LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PRINTED: 11/02/2023 FORM APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205122	A. BUILDING _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HILL CENTER	2 FOOTBRIDGE RD BELFAST, ME 04915

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Nancy Hanson Administrator 12/1/23

F 584	Continued From page 1 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, interview and review of facility Safety Data Sheets, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable interior for the 2 of 2 units(Harbor House and Fort Point), a common area and the laundry room for 1 of 1 facility tours (10/19/23). Findings: On 10/19/23 from 8:20 a.m. to 9:20 a.m., an environmental tour was conducted with the Administrator, the Maintenance Supervisor and the Health Care Services District Manager in which the following findings were observed: Common Area: > There were three(3) ceiling tiles near the	F 584	Harbor House Unit: Two ceiling tiles above the menu sign will be replaced. Inflatable hair wash tray in shower room will be cleaned The dark black markings near room 105 will be removed Rms 107, 108, 110, 1st dining room and kitchenette floors will be swept and washed Rm 107-ceiling tile will be replaced and the ceiling exhaust vent will be cleaned. Bathroom floor, with emphasis around the toilet base, will be washed. Rm 108 a/c unit will be removed. Bathroom floor, with emphasis around the toilet base, will be washed. Ceiling exhaust vent will be dusted. Rm 109 Nail will be removed and trim piece replaced. The wall will be cleaned. Bathroom ceiling exhaust will be cleaned 1st and 2nd dining room floor seams will be repaired The exhaust vent in kitchenette will be cleaned The wheelchair scale non-skid tape's uncleanable surface will be repaired/replaced The wood base in the laundry room will be painted. The ceiling tile will be replaced A lens cover will be put on the ceiling light The cement floor uncleanable surface will be repainted The swing bar cover on the Reliant 600 lift will be cleaned The Reliant RPS 350 will be cleaned and touched up Kitchenette exhaust vent will be cleaned Rm 202-the bathroom floor, with emphasis around the toilet base, will be washed. The exhaust vent will be cleaned and the bathroom walls will be repaired and painted. The door frame entering the dining room will be repaired Rm 205-The floor will be cleaned, the ceiling exhaust vent cleaned, and the toilet seat replaced. The bathroom walls will be cleaned or painted, if needed. Rm 206- Wheelchair will be cleaned	11/22/23

			The swing bar cover on the Reliant 600 lift will be cleaned The Reliant RPS 350 will be cleaned and touched up Kitchenette exhaust vent will be cleaned Rm 202-the bathroom floor, with emphasis around the toilet base, will be washed. The exhaust vent will be cleaned and the bathroom walls will be repaired and painted. The door frame entering the dining room will be repaired Rm 205-The floor will be cleaned, the ceiling exhaust vent cleaned, and the toilet seat replaced. The bathroom walls will be cleaned or painted, if needed. Rm 206- Wheelchair will be cleaned	
			Ceiling tiles near room 212 will be replaced Rm 211-the door frame at the room entrance will be repaired and painted Rm 214-The floor mat will be cleaned or replaced, if needed Rm 215- The privacy curtain will be replaced. The window screen will be replaced. The exhaust vent will be cleaned. The bathroom floor will be washed, with emphasis around the base of the toilet. The grout will be repaired in the shower room	

