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	205020	A. BUILDING _____ B. WING _____	10/26/2023

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BANGOR NURSING & REHABILITATION CENTER	**103 TEXAS AVE BANGOR, ME 04401**

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F 000	INITIAL COMMENTS From 10/23/23 through 10/26/23, on-site visits were conducted at Bangor Nursing & Rehabilitation Center for the purpose of completing the Long Term Care Survey Process recertification, investigating facility reported incidents #ME00042866, #ME00044389, #ME00045196 and complaints #ME00042928, #ME00043505, #ME00044118. It was determined that Bangor Nursing & Rehabilitation Center was not in 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

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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 interviews, the facility failed to ensure that a resident's choice in the area of bathing was being followed for 1 of 1 sampled residents (Resident #26 [R26]). Finding: On 10/24/23 at approximately 8:15 a.m., during an interview with a surveyor, R26 stated that he/she didn't get a shower last Tuesday evening (10/17/23) but received one the Tuesday before (10/10/23) but not the Tuesday before that (10/3/23). R26 stated that last week they told him/ her there wasn't enough staff but then found out that there was and that they just didn't want to do it. On 10/24/23, R26's clinical record was reviewed which indicated that R26 was to receive a shower on Tuesday evening shift. On 8/18/23, an annual Minimum Data Set (MDS) 3.0 was completed which included documentation under Section F0400 C. How important is it to you to choose between a tub bath, shower, bed bath, or sponge bath to which the response was - 1. very important. 10/26/23 at 10:08 a.m., a surveyor and the Director of Nursing (DON) reviewed R26's bathing documentation for the months of August thru October 2023 which noted a lot of	F 561		

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F 561	Continued From page 2 missing/incomplete documentation in regard to showers. The DON stated she would look into this. At 11:15 a.m., the DON stated that she had a phone call out to some staff regarding R26's showers. At 10/26/23 at 1:02 p.m. the DON stated she was unable to find any additional documentation or information regarding bathing for R26. The surveyor and DON then reviewed the documentation to see if R26 received a shower on 10/24/23 (Tuesday of survey week) and there was no evidence that a shower was given on that date also. The surveyor confirmed there is no evidence that R26's choices are being honored for bathing.	F 561		
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.	F 583		

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F 583	Continued From page 3 §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure the confidentiality of protected health information for 9 of 51 residents during 1 of 4 days of survey (Resident (R) #1, #10, #206, #17, #105, #43, #31, #9, and #47). Finding: On 10/24/23 at 10:26 a.m., a surveyor observed on the nurses station counter near the front entrance, an unattended, printed, email from the Director of Nursing displayed, visible and easily accessible to residents, visitors, or other unauthorized persons. The subject of the email was entitled, "Covid update for 10/23/23", and listed R1 is off isolation; R10 day 1; R206 day 2; R17 day 2; R105 day plus C-diff; R43 day 2; R31 day 5; R9 day 1; and R47 day 5 as Residents that have or had Covid, and/or Cdiff. On 10/24/23 from 10:26 a.m. through 10:41 a.m., three staff, and two visitors passed by the nursing station counter where the displayed email was sitting.	F 583		

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F 583	Continued From page 4 On 10/24/23 at 10:41 a.m. in an interview with a surveyor, the Educational Director acknowledged the unsecured medical information, and she moved and turned over the printed email, stating they will have to provide some education.	F 583		
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.	F 645		

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F 645	Continued From page 5 §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 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 Pre-Admission Screening and Resident Review (PASRR), included current	F 645		

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F 645	Continued From page 6 diagnoses, and was updated for 1 of 2 residents reviewed for PASRR (Resident 39 [R39]). Finding: During review of R39's medical record, it was determined that R39 was admitted to the facility on 11/6/21 and the record contained a PASRR Level I Screen dated 6/10/22 completed while the resident was at St. Joseph Hospital. The PASRR Level I Screen in the diagnosis section, stated, "No mental health diagnosis is known or suspected regarding mental health diagnoses", and did not include a diagnosis of anxiety or depression. The resident record lacked evidence that the PASRR Level I Screen was updated to include R39's current diagnosis of anxiety, and depression and was forwarded to the State-designated authority to determine if a Level II assessment was needed. On 10/25/23 at 10:31 a.m., in an interview with the Director of Social Services, a surveyor confirmed that the PASRR Level I for R39 did not include a diagnosis of anxiety, and depression and was not forwarded to the State-designated authority to determine if a Level II assessment was needed. The Director of Social Services said that R39 has a diagnosis of anxiety, and depression and should send in another PASSR Level I form for redetermination.	F 645		
F 656 SS=D	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	F 656		

