STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205114	A. BUILDING _____ B. WING _____	05/01/2024

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HIGH VIEW MANOR	517 RIVERVIEW ST MADAWASKA, ME 04756

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F 000	INITIAL COMMENTS From 4/29/24 through 5/1/24 on-site visits were conducted at Highview Manor for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification. It was determined that High View Manor was not in compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any,	F 580		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Cote Daigle
TITLE: Administrator
(X6) DATE: 5/17/24

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 findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 580	Continued From page 1 when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to notify the physician of a change in status for 1 of 1 sampled residents reviewed for a choking event, (Resident [R]1). Finding: On 4/29/24 at 11:36 a.m., a surveyor observed from the hallway a Certified Nursing Assistant Medication Aide (CNA-M) checking on R1 who was choking. The surveyor heard coughing sounds, almost vomiting, choking sounds, then more repetitive coughing. CNA-M left to get the Registered Nurse (RN3). On 4/29/24 at 11:39 a.m., RN3 entered the room to aid R1. R1's coughing cleared. RN3 stated to	F 580		

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F 580	Continued From page 2 the surveyor that the gravy must have gone down the wrong pipe. On 04/29/24 11:41 a.m., RN3 stated that CNA-M is supervising him to eat now. On 04/29/24 at 12:24 p.m., RN3 documented the choking incident in a nurse note as "Category: Change of Condition". The note indicates initiating a nursing measure of "aspirations precaution monitoring opened [for] 72 hours." There was no evidence to indicate the provider was notified of the incident. On 5/1/24 at 10:30 a.m., in an interview the interim Director of Nursing (DON), she stated that when residents are placed on aspiration precautions for 72 hours following aspiration, this is done following the facility's practice. There is not a policy. The facility's practice includes checking lung sounds, temperature, oxygen saturation, respiratory rate, and making any necessary adjustments like having them out of bed to eat their meals. At this time, the DON called the provider to notify her of the aspiration event and received orders. On 5/1/24 at 10:37 a.m., in an interview with a surveyor, the DON stated, staff should notify the provider after each incident. The provider should have been told while in house yesterday. At this time, the surveyor confirmed the provider had not been notified of a change in status.	F 580		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer.	F 623		

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F 623	Continued From page 3 Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.	F 623		

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F 623	Continued From page 4 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility	F 623		

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F 623	Continued From page 5 must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to identify the reason for a transfer on the transfer notice and failed notify the resident and/or the resident's representative in writing of the transfer/discharge to an acute care hospital for 1 of 1 residents sampled for hospitalizations (Resident [R]34). Finding: R34 was admitted to the facility on 2/13/24 and transferred to the hospital on 2/27/24. A review of R34's clinical record lacked evidence of the reason for the transfer identified on the transfer form. This form was signed by the resident on 2/27/24 and also had an area that was to be completed that indicated who received this written notice, that was blank. On 4/29/24 at 2:30 p.m., during an interview with a surveyor, the Social Worker-Conditional stated that the nurses complete the form when they fill out the paperwork for the transfer.	F 623		

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F 623	Continued From page 6 On 04/30/24 at 9:34 a.m., during an interview with a surveyor, Registered Nurse (RN) 2 stated that she called the Resident Representative, but she did not mail a written copy of the notice nor did she give a written copy to the resident after the notice was signed. The surveyor also reviewed the form noting that the reason for the transfer was not indicated.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy	F 625		

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F 625	Continued From page 7 described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to notify the resident and/or the resident's representative in writing of a bed hold notice after a transfer/admission to an acute care hospital for 1 of 1 residents sampled for hospitalizations (Resident [R]34). Finding: R34 was admitted to the facility on 2/13/24 and transferred to the hospital and was admitted on 2/27/24. The Bed Hold Notification form was signed by the resident on 2/27/24 and also had an area that was to be completed that indicated who received this written notice, that was blank. On 4/29/24 at 2:30 p.m., during an interview with a surveyor, the Social Worker-Conditional stated that the nurses complete the form when they fill out the paperwork for the transfer. On 04/30/24 at 9:34 a.m., during an interview with a surveyor, Registered Nurse (RN) 2 stated that she called the Resident Representative but she did not mail a written copy of the notice, nor did she give a written copy to the resident after the notice was signed.	F 625		
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	F 684		

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F 684	Continued From page 8	F 684		

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 review, facility protocol, and interviews, the facility failed to complete neurological (neuro) assessments for 1 of 1 residents reviewed who fell and hit their head (Resident [R]136) and the facility failed to ensure Physician orders were followed for 1 of 1 resident observed for Activities of Daily Living (ADL) care (the acts of bathing, dressing, and personal hygiene care), (Resident [R]16).

