Brewer Center for Health & Rehabilitation

74 Parkway South Brewer Maine 04412
207-989-7300

3-28-25

F 561 Self-Determination:

Resident 11 has been provided with yellow and white briefs, per R11 preference.

Resident 11 care plan has been reviewed and updated to reflect the resident personal choice.

Other residents were interviewed to determine personal choices regarding incontinent care products.

Education provided to nursing staff on how to educate residents regarding risks and benefits of wearing incontinent products outside the sizing protocol and how care plan will be updated appropriately.

RN 3 Supervisor has been educated on the procedure for resident brief preference.

If a resident requests an incontinent product outside the sizing protocol, the resident will be educated about risks and benefits, and the care plan updated as appropriate. Resident will be provided brief preference.

The Director of Nursing or designee will complete random audits to assure residents are receiving incontinent products of their choice, resident was educated about risk and benefits, and care plan was updated reflecting residents' choice. and audit that care plans are up to date if resident receives product not recommended by nursing department

Results of the audits will be reported to the facility Quality Assurance Performance Improvement Commitee until 100 % compliance is achieved for 3 consecutive months.

Compliance date 4-15-25

F 578 Request/ Refuse/ Discontinue Treatment: Formite Advance Directive

Resident 98's Advance Directive was completed, uploaded into PCC, and care plan updated on 3-21-25.

Resident 8 POLST was updated, POLST was uploaded into PCC, and care plan was updated.

Full House audit was completed for Advance Directive being offered.
Advance directives were offered, completed, uploaded into PCC and care plans were updated.

Full house audit for POLST accuracy completed.

Education was provided to social services on offering and completing advance directives with residents.

Education was provided to social services updating POLST as needed was completed with social worker.

A new workflow has been created. During team-based assessment the resident will be asked if they have an Advance Directive. The social worker will offer and aid in completion of an advance directive.

A new tracking system was created to ensure POLST would be reviewed minimally every quarter and/or if code status changes.

The administrator or designee will complete random weekly audits for residents being offered advance directives and completion of advance directives. Results of the audits will be reported to the facility Quality Assurance Performance Improvement Commitee until 100 % compliance is achieved for 3 consecutive months.

The administrator or designee will complete random audits for POLST forms being reviewed and updated as needed. Results of the audits will be reported to the facility

Quality Assurance Performance Improvement Commitee until 100 % compliance is achieved for 3 consecutive months.

Compliance date 4-15-25

F 580 Notify of Changes:

Resident 203 discharged to hospital and has not returned.

Facility risk management reports and daily nursing notes were reviewed for provider notification.

Education provided to licensed staff on resident change in condition and provider notification, including SBAR communication and documentation of provider notification.

Education provided to providers regarding timely follow up and evaluation of resident changes in conditions.

Unit managers will review 24-hour nursing reports to monitor provider notification for changes in condition as part of preparing for morning meeting.

Director of nursing or designee will complete random audits for provider notification when a changes condition or risk management occurs.

Results of the audits will be reported to the facility Quality Assurance Performance Improvement Commitee until 100 % compliance is achieved for 3 consecutive months.

Compliance date 4-15-25

F 644 Coordination of PASRR and Assessments

Resident 90 PASRR level II obtained, uploaded, care planned updated, and recommended services were offered, and referrals were completed.

A house wide audit completed, PASRR screenings outcomes were obtained and uploaded to PCC.

A new tracking system was created to ensure outcomes are printed, uploaded, care planned, and referrals are followed up as appropriate.

Education was provided to social services on steps to take to retrieve PASRR outcomes to screenings that were requested.

Administrator or designee will complete random audits of PASRR screening requests, PASRR outcomes, appropriate care planning, and follow up on recommendations.

Results of the audits will be reported to the facility Quality Assurance Performance Improvement Commitee until 100 % compliance is achieved for 3 consecutive months.

Compliance date 4-15-25

F 645 PASRR Screening for MD/ID

Resident 24 new PASRR screening requested, outcome uploaded into PCC, care plan was updated.