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F 584	Continued From page 2 reception desk that had brown stains on them. Harbor House Unit: > There were two(2) ceiling tiles above the Menu sign that had brown stains on them. > The shower room had an inflatable hair wash tray that was observed dirty and soiled. > The low ceiling near resident Room 105 had dark black markings on it. > Resident Room 107 - The floor had dirt, debris and dried liquid spots on it. The wall behind a chair had unpainted drywall paste creating an uncleanable surface. The bathroom floor and around the base of the toilet was dirty, the ceiling exhaust vent was dusty/dirty and there was one(1) ceiling tile with a large brown stain on it. > Resident Room 108 - The floor had dirt, debris and dried liquid spots on it, the air conditioning unit in the window was not sealed leaving large gaps to the outside, and there were unpainted drywall patches creating uncleanable surfaces. The bathroom floor and around the base of the toilet was dirty and the ceiling exhaust vent was dirty/dusty. > Resident Room 109 - The entrance door had a nail sticking out of it and a trim piece was coming off. The room entrance flooring was lifted/gapped creating an uncleanable surface. The wall behind the right side bed and chair was marred/scuffed with black marks. The bathroom ceiling exhaust vent was dusty/dirty and there was a bedpan stored on the floor. > Resident Room 110 - The floor had dirt, debris and dried liquid spots on it. > The 1st dining room floor had dirt, debris and dried liquid spots on it, and left entrance doorway had floor seams that were separated and unsealed creating uncleanable surfaces. > The kitchenette area floors were dirty with	F 584	An environmental audit will be conducted of resident rooms and common areas. Work orders will be entered into TELS for deficiencies found during the audit. A monthly Environmental Audit task will be added to TELS. Maintenance & Environmental Audits will be conducted monthly for the next three months and findings will be reported at the monthly QAPI. Admin/Designee to monitor.	

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F 584	Continued From page 3 spillage and crumbs and the floor seam is gapped and unsealed creating an uncleanable surface. > The kitchenette area exhaust vent is dusty/dirty. > The 2nd dining room had floor seams that were separated and unsealed creating uncleanable surfaces. > The wheelchair scale had ripped/missing non-skid tape creating uncleanable surfaces. Laundry Room: > The wood base under the laundry chemicals was untreated creating an uncleanable surface. > The cement floor by the washing machines had chipped/missing paint creating an unsealed and uncleanable surface. > 0ne(1) ceiling tile had a large brown stain on it. > A ceiling light was missing the lens cover. Fort Point Unit > A Reliant 600 patient lift had a dirty/stained swing bar cover. > A Reliant RPS 350 patient sit-to-stand lift had dirt/debris in the foot base area and had chipped/missing paint on the legs creating uncleanable surfaces. > The exhaust vent in the kitchenette was dusty/dirty and the floor had dirt/debris on it. > Resident Room 202 - The bathroom walls had unpainted drywall patches creating uncleanable surfaces. The floor around the base of the toilet was dirty and the bathroom ceiling exhaust vent was dusty/dirty. > The bottom of the door frame to the entrance of the dining room was marred/ scuffed and the wood is chipped/gouged and had pieces missing. > Resident Room 205 - The bathroom walls were marked/marred, the floor around the base of the toilet was dirty, the bathroom ceiling exhaust vent	F 584		

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F 584	Continued From page 4 was dusty/dirty and the toilet seat was split open creating an uncleanable surface. > Resident Room 206 - Resident #22's wheelchair had dried liquid residue and food particles on it. > There were five(5) ceiling tiles in hall by resident room 212 that had brown stains on them. > Resident Room 211 - The room entrance door frame had marred/chipped paint and pieces of the door frame were missing creating uncleanable surfaces. > Resident Room 214 - The floor mat was dirty and soiled. > Resident Room 215 - The privacy curtain was missing hooks, ripped and in disrepair. The window was open and missing the screen. The bathroom had a wash basin on the floor, the floor was dirty around the base of the toilet and the bathroom exhaust vent was dusty/dirty. > The shower room was missing the grout on the floor in front of the shower creating an uncleanable surface. On 10/19/23 at 9:20 a.m., in an interview, the Administrator, the Maintenance Supervisor and the Health Care Services District Manager confirmed the findings.	F 584		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;	F 622	Transfer and Discharge Requirements Facility corrected in the moment, resident R35 was not discharged from the facility. The facility has a Transfer and discharge policy. IDT/leadership team will be re-educated to facility policy regarding facility initiated discharges. All pending discharges to be discussed at morning clinical meeting daily beginning on 12/1/23. Any changes throughout the day will be brought to the attention of the Director of Nursing and Social Worker.	11/22/23

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F 622	Continued From page 5 (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer	F 622	Administrator or designee will audit all facility initiated discharges to ensure compliance. Audit results will be provided to the monthly QAPI committee for review and further recommendations.	