Findings:

A review of the facility's protocol, "High View Rehab and Nursing Center Fall Protocol", revised 9/1/23, indicated that "If resident hits his/her head or are suspected of hitting their head, initiate neuro checks every shift for 72 hours.

1. A review of R136's clinical record included a nursing note written by Registered Nurse (RN)4 that indicated R136 was on the floor, the nose was bruised and tender to touch and slightly abraded (scraped). R136 was sent to the hospital for evaluation for a possible concussion. A review of the hospital records indicated that on 4/5/24, R136 was sent to the hospital after R136 rolled out of bed, hit his/her nose, landed on the floor, striking face and head. The surveyor was unable to find any evidence of neurological assessments in the clinical record.

On 4/30/24 at 9:45 a.m., during a joint interview with Interim Director of Nursing (DON) and Registered Nurse (RN)2, the surveyor asked

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F 684	Continued From page 9	F 684		

when would you do neurological assessments on a resident? RN2 stated that nursing would enter (special circumstances) in the computer that would direct nursing to complete neuro assessments when a resident "hits their head or has an unwitnessed fall." The DON stated that RN4 should have entered a task to complete the neuro assessments in the computer, but did not. The surveyor confirmed that neuro assessments were not completed for R136 during this interview.

2. On 5/1/24 at 10:24 a.m., during observation of ADL care for R16, a surveyor observed RN3 enter the room with a medicine cup containing a white ointment. RN3 identified the ointment as "Lantiseptic" and applied it to open skin areas on R16's buttocks. RN3 assessed the skin under the breasts and stated she would get some powder for R16. Certified Nursing Assistant (CNA1) dressed R16 while waiting for the powder.

On 5/1/24 at 10:27 a.m., a surveyor observed RN3 return to R16's room holding a medicine cup with white powder in it. RN3 handed the cup to CNA1, then left the room. CNA1 lifted R16's shirt to apply the powder under the breasts, then restored R16's clothing.

On 5/1/24 review of the clinical record revealed a physician order written on 3/9/24 for "Caldesene Powder - apply topically under breasts, armpits, abdominal fold [and] to left/right [abdominal] fold above hips twice daily preventative for preventative measure for redness [and] BID (twice per day) PRN (as needed)", and a physician order written on 3/18/24 for "Lantiseptic apply small amount barrier to right inner thigh [and] groin for redness/irritation to skin BID [and]

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F 684	Continued From page 10 BID PRN." On 5/1/24 at 12:15 p.m., review of the electronic -Treatment Administration Record (e-TAR) indicated: "Lantiseptic apply small amount barrier to right inner thigh and groin for redness and irritation to skin twice a day and twice daily prn", "Caldesene Powder Apply topically under breasts, armpits, abdominal fold and to left and right side of abdominal fold above hips twice a day for preventative measures for redness. (and BID PRN)", and "Calmoseptine with stoma powder to buttocks twice a day", were marked with a checkmark indicating they were administered. On 5/1/24 at 12:28 p.m., in an interview with a surveyor, RN3 stated the documented administrations reflected the applications of ointment and powder during ADL care. RN3 also stated "CNA1 was supposed to apply Calmoseptine with stoma powder, it is in a jar in the resident's room." At this time the surveyor confirmed the Lantiseptic, Caldesene, and Calmoseptine were not administered as ordered.	F 684		
F 756 SS=D	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	F 756		

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F 756	Continued From page 11 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, 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 review and interview, the facility failed to ensure the pharmacist identified an irregularity for a psychotropic medication for 1 of 4 residents reviewed for the use of Psychotropic medications (Resident [R]28) Finding: On 5/1/24 at 10:00 a.m., R28's clinical record was reviewed, it revealed that the R28 was on an	F 756		