A house wide audit of PASRR convalescence categorial outcomes, new PASRR screenings requested, outcomes uploaded to PCC, and care plans updated.

Education provided to social services on tracking resident's with convalescence categorical outcomes so a new PASRR screen may be completed if resident remains in facility greater than 30 days.

Social Services will place appointment reminders in the Outlook Calendar for when a new PASRR screen is required. The appointment reminder will be sent to other social worker and administrator.

The administrator or designee will complete weekly audits for completion of rescreens of resident's who had a convalescence category outcome.

Results of the audits will be reported to the facility Quality Assurance Performance Improvement Commitee until 100 % compliance is achieved for 3 consecutive months.

Compliance date 4-15-25

F 692 Nutrition/Hydration

Resident 258's tray was delivered to the unit, containment, a new meal tray retrieved from the kitchen, provided to resident and resident was assisted to eat.

Residents who prefer to eat in their room were identified so nursing can validate their meal trays are served timely.

Education was provided to nursing staff on the workflow of delivering meal trays from the meal cart prior to placing dirty meal trays back in the cart.

Unit Managers or designee will complete random audits during mealtimes to ensure meal trays are removed and served to residents.

Results of the audits will be reported to the facility Quality Assurance Performance Improvement Commitee until 100 % compliance is achieved for 3 consecutive months.

Compliance date 4-15-25

F695 Respiratory/ Trach care and suctioning

Resident's 14, 40, 29, 32, and 82 had oxygen concentrators and filters cleaned.

Resident 82's oxygen concentrator was turned on to provide oxygen as ordered.

Residents who have oxygen orders have been identified and orders updated on TAR to include cleaning schedule for concentrators and filters.

Licensed nurses will validate oxygen orders are being followed every shift to ensure oxygen is administered as ordered.

Education was provided to licensed nurses on cleaning oxygen concentrators and filters.

Education was provided to nurses on validating oxygen orders are being followed each shift.

Cleaning oxygen concentrator and filters have been added to the TAR for completion by licensed nurses.

Unit managers or designee will complete weekly audits on oxygen concentrators and filters being clean. Weekly audits to validate oxygen concentrators are turned on and residents receiving oxygen as ordered.

Results of the audits will be reported to the facility Quality Assurance Performance Improvement Commitee until 100 % compliance is achieved for 3 consecutive months.

Compliance date 4-15-25

F 711 Physician Visits/Block orders

Residents 1, 25, 37, 40, 8, and 3 have had Block orders reviewed and signed by the providers.

A house wide audit completed for signatures on block orders. Providers have signed block orders according to regulatory compliance.

Education provided to medical records coordinator on providing upcoming dates when providers need to sign block orders for regulatory compliance.

Education was provided to the providers on the regulatory compliance of signed block orders.

Medical records will track and provide a list of residents who require signature on block orders weekly to providers.

The Director of Nursing or designee will complete weekly audits of identified residents due for block order signature to ensure timely review and signature completed by providers.

Results of the audits will be reported to the facility Quality Assurance Performance Improvement Commitee until 100 % compliance is achieved for 3 consecutive months.

Compliance date 4-15-25

F 730 Nurse Aide Performance Review

CNA 1, 2, 3, and 4 have had performance review evaluation completed.

Employee files have been audited, and missing performance reviews have been completed.

Nurse Mangers to be educated on completing timely performance evaluation reviews for staff members.

Education provided to Human Resource on maintaining a list of employees hire date and when performance evaluations are due. Each month the Human Resource will provide a list of employees due to have their annual review completed.

Human Resources will track completed performance reviews and will report to DNS/Administrator any outstanding performance reviews weekly.

Human Resource or designee will complete random audits of annual employee evaluations being completed on time.

Audits will be brought to the monthly QAPI meeting until substantial compliance has been determined.

Compliance date 4-15-25

F 756 Drug Regimen Review

Resident 53 pharmacy recommendations reviewed by provider.

Pharmacy recommendations for December, January, and February were reviewed by the provider and recommendations accepted or declined.

Education provided to providers on reviewing pharmacy recommendations timely, which includes response, date, and signature to the recommendation.