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F 622	Continued From page 6 or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1) (i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c) (2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on interviews, and record reviews the	F 622		

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F 622	Continued From page 7 facility failed to meet the requirements for a facility-initiated discharge for 1 of 1 resident reviewed for facility-initiated discharge (Resident 35 [R35]). Finding: On 10/16/23 at 2:00 p.m., during a resident interview, R35 stated he/she was told he/she had to leave the facility tomorrow because he/she was no longer skilled and his/her needs are long-term care (LTC) needs, R35 asked to stay and was told the facility didn't have any LTC beds available and there were two people waiting to get in. Medical record indicated R35 was admitted on 9/8/23 for skilled services after a partial amputation of his/her right foot, the initial plan was to gain strength and go to a lower level of care (assisted living). During his/her skilled rehabilitation R35 was not able to complete the rehab program due to a decline in his/her health status and was subsequently discharged from skilled services on 10/15/23. Once discharged from skilled services the facility set a discharge date of 10/17/23. R35 was not given the choice to stay in this facility for his/her LTC needs. The facility initiated a facility-initiated discharge. On 10/16/23 at 2:30 p.m., during an interview with the Clinical Licensed Social Worker (CLSW), she stated R35 is scheduled to go to Bayview Manor, a residential organization, and R35 will be transported by ambulance as he/she is not able to sit in a wheelchair to be able to go by facility van, and discharge is set for 10/17/23. She stated R35 is leaving because he/she is no longer skilled, and he/she needs a long-term care bed.	F 622		

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F 622	Continued From page 8 On 10/16/23 at approximately 2:45 p.m., during an interview with the Administrator, she stated that Corporate wants the skilled beds to be open, so because the resident is no longer skilled, they must be discharged. The surveyor confirmed with the Administrator that the facility has dually certified beds. The Administrator stated that the resident could not stay as he/she was no longer skilled. Review of the facility's discharge policy with a revision date of 11/15/22 documents on page 1 of 5 that The Center must permit each patient to remain in the Center and not transfer or discharge the patient from the Center unless: o The transfer or discharge is necessary for the patient's welfare and the patient's needs cannot be met by the Center. o The transfer or discharge is appropriate because the patient's health has improved sufficiently so the patient no longer needs the services provided by the Center. o The safety of individuals in the Center is endangered due to the clinical or behavioral status of the patient. o The patient's clinical or behavioral status endangers the health of individuals in the Center. o The patient has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the Center. Non-payment applies if the patient. does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the patient refuses to pay for their stay. For a patient who becomes eligible for Medicaid after admission to a Center, the Center may charge a patient only allowable	F 622		

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F 622	Continued From page 9 charges under Medicaid; or o The Center ceases to operate. Upon review of the residents clinical record there is no evidence to support that he/she met the requirements for a facility-initiated discharge. On 10/17/23 at approximately 8:15 a.m. the Administrator spoke to R35 and was made aware by resident that he/she had asked to stay at this facility resulting in the discharge/transfer being stopped allowing R35 to stay at this facility. Quality of Care CFR(s): 483.25	F 622		
F 684 SS=E	§ 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 record reviews, observations and interviews, the facility failed to ensure that Physician orders were followed for 1 of 29 sampled residents (Resident #21 (R21)) reviewed for meal assistance; 1 of 29 sampled residents for medications (R2), and 2 of 29 sampled residents for testing neurological signs post fall (R21, and R16). Findings: 1. On 10/16/23, R21's clinical record was	F 684	F684- Quality of Care R21 is currently receiving assistance with feeding for all meals. R21's identified occurrence of fall happened in the past and can't be corrected. R2 is currently being provided (Senokot-S) per the MD order. R16's identified occurrence of fall happened in the past and can't be corrected. The facility conducted an audit of residents with orders to assist with meals to validate that staff are following MD orders. The facility conducted an audit of residents with falls over the last 7 days to validate neurological checks were initiated and/or completed as indicated per policy. The facility completed medication pass competencies for staff providing medications to residents. The facility ensures that any patient who sustains an injury to the head from a fall and/or has an unwitnessed fall will be observed for neurological abnormalities by performing neurological check, inclusive of LOC, orientation, ability to follow commands, response to sensation and/or pain, pupil reaction, motor function, temperature, pulse, respiration, and blood pressure. These observations will be recorded on the facility Neurological Assessment Flow Sheet. Licensed staff will be re-educated to this process. The facility follows physician orders as it relates to the assistance needed by each resident to complete ADLs. Licensed staff will be re-educated to this process.	11/22/23