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F 756	Continued From page 12 anti-psychotic medication, Olanzapine. R28's current physician order dated 4/16/24 contained a treatment to complete Abnormal Involuntary Movement Scale (AIMS) testing every 6 months. The last AIMS test completed for R28 was done on 5/27/23. On 05/01/24 at 10:55 a.m. During a clinical record review with the Minimum Data Set (MDS) nurse. The surveyor confirmed at this time the Pharmacist did not identify in their monthly medication reviews that the AIMS test for R28 was not completed in November and that the AIMS test is supposed to be done every 6 months.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 758		

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	205114	A. BUILDING _____ B. WING _____	05/01/2024

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F 758	Continued From page 13 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure an Abnormal Involuntary Movement Scale (AIMS), used to monitor for potentially irreversible side effects of anti-psychotic medications, was completed every 6 months for 1 of 4 sampled residents reviewed for the use of Psychotropic medications (Resident [R] 28). Finding:	F 758		

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F 758	Continued From page 14 On 5/1/24 at 10:00 a.m., R28's clinical record was reviewed, and revealed that the R28 was on an anti-psychotic medication, Olanzapine. R28's current physician order dated 4/16/24 contained a treatment to complete Abnormal Involuntary Movement Scale (AIMS) testing every 6 months. In the electronic record under the other assessments tab, documentation shows the last AIMS test was completed on 5/27/23. Review of the electronic treatment administration record (e-tar) shows that the AIMS test was due to be completed on 11/26/23, the AIMS test was not completed. On 5/1/24 at 10:55 a.m., during an interview with the Minimum Data Set (MDS) Nurse the surveyor confirmed that the AIMS test was not completed for R28 in November.	F 758		
F 801 SS=E	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified	F 801		

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	205114	A. BUILDING _____ B. WING _____	05/01/2024

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F 801	Continued From page 15 nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food	F 801		

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F 801	Continued From page 16 service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on interviews, the facility failed to ensure they had a qualified Food Service Director for 3 of 3 days of survey (4/29/24, 4/30/24, and 5/1/24). This has the potential to affect all the residents. Findings: On 4/29/24 at 10:10 a.m., Dietary Aide [DA]2 stated, we do not have a Food Service Director, the Administrator is filling the role until one is hired. We are working on it, but they are hard to find in Northern Maine. On 04/30/24 at 7:55 a.m., in an interview with the	F 801		

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F 801	Continued From page 17 Cook, DA1, and DA2; they stated they do not have serve safe certifications. On 04/30/24 at 2:24 p.m., In an interview with a surveyor, the Administrator stated, "no, I do not have a serve safe manager certificate". On 05/01/24 at 11:58 a.m., in an interview with the Administrator, a surveyor confirmed the facility did not have a qualified Food Service Director.	F 801		
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 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, and interviews, the facility failed to store, prepare, and serve food in accordance with professional standards for food	F 812		

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F 812	Continued From page 18 service safety by not storing dishes in a sanitary manner for 1 of 3 days of survey (4/30/24), not storing food in a sanitary manner, not wearing hair nets or beard restraints while preparing food, and not maintaining the kitchen in a clean and sanitary manner for wall around oven for 2 of 3 days of survey (4/29/24 and 4/30/24), and not maintaining a clean kitchen floor for 3 of 3 days of survey (4/29/24, 4/30/24, and 5/1/24) . Findings: On 4/29/24 at 10:10 a.m., during initial tour of the kitchen a surveyor observed that portions of the floor were uncleanable, including a circular patch of concrete near the oven, circular slices in the linoleum where tables were relocated within the kitchen, and broken tiles around a drain in front of the walk in freezer. In the dry storage area on the shelf and available for use the following items: 2 cans labeled 28.2oz Mushroom Pieces and Stems, both cans had dented in bottom seals 1 can labeled 7 pounds (lb) 4oz West Creek Cherry Pie Filling Ready to Use, with a dented in bottom seal 1 package 12oz Pork Flavored Gravy mix, undated and open to the environment On 4/29/24 at 10:31 a.m., a surveyor observed and confirmed the above findings with Cook. On 4/29/24 at 10:45 a.m., a surveyor observed in back storage on the shelf and available for use 2 package of cereal, open, and undated 1 bottle of Glucerna original shake Rich Chocolate flavor with an expiration date of 12/1/2023	F 812		