Pharmacy recommendations will be reconciled monthly by Nursing Leadership to ensure recommendations have been reviewed by the provider.

Director of Nursing or designee will complete monthly audits to ensure pharmacy recommendations have been reviewed by the provider with a response identified.

Results of the audits will be reported to the facility Quality Assurance Performance Improvement Commitee until 100 % compliance is achieved for 3 consecutive months.

Compliance date 4-15-25

F 761 Label/Store Drugs and Biologicals

B-Unit Treatment Cart 1 removed and replaced all identified medication stored improperly.

B-Unit Medication cart 1 had individual inhalers and nasal sprays correctly labeled and stored for each individual resident.

The ABI treatment cart was locked by licensed nurse prior to nurse leaving cart unattended. Medications improperly stored or labeled were removed and replaced.

A-Wing Treatment cart removed and replaced improperly stored medications.

Medication carts and Treatment carts for A-Wing, ABI, and B-Wing were audited for medications being stored improperly. Medications that were identified were removed and replaced.

A product reference guide regarding medication storage and labeling were added to each med chart and treatment cart.

Education provided to nursing staff on medication storage policy.

Education provided to nursing staff on locking the medication and treatment cart when leaving it unattended.

Unit Manager or designee will complete weekly random audits of Medication and Treatment carts.

Unit manager or designee will complete random audits weekly to validate that Medication and Treatment carts are locked when the LN/Med. Tech are not at the cart.

Results of the audits will be reported to the facility Quality Assurance Performance Improvement Commitee until 100 % compliance is achieved for 3 consecutive months.

Compliance date 4-15-25

F 791 Dental Services

Resident 8 had oral inspection completed. Referral to Aspen Dental completed. Appointment scheduled for 3-31-25 at 7am. Referral made to Northern Light Surgery and Trauma for possible dental extractions.

A full house audit of resident oral health was completed. Facility is arranging dental services for residents as needed.

Education provided to the transportation coordinator on documenting efforts to get dental services for residents requiring dental work.

Education provided to licensed nursing staff on provider notification of new dental pain or dental concerns for provider follow up.

A tracking sheet has been developed to track those residents identified with dental needs and steps taken to address the resident's need.

Unit manager or designee will complete monthly audits on dental concerns, requests for dental care, referrals for dental services, and follow up to dental appointments as ordered. Results of the audits will be reported to the facility Quality Assurance Performance Improvement Commitee until 100 % compliance is achieved for 3 consecutive months.

Compliance date 4-15-25

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F 000	INITIAL COMMENTS From 3/3/25 through 3/6/25, on-site visits were conducted at Brewer Center for Health and Rehabilitation for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification and to investigate facility reported incident #ME00050447; and complaints #ME00050651, #ME00050500, #ME00050393, #ME00049752, and #ME00045206. It was determined that Brewer Center for Health and Rehabilitation is not in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.	F 561		

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

[signature] Administrator 3-28-25

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 561	Continued From page 1 §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to respect a resident's choice for the use of an incontinent product preference for 1 of 1 sampled resident (Resident #11 [R11]) who's incontinent product choice was denied. Finding: On 3/3/25, a review of R11's clinical record was completed. Documentation indicated that one of R11's medical concerns was incontinence. On 3/3/25 at 11:50 a.m., in an interview with the surveyor, R11 stated they have always worn yellow colored incontinent briefs during the day and wears the white colored incontinent briefs at night. R11 stated the white briefs at night make him/her feel safer as not to leak urine and is more comfortable. R11 stated on Fridays, the supply clerk stocks her dresser drawer with yellow and white briefs to last her over the weekend. R11 stated this past Friday, 3/1/25, the supply clerk was not working and R11's drawer was not stocked with white briefs; all that was left were yellow briefs. On 3/3/25 at 1:40 p.m., in an interview with the surveyor, the supply clerk stated he does stock R11's dresser with yellow briefs for the daytime and white briefs for night time use. He stated the briefs have the same absorbency but R11 prefer's the white briefs at night. He stated he was unable to stock the drawer on 3/1/25, because he was	F 561		