			Licensed staff verifies medication order on Medication Administration Record (MAR) with medication label for correct patient, drug, dose, route, time, special considerations, and exp date. Licensed staff will be re-educated to this process. Director of Nursing/designee will complete random observation audits of meal assistance and medication pass. DON/Designee will complete audits of residents with falls to validate neurological checks were initiated and/or completed as indicated. These audits will be weekly audits X 4 weeks, then bi-weekly X 4 weeks, then monthly X 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	

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F 684	Continued From page 10 reviewed. Documentation on the current Physician orders indicated that R21 was to have assistance with feeding for all meals. On 10/16/23, at lunch time, observed R21 in his/her room eating lunch without staff assistance. On 10/17/23, at lunch time, observed R21 eating breakfast without staff assistance and observed Certified Nursing Assistant #5 (CNA5) set up R21's lunch tray but CNA5 did not stay and assist R21 with feeding. On 10/18/23, at breakfast time, observed a CNA set up breakfast tray but did not stay and assist R21 with feeding. On 10/18/23 at 9:00 a.m., in an interview with R21, he/she stated that staff do not stay with him/her and assist with feeding. On 10/16/23 at 12:55 p.m., in an interview with the surveyor, CNA5 stated, "We don't feed residents in their rooms. We don't have enough staff. If they want to be fed, they have to go to the dining room. R21 refuses to leave his/her room, so we can't help him/her." On 10/18/23 at 11:50 p.m., the surveyor discussed with the Director of Nursing (DON) and the Regional Clinical Lead (RCL) that the MD order for assisting R21 with all meals was not being followed. 2. On 10/18/23, the facility Falls Management policy and procedure was reviewed. Under Section 5-#5.3-"any patient who sustains an injury to the head from a fall and/or has an unwitnessed fall will be observed for neurological abnormalities by performing neurological check, per policy." On 10/18/23, R21's clinical record was reviewed for neurological checks post the 6/23/23	F 684		

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F 684	Continued From page 11 unwitnessed fall. There was no evidence that neurological checks were completed per facility post fall management policy and procedure. On 10/18/23 at approximately 2:15 p.m., in an interview with the DON and the RCL, the surveyor discussed not locating neurological checks in the resident's record. On 10/19/23 at 8 a.m., the DON and RCL confirmed that they were unable to locate any neurological checks post the resident's fall on 6/23/23. 3. On 10/18/23 at 10:00 a.m. during a medication administration observation the Certified Nursing Assistant-Medications (CNA-M) administered 1 Senokot (a stimulant laxative used to treat constipation) 8.6 milligram (mg) tablet to R2. Upon review of R2's signed physician orders with a revision date of 10/11/23, the medication ordered was Sennosides-docusate sodium (Senokot-S) (a stimulant laxative with a stool softener to treat constipation) tablet 8.6-50 mg give 1 tablet by mouth one time a day for constipation with an order date of 2/27/23. On 10/19/23 at 1:50 p.m. during an interview with the CNA-M, she stated that the reason she gave the Senokot 8.6 mg tablet instead of the Senokot-S 8.6-50 mg tablet was because she didn't think that R2 would take it as it was a different color from the medication he/she was used to taking. 4. On 10/18/23, the facility Falls Management policy and procedure was reviewed. Under Section 5-#5.3-"any patient who sustains an injury to the head from a fall and/or has an unwitnessed fall will be observed for neurological abnormalities by performing neurological check, per policy."	F 684		