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F 812	Continued From page 19 23 bottles of Glucerna Homemade Vanilla flavor, with an expiration date of 4/1/24 A surveyor observed and confirmed these findings with DA1 at the time of the observations. On 4/29/24 at 11:10 a.m., Observation of the walk-in freezer revealed a box labelled 5lb Fully Cooked Ground Italian Sausage, within the box was an opened, undated and unlabeled bag. The surveyor confirmed this with DA2 at the time of the observation. On 04/30/24 at 7:47 a.m., review of the walk-in refrigerator revealed the following: 1 unopened box containing 48 cups, 4oz each, Yoplait Light strawberry/ banana yogurt, with a use by date of 4/29/24 1 open box containing 40 cups, 4oz each, Yoplait Light strawberry/ banana yogurt, with a use by date of 4/29/24 At this time the surveyor confirmed with the Cook that 88 cups were available for use and the yogurt was used during breakfast service that morning. No residents were effected. On 04/30/24 at 12:50 p.m., a surveyor observed and confirmed with the Cook that the serving pans were stored in an unsanitary manner, face up, and exposed to the environment with debris visibly accumulated on pans. The surveyor also confirmed wet stacking of serving pans on kitchen racks with the Cook. On 04/30/24 at 01:10 p.m., Two surveyors observed and confirmed with Cook that portions of the floor were uncleanable, including a circular patch of concrete near the oven, circular slices in the linoleum where tables were relocated within the kitchen, and broken tiles around a drain in	F 812		

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F 812	Continued From page 20 front of the walk in freezer. Two surveyors also confirmed at that time food splashings dried to the wall around and behind the stove top, and preparation of food by Cook without a hairnet or beard restraint on 4/29/24 and 4/30/24. On 5/1/24 at 4:45 p.m., a surveyor observed that portions of the floor remained uncleanable, including a circular patch of concrete near the oven, circular slices in the linoleum where tables were relocated within the kitchen, and broken tiles around a drain in front of the walk in freezer.	F 812		
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 §483.70(e) and following accepted national standards;	F 880		

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F 880	Continued From page 21 §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 22 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 Infection Prevention Control Program (IPCP) review and interview, the facility failed to implement the elements of the Legionella Water Management Program for 1 of 1 Water Management Program reviewed. Finding: On 5/1/24, the facility's Legionella Water Management Program policy was reviewed. In Policy Interpretation and Implementation: Under #5: the water management program includes the following elements: 5c - The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria, including: 1) storage tanks; 2) Water heaters; 3) Filters; 4) Aerators; 5) Showerheads and hoses; 6) Misters, atomizers, air washers and humidifiers; 7) Whirlpool tubs; 8) Fountains; and 9) Medical devices such as CPAP machines, hydrotherapy equipment; etc. 5d - The identification of situations that can lead to Legionella growth, such as: 1) Construction; 2) Water main breaks; 3) Changes in municipal water quality; 4) The presence of biofilm, scale or sediment; 5) Water temperature fluctuations; 6) Water pressure changes; 7) Water stagnation and; 8) Inadequate disinfection. On 5/1/24 at 1:55 p.m., in an interview with the Administrator, a surveyor confirmed that the facility does not have measures in place to	F 880		

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F 880	Continued From page 23 assess and monitor areas where Legionella and opportunist waterborne pathogen can grow and spread.	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 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	F 883		

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F 883	Continued From page 24 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 (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 reviews, record reviews, Centers for Disease Control and Prevention (CDC) recommendations, and interview, the facility failed to offer the influenza vaccination to 4 of 5 residents reviewed (Resident [R]9, R15, R24, and R30) and failed to offer the updated Pneumococcal vaccination to 5 of 5 residents (R9, R15, R17, R24, and R30). Findings: The facility's policy, "Influenza Vaccine", revised 9/2022, indicated that between October 1st and March 31st each year, the influenza vaccine shall be offered to residents. The facility's policy, "Pneumococcal Vaccine",	F 883		

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F 883	Continued From page 25	F 883		

revised 10/2023, indicated prior to or upon admission, residents will be assessed for eligibility to receive the Pneumococcal vaccine series and when indicated, will be offered the vaccine series within thirty days of admission to the facility unless medically contraindicated or the resident has already been vaccination. Assessments of Pneumococcal vaccination status will be conducted within five working days of the resident's admission if not conducted prior to admission. Administration of the Pneumococcal vaccines or revaccinations will be made in accordance with current CDC recommendations at the time of the vaccination.