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F 561	Continued From page 2 not working. He stated the nursing staff have two stock closets they can go too and get incontinent briefs. On 3/3/25 at 2:10 p.m., in an interview with the surveyor, the evening/night Registered Nurse #3 (RN3), stated she did work this past week end. She confirmed that R11 asked her for white briefs for the night, but RN3 stated all she had was yellow briefs in her drawer and that was the color/size that fit her best. RN3 confirmed she did not provide R11 with any white briefs that weekend, even though R11 was asking for them.	F 561		
F 578 SS=D	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. (iii) Facilities are permitted to contract with other	F 578		

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F 578	Continued From page 3 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 interview, the facility failed to ensure that the resident and/or resident representative was provided with written information concerning the right to formulate an advanced directive, and/or ensure a resident's right to formulate an advanced directive regarding code status (cardiopulmonary resuscitation [CPR]) was accurate in the electronic record for 2 of 10 residents (Residents #98 [R98] and [R8]). Findings: 1. During a record review R98 was admitted in January of 20251. A review of R98's paper and electronic clinical record lacked evidence that the facility offered or provided the resident and/or resident representative with written information concerning the right to formulate an advanced directive. On 3/05/25 at 2:15 p.m., during an interview with	F 578		

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F 578	Continued From page 4 the Director of Nursing and the Regional Clinical Director the surveyor confirmed that some new admissions that were admitted after the facility identified an issue with Advanced Directives in September 2024 and after they developed a plan to address Advanced directives with new admissions R98's clinical record lacked evidence that he/she was offered or provided with written information concerning the right to formulate an Advanced Directive. 2. On 3/4/25, R8'c clinical record was reviewed. R8's electronic chart indicates "(Advanced Directives) Do Not Intubate, Do Not Resuscitate" (Do not perform CPR). The "(Advanced Directives)" is a link to the scanned image of R8's signed Physician Orders for Life-Sustaining Treatment (POLST) form. R8's POLST form indicated "Attempt Resuscitation/CPR". On 3/5/25 at 12:10 p.m., during an interview with a surveyor and the Administrator, R8's code status and scanned POLST form were reviewed. The Administrator stated the POLST may be old and should be updated. At this time, the surveyor confirmed R8's advance directive regarding code status had conflicting information.	F 578		
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;	F 580		

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F 580	Continued From page 5 (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, 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	F 580		

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F 580	Continued From page 6 under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the physician of a change in condition after a resident developed blisters after an incident with spilled hot soup for 1 of 4 residents reviewed for Accidents (Resident #203 [R203]). Finding: During a review of R203's clinical record and the facilities incident/accident reports. It was documented that R203 had an incident at 12:00 p.m. on 1/28/25. R203 nursing progress note documents that R203 accidentally dumped hot soup on his/her chest and upper abdomen. The chest and upper abdomen were reddened with a little bit of peeled skin. The provider was notified, and she gave a one-time order for topical bacitracin antibiotic. On 1/31/25 at 3:54 p.m., documentation of a late entry for 1/30/25 "on this day I was doing treatments on the coccyx and noticed the blisters on the chest going to the right side of the body /breast, was told he/she burnt self with the coffee from A wing, resident did not complain of discomfort to the area, evening supervisor also saw the blisters." Review of R203's clinical records (paper and electronic) lacks evidence of a medical provider being made aware of the worsening of this burn and blisters developing. The Provider was made aware 5 days after the blisters were found. Provider progress note dated 2/4/25 documented	F 580		

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F 580	Continued From page 7 by the provider, documented that she was made aware of the wound from the burn 6 days after the burn occurred. On 3/5/25 at 9:57 a.m., during an interview with the Director of Nursing, the surveyor confirmed that the Provider was not made aware of the change in the burn and the developing blisters until 2/4/25.	F 580		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to obtain recommendations from the Preadmission Screening and Resident Review (PASRR) level II determination-Maine Summary of Findings for 1 of 2 sampled resident's reviewed	F 644		

