 11:22 a.m., 2 surveyors observed a skin tear on R3's right upper forearm. R3's mattress observed to be smaller than the bed frame, exposing a mechanical hinge, a screw, and sharp metal edges where plastic caps are missing. At 2:19 p.m., the Maintenance/Housekeeping/Laundry Supervisor stated the mattress does not fit the frame, the mattress is 36 inches, and the frame is 39 inches (See F689 for details).

3. On 3/31/25 at 2:00 p.m., a surveyor observed R13's mattress length was not compatible with the length of the bed frame creating a 3 inch gap between the end of the mattress and the foot board (See F558 for details).

On 3/31/25 at 1:10 p.m., during an interview with a surveyor, the Maintenance/Housekeeping/Laundry Supervisor stated the facility has a tool to measure the bed

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F 909	Continued From page 34 rail gaps, but he does not know how to use it, or what the proper measurements are supposed to be (between mattress and bed side rail). He stated bed inspections were recently completed but he was not sure what the inspection included. On 4/1/25 at 7:15 a.m., during an interview with a surveyor, the Administrator stated the recent bed inspections only evaluated the electrical mechanics of resident beds. At this time a surveyor confirmed that bed inspections did not evaluate bed mattress and bed frame compatibility or identify areas of possible entrapment. The immediate jeopardy that began on 3/31/25 when the facility failed to implement an effective inspection of all resident bed equipment or identify the existing risk for entrapment of body parts. The Administrator was notified of the immediate jeopardy at 12:25 p.m. on 4/1/25. Please See F-000 Initial Comments related to the IJ removal plan.	F 909		