On 4/30/24, between 12:30 p.m. - 1:00 p.m. during an interview with the Interim Director of Nursing/Infection Preventionist (DON), resident's vaccination records were reviewed for influenza and Pneumococcal vaccinations. During this interview, the DON used the "PneumoRecs VaxAdvisor: Vaccine Provider App | CDC" tool to determine Pneumococcal vaccination recommendations for the 5 residents. During this interview, the DON confirmed that the Pneumococcal assessments were not conducted within 5 days of admission nor were the Pneumococcal vaccines offered within 30 days of admission to the facility and confirmed that influenza had not been offered/administered either.

The following were confirmed during this interview:

1. R9 was admitted to the facility on 8/17/23. The clinical record lacked evidence of offering the influenza vaccination and the CDC recommendation was to administer one dose of

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F 883	Continued From page 26 Prevnar 20 which had not been offered. 2. R15 was admitted to the facility on 2/22/24. The clinical record lacked evidence of offering the influenza vaccination and the CDC recommendation was to administer one dose of Prevnar 20 which had not been offered. 3. R17 was admitted to the facility on 11/5/23. The CDC recommendation was to administer one dose of Prevnar 20 which had not been offered. 4. R24 was admitted to the facility on 1/11/24 and is currently 85 years old. The clinical record lacked evidence of offering the influenza vaccination and the CDC recommendation was to administer one dose of Prevnar 20 which had not been offered. 5. R30 was admitted to the facility on 2/26/24. The clinical record lacked evidence of offering the influenza vaccination and the CDC recommendation was to administer one dose of Prevnar 20 which had not been offered.	F 883		
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education	F 887		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205114	A. BUILDING _____ B. WING _____	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGH VIEW MANOR	517 RIVERVIEW ST MADAWASKA, ME 04756

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F 887	Continued From page 27 regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or	F 887		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 887	Continued From page 28 information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on clinical records review, facility policy review, Centers for Disease Control and Prevention (CDC) recommendations, and interview, the facility failed to follow the CDC guidelines and offer the updated 2023-2024 Coronavirus (COVID-19) vaccine doses for 4 of 5 residents reviewed (Resident [R]15, R17, R24, and R30). Findings: The facility's policy, "COVID-19 Vaccination of Residents", revised 6/2023, indicated that vaccine recommendations and schedules are consistent with the Centers for Disease Control Interim Clinical Considerations for the Use of COVID-19 Vaccines in the United States. Booster vaccine doses are provided in accordance with current CDC guidance. The CDC website, "Stay Up to Date with COVID-19 Vaccines | CDC", indicated that CDC recommends the 2023-2024 updated COVID-19 vaccines: Pfizer-BioNTech, Moderna, or Novavax, to protect against serious illness from COVID-19 and that people aged 65 years and older who received 1 dose of any updated 2023-2024 COVID-19 vaccine (Pfizer-BioNTech, Moderna or Novavax) should receive 1 additional dose of an updated COVID-19 vaccine at least 4 months after the previous updated dose, and that you are up to date when you have received 2 updated	F 887		

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	205114	A. BUILDING _____ B. WING _____	05/01/2024

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F 887	Continued From page 29 2023-2024 COVID-19 vaccine doses. On 4/30/24, between 2:00 p.m. - 2:15 p.m. during an interview with the Interim Director of Nursing/Infection Preventionist, the following resident's vaccination records were reviewed and confirmed that the updated 2023-2024 COVID-19 vaccinations were not offered: 1. R15 was admitted to the facility on 2/22/24 and is currently 78 years old. R15's last documented COVID-19 vaccination was 10/10/22. The clinical record lacked evidence of offering the updated COVID-19 vaccination. 2. R17 was admitted to the facility on 11/5/23 and is currently 87 years old. R17's last documented COVID-19 vaccination was 10/25/23. The clinical record lacked evidence of offering the additional dose of the updated COVID-19 vaccination. 3. R24 was admitted to the facility on 1/11/24 and is currently 85 years old. R24's last documented COVID-19 vaccination was 12/23/21. The clinical record lacked evidence of offering the updated COVID-19 vaccination. 4. R30 was admitted to the facility on 2/26/24 and is currently 66 years old. R30's last documented COVID-19 vaccination was not found in the clinical record. The DON called the Medical Providers office and was given documentation that the last documented COVID-19 vaccination was 6/4/21. The clinical record lacked evidence of offering the updated COVID-19 vaccination.	F 887		