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F 656	Continued From page 7	F 656		

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 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

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F 656	Continued From page 8 care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to review/revise and update care plan interventions for the problem areas of Post Traumatic Stress Disorder (PTSD) for 1 of 17 sampled residents/care plans reviewed (Resident #19)(R19). Findings: On 10/24/23, R19's clinical record was reviewed. A review of the resident's diagnoses indicated a diagnosis of PTSD and R19's current medication orders indicated R19 received Risperidone for PTSD. A review of the Physician progress notes, dated 6/26/23 and 7/24/23, on the follow-up/acute visits, the last sentence of the first paragraph indicated PTSD started after the resident's son's untimely death. R19's care plan indicated that one of his/her current PTSD problems was, 'Resident has a psychosocial well being problem related to PTSD.' There was no evidence of interventions addressing what the triggers are that may re-traumatized the resident. No trigger specific interventions that staff should or should not do that may cause re-traumatization. Another care plan problem that addressed PTSD, according to the Director of Nursing, was 'Resident is/has potential to be verbally aggressive when around certain male individuals related to ineffective coping skills, mental/emotional illness, poor impulse control.' There was no evidence of interventions addressing what the triggers are that may re-traumatized the resident. No trigger specific	F 656		

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F 656	Continued From page 9 interventions that staff should or should not do that may cause re-traumatization. On 10/25/23 at 7:00 a.m., in an interview with the surveyor, the Director of Nursing stated she miss understood what caused the PTSD and confirmed the above findings.	F 656		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record reviews, interviews and facility policy review, the facility failed to follow a physician order for making a referral to a specialist for 1 of 5 residents reviewed for unnecessary medications (Resident #26 [R26]) and failed to follow it's own policy for 1 of 2 residents reviewed with a fall (Resident #46[R46]). Findings: 1. On 10/23/23, R26's clinical record was reviewed and contained a physician order, dated 7/17/23, to obtain a urology referral for recurrent urinary tract infections and a gynecology referral for frequent vaginal pain, irritation, and atrophic vaginitis. On 8/2/23, a physician progress note	F 684		

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F 684	Continued From page 10	F 684		

was completed by the Medical Provider that indicated both referrals were pending. The surveyor was unable to find evidence that these appointments were made. On 10/24/23 at 2:18 p.m., during an interview with a surveyor, the Director of Nursing stated she was unable to find evidence that these referrals were addressed.

2. The facility's "Fall Training Materials" policy, dated 1/15/2020, directed staff that in the event a resident falls, the following measures will be instituted to include to monitor vital signs every shift for 72 hours and neuro checks if the fall was unwitnessed or if a head injury is suspected. The Neurological Flow Sheet directs staff to complete vital signs and neuro checks every 15 minutes times (x) 1 hour, every 30 minutes x 1 hour, every 1 hour x 4 hours, and every 4 hours x 24 hours.

On 10/23/23, R46's clinical record was reviewed and included that the resident had a few recent falls.

- On 10/3/23 at 10:05 a.m., a fall note was written that indicated, "Resident attempting to ambulate to the bathroom without assistance and slipped off of the side of his bed. He/she landed on buttocks and bumped his/her head on the bedside table." No injury or treatment at this time, neurochecks initiated. A review of the clinical record lacked evidence that vital signs were completed every shift x 72 hours and that the Neurological Flow Sheet had not been fully completed.
- On 10/11/23 at 1:39 a.m., an incident note was documented that indicated staff heard a banging sound coming from R46's room and went in to check. The patient was seen on the floor lying on his/her chest with his/her right arm

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F 684	Continued From page 11 under him/her and blood coming from a laceration to the right side of his/her head. The patient was assessed and assisted back to bed. Neuro checks are within normal limit for the patient. Wound to head cleaned and pressure bandage applied. Vitals charted. The resident was sent to the Emergency Room. A review of the clinical record lacked evidence that vital signs were completed x 72 hours and there was no Neurological Flow Sheet completed. On 10/26/23 at 1:00 p.m., during an interview with a surveyor, the Director of Nursing stated she was unable to find any additional information.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interviews, the facility failed to ensure that a treatment was followed for 1 of 1 resident reviewed for pressure ulcers (Resident #33 [R33]).	F 686		

