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	205069	A. BUILDING _____ B. WING _____	08/08/2024

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SANDY RIVER CENTER	119 LIVERMORE FALLS RD FARMINGTON, ME 04938

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F 000	INITIAL COMMENTS From 8/5/2024 to 8/8 2024, on-site visits were completed at Sandy River Center for the purpose of conducting the annual Long Term Care Survey Process for Federal Recertification, and complaint investigations #ME00048310, ME00048033, ME00047725, ME00045419, ME00045129, ME00044719, ME00044717, ME00043933, ME00043688, ME00043437, ME00043358, ME00042995, and ME00042790. It was determined that Sandy River Center was not in compliance with 42 CFR Part 483, Subpart B-Requirements for Long Term Care Facilities.	F 000		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 578		

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

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(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on record review and interviews the facility failed to provide residents/representatives written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive for 7 of 15 residents reviewed for advanced directives (Resident's #7, #33, #51, 65, #16, #34, #69).

Findings:

1. Resident #7 was admitted to the facility on 1/24/23. A review of Resident #7's clinical record lacked evidence that the facility provided resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive.

2. Resident #33 was admitted to the facility on 12/8/22. Review of Resident #33's clinical record

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lacked evidence that the facility provided/obtained resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and or formulate an advance directive.

3. Resident #51 was admitted to the facility on 5/23/23. Review of Resident #51's clinical record lacked evidence that the facility provided/obtained resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and or formulate an advance directive.

4. Resident #65 was admitted to the facility on 2/15/24. A review of Resident #65's clinical record lacked evidence that the facility provided resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive.

On 8/6/24 at 10:17 a.m., Market Clinical Advisor confirmed Residents #7, #33, #51, and #65's clinical records did not include evidence that the residents and/or representatives were asked, or offered and refused, assistance filling out an advanced directive.

5. Resident #16 was admitted to the facility on 5/26/23. A review of Resident #16's clinical record lacked evidence that the facility provided resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive.

6. Resident #34 was admitted to the facility on 1/26/24. A review of Resident #34's clinical record lacked evidence that the facility provided

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F 578	Continued From page 3 resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. 7. Resident #69 was admitted to the facility on 4/30/24. A review of Resident #69's clinical record lacked evidence that the facility provided resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. On 8/7/24 at 11:51 a.m., Market Clinical Advisor confirmed Residents #16, #34, and #69's clinical records did not include evidence that the residents and/or representatives were asked or offered and refused assistance filling out an advanced directive.	F 578		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for	F 584		

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the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observations and interviews, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable interior for the 6 of 6 units (Mt. Abram, Mt. Blue, Sugarloaf, Clearwater, Rangeley and Porter), the upper level common area, the lower level common area, a patio and the laundry for 1 of 1 facility tours (8/8/24).

Findings:

On 8/8/24 from 7:50 a.m. to 8:30 a.m., during a tour of the facility with the Maintenance Director,

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the Regional Health Care Services Housekeeping Supervisor and the Administrator, the following findings were observed:

1. Upper Level Common Area
> The public bathroom near the main office had a dirty floor and dirty caulking around the base of toilet.

Mt. Abram Unit:
> Resident Room 102 - The floor was soiled with dust/dirty inside of the room entrance door and around the entire edge of the room. The caulking was dirty around the base of the toilet.
> Resident Room 103 - The floor was soiled with dust/dirty inside of the room entrance door and around the entire edge of the room.
> Resident Room 104 - The floor was soiled with dust/dirty inside of the room entrance door and around the entire edge of the room. The caulking was dirty around the base of the toilet.
> Resident Room 105 - The floor was soiled with dust/dirty inside of the room entrance door and around the entire edge of the room.
> The kitchenette upper cabinet doors had chipped/missing paint on the corners of the doors.

Mt. Blue Unit:
> The entire dining room floor and the edges were heavily soiled with dirt suspended in the wax.
> Resident Room 202 - The room entrance door frame had chipped/missing paint creating an uncleanable surface.
> Resident Room 204 - The room entrance door and bathroom door frames had chipped/missing paint creating uncleanable surfaces. The bathroom ceiling light had debris in it.

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F 584	Continued From page 6 > Resident Room 205 - The room entrance door and bathroom door frames had chipped/missing paint creating an uncleanable surface. The walls by the sink were gouged and marked. The baseboard heater cover on right side of room was broken apart and the entire baseboard heater had chipped/missing paint creating uncleanable surfaces. The box fan on the left side of the room was heavily soiled with dust. The black, circular standing floor fan on the right side of the room was heavily soiled with dust. The ceiling tile, next to the air vent on the right side of room had a large brown stain on it. The air vent was heavily soiled with dust. The caulking and floor around base of toilet were dirty. The bathroom ceiling light has debris in it. > Resident Room 208 - There was a broken/missing floor tile as you enter the room. There was a dusty white floor fan by the sink. There were multiple ceiling tiles stained with brown stains. The bathroom door frame and room entrance door frame had chipped/missing paint. The walls by the sink were marked/marred and gouged. The caulking and floor were dirty around the base of the toilet. The bathroom ceiling light was full of dust/debris. The box fan by the window was heavily soiled with dust. > Resident Room 209 - The wall by the window on the right side of the room had holes in it. The fan in the window is heavily soiled with dust. The bathroom door frame and room entrance door frame had chipped/missing paint. The caulking was dirty around the base of the toilet. The bathroom privacy curtain was missing hooks, hanging down and in disrepair. There was a wash basin on the bathroom floor. Sugarloaf Unit: > There were 2 ceiling tiles in the hallway by	F 584		

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resident room 301 that had large brown stains on them.
> Resident Room 301- The caulking was dirty around the base of the toilet.
> Resident Room 302 - The caulking was dirty around the base of the toilet. There were 3 wash basins on the bathroom floor.
> There air conditioning unit in the dining room had a dirty/dusty filter.
> Resident Room 305 - The caulking was dirty around the base of the toilet. The bathroom ceiling light was full of dust/debris.
> Resident Room 308 - The towel bar was missing on the bathroom door. The caulking was dirty around the base of the toilet. There was a wash basin on the bathroom floor.