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F 644	Continued From page 8 for PASRR evaluation (Resident #90 [R90]). Finding: R90's clinical record was reviewed and there was a PASRR Level I Screen Outcome, dated 11/26/24, that determined "No Level II Required". R90's PASRR Level I Screen Outcome dated 11/26/24 did not include all R90's diagnoses. R90's care plan dated 12/16/24 was reviewed and stated, "Focus: PASRR outcome: referred for Level II, awaiting assessment completion. Date initiated: 12/12/24; under Goal: Monitor resident for need of new PASRR screening throughout assessment period; and, under Interventions: Request PASRR screening as needed." On 3/6/25 at 1:45 p.m., during an interview with the Social Worker (SW), a surveyor requested additional information about if another PASRR screening was completed for R90. The SW obtained a copy of R90's PASRR Level I Screen Outcome determination dated 12/2/24 that stated to refer R90 for Level II onsite, and stated, "shows that you need a face-to-face Level II evaluation", and obtained a copy of R90's PASRR Level II. The surveyor confirmed at this time that the facility did not have the PASRR Level II determination until 3/6/25. On 3/6/25 at 1:45 p.m., during an interview with a surveyor, the Social Worker (SW) stated that a PASRR Level I screen was resubmitted on 12/3/24 with additional diagnoses but did not have the outcome of the screening. The SW was able to obtain the PASRR Level II recommendations on 3/6/25, and a surveyor confirmed that the SW was responsible to obtain	F 644		

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F 644	Continued From page 9 these services and could not find documentation that indicated that these services had been offered or refused.	F 644		
F 645 SS=D	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 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	F 645		

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F 645	Continued From page 10 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 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 review and interview, the facility failed to ensure a resident with a specialized mental health diagnosis, whose stay went beyond the expected 30 days, had been referred to the appropriate state-designated authority for	F 645		

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F 645	Continued From page 11 Pre-Admission Screening & Resident Review Level II (PASRR) evaluation and determination for 1 of 3 residents reviewed for PASRR (Resident #24 [R24]). Finding: On 3/6/25, clinical record review indicated R24 was admitted in December of 2024. Admitting diagnosis included Anxiety Disorder, Major Depression, and Obsessive Compulsive Disorder (OCD). Review of R24's PASRR, dated 10/28/24, indicated R24 had a Convalescence Categorical exemption (a time-limited 30 day exemption). Review of R24's care plan for PASRR, initiated 1/2/25 indicated, "Will submit reassessment if resident remains in facility after 30 days of admission" On 3/6/25 at 10:52 a.m., during an interview with a surveyor and the Social Worker (SW), the clinical record for R24 was reviewed. At this time the SW confirmed R24 was not referred for a PASARR level II determination after the 30 day Convalescence period ended.	F 645		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or	F 692		

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F 692	Continued From page 12 desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to provide recommended nutritional services to 1 of 1 resident (Resident #258 [R258]) observed during mealtimes for 1 of 3 lunch meals observed (3/3/25, lunch). Finding: During an initial observation of R258 on 3/3/25 at approximately 12:50 p.m. and interview with R258's spouse, the spouse remarked that R258 hasn't had lunch yet and that a lunch tray usually comes by 12:30 p.m. The surveyor observed a closed lunch cart in the hallway and on 3/3/25 at 1:20 p.m. in an interview with a surveyor, the LPN, charge nurse stated that all trays were passed and confirmed at this time that R258 did not receive a lunch meal.	F 692		
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	F 695		

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F 695	Continued From page 13 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 observation, record review, and interview, the facility failed to maintain respiratory equipment in a sanitary manner to help prevent the development and transmission of disease and infection related to respiratory care for 5 of 8 residents reviewed on survey (Resident #14 [R14], [R40] [R29], [R32], and [R82]). Findings: 1. On 3/3/25 at 12:36 p.m., a surveyor observed R14's oxygen concentrator filters to be heavily soiled with dust/debris. Record review indicates R14 receives oxygen 2 liters (L) / minute (min) continuously for the diagnosis of Chronic Respiratory Failure with Hypoxia (inadequate oxygen to the body), and Chronic Obstructive Pulmonary Disease (COPD). 2. On 3/3/25 at 12:40 p.m., a surveyor observed R40's oxygen concentrator filter to be heavily soiled with dust/debris. Record review indicates R40 receives oxygen 4 L/min continuously for the diagnosis of Chronic Respiratory Failure with Hypoxia, Chronic Respiratory Failure with Hypercapnia (elevated levels of carbon dioxide in the blood), and COPD. 3. On 3/3/25 at 1:32 p.m., a surveyor observed R29's oxygen concentrator filter to be heavily soiled with dust/debris. Record review indicates	F 695		