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BANGOR NURSING & REHABILITATION CENTER	**103 TEXAS AVE BANGOR, ME 04401**

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F 686	Continued From page 12 Finding: A review of R33's clinical record noted an admission date of 3/9/23. "The Medication Review Report", under other, order summary listed, on 9/3/23, "wash sacrum with Dermal wound cleanse, apply Lotrisone (generic name, Clotrimazole/Betamethasone, a combination medication, clotrimazole, is an antifungal, and betamethasone, is a corticosteroid that works by stopping the fungus from being able to make a protective covering, making it difficult for the fungus to grow or survive, and corticosteroid - that lowers certain chemicals in your body that cause inflammation in your skin) to peri wound ... every day shift for sacral wound". The "Treatment Administration Record (TAR)", listed under, "schedule for Oct 2023" lists, "wash sacrum with Dermal wound cleanse, apply Lotrisone to peri wound (around the wound) ...". On 10/23/23 at approximately 3:44 p.m., during an interview with a surveyor, the Registered Nurse (RN) completing a dressing change for R33 could not find Lotrisone cream for peri wound on a sacrum wound as ordered on the TAR. He stated he would order more from the pharmacy. He also stated he will do the dressing change without the Lotrisone cream because the dressing needed to be changed and R33 wouldn't mind. On 10/23/23 at approximately 4:00 p.m., a surveyor observed the RN complete dressing change for R33 without using Lotrisone cream for peri wound. The RN failed to contact the provider prior to providing the dressing change to ensure that it was okay to complete without the Lotrisone	F 686		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BANGOR NURSING & REHABILITATION CENTER	103 TEXAS AVE BANGOR, ME 04401

(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 686	Continued From page 13 cream. This finding was confirmed at this time.	F 686		
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a resident's physician supervised and evaluated weight loss for 1 of 1 residents reviewed with significant weight loss (Resident #31 [R31]). Finding: On 10/24/23, R31's clinical record was reviewed. On 9/26/23, the resident's admission weight was documented at 144 lbs. Additional weights were documented as follows: 10/3/23 144.2 lbs	F 710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205020	A. BUILDING _____ B. WING _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BANGOR NURSING & REHABILITATION CENTER	103 TEXAS AVE BANGOR, ME 04401

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F 710	Continued From page 14 10/10/23 125.4 lbs -12.99 percent loss from admission weight 10/17/23 123 lbs. - 14.58 percent loss from admission weight. The clinical record contained documentation that on 10/11/23, the Dietitian visited R31 to discuss food allergies but no mention of weight loss was included in this note. Further review of the clinical record indicated that on 10/18/23, R31 was diagnosed with the Coronavirus but this was after the weight loss started. On 10/26/23 at 1:03 p.m., a surveyor and the Director of Nursing (DON) reviewed R31's clinical record and there was no evidence that the physician was notified of significant weight loss nor were there any Provider Progress Notes in the clinical record that indicated so. The DON stated that is nursing's responsibility to notify the Provider.	F 710		
F 730 SS=B	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 employee record review, and interviews, the facility failed to complete annual performance evaluations at least every 12 months for 4 of 5 sampled licensed staff (Certified Nursing Assistant (CNA) #1, #2, and	F 730		

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	205020	A. BUILDING _____ B. WING _____	10/26/2023

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F 730	Continued From page 15 Certified Nursing Assistant-Medications (CNA-M) #1, and #2). Findings: 1. CNA1 was hired on 3/11/20. The last performance evaluation was completed on 3/11/21. The facility was unable to provide evidence of a completed annual performance evaluation for 2022 and 2023. 2. CNA2 was hired on 9/27/22. The facility was unable to provide evidence that an annual performance evaluation was completed. 3. CNA-M1 was hired on 8/19/11. The last performance evaluation was completed on 8/19/20. The facility was unable to provide evidence of a completed annual performance evaluation for 2021, 2022, and 2023. 4. CNA-M2 was hired on 1/7/22. The facility was unable to provide evidence that an annual performance evaluation was completed. On 10/25/23 at 3:15 p.m., in an interview with a surveyor, the Employee Experience Business Partner, Senior Employee Experience Business Partner, and Director of Employee Experience confirmed the above findings.	F 730		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205020	A. BUILDING _____ B. WING _____	10/26/2023

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BANGOR NURSING & REHABILITATION CENTER	103 TEXAS AVE BANGOR, ME 04401

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F 755	Continued From page 16	F 755		

personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-

§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure that physician ordered medications were available for use to meet the needs of the residents for 1 of 4 sampled residents (Resident #22[R22]).