F580 SS=D

The facility failed to consult with a resident's physician and the representative regarding a choking episode.

1. The resident was not adversely affected by this deficiency.
2. All residents who have a change in condition have the potential to be affected by this practice.
3. The facility has since reviewed with all Charge Nurses and appropriate staff the procedure/process of notifying the resident's physician and POA/guardian regarding any incidents that compromises our resident's safety and well-being. Education started on 05/17/24 and will be on-going.
4. The facility will implement a 72 hours following aspiration policy.
5. DON/Nurse Managers will audit that physician's notifications are completed for all events or injury at the time of each event of notification. We will report findings of the audits within the Quarterly QA Committee meetings and the committee will evaluate effectiveness of education and compliance for the next three months. Once 100% compliance is achieved. The committee will reevaluate time frames of audits and revise as needed to assure compliance is sustained.
6. Correction date of 06/11/24.

F623 SS=D

The facility failed to identify the reason for a transfer on the transfer notice and failed to notify the resident/representative in writing on the transfer/discharge notice.

1. Resident #34 was not affected by this deficient practice and suffered no harm.
2. All residents who are transferred or discharged can be affected by this practice.
3. Transfer discharge notifications will be completed with each transfer or discharge.
4. Appropriate staff will be educated on the process for notification of all transfer and discharge to prevent non-compliance. Education started on 05/17/24 and will be on going.
5. Nurse Managers will review each transfer/discharge for evidence of notification and report findings within the Quarterly QA Committee meetings. The committee will evaluate effectiveness of education and compliance for the next three months. Once 100% compliance is achieved and the committee will reevaluate time frames of audits and revise as needed to assure compliance is sustained.
6. Completion date is 06/11/24.

F625 SS=D

The facility failed to notify the resident/representative in writing of a bed hold notice after a transfer to an acute care hospital.

1. Only one resident #34 was affected by this deficiency and no harm was noted.
2. All residents who require a bed hold can be affected by this practice.
3. No resident was harmed by this practice.
4. Bed hold notifications will be completed with each transfer to hospital.
5. Appropriate nursing staff and social worker will be educated on completing bed hold notification. Education started on 05/17/24 and will be ongoing.
6. Social worker is to check daily for prior day transfers to hospital and validate completion of bed-hold notification and follow up on any variances to assure compliance is sustained.

7. Nurse Managers will review each transfer/discharge for evidenced of notification and report findings within the Quarterly QA Committee meetings. The committee will evaluate effectiveness of education and compliance for the next three months. Once 100% compliance is achieved the committee will reevaluate time frames of audits and revise as needed to assure compliance is sustained.
   Completion date 06/11/24.

F684 SS=D

The facility failed to follow the "Fall Protocol "which includes neurological assessment.

1. One resident #136 was affected by this deficiency and no harm was noted from the failure to complete the assessment.
2. All residents who fall have the potential to be affected by this practice but no residents were harmed by this practice.
3. The Charge Nurses will follow the Fall Protocol to include setting up for neurological assessments.
4. The Charge Nurses will be educated on the management of falls and all documentation and assessment. Education started on 05/17/24 and will be ongoing.
5. DON/Nurse Manager will review each fall to assure all falls have been reviewed, documented and managed per policy. When appropriate, neurological assessments will be completed.
6. DON will report findings from audits within the Quarterly QA Committee meetings. The committee will evaluate effectiveness of education and compliance for the next three months. Once 100% compliance is achieved the committee will reevaluate time frames of audits and revise as needed to assure compliance is sustained
7. Completion date 06/11/24.