Porter Unit:
>The kitchenette upper and lower cabinets had chipped/missing paint on the doors creating uncleanable surfaces. The wall near the cupboard had chipped/missing paint. The dining room floor was dusty/dirty in the corners.
> Resident Room 403 - The room entrance door frame had chipped/missing paint.

Rangeley Unit:
> Shower Room - There was a commode bucket on the floor.
> Resident Room 503- The room entrance door had loose/chipped/missing laminate creating an uncleanable surface.
> Resident Room 508 - The walls by the beds had chipped/missing paint and exposed sheetrock creating uncleanable surfaces.

Clearwater Unit:
> Resident Room 608 - The bathroom wall by the toilet had chipped/missing paint with exposed

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F 584	Continued From page 8 sheetrock creating an uncleanable surface. Lower Level Common Area > There were 3 ceiling tiles, by the elevator, that had large brown stains on them. Laundry Room > There was a heavy build-up of lint behind and on the dryers and washers. On 8/8/24 at 8:30 a.m., in an interview, the Maintenance Director, the Regional Health Care Services Housekeeping Supervisor, and the Administrator confirmed the findings. 2. On 8/8/24 at 11:45 a.m., a surveyor observed the patio fence door, between the Rangeley Unit and the Porter Unit, to be broken and missing 2 door panels. There was a green chair blocking the fence opening. On 8/8/24 at 11:50 a.m., in an interview, the Administrator confirmed the finding.	F 584		
F 645 SS=E	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires	F 645		

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the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing

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facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and interview, the facility failed to ensure that 3 of 3 residents reviewed with a specialized mental health diagnosis, whose stay went beyond the expected 30 days, had been referred to the appropriate state-designated authority for Pre-Admission Screening & Resident Review Level II (PASRR) evaluation and determination (Residents #48, #66 and #68).

Findings:

1. Resident #48 was admitted to the facility on 6/25/24 with diagnosis of Bipolar Disorder. Resident #48's clinical record contained a PASRR Level I determination letter dated 6/24/24 that stated further PASRR evaluation was not required due to Resident #48 met the criteria for a short-term convalescence admission. Resident #48 was not discharged after a short stay and was assessed to be Nursing Facility level of care and continued to reside in the facility. The clinical record lacked evidence to indicate that the PASRR Level I was forwarded again to the State Mental Health Authority to determine if a PASRR

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Level II evaluation and determination was needed after Resident #48's stay changed from short-term to long-term.

2. Resident #66 was admitted to the facility on 4/3/24 with diagnosis of Anxiety. Resident #66's clinical record contained a PASRR Level I determination letter dated 2/23/24 that stated further PASRR evaluation was not required due to Resident #66 met the criteria for a short-term convalescence admission. Resident #66 was not discharged after a short stay and was assessed to be Nursing Facility level of care and continued to reside in the facility. The clinical record lacked evidence to indicate that the PASRR Level I was forwarded again to the State Mental Health Authority to determine if a PASRR Level II evaluation and determination was needed after Resident #66's stay changed from short-term to long-term.

3. Resident #68 was admitted to the facility on 4/25/24 with diagnosis of Bipolar Disorder. Resident #68's clinical record contained a PASRR Level I determination letter dated 4/18/24 that stated further PASRR evaluation was not required due to Resident #68 met the criteria for a short-term convalescence admission. Resident #68 was not discharged after a short stay and was assessed to be Nursing Facility level of care and continued to reside in the facility. The clinical record lacked evidence to indicate that the PASRR Level I was forwarded again to the State Mental Health Authority to determine if a PASRR Level II evaluation and determination was needed after Resident #68's stay changed from short-term to long-term.

On 8/7/24 at 11:20 a.m., in an interview, the

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F 645	Continued From page 12 Market Clinical Advisor, confirmed the findings.	F 645		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 656		

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local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and interviews the facility failed to update and/or implement goals and interventions for 2 of 23 care plans reviewed for respiratory care, and 1 of 1 careplans reviewed for Post-Traumatic Stress Disorder (PTSD). (Resident's #28, #69, #26).

Findings:

1. Resident #28 was admitted on 3/5/22 and has diagnoses to include obstructive sleep apnea, morbid obesity and chronic obstructive pulmonary disease (COPD).

Review of Resident #28's care plan updated 5/6/24 states "[Chronic Obstructive Pulmonary Disease (COPD)-Clinical Management Chronic Bronchitis; The patient will experience improved exercise tolerance as evidenced by a decrease in episodes of dyspnea on exertion. CPAP as ordered: set at 18, per resident ..."

Review of Resident #28's clinical record revealed progress note dated 7/14/24 stating "CPAP is broken. Resident requested if possible [he/she] can have oxygen for tonight. Notified on call provider ...about the request of the patient.

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hooked oxygen 2 LPM as ordered."