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F 695	Continued From page 14 R29 receives oxygen 1-2 L/min continuously for shortness of breath related to Acute and Chronic Respiratory Failure with Hypoxia, and COPD. 4. On 3/3/25 at 2:28 p.m., a surveyor observed R32's oxygen concentrator filter to be heavily soiled with dust/debris. Record review indicates R32 receives oxygen 2 L/min continuously for Chronic Respiratory Failure with Hypoxia. 5. On 3/3/25 2:33 p.m., a surveyor observed R82 wearing oxygen tubing attached to an oxygen concentrator. The concentrator did not appear to be functioning. The concentrator filter was observed to be heavily soiled with dust/debris. On 3/3/25 at 2:41 p.m., during an interview with a surveyor and the RN Supervisor, R82's concentrator was observed. The RN Supervisor confirmed the machine was not turned on, and stated that the machine should be running continuously. On 3/5/25 at 1:48 p.m., during an interview with the Administrator, a surveyor confirmed above residents oxygen concentrator filters was heavily soiled with dust /debris.	F 695		
F 711 SS=E	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress	F 711		

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F 711	Continued From page 15 notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews and interview, the facility failed to ensure the attending physician made required visits, at least every 60 days for 6 of 8 sampled residents (Resident #1 [R1], [R25], [R37], [R40], [R8], and [R3]). Findings: 1. On 3/5/25, a review of R1's clinical record indicated that R1's last physician visit was on 11/26/24, in which the physician signed the medication block orders. The next 60 day physician visit, including a 10-day grace period, which required the physician to sign the 60 day block orders was due on 2/5/25. The block orders were signed on 3/4/25; signed 26 days late. 2. On 3/5/25, a review of R25's clinical record indicated that R25's last physician visit was on 11/26/24, in which the physician signed the medication block orders. The next 60 day physician visit, including a 10-day grace period, which required the physician to sign the 60 day block orders was due on 2/5/25. The block orders were signed on 3/4/25; signed 26 days late. On 3/5/25 at 11:45 a.m., in an interview with the surveyor, the Director of Nursing, confirmed that	F 711		

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F 711	Continued From page 16 the last required physician visit to sign the 60 day orders was 26 days late. 3. On 3/5/25, a review of R37's clinical record indicated that R37's last physician visit was on 12/10/24, in which the physician signed the medication block orders. The next 60 day physician visit, including a 10-day grace period, which required the physician to sign the 60 day block orders, was due on 2/18/25. On 3/6/25 at 10:50 a.m., during an interview with a surveyor and the DON, the clinical record for R37 was reviewed. At this time, the DON confirmed that the last required physician visit to sign the 60 day orders was 14 days late. 4. On 3/5/25, a review of R40's clinical record indicated that R40's last physician visit was on 11/7/24, in which the physician signed the medication block orders. The next 60 day physician visit, including a 10-day grace period, which required the physician to sign the 60 day block orders, was due on 1/16/25. On 3/6/25 at 10:50 a.m., during an interview with a surveyor and the DON, the clinical record for R40 was reviewed. At this time, the DON confirmed that the last required physician visit to sign the 60 day orders was 47 days late. 5. On 3/5/25, a review of R8's clinical record indicated that R8's last physician visit was on 11/21/24, in which the physician signed the medication block orders. The next 60 day physician visit, including a 10-day grace period, which required the physician to sign the 60 day block orders, was due on 1/30/25. On 3/6/25 at 10:50 a.m., during an interview with a surveyor and the DON, the clinical record for R8 was reviewed. At this time, the DON	F 711		