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F 684	Continued From page 12 R16's clinical record was reviewed for neurological checks post the 4/21/23 unwitnessed fall. There was no evidence that neurological checks were completed per facility post fall management policy and procedure. On 10/18/23 at 1:30 p.m., in an interview, the RCL confirmed that the facility was unable to locate any neurological checks post the resident's unwitnessed fall on 4/21/23.	F 684		
F 730 SS=E	Nurse Aide Perform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(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 evaluations and interviews, the facility failed to complete annual performance evaluations at least every 12 months for 3 of 5 sampled Certified Nursing Assistants (CNA1, CNA2, and CNA3). Findings: 1. CNA1 was hired on 1/18/07. The last performance evaluation was completed on 2/12/21. The facility was unable to provide evidence of a completed annual performance evaluation for 2022 and 2023. 2. CNA2 was hired on 1/20/21. The facility was unable to provide evidence that any annual performance evaluations were completed. 3. CNA3 was hired on 8/19/20. The facility was unable to provide evidence that any annual performance evaluations were completed.	F 730	F730- CNA Inservice CNA1, CNA2, and CNA3 had a written performance appraisal completed on 2/21/23, 2/12/21 and no appraisal completed. An audit of annual evaluations was completed of employed CNAs. Any outstanding CNA annual performances were completed. The facility validates that managers will meet with their regular full-time, part-time, and casual employees at least annually to conduct a written performance appraisal. Nursing management staff will be re-educated to this process. NHA/designee will complete audits to validate performance evaluations are being administered timely to CNAs. This audit will be weekly x 4, Bi-weekly x 4 weeks, monthly x 3 months to ensure completion. Results of these audits will be submitted to the QAPI committee for further review and recommendation.	11/22/23

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F 756 SS=D	Continued From page 13 On 10/19/23 at 12:13 p.m., in an interview with a surveyor, the Director of Nursing and Regional Clinical Lead confirmed the above findings. Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any,	F 756	F756 Drug Regimen Review Resident #34's "Omnicare Consultation report" dated 8/13/23 was addressed by the MD on 10/18/2023. An audit of Omnicare Consultation report for the last 90 days was completed to validate Medication regimen reviews and recommendations were addressed and appropriate action taken. The facility ensures that when the Consultant Pharmacist identifies an urgent medication irregularity during MRR that requires immediate action, the consultant pharmacist will notify the nurse and request the facility contact the attending physician to communicate the issue and obtain direction or new orders. If the attending physician has not responded by the time the consultant pharmacist has completed his/her consultation for the day, the issue will be escalated to the Medical Director for immediate action. If an irregularity does not require urgent action but should be addressed before the consultant pharmacist's next monthly MRR, the facility staff and the consultant pharmacist will confer on the timeliness of attending physician responses to identified irregularities based on the specific resident's clinical condition. The attending physician should address the consultant pharmacist's recommendation no later than their next scheduled visit to the facility to assess the resident, either 30 or 60 days per applicable regulation. DON, Nurse Management, providers, and NHA will be re-educated to this process. Director of Nursing/designee will complete audits to validate MRRs are being addressed. Weekly audits will be conducted x 4 weeks, then monthly audits x 2, then bi-monthly audits x 2. Results of these audits will be submitted	11/22/23

			to the QAPI committee for further review and recommendation. F880 Infection Prevention and Control The Infection prevention and control program was reviewed by the QAPI committee members on 10/24/23 . The facility conducts an annual review of its IPCP and updates the program, as necessary. Medical Director, NHA, and nursing leadership will be re-educated to this process. NHA/Designee will conduct a monthly audit to validate that the IPCP has been reviewed annually. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	