During an interview on 8/5/24 at 10:50 a.m., Resident#28 indicated his/her CPAP machine broke more than a month ago and they have not replaced it yet.

During an interview on 8/6/24 at 12:48 p.m., Unit Manger and a surveyor reviewed Resident #28's care plan confirming his/her care plan had not been updated to reflect his/her current respiratory status.

2. Resident #69 was admitted on 4/30/24 with a diagnosis of COPD and Congestive Heart Failure (CHF). A review of Resident #69's July 2024 Medication Administration Records (MAR) indicates that the resident received Oxygen at 2 liters per nasal cannula continuously from 5/1/24 - 7/29/24.

A review of Resident #69's care plan did not include a focus, goals or interventions in the area of oxygen therapy.

On 8/7/24 at 1:46 p.m., a surveyor confirmed the above finding during an interview with the Market Clinical Advisor.

3. Resident #26 was admitted on 11/21/23 with diagnoses to include post-traumatic stress disorder, depression, and anxiety.

Review of Care Plan for Resident #26, updated 6/5/24, states "DX: PTSD from time served as a Marine ... Resident/Patient will identify stressors and report to staff. ... Encourage Resident/Patient to identify personal trauma and triggers and take steps to eliminate/minimize. ..."

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F 656	Continued From page 15 Review of Resident #26s entire clinical record lacked evidence that he/she was asked about PSTD triggers or how to eliminate/minimize them. During a review of Resident#26's care plan on 8/08/24 at 11:36 a.m., the Director of Nursing confirmed the above findings.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657		

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by:
Based on interviews and record review, the facility failed to ensure residents' care plans were reviewed and revised by the interdisciplinary team (IDT) within 7 days after each comprehensive assessment for 4 of 4 residents reviewed for IDT meetings (Resident's #7, #32, #33 and #65). In addition, the facility failed to ensure a a resident's care plan was revised to address nutrition and weight loss (#42).

Findings:

1.Review of Resident #7's clinical record revealed quarterly Minimum Data Set (MDS) dated 6/19/24. Further review of Resident #7's clinical record revealed an Interdisciplinary Team Meeting (IDT) was held on 7/19/24 (30 days after MDS date).

2.Review of Resident #32's clinical record revealed quarterly MDS dated 5/20/24. Further review of Resident #32's clinical record revealed an IDT meeting was held on 5/1/24 (19 days before the MDS date).

3. Review of Resident #33's clinical record revealed quarterly MDS dated 5/28/24. Further review of Resident #33's clinical record revealed an IDT meeting was held on 5/1/24 (27 days before MDS date).

4. Review of Resident #65's clinical record revealed quarterly MDS dated 5/28/24. Further review of Resident #65's clinical record revealed an IDT meeting was held on 5/1/24 (27 days before the MDS date).

During an interview on 8/7/24 at 3:12 p.m.,

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Director of Nursing confirmed IDTs were not held within 7 days after MDS dates, but in the future, it would be happening.

During an interview on 8/8/24 at 9:28 a.m., Unit Manger indicated they haven't had a Social Woker since 7/5/24 and she was assisting with holding the IDT meetings and didn't understand that they were supposed to be held withing 7 days after the MDS date.

5. A review of Resident #42's clinical record revealed an admission date of 5/24/24. Physician orders upon admission included a dysphagia, advanced texture diet, and weigh every day shift every Monday for baseline for 4 weeks, AND every day shift every 1 month starting on the 24th.

An admission MDS assessment was completed on 5/29/24. Review of the MDS noted no issues identified with swallowing or weight changes, and revealed the resident received a mechanically altered diet. The baseline care plan was initiated on 5/2/24, and the IDT meeting was held on 5/28/24. A review of the care plan, noted under Activities of Daily Living (ADLs), included regular diet, dysphagia advanced. On 7/3/24, the Registered Dietitian noted a weight loss of 10.3 lbs. since admission and recommended the resident receive a house supplement twice daily. The last recorded weight was on 7/3/24.

On 8/7/24 at 2:45 p.m., in an interview with the Registered Dietitian and the Market Clinical Advisor, the surveyor noted Resident #42's care plan had not been revised to address weight loss or include appropriate nutritional interventions. In addition, the record lacked evidence of a follow-up monthly weight being obtained on

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F 657	Continued From page 18 7/24/24. The surveyor asked how staff would monitor to see if interventions for weight loss had been effective. The RD stated he/she would follow up. The Market Clinical Advisor confirmed the care plan had not been revised to address nutrition.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the resident's environment was free of accident hazards relating to a desk wall laminate covering for 1 of 3 days of survey. (8/5/24) Finding: On 8/5/24 at 11:15 a.m., a surveyor observed the nursing station laminate wall covering to be chipped/gouged and missing pieces along the bottom edge. This created sharp edges which were accessible to residents, staff and visitors creating an accident hazard. On 8/5/24 at 11:29 a.m., in an interview, the Market Clinical Advisor observed and confirmed the nursing station laminate wall covering was chipped/gouged and missing pieces and was an	F 689		

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F 689	Continued From page 19 accident hazard to passersby.	F 689		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed provide respiratory care consistent with professional standards of practice by failing to ensure that respiratory equipment was replaced for 1 of 1 resident (Resident #28) and failed to change oxygen tubing for 1 of 2 residents reviewed (Resident #69). Findings: 1. Resident #28 was admitted on 3/5/22 and has diagnoses to include severe morbid obesity, chronic obstructive pulmonary disease (COPD) and obstructive sleep apnea, requiring a CPAP machine (a machine that uses mild air pressure to keep breathing airways open while you sleep). Review of Resident #28's clinical record reviewed "Hospital Discharge Summary" dated 2/12/24 states "Special Instructions: Make sure you use your CPAP for any sleep, including daytime napping ..."	F 695		