Finding:

On 10/25/23 at 9:38 a.m., a surveyor observed Certified Nursing Assistant - Medication (CNA-M) #2 prepare R22's medications. CNA-M #2 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205020	A. BUILDING _____ B. WING _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 755	Continued From page 17	F 755		

unable to locate any Artificial Tears to be able to administer to R22 who was supposed to receive 1 drop to each eye three times a day and as needed as instructed per physician order dated 1/23/23. CNA-M #2 reported to the Charge Nurse and a "hold order" was received. CNA-M #2 and CNA-M #1 looked for unopened Artificial Tears in the medication storage rooms and were unable to locate any.

On 10/26/23 at 8:15 a.m., during an interview with a surveyor, CNA-M #1 stated that the process is to notify the Charge Nurse and/or Unit Secretary when the medication is not available. At this time, the surveyor and CNA-M #1 observed Central Supply and noted that there were no Artificial Tears located here.

On 10/26/23 at 9:44 a.m., during an interview with a surveyor, CNA-M #3/Unit Secretary stated she was unaware there was no Artificial Tears in the building. The surveyor explained that there are 4 residents with this order and only two residents have this medication available for use and that R22 and R5 do not have this medication available to use. CNA-M #3/Unit Secretary then stated that she wasn't sure what the ingredients were between the other eye drops (available) but she told "them" to change it to one they have months ago.

On 10/26/23 at 10:04 a.m., during an interview with a surveyor, the Director of Nursing stated she was unaware that there was no (unopened) Artificial Tears in the building.

On 10/26/23 at 10:46 a.m., a surveyor observed the most recent Artificial Tears that was opened and available in a medication cart was dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205020	A. BUILDING _____ B. WING _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BANGOR NURSING & REHABILITATION CENTER	103 TEXAS AVE BANGOR, ME 04401

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F 755	Continued From page 18 8/10/23.	F 755		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, 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	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205020	A. BUILDING _____ B. WING _____	10/26/2023

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F 756	Continued From page 19	F 756		

the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:

Based on record reviews and interviews, the facility failed to respond to the consultant pharmacist's recommendations in a timely manner for 2 of 5 sampled residents reviewed for unnecessary medications (Resident #37 [R37], and Resident #39 [R39]).

Findings:

1. Review of R37's "Consultant Pharmacist's Medication Regimen Review" dated 6/26/23 states: "Please consider clarifying the diagnosis listed for Donepezil therapy. The Medication administration record (MAR) currently lists a diagnosis "anxiety" which is not an approved indication for use. This medication is generally used to treat Alzheimer's dementia. Thank you".

Review of R37's clinical record lacked evidence that the provider was provided the pharmacy consultant report dated 6/26/23. Review of R37's clinical record lacked evidence that this recommendation was addressed.

On 10/26/23 at 12:20 a.m. the surveyor confirmed with the Educational Director that the pharmacy recommendation was not provided to the provider.

2. R39 was originally admitted to the facility on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205020	A. BUILDING _____ B. WING _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BANGOR NURSING & REHABILITATION CENTER	103 TEXAS AVE BANGOR, ME 04401

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F 756	Continued From page 20 11/6/21 and has diagnoses to include Parkinson's Disease (a brain disorder that causes unintended or uncontrollable movements), Anxiety, and Depression. Review of R39's "Consultant Pharmacist's Medication Regimen Review" dated 7/25/23 states: "Please confirm diagnosis listed for Donepezil (a cognition-enhancing medication) therapy. The current MAR (medication administration record) lists a diagnosis of Parkinsons which is not an approved indication for use, this medication is generally used to treat Alzheimer's dementia. Thank you". Review of R39's clinical record lacked evidence that the provider was provided the pharmacy consultant report dated 7/25/23. Review of R39's clinical record lacked evidence that this recommendation was addressed. On 10/26/23 at 11:30 a.m. the surveyor confirmed with the Educational Director that the pharmacy recommendation has not been addressed.	F 756		
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	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205020	A. BUILDING _____ B. WING _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 21	F 812		

gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure the kitchen was maintained in a clean manner on 3 of 4 days of survey (10/23/23, 10/24/23, 10/25/23) the facility failed to ensure that dented cans were removed from use, failed to label thawed whipped topping with a thaw date on 1 of 4 days of survey. (10/23/23)