On 05/01/24, the facility failed to administer the proper topical medications as prescribed.

1. One resident was affected by this deficiency and no harm was noted from it.
2. All residents have the potential to be affected by this practice.
3. The Charges Nurses have been educated on the policy and procedure for administering the topical medications as prescribed.
4. Charge Nurse will be educated on the completion of physician orders as written. Education started on 05/17/24 and will be ongoing.
5. DON/Nurse Managers will complete audits to assure completion of treatments and physicians orders and that all are documented and managed by the nurse per the MD written orders.
6. DON will report findings from audits within the Quarterly QA Committee meetings and the committee will evaluate effectiveness of education and compliance for the next three months. Once 100% compliance is achieved the committee will reevaluate time frames of audits and revise as needed to assure compliance is sustained
7. Completion date 06/11/24.

F756 SS=D

The facility failed to ensure that the pharmacist identified an irregularity for a psychotropic medication for one resident #28. We failed to identify that the AIMS test was to be done every six months.

1. One resident was affected by this deficiency and no harm was noted.

2. All residents who receive antipsychotics have the potential to be affected by this practice.
3. We will educate our nursing staff on the time frames Aims testing are to be completed prior to starting an antipsychotic and every 6 months thereafter. Education started on 05/17/24 and will be ongoing.
4. The facility will have the Nurse Manager monitor this on an ongoing basis.
5. We will review regulations with pharmacy consult to assure the understanding of the regulation related to use of antipsychotics in Long Term Care facilities.
6. DON/Nurse Managers will complete audits to assure completion of Aims test per regulations on all residents who require physicians orders for antipsychotic use, and that all are documented and compliance is sustained.
7. DON will report findings from audits within the Quarterly QA Committee meetings and the committee will evaluate effectiveness of education and compliance for the next three months. Once 100% compliance is achieved the committee will reevaluate time frames of audits and revise as needed to assure compliance is sustained.
8. Correction date is 06/11/24.

F758 SS=D

The facility failed to ensure that High View Manor complete the AIM's assessment for one resident #28.

1. One resident was affected by this deficiency and no harm was noted.
2. All residents who receive antipsychotics have the potential to be affected by this practice.
3. We will educate our nursing staff on the time frames Aims testing are to be completed prior to starting an antipsychotic and every 6 months thereafter. Education started on 05/17/24 and will be ongoing.
4. The facility will have the Nurse Manager monitor this on an ongoing basis.
5. Reviewed regulations with pharmacy consult to assure understanding of the regulation related to use of antipsychotics in Long Term Care facilities.
6. DON/Nurse Managers will complete audits to assure completion of Aims test per regulations on all residents who require physicians orders for antipsychotic use, and that all are documented and compliance is sustained.
7. DON will report findings from audits within the Quarterly QA Committee meetings and the committee will evaluate effectiveness of education and compliance for the next three months. Once 100% compliance is achieved the committee will reevaluate time frames of audits and revise as needed to assure compliance is sustained
8. Correction date is 06/11/24.

F801 SS=E

The facility failed to secure a Qualified Food Service Director.

1. No residents were affected by this deficiency.
2. All residents have the potential to be affected by this practice.
3. The facility will ensure at least one employee has the Serv-Safe Managers Certification.
4. Ongoing recruitment efforts to employee a Food Service Director with sign on bonus and wage increase is in process.

5. The facility will provide the proper education per regulation F801 to all appropriate dietary staff.
6. The Administrator will complete audits to assure dietary staff has completed the appropriate certifications and compliance is sustained.
7. The Administrator will report findings from audits within the Quarterly QA Committee meetings and the committee will evaluate effectiveness of education and compliance for the next three months. Once 100% compliance is achieved the committee will reevaluate time frames of audits and revise as needed to assure compliance is sustained
8. Correction date 06/11/24.

F812 SS=E

The facility failed to store, prepare and serve food in accordance with professional standards for food service safety by not storing dishes in a sanitary manner (1 of 3 days), not wearing a hair net or beard restraints (2 of 3 days) while preparing food and not maintaining the kitchen in a clean and sanitary manner for the wall surrounding the oven and not maintaining a clean floor (3 of the 3 days).