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F 695	Continued From page 20 Review of Resident #28's active orders dated August 2024 revealed the following: 1.Order with start date of 10/26/24 states "CPAP [a machine that uses mild air pressure to keep breathing airways open while you sleep] mask on at HS. Fill reservoir to line with distilled water. Do not overfill. at bedtime for sleep apnea." Review of Resident #28's Treatment Administration Record (TAR) from 7/13/24 through 8/6/24 revealed this was not completed: broken (24 days). 2. Order with start date of 10/9/24 states "CPAP mask to be removed in a.m. Clean mask and reservoir with warm soapy water, rinse and air dry. Every night shift for sleep apnea CPAP mask to be removed in a.m. clean mask and reservoir with warm soapy water, rinse and air dry. every night shift for sleep apnea." Review of Resident #28's Treatment Administration Record (TAR) from 7/13/24 through 8/6/24 revealed this was not completed: broken (24 days). Review of Resident #28's care plan updated 5/6/24 states "Chronic Obstructive Pulmonary Disease(COPD)-Clinical Management Chronic Bronchitis; The patient will experience improved exercise tolerance as evidenced by a decrease in episodes of dyspnea on exertion. CPAP as ordered ..." Review of Resident #28's clinical record revealed the following progress notes:	F 695		

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-7/13/24 "Water reservoir is leaking. This writer attempted to contact CPAP supplier without success." Further review of Resident #28's clinical record lacked evidence that facility made any further attempts to contact CPAP supplier.

-7/14/24 "Telehealth Notification Note" "The Cpap is not working and is leaking water; the patient is requesting supplemental oxygen tonight. Plan: supplement 0xygen 2-3 L, nurse to follow up Cpap machine in AM. Further review of Resident #28's clinical record lacked evidence this was done.

-7/15/24 17:54:27 Night nurse passed onto writer that cpap wasn't working and [sister/brother] was called and was going to get it fixed due to being pt's own machine. Writer called, [sister/brother], and [he/she] stated [he/she] knew nothing about this and doesn't know how to reach out to company to get fixed. ... Note put in MD's folder on above, ?ordering new machine."

7/16/24 "Pt called company on CPAP machine. Pt stated they needed a new script for machine and supplies. Note put in MD's folder with above request."

Review of Resident #28's clinical record revealed "Provider Communication" dated 7/15/24 states "CPAP not working, this is Pt's [patients] personal machine ...order new one?" Review of provider response dated 7/16/24 states "Please contact [Respiratory Company] May need a new sleep study."

Review of provided fax states: "Referral for new c-pap" dated 7/25. No follow up documentation is noted in the resident chart.

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During an initial interview on 8/5/24 at 10:50 a.m., Resident #28 indicated [his/her] CPAP broke more than a month ago and hasn't been replaced.

During a follow-up interview on 8/6/24 at 1:09 p.m., Resident #28 confirmed he/she did not receive CPAP last night and believed he/she was still waiting for a sleep study to happen.

During an interview on 8/6/24 at 12:48 p.m., Director of Nursing and Unit Manager confirmed the facility has not followed-up with the respiratory company regarding replacement of CPAP or sleep study. At this time Unit Manager indicated that she "grabbed order today and sent it to [respiratory company], but the unit secretary (UH) had been working on the sleep study referral.

During an interview on 8/8/24 at 12:47 p.m., UH indicated that she is the only one that sends out referrals and also works as a Certified Nursing Assistant (CNA) on the floor as well as the UH position. UH further indicated that when a referral is done, they usually bring it right up to her or put it in her box and in this case, and it was probably bought up on that day, but she had been working the floor, so she didn't get back to her UH position until 7/25/24 and has not followed up on the referral.

During an interview on 8/6/24 at 12:50 p.m., Unit Manager confirmed that Resident #28 has been without a CPAP machine since 7/15/24, and no one has followed up with the respiratory company.

2. Review of the Procedure: Oxygen: Nasal

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F 695	Continued From page 23 Cannula Revision dated 8/7/23., #22. Replace disposable set-up every seven days. Date and store cannula in treatment bag when not in use. On 8/5/24 at 10:05 a.m., the surveyor and Licensed Practical Nurse #2 (LPN) observed Resident #69's oxygen nasal cannula tubing wrapped up and stored with the cylinder on the back of the wheelchair. The date on the oxygen tubing indicated the tubing had been changed on 6/18/24. On 8/5/24 at 10:10 a.m., during an interview with a surveyor, LPN #2 stated oxygen tubing gets changed weekly. Review of Resident #69's active orders for August 2024 revealed an order with a start date of 6/3/24 change the oxygen tubing weekly, label each component with the date and initials. The Treatment Administration Record (TAR) indicates that the oxygen tubing was changed on 6/24/24, 7/1/24, 7/15/24, 7/22/24 & 7/29/24. On 8/7/24 at 1:46 p.m., a surveyor confirmed the finding above of inaccurate documentation with the Market Clinical Advisor who stated she would inform the staff to change the tubing again.	F 695		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial	F 725		

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well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
(i) Except when waived under paragraph (e) of this section, licensed nurses; and
(ii) Other nursing personnel, including but not limited to nurse aides.