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F 711	Continued From page 17 confirmed that the last required physician visit to sign the 60 day orders was 34 days late. 6. On 3/5/25, a review of R3's clinical record indicated that R3's last physician visit was on 12/3/24, in which the physician signed the medication block orders. The next 60 day physician visit, including a 10-day grace period, which required the physician to sign the 60 day block orders, was due on 2/11/25. On 3/6/25 at 10:50 a.m., during an interview with a surveyor and the DON, the clinical record for R8 was reviewed. At this time, the DON confirmed that the last required physician visit to sign the 60 day orders was 22 days late.	F 711		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on performance evaluation reviews and interview, the facility failed to complete annual performance evaluations at least every 12 months for 1 of 5 sampled employees (Certified Nursing Assistant #1 [CNA1], CNA2, CNA3, CNA4). Findings: 1. CNA1 was hired on 11/7/2015. The facility was unable to provide evidence of completed annual	F 730		

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F 730	Continued From page 18 performance evaluations for 2023 and 2024. 2. CNA2 was hired on 8/29/2020. The facility was unable to provide evidence of completed annual performance evaluations for 2023 and 2024. 3. CNA3 was hired on 3/19/2003. The facility was unable to provide evidence of completed annual performance evaluations for 2023 and 2024. 4. CNA4 was hired on 6/18/2020. The facility was unable to provide evidence of completed annual performance evaluations for 2023 and 2024. On 3/6/24 at 2:40 p.m., in an interview with a surveyor, the Director of Nursing confirmed that the above CNA's annual performance evaluations for 2023 and 2024 were not completed.	F 730		
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 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	F 756		

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F 756	Continued From page 19 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 follow up on pharmacist recommendations timely, for 1 of 5 residents reviewed for unnecessary medications (Resident #53 [R53]). Finding: On 3/6/25, a review of R53's clinical record was completed. Documentation in the physician orders indicated the resident had an insulin (Novolog) sliding scale for insulin coverage on Mondays, Wednesdays and Fridays (a sliding scale is the amount of insulin to be administered changes or "slides" up or down based on the persons blood sugar).	F 756		

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F 756	Continued From page 20 A review of the pharmacist recommendations, dated 12/31/24 and 2/26/25 indicated the pharmacist recommendation for 12/21/24 was to confirm the Novolog sliding scale for Mondays, Wednesdays, and Fridays because there was no insulin coverage for the other days of the week. Documentation next to this recommendation indicated no changes to this order, but there was no evidence as to when this documentation occurred. On 2/26/25, during the pharmacist's monthly visit, again made a recommendation to confirm the Novolog sliding scale for Mondays, Wednesdays, and Fridays because there was no insulin coverage for the other days of the week. On 3/5/25, a provider responded to the pharmacist's recommendation, 64 days after the original recommendation was made. On 3/6/25 at 8:10 a.m., in an interview with the Director of Nursing, she confirmed that the 12/31/24 response to the pharmacy recommendation had no evidence when done and that the siding scale was not responded to and dated until 3/5/25.	F 756		
F 761 SS=D	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 appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 21 §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 observation and interview, the facility failed to ensure medications were labelled, stored at the appropriate temperature, and secured properly by having an unlocked, unattended medication cart allowing residents and unauthorized persons access to medications on 1 of 3 survey days (3/5/25). Findings: On 3/5/25 at 9:31 a.m., during review of the B-unit Treatment Cart #1, a surveyor and the Unit Manager #1 (UM1) observed, an unopened Basaglar KwikPen (insulin glargine) 100 units (u) / milliliter (mL) was observed in the top drawer. The 3 mL pre-filled syringe was labeled with a refrigerate sticker. The UM stated it should be stored in the refrigerator until it is used. On 3/5/25 at 9:42 a.m., during review of the	F 761		

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	205062	A. BUILDING _____ B. WING _____	03/06/2025