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F 756	Continued From page 14 action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to respond to the consultant pharmacist's recommendations in a timely manner for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #34 [R34]). Findings: The medical record indicated R34 was originally admitted to the facility on 8/12/23 and has diagnoses to include unspecified depression, unspecified mood disorder and anxiety. Review of R34's "Omnicare Consultation report dated 8/13/23 states: "This resident has been receiving an antipsychotic, risperidone without documentation of diagnosis and adequate indication for use, in the medical record". Recommendation from the consultant Pharmacist: "If the antipsychotic order is to continue, please update the medical record to include the specific diagnosis/indication requiring treatment that is based upon an assessment of the resident's condition and therapeutic goals, a list of symptoms or target behaviors including	F 756		

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F 756	Continued From page 15 their impact on the resident and documentation that the other causes and medications have been considered, that individualized non-pharmacological interventions are in place, and that ongoing monitoring has been ordered". Provider documented on 8/15/23 for diagnosis to be depression with psychotic features, not in remission. Review of R34's clinical record lacked evidence that the new diagnosis was included in R34's clinical record. Review of R34's "Omnicare Consultation report dated 9/15/23 through 9/18/23 states "this resident receives Risperidone which may cause involuntary movements including tardive dyskinesia (TD) but an abnormal involuntary movement scale (AIMS) or other appropriate assessment was not documented in the medical record within the previous 6 months" Recommendation from the consultant Pharmacist: "please monitor for involuntary movements now and at least every 6 months or per facility protocol. If involuntary movements are present, it is recommended that a risk/benefit assessment be completed and Risperidone be considered for discontinuation". Review of Resident #34's clinical record lacked evidence that this recommendation was addressed. On 10/18/23 at 11:15 a.m. the surveyor confirmed with the Regional Clinical Lead that the pharmacy recommendations had not been addressed.	F 756		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		

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F 812	Continued From page 16 §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 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to ensure that proper hand sanitizing and proper food handling during lunch service was followed for 1 of 2 lunch observations (10/16/23) on the Fort Point Unit. The facility also failed to ensure the kitchen was maintained in a clean, sanitary and safe manner for a food slicer, ceiling vents, the dish machine, the food disposal unit and wiring, the walk-in freezer, and a kitchenette refrigerator; and failed to ensure that chemicals were not stored openly in a multipurpose storage room with food for 1 of 1 kitchen tour (10/16/23). Findings: 1. On 10/16/23 at approximately 12:20 p.m., the meal server pushed the steam cart onto the Fort	F 812	Food Procurement, Store/Prepare/Serve-Sanitary The NPE will educate staff on proper hand hygiene. The Dietary Manager will provide education on food handling and serving. Daily rounds to be conducted by Dietary Manager or designee to check monitor compliance. Audit tool to be shared weekly with the Administrator. A summary report will be submitted to the QAPI committee monthly for further review and recommendations. The food slicer will be cleaned and dried food particles on the shroud and the base.will be removed Three(3) ceiling vents, above food preparation areas, will be cleaned. The low temperature dish machine will be cleaned inside and outside.. The food disposal unit and electrical line from the control box will be cleaned and liquid residue removed. The walk-in freezer will be serviced to prevent ice build up in the future.. The Harbor House unit kitchenette refrigerator will be cleaned Daily rounds to be conducted by Dietary Manager or designee to check monitor compliance. Audit tool to be shared weekly with the Administrator. Staff to be educated on proper cleaning and sanitation procedures and review of cleaning schedule, including sign off. Log to be shared with the Administrator weekly. A summary report will be submitted to the QAPI committee monthly for further review	11/22/23