§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on record review and interviews, the facility failed to ensure sufficient direct care staff were scheduled and on duty to meet the needs of residents that reside in the facility. This has the potential to affect all residents needing assistance with Activities of Daily Living ("ADLs").

Findings:

During an interview on 8/5/24 10:33 a.m., Resident #181 indicated 2 Certified Nursing Assistant (CNA)'s on duty to cover entire floor - days and evening, and they are not offering a basin of water or assist to brush teeth. Resident #181 further indicated he/she asked a CNA for help the other day and she said, "that figures"

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because she was too busy.

During an interview on 8/5/24 at 11:11 a.m., Resident #185 indicated that last week he/she called his/her girlfriend/boyfriend because he/she had used the call bell at 4 pm to be changed, as he/she had been incontinent of bowel. His/her girlfriend/boyfriend arrived at 6 p.m., and notified staff Resident #185 needed to be changed and a staff member stated they were busy with dinner, and he/she was finally changed around 6:30 p.m. Resident #185 further indicated he/she rang the call bell about 3:00 a.m. last Wednesday (7/31/24) to be changed and staff came an hour later.

During a resident council meeting on 8/7/24 at 11:00 a.m., Resident #50 indicated that the staff take a very long time to answer call bells and it's been brought up in resident council many times. Review of April, May, June and July 2024 Resident Council meeting minutes revealed the call bells are not being answered in a timely manner and residents feel that staff are not always busy.

During an interview on 8/7/24 at 1:55 p.m., Resident Representative indicated that his/her husband/wife never gets shaved unless he/she comes in to do it, and his/her teeth aren't getting brushed. Resident Representative states that he/she is being told that there aren't enough staff, or they're too busy. Weekend staffing is very poor and there are a lot of 2 person assists, and often the CNA has to go to another unit to get help and the floor is left unattended until they get back.

During an interview on 8/8/24 at 10:23 a.m.,

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F 725	Continued From page 26 CNA3 indicated that staffing is really bad and it's very difficult to get personal care done as it should and it's really hard to be the only CNA on a unit when you have a lot of residents with dementia and there are quite a few residents that are a 2 person assist. CNA3 further indicated that there were 3 falls during the same shift last week that could have been prevented, call bells are taking a long time to answer, and residents are going a long time between incontinent care episodes because there is so much to be done. The nurses try to help when they can, but they have their own responsibilities. During an interview on 8/8/24 at 10:45 a.m., Registered Nurse (RN) indicated that staffing has been an ongoing problem at the facility and there have been a lot of preventable falls. RN further indicated there are a lot of 2 person assists so a CNA needs someone to help them, and medication technicians and nurses try to help, but today there is one med tech to pass meds on three units so there's no way they can help at all. Review of 3 month fall report revealed there were 18 falls on the day shift, 43 falls during the evening shift and 21 falls during the night shift. During an interview on 8/7/24 at 1:48 p.m., Director of Nursing confirmed there have been some falls on the days they were short staffed, and the facility does not staff to acuity level, but the facility tries really hard to staff at least to state minimums.	F 725		
F 742 SS=D	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure	F 742		

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that-
§483.40(b)(1)
A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being;
This REQUIREMENT is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure that a resident who had a diagnosis of Post-Traumatic Stress Disorder (PTSD) received the care and services necessary to reach and maintain the highest level of mental and psychosocial wellbeing for 1 of 4 residents reviewed for mood/behavior (Resident #26).

Findings:

Resident #26 was admitted on 11/21/23 with diagnoses to include post-traumatic stress disorder, depression, and anxiety.

Review of entry Minimum Data Set (MDS) dated 11/27/23 revealed Resident #26 had a brief interview for mental status score of 13 of 15 indicating he/she is cognitively intact.

Review of Care Plan for Resident#26, updated 6/5/24, states "DX: PTSD from time served as a Marine ... Resident/Patient will identify stressors and report to staff. ... Encourage Resident/Patient to identify personal trauma and triggers and take steps to eliminate/minimize. ..."

On 8/07/24 at 8:45 a.m., during an interview, Resident #26 states his/her typical mood is "kind

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of ugly". He/she states he/she hasn't talked with his/her provider about this but has talked to nursing and hopes to talk to his/her doctor soon.

On n 8/6/24 at 1:35 p.m., during an interview, Licensed Practical Nurse (LPN) #1 indicated that Resident#26 is not receiving trauma specific therapy at this time. During a follow up interview on 8/07/24 at 8:49 a.m. LPN#1 indicates she was unaware Resident#26 had requested to speak with the provider.

On 8/08/24 at 8:37 a.m., during an interview, Unit Manager indicated she didn't know residents with PTSD were supposed to be asked about triggers and confirmed Resident #26 was not asked what his/her PTSD triggers were.

On 8/08/24 at 11:36 a.m., during an interview Director of Nursing confirmed above findings.

Review of Policy titled Person Centered Care Plan last revised 10/24/24 states "The baseline care plan will ensure that patients who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for patients' experiences and preferences."

Centers for Medicare and Medicaid Services Trauma Informed Care Training states "When care planning to address a resident's history of trauma ... , there should be evidence that the facility collaborated with ... health care professionals to understand the resident's trauma experience. This includes finding out triggers that may re?traumatize the resident and developing interventions to help avoid these triggers."