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F 761	Continued From page 22 B-unit Medication Cart #1, a surveyor and Certified Nursing Assistant-Medications (CNA-M) observed: -a box labeled Breyna (Budesonide Formoterol Fumarate) 80 microgram (mcg)/ 4.5 mcg. The box was observed to contain 2 inhaler devices. One device had a dose of 80 mcg /4.5 mcg, the second device has a dose of 160 mcg/4.5 mcg and labeled with R53's initials. Review of R53's electronic record revealed an order for Budesonide Formoterol Fumarate 80 mcg/4.5 mcg. -a Trelegy Ellipta inhaler was observed unlabeled and stored inside a Breo-Ellipta box labelled as belonging to R14. CNA-M stated the Trelegy inhaler belongs to R15, as he/she is the only resident who has Trelegy. An unlabeled Breo-Ellipta inhaler was observed loose in the medication drawer, CNA-M stated that Breo-Ellipta inhaler belongs to R14. During this review, CNA-M stated individual inhalers, and nasal sprays are unlabeled as the facility labels patient identifier and expirations on the container box(s) only. On 3/5/25 at 10:29 a.m., during review of the treatment cart on the ABI unit, a surveyor and Unit Manager #2 (UM2) observed: -the treatment cart was unattended and left unlocked in the hallway where residents have direct access. The cart contains insulin(s) and sharps in addition to dressings and ointments. -1 multidose 10ml vial of Lantus (Insulin Glargine) 100u/mL , opened and unlabeled. -2 pre-filled 3mL insulin pen labeled Lantus Solostar (Insulin Glargine) 100u/mL stored in a bag. One of the insulin pens was labeled with conflicting open dates (cap labelled with an open date of "2/24", pen base labelled as opened	F 761		

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F 761	Continued From page 23 "3/3/25"), the second insulin pen was unopened/unlabeled, and not stored in the refrigerator. UM2 stated the pen should have been stored in the refrigerator when it was received. On 3/5/25 at 10:45 a.m., during review of the A-wing treatment cart, a surveyor and UM2 observed, 1 pre-filled 3mL insulin pen labeled Insulin Lispro 100u/mL, unlabeled / unopened, stored in a bag with a sticker indicating it should be refrigerated. UM2 stated that it should have been stored in the refrigerator. On 3/6/25, review of the "Storage of Medication" policy indicated under the procedures heading, "12. Insulin vials should be stored in the refrigerator until opened. Date insulin vials when first opened. May store opened vial in refrigerator or at room temperature." The above findings were observed and confirmed at the time of the finding.	F 761		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered	F 791		

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F 791	Continued From page 24 under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to obtain dental services for a resident with broken teeth for 1 of 1 residents reviewed for dental services (Resident #8 [R8]). Finding: On 3/4/25 at 3:00 p.m., during an interview with	F 791		

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F 791	Continued From page 25 R8, a surveyor observed R8's gums appeared red and enflamed with several broken teeth with visible decay. R8 stated they were painful. On 3/6/25, Review of R8's clinical record revealed the following: - On 3/31/16 the care plan was revised to include focus area "The resident has oral/dental health problems [related to] Poor oral hygiene". The Intervention for this care area indicates "Coordinate arrangements for dental care, transportation as needed/as ordered", and "Document /report [as needed] any [signs or symptoms] of oral/dental problems needing attention: Pain ...Teeth missing, loose, broken, eroded, decayed, ...". -On 5/29/24 the Pre-Care Conference Review Form indicated "[R8] asks about dentist appt daily". -On 7/16/24 at 11:25 p.m., the provider wrote in a regulatory review note, "When I ask how [R8] is doing, [R8] tells me he/she wants false teeth. I tell [R8] that it can be difficult to get insurance to pay for them, but that I can ask [Social Worker] about it." -On 7/25/24 at 2:36 p.m., the provide wrote in a progress note, "poor dentition, missing several teeth, remaining teeth with visible decay." -On 8/12/24 at 10:38 a.m., the Care Plan Meeting note indicated R8 "Has complained of oral pain recently". On 3/6/25 at 12:25 p.m., during an interview with a surveyor and the Director of Nursing, R8's clinical record was reviewed. At this time the surveyor confirmed the medical record lacked evidence that the facility addressed R8's dental concerns and/or requests for dental services.	F 791		