			and recommendations	

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F 812	Continued From page 17 Point Unit and set it up for lunch service. The meal server did not sanitize his hands before starting to serve up plates. At 12:35 p.m., the surveyor observed the meal server contaminate his hands by touching a transport handle on the steam cart and wiping his hands on his pant legs while dishing food onto meal plates from the steam cart. The meal server did not wash his hands after contaminating them. The meal server then was observed touching the inside of the resident's meal plates with his contaminated thumb and fingers. The surveyor discussed this finding at the time of observation with the meal server. 2. On 10/16/23 from 10:50 a.m. to 11:30 a.m., an initial kitchen tour was conducted with the Food Service Director in which the following findings were observed: > The food slicer had dried food particles on the shroud and the base. > Three(3) ceiling vents, above food preparation areas, were dusty and dirty. > The low temperature dish machine had heavy scale build up the outside on top, the outside on the sides and on the inside of it. > The food disposal unit and electrical line from control box was heavily soiled with dried liquid residue. > The walk-in freezer had a buildup of ice on a large bag of unopened cheese. > The Harbor House unit kitchenette refrigerator had dried liquid residue on the bottom inside shelf edge. > The multipurpose storage area, where the kitchen keeps emergency food supplies, was also used to store four(4)- 8 ounce bottles of remedy skin repair cream, six(6)- 5 ounce bottles of	F 812	The Remedy Olivamine Skin Repair Cream, Hydrogen Peroxide, No Rinse Body Wash, and Medspa Aerosol Deodorant will be removed from the current storage area, and relocated to a safe storage area. Staff will be educated on the proper storage of these items. Daily rounds to be conducted by Dietary Manager or designee to check monitor compliance. Audit tool to be shared weekly with the Administrator. A summary report will be submitted to the QAPI committee monthly for further review and recommendations	11/22/23

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F 812	Continued From page 18 Antiperspirant/Deodorant, ten(10) - 8 ounce bottles of No Rinse Body Wash and twenty(20) -16 oz bottles of 3% hydrogen peroxide. Safety Data Sheets: 1. Remedy Olivamine Skin Repair Cream - Section 4. First aid measures. Eye contact wash with copious amounts of water. If discomfort continues, get medical attention. Skin contact: If irritation occurs, wash with soap and water. Get medical attention if irritation develops or persists. Ingestion: Do not ingest. If large amount is swallowed seek medical attention. Inhalation: Remove to fresh air. If not breathing, give artificial respiration. Get immediate medical attention. 2. Medspa Aerosol Antiperspirant/Deodorant - Section 2. Hazards Identification - Acute Toxicity Section 4. First aid measures. Eye contact: Avoid rubbing eyes. Immediately flush eyes with large amounts of water, occasionally lifting upper and lower lids, until no evidence of product remains (minimum 15 minutes is typically recommended). Remove contact lenses, if present and easy to do. Get medical attention if pain or irritation persists. Skin contact: If irritation develops wash area with water. Get medical attention if irritation persists. Inhalation: Remove to fresh air. If not breathing, give artificial respiration. If breathing is difficult, give oxygen. Get immediate medical attention. Ingestion: If swallowed, call a physician immediately. Rinse mouth and throat thoroughly with water. Do not induce vomiting unless directed to do so by a physician. Never give anything by mouth to an unconscious person. If vomiting occurs spontaneously, keep head below hips to prevent aspiration of liquid into lungs. If	F 812		

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F 812	Continued From page 19 patient is conscious and alert, give large amounts of water. Get medical attention. 3. No Rinse Body Wash - Section 4. First aid measures. Ingestion: Rinse mouth thoroughly. Get medical attention if any discomfort continues. Eye contact: Make sure to remove any contact lenses from the eyes before rinsing. Promptly wash eyes with plenty of water while lifting the eyelids. Get medical attention promptly if symptoms occur after washing. 4. Aplicare hydrogen peroxide 3% - Section 2. Hazards Identification - Serious eye damage/Eye irritation. Section 4. First aid measures. Eye contact: Rinse immediately with plenty of water, also under the eyelids, for at least 15 minutes. Remove contact lenses, if present and easy to do. Continue rinsing. Keep eye wide open while rinsing. Do not rub affected area. Get medical attention if irritation develops and persists. Skin contact: Wash with soap and water. Inhalation: Remove to fresh air. Ingestion: Rinse mouth immediately and drink plenty of water. Never give anything by mouth to an unconscious person. Do Not induce vomiting. Call a physician. On 10/16/23 at 11:30 a.m. in an interview with the Food Service Director, a surveyor confirmed the findings.	F 812		
SS=E	14 Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by:	F 814	Dispose of Garbage and Refuse Properly Any paper trash, plastic, cardboard, etc. will be placed in the dumpster by housekeeping, dietary,and maintenance staff,and the side door and top covers will be closed to not expose trash.	