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F 757	Continued From page 29	F 757		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to provide documentation of monitoring of psychotropic medication side effects for 1 of 5 residents reviewed for unnecessary drug use (#7). Findings: Resident #7 was originally admitted on 1/24/23 and has diagnoses to include anxiety and depression. Review of Resident #7's active physician orders as of August 2024 revealed the	F 757		

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F 757	Continued From page 30 following medications: -Order with start date of 6/4/24 for "Abilify Oral Tablet 15 mg (milligram) (Aripiprazole) Give 15 mg by mouth one time a day for depression. -Order with start date of 6/4/25 for "Buspirone HCL Oral Tablet 10 mg (Buspirone HCL) Give 1 tablet by mouth in the afternoon for anxiety" -Order with start date of 6/4/24 for "Buspirone HCL Oral Tablet 10 mg (Buspirone HCL) Give 1 tablet by mouth one time a day for anxiety." -Order with start date of 6/4/24 for " Buspirone HCL Oral Tablet 10 mg (Buspirone HCL) Give 2 [tablet] by mouth at bedtime for anxiety dose equals 20 mg." -Order with start date of 4/22/24 for "Trazodone HCl Oral Tablet (Trazodone HCl) Give 175 mg by mouth at bedtime for depression -Order with start date of 3/23/24 for "Sertraline HCl Oral Tablet 100 MG (Sertraline HCl)Give 200 mg by mouth one time a day for anxiety." Further review of Resident #7's clinical record, the surveyor was unable to locate evidence of monitoring for side effects of these medications. During an interview on 8/08/24 at 10:56 a.m., the Director of Nursing confirmed Resident #7's clinical record lacked evidence of monitoring for side effects of psychotropic medications in the presence of 4 surveyors.	F 757		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		

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appropriate accessory and cautionary instructions, and the expiration date when applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure that medications were stored properly by having an unlocked, unattended medication cart allowing residents and unauthorized persons access to medications, on 1 of 4 days of survey. In addition, the facility failed to ensure expired medications were removed from the supply available for use in 1 of 2 medication storage rooms and 1 of 3 medication carts reviewed.

Findings:

1. On 8/5/24 at 9:01 a.m. two surveyors observed an unlocked and unattended medication cart in the hallway of the Sugarloaf unit for

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approximately 2 minutes. During this time, one resident was observed in the hallway. Upon return to the medication cart at 9:03 a.m., the Unit Manager confirmed she had left the medication cart unlocked and unattended.

2. On 8/6/24 at 12:15 p.m., during review of the lower level Medication Storage room with LPN #1, a surveyor observed 1 open/undated 8 ounce bottle of Geri Care Senna liquid with an expiration date of 4/24, and 1 unopened 8 ounce bottle of Geri Care Senna liquid with an expiration date of 4/24.

3. On 8/6/24 at 12:20 p.m. during a review of the Rangeley Lake unit medication cart with LPN #1, a surveyor observed 1 open bottle of Geri Care Asprin 81 mg (milligram) Enteric coated with an open date of 7/1/24 and an expiration date of 6/24.

4. On 8/6/24 at 12:34 p.m., a surveyor observed the medication room refrigerator with LPN #2 and noted a dormitory style refrigerator with a freezer. Inside the refrigerator were 5 pneumococcal vaccines and 5 Purified Protein Derivative (PPD) which is used to test for tuberculosis for staff and residents.

The United States Centers for Disease Control and Prevention's website, Vaccine Storage and Handling Toolkit, dated 3/24, states "Do not store any vaccine in a dormitory-style or bar-style combined refrigerator/freezer unit under any circumstances. These units often have a single exterior door and an evaporator plate/cooling coil, usually located in an icemaker/freezer compartment. These units pose a significant risk of freezing vaccines, even when used for

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F 761	Continued From page 33 temporary storage." On 8/6/24 at 12:43 p.m., a surveyor interviewed the Clinical Market Advisor and confirmed that a dorm style refrigerator with a freezer was being used to store vaccinations.	F 761		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to offer nourishing snacks to residents who want to eat at non-traditional times or outside of scheduled meal service times on 6 of 6 units (Mt. Abram, Mt. Blue, Sugarloaf, Clearwater, Rangeley and Porter), for 2 of 4 days of survey.	F 809		

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Findings:

On 8/5/24 at 10:37 a.m., in an interview, Resident #181 stated "They don't have a snack cart and we don't get offered snacks. I was told there's a bag in the cupboard if you want something. No yogurt or puddings. No hydration cups."

On 8/5/24 at 11:08 a.m., a surveyor checked and confirmed the Sugarloaf Unit cupboard contained only white bread and Ensure. No sandwich fillings, peanut butter, etc.

On 8/5/24 at 12:36 p.m., a surveyor checked the Mt. Blue cupboards and refrigerator and found there was only a few small cracker packages, 2 small snack oatmeal pies, 1 very small container of tuna salad in the fridge and 1 loaf of bread.

On 8/6/24 at 9:15 a.m., Resident #73 said to a surveyor that he/she is never offered snacks because they never have any snacks on the units. He/she said there is never anything in the refrigerator or cupboards. He/she said that he/she could have toast and that was it.

On 8/6/24 at 9:30 a.m., a surveyor and the Food Service Director observed the Mt. Blue snack cupboards. The Food Service Director confirmed there was only a few small cracker packages, 2 small snack oatmeal pies, 1 very small container of tuna salad and 1 loaf of bread and agreed there was not enough snacks or a variety of snacks for the number of residents on the unit. The surveyor discussed with the FSD that it had been like this on 8/5/24 and 8/6/24. The FSD stated that the 2 staff that normally stock the snacks in the kitchenettes have had time off from work.