1. No residents were directly affected by this practice.
2. All residents have the potential to be affected by these practices.
3. The facility will ensure that every employee who prepare and serve food will wear a hair net of beard guard at all times.
4. The facility will also maintain and follow a cleaning schedule involving clean walls and floors. It will also allow for proper drying of all dietary pots and pans.
5. All dietary staff was educated on the proper process and procedures for each area identified to be in deficient practice.
6. The facility will complete a cleaning schedule and monitor the wet stacking through audits to assure compliance is achieved and maintained.
7. The wearing of proper hair/beard nets, wet stacking and cleaning of the kitchen will be monitored through our quarterly QA meetings.
8. The Administrator/designee will complete audits to assure dietary staff have completed the appropriate certifications and compliance is sustained.
9. The Administrator/designee will report findings from audits within the Quarterly QA Committee meetings and the committee will evaluate effectiveness of education and compliance for the next three months once 100% compliance is achieved the committee will reevaluate time frames of audits and revise as needed to assure compliance is sustained
10. Correction date 06/11/24.

F880 SS=E

The facility failed to implement the full elements of the Legionella Water Management Program.

1. No residents were immediately affected by this deficiency.
2. The facility will ensure that the facility follow its Legionella Water Management Program on an annual basis.
3. The facility has completed the full elements of its Legionella Water Management Program with an annual water inspection and an internal Legionella Risk Analysis.

4. Environmental service director or designee have been educated on the Legionella water management program and will assure compliance is sustained by reporting status to administrator within the QA meetings.
5. The Administrator/designee will report findings from audits within the Quarterly QA Meetings and the committee will evaluate effectiveness of education and compliance for the next three months. Once 100% compliance is achieved the committee will reevaluate time frames of audits and revise as needed to assure compliance is sustained.
6. Correction date 06/11/24.

F883 SS=E

The facility failed to offer the influenza vaccination to 4 of 5 residents (#9, 15, 24 & 30). It also failed to offer the Pneumococcal vaccination to 5 residents (#9, 15, 17, 24 & 30).

1. No residents were directly affected by this practice.
2. All residents have the potential to be affected by this practice.
3. The facility will ensure that each resident upon admission and on an annual basis will be offered the influenza and Pneumococcal vaccinations to all residents whom are not up to date with the vaccines.
4. The facility will follow its protocol and procedures of offering the required vaccinations upon admission and thereafter on an annual basis to all residents.
5. All appropriate staff have been educated on the policies and procedures for all required vaccines of the residents and the ICP will monitor and assure compliance is achieved and sustained for all residents. Education started on 05/17/24 and will be ongoing.
6. ICP /Nurse Managers will complete audits upon admission to assure completion of all resident vaccines per regulations and that all are documented and compliance is sustained ongoing.
7. ICP will report findings from audits within the Quarterly QA Committee meetings and the committee will evaluate effectiveness of education and compliance for the next three months. Once 100% compliance is achieved the committee will reevaluate time frames of audits and revise as needed to assure compliance is sustained.
8. Correction date 06/11/24.

F887 SS=E

The facility failed to offer the COVID-19 vaccinations to 4 of its new admissions/residents.

1. No residents were directly affected by this deficiency.
2. All residents have the potential to be affected by this practice.
3. The facility will ensure that each resident upon admission and on an annual basis will offer the Covid-19 vaccinations to all residents whom are not up to date with the vaccine.
4. The facility will follow its protocol and procedures of offering COVID-19 vaccinations upon admission and thereafter as recommended by the CDC to assure all residents are up to date on COVID-19 vaccination to all residents.
5. All appropriate staff have been educated on the policies and procedures for all required vaccines of the residents and the ICP will monitor and assure compliance is achieved and sustained for all residents. Education started on 05/17/24 and will be ongoing.

6. ICP /Nurse Managers will complete audits upon admission to assure completion of all resident vaccines per regulations and that all are documented and compliance is sustained ongoing.
7. ICP will report findings from audits within the Quarterly QA Committee meetings and the committee will evaluate effectiveness of education and compliance for the next three months. Once 100% compliance is achieved the committee will reevaluate time frames of audits and revise as needed to assure compliance is sustained.
8. This will be monitored through our quarterly QA Meetings.
9. Correction date 06/11/24.