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F 814	Continued From page 20 Based on observations and interviews, the facility failed to maintain garbage storage areas in a sanitary condition to prevent the harborage and feeding of pests for 1 trash dumpster and the surrounding grounds for 2 of 4 days of survey. (10/16/23, and 10/19/23) Findings: 1. On 10/16/23 at 10:50 a.m., a surveyor and the Food Service Director (FSD) observed paper trash, plastic, used disposable gloves and a large cardboard box on the ground around the dumpsters. At this time, in an interview, the FSD confirmed the finding. 2. On 10/19/23 at 8:15 a.m., a surveyor observed the right side door of trash dumpster open, exposing trash. On 10/19/23 at 8:20 a.m., in an interview, the surveyor discussed the finding with the Administrator.	F 814	Morning and afternoon rounds to be conducted by Dietary Manager or designee to monitor compliance. Audit tool to be shared weekly with the Administrator. Education to staff on proper trash removal procedures will be provided. A summary report will be submitted to the QAPI committee monthly for further review and recommendations	11/22/23 12/2/23
F 880 SS=C	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	F 880	F880 Infection Prevention and Control The Infection prevention and control program was reviewed by the QAPI committee members on 10/24/23 The facility conducts an annual review of its IPCP and updates the program, as necessary. Medical Director, NHA, and nursing leadership will be re-educated to this process. NHA/Designee will conduct a monthly audit to validate that the IPCP has been reviewed annually. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	11/22/23

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F 880	Continued From page 21 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 §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 22 §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 review of the facility's Infection Prevention and Control Program (IPCP) and interview, the facility failed to ensure that the IPCP was reviewed annually. Finding: On 10/18/23 at 1:00 p.m., the facility's IPCP was reviewed. Documentation indicated the last annual review was completed on 5/22/22. The Infection Preventionist stated she has only been in the position for a month and did not know that the IPCP needed to be reviewed annually. On 10/18/23 at approximately 2:30 p.m., the surveyor discussed this finding with the Director of Nursing and the Regional Clinical Lead.	F 880		
F 882 SS=E	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP.	F 882		

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F 882	Continued From page 23 The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to ensure that the facility Infection Preventionist (IP) had completed specialized training prior to starting the IP position. Finding: On 10/18/23 at 1:00 p.m., in an interview with the surveyor, the Registered Nurse-Infection Preventionist (RN-IP) stated she started this position in September and has enrolled in an on-line training for Infection Control and Prevention. She stated she has not been consistently trained or been overseen by another IP. On 10/19/23 at 1:00 p.m., in an interview with the Regional Clinical Lead, the surveyor discussed that there was no IP overseeing and training the current IP and that the IP has not completed the specialized training-Certificate in Infection Prevention and Control.	F 882	F882 IP Qualifications The facility Infection Preventionist (IP) completed The Nursing Home Infection Preventionist Training course on 11/21/2023. All residents have the potential to be affected by this practice. The facility employs a staff member, part time at the minimum, who oversees the IPCP. The facility ensures that this employee has completed specialized training in infection prevention and control. Facility NHA and Nursing leadership will be re-educated to this process. NHA/Designee will complete monthly audits of the designated IC employee to validate they have completed specialized training in infection prevention and control. Results of these audits will be brought to the monthly QAPI committee for further review and recommendations.	11/22/23