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F 809	Continued From page 35 On 8/6/24 at 9:45 a.m., in an interview, CNA #2 stated that before this week that there were hardly ever any snacks and drinks or a variety of snacks and drinks stocked on the units. She stated that maybe there would be a few small packages of crackers(2 in a package) and a loaf of bread. There was never coffee or tea left for the residents after any meals. If the residents wanted something other than toast, she would have to call the kitchen and then have to wait hours to get anything. On 8/6/24 at 10:00a.m., in an interview, CNA #3 stated that before this week that there was no variety of snacks and drinks. There were minimal snacks and drinks. She said that there might be a loaf of bread for toast but not much else. A few crackers and a couple small packages of oatmeal pies but that is it. There would be no sandwich making supplies or coffee and tea for the residents. She said if they called the kitchen for something for a resident, they had to wait over an hour to get anything. On 08/06/24 at 2:00 p.m., a surveyor and the Food Service Director District Manager looked at Sugarloaf Unit cupboards and refrigerator. The Food Service Director District Manager stated that when he arrived at the facility, he had checked all the units and they were not properly stocked with enough snacks or a variety of snacks for the residents on the units. He stated that as of right now, all units had been stocked now with snacks according to the newly created Snack Par List given to surveyor. He stated that kitchenettes will be stocked 3 times a day(10 am, 2 pm and 5pm) from now on. No policy or procedure could be provided to the surveyor for	F 809		

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F 809	Continued From page 36 stocking snacks in the kitchenettes.	F 809		
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, interviews, the facility's "Refrigerated/Frozen Storage" policy revision date 6/15/18, the facility's "Environment: policy HCSG 028 revised 9/2017, the facility's "Warewashing" policy HCSG 022 revised 2/2023, the facility's "Food Storage: Cold Storage" revised 2/2023, the facility's "Food Storage: Dry Goods" revised 9/2017, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for ceiling vents, ceiling tiles, ceiling lights, he hood system, the food slicer, the food mixer, and cement blocks. Additionally, the facility failed to ensure that foods in the dry storage	F 812		

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room, the reach-in refrigerator and the walk-in refrigerator were labeled and/or dated. Further, the facility failed to ensure refrigerator temperatures were monitored for an area refrigerator.

Findings:

A surveyor completed Initial Kitchen Tour on 8/5/24 from 9:15 a.m. to 10:00 a.m. with the Food Service Director in which the following findings were observed:

1. > There were 3 ceiling vents, 2 ceiling lights and the 4 surrounding ceiling tiles, in the dish room, that were heavily soiled with dust/dirt.
> There was 1 ceiling air, vent just inside the kitchen entrance door, that was heavily soiled with dust/dirt.
> All ceiling tiles throughout the entire kitchen were marked/marred and/or dirty.
> The hood system had chipped/missing paint creating an uncleanable surface.
> The food slicer had dried food particles on the blade and blade protector.
> The food mixer had dried food particles on the base and bowl riser arm and base.
> There were 4 untreated cement blocks under the legs of the ice machine.
> The dry storage room had 2 small bags of chips and 1 bag of clear small containers of peanut butter that were unlabeled and undated.
> The reach-in refrigerator had one, 2-quart pitcher of red liquid that was unlabeled and undated.
> The walk-in refrigerator had 2 large clear square containers of an unidentified creamy food, 1 large bowl of an unidentified creamy food and 1

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bag of sliced potatoes that were unlabeled and undated.
> The walk-in freezer had 1 previously opened bag of chicken patties that was unlabeled and undated.
> The Activity room refrigerator contained 2 opened and undated whipped cream canisters.
Additionally, the Refrigerator/Freezer Temperature Log for August 2024 was missing documented temperatures for the 2nd through the 5th.

The facility's "Refrigerated/Frozen Storage" noted: 1. Refrigeration: 1.4 All foods are labeled with the name of product and the date received and "used by" date once opened. 1.5 prepared foods are labeled and dated with the name of the product, date open, and use by date. 1.10 Food and nutrition services employees observe and record equipment temperatures.

The facility's "Food Storage: Cold Storage" noted: Procedures . All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination.
The facility's "Food Storage: Dry Goods" noted: Procedures 6. Storage areas will be neat, arranged for easy identification, and date marked as appropriate.

The facility's "Environment: policy HCSG 028 revised 9/2017 noted: 1. The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation. 2. The Dining Services Director will ensure that all employees are knowledgeable in the proper procedures for cleaning and sanitizing of all food

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F 812	Continued From page 39 service equipment and surfaces. 3. All food contact services will be cleaned and sanitized after each use. The facility's "Warewashing" policy HCSG 022 revised 2/2023, noted: Procedures 1. The dining services staff will be knowledgeable in the proper technique for processing dirty dishware through the dish machine and proper handling of sanitized dishware. 2. All dish machine water temperatures will be maintained in accordance with manufacturer's recommendations for high temperature and low temperature machines. 3. Temperature and or sanitizer concentration logs will be completed, as appropriate.. On 8/5/24 at 10:00 a.m., in an interview, the Food Service Director confirmed the findings. 2. On 8/6/24 at 8:00 a.m., a surveyor observed the cook with facial hair not wearing facial hair protection. At this time, in an interview, the cook confirmed he was not wearing facial hair protection. On 8/6/24 at 8:03 a.m., in an interview, a surveyor discussed the finding with the Administrator	F 812		
F 814 SS=E	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: Based on observation and interview, the facility failed to maintain a garbage storage area in a sanitary condition to prevent the harborage and feeding of pests for 2 trash collection container for 4 of 4 days of survey. (8/5/24, 8/6/24, 8/7/24	F 814		

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	205069	A. BUILDING _____ B. WING _____	08/08/2024

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F 814	Continued From page 40 and 8/8/24) Findings: 1. On 8/5/24 at 9:05 a.m., a surveyor observed trash bags stored in an open container outside the building by a lower level exit. 2. On 8/6/24 at 7:30 a.m., a surveyor observed trash bags stored in an open container outside the building by a lower level exit. On 8/6/24 at 7:40 a.m., in an interview, the Administrator confirmed the findings. 3. On 8/7/24 at 9:05 a.m., a surveyor and the Administrator observed trash bags stored in an open container outside the building by a lower level exit. At this time, in an interview, the Administrator confirmed the findings. 4. On 8/8/24 at 8:30 a.m., a surveyor and the Maintenance Director observed trash stored in an open container outside the kitchen. At this time, the Maintenance Director confirmed the finding.	F 814		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F 842		

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F 842	Continued From page 41 §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or	F 842		

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(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and interview, the facility failed to ensure that clinical records were complete and contained accurate information for 1 of 1 residents reviewed for activities of daily living (#183), and 1 of 2 residents reviewed for oxygen use (#69).
Findings:

1. A review of Resident #183's clinical record noted an admission date of 7/26/24. Certified Nursing Assistant (CNA) documentation of activities of daily living (ADLs) for 7/26/24 through 8/5/24 revealed multiple days lacking documentation on multiple shifts as follows:

Bed Mobility: 7 out of 11 days
Eating: 3 out of 11 days
Bathing: 6 out of 11 days
Dressing: 6 out of 11 days
Drinks/snacks other than meals: 7 out of 11 days
Hygiene: 7 out of 11 days
Toileting: 7 out of 11 days

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F 842	Continued From page 43 Transfers: 7 out of 11 days Wheelchair mobility - 7 out of 11 days Walking - 7 out of 11 days On 8/6/24 at 2:45 p.m., in an interview with a surveyor, the Director of Nursing confirmed CNA documentation lacked evidence Resident #183 had received a shower or tub bath since admission, and that multiple shifts were lacking documentation of the care provided. 2. On 8/5/24 at 10:05 a.m., the surveyor and Licensed Practical Nurse #2 (LPN) observed Resident #69's oxygen nasal cannula tubing wrapped up and stored with the cylinder on the back of the wheelchair. The date on the oxygen tubing indicated the tubing had been changed on 6/18/24. Review of Resident #69's active orders for August 2024 revealed an order with a start date of 6/3/24 change the oxygen tubing weekly, label each component with the date and initials. The Treatment Administration Record (TAR) indicated that the oxygen tubing was changed on 6/24/24, 7/1/24, 7/15/24, 7/22/24 & 7/29/24. On 8/7/24 at 1:46 p.m., a surveyor confirmed the finding above of inaccurate documentation with the Market Clinical Advisor who stated she would inform the staff to change the tubing again.	F 842		
F 868 SS=E	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality	F 868		

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F 868	Continued From page 44 assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on review of the quarterly Quality Assurance Performance Improvement/Quality Assurance Assessment (QAPI/QAA) Committee meeting attendance sheets and interview, the facility failed to ensure that the Infection	F 868		

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F 868	Continued From page 45 Preventionist attended 4 of 4 quarterly meetings. Finding: A review of the quarterly QAPI/QAA meeting attendance sheets indicate that the Infection Preventionist did not attend the 10/31/23, 1/26/24, and 7/29/24 quarterly meetings. A review of the facility's policy, Center Quality Assurance Performance Improvement process, with a revision date of 10/24/22, stated, "Process. 2. The QAA Committee: 2.1. Functions under the authority of the Administrator and the governing Body and is composed of 2.1.1 Administrator, 2.1.2 Director of Nursing, 2.1.3 Medical Director, 2.1.4 Infection Preventionist, or designee, 2.1.5 Consultant Pharmacist (recommended), 2.1.6 Patient and/or family representatives (if appropriate), 2.1.7 Three (3) additional staff representatives, including, but not limited to department heads, certified nursing assistants, rehabilitation services, hospice, home health, etc. 2.2 Meets at least quarterly." On 8/8/24 at 10:10 a.m., the Administrator and Director of Nursing (DON) stated the facility did not have an alternate designee for the Infection Preventionist (IP), and that the IP provides copies of reports for review at QAPI/QAA committee meetings. The Administrator and DON confirmed that the IP did not attend 3 of 4 quarterly committee meetings during the past year.	F 868		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		

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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;

§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

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F 880	Continued From page 47 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure appropriate infection control procedures were followed related to hand sanitizing during the medication pass task for 1 of 2 medication passes observed. Finding: On 8/8/24 at 8:34 a.m., during a medication administration observation, a surveyor observed a Certified Nursing Assistant Med Technician (CNA-M) administering medications to (Resident #49) in a plastic medication cup. The CNA-M was then observed discarding the medication cup	F 880		

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F 880	Continued From page 48 into the trash can and walked by a hand sanitizer located on the wall in Resident #49's room. The CNA-M was then observed to walk back to the medication cart, unlocked the cart and began to prepare medications for Resident #66. At this time a surveyor intervened and asked CNA-M if she had washed or sanitized her hands. CNA-M stated "No." and acknowledged that she should sanitize her hands between residents. On 8/8/24 9:53 a.m., a surveyor discussed the lack of handwashing/sanitizing between residents during the medication pass with the Market Clinical Advisor.	F 880		