Findings:

On 10/23/23 at 11:11 a.m. during the initial tour the following was observed:
-The kitchen floors were observed to be heavily soiled with food and food peelings, the grout lines in the tile floor are heavily soiled with dirt and grime.
-The table on left hand side of stove the bottom shelf was observed to be heavily soiled with dirt/grime.
-The bottom of the steamtable was observed to be soiled with dirt/dust and grime.
-The ceiling tiles throughout the kitchen were observed to have black marks including handprints, water stains and areas were observed to be bubbled.
-The floor drain near the stove was heavily soiled with food debris, dirt and grime, the floor mats were torn and uncleanable.
-The wall behind the stove was soiled with grease

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205020	A. BUILDING _____ B. WING _____	10/26/2023

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F 812	Continued From page 22 and grime. In the reach in refrigerator in front of the steamtable has an unopened thawed bag of whipped topping that did not have a thaw date. instructions on the 16 oz bag was the topping has a shelf life of 2 weeks once thawed. On 10/23/23 at 11:40 a.m. the surveyor confirmed the above findings with the cook. On 10/23/23 tour of the dry food storage area it was noted that 3 boxes of plastic utensils (fork, spoon, and knives) were all uncovered and exposed to potential contaminants. On the rack that holds can goods the following was observed: - A six pound (6 lb.) eight ounce (8 oz) can of sliced apples that was dented on top seal. -Two (2) cans of diced peaches six pounds/nine ounces (6 lb. 9 oz) one (1) can was dented on the top seal and one (1) can was dented on bottom seal. - A seven pound (7 lb.) can of refried beans that was dented on the top seal. On 10/23/23 at 11:42 a.m. the surveyor confirmed these findings with the dietary aide On 10/23/23 at 1:45 p.m. during a tour of the kitchen with the Director of Nursing the surveyor confirmed the following: -floors being dirty with grout being caked with dirt/grime, the dented cans (sliced apples, diced peaches and refried beans, dirty ceiling tiles, the kitchen floor mats that are torn and uncleanable, the drain near stove is heavily soiled, backwall behind stove was dirty. 10/24/23 at 11:00 a.m. during a second tour of	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205020	A. BUILDING _____ B. WING _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BANGOR NURSING & REHABILITATION CENTER	103 TEXAS AVE BANGOR, ME 04401

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F 812	Continued From page 23 the kitchen, the following were observed, kitchen floor grout lines remain soiled with dirt/grime, back wall behind stove remains soiled, ceiling tiles are dirty floor mats remain in place torn, cracked and uncleanable. On 10/25/23 at 1:30 p.m. during a tour of the kitchen with the dietary manager the surveyor confirmed the following findings: the floors remained unclean the floor mats are torn, cracked and uncleanable, tables near the stove and bottom part of steamtable remain uncleaned, ceiling tiles dirty.	F 812		
F 842 SS=D	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. §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,	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205020	A. BUILDING _____ B. WING _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BANGOR NURSING & REHABILITATION CENTER	103 TEXAS AVE BANGOR, ME 04401

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F 842	Continued From page 24	F 842		

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
(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205020	A. BUILDING _____ B. WING _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BANGOR NURSING & REHABILITATION CENTER	103 TEXAS AVE BANGOR, ME 04401

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F 842	Continued From page 25 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 review, observation, and interviews, the facility failed to ensure that clinical records were complete and contained accurate information for 1 of 1 resident reviewed for pressure ulcers (Resident #33 [R33]). Finding: A review of R33's clinical record noted an admission date of 3/9/23. "The Medication Review Report", under other, order summary listed, on 9/3/23, "wash sacrum with Dermal wound cleanse, apply Lotrisone (generic name, Clotrimazole/Betamethasone, a combination medication, clotrimazole, is an antifungal, and betamethasone, is a corticosteroid that works by stopping the fungus from being able to make a protective covering, making it difficult for the fungus to grow or survive, and corticosteroid - that lowers certain chemicals in your body that cause inflammation in your skin) to peri wound ... every day shift for sacral wound". The "Treatment Administration Record (TAR)", listed under, "schedule for Oct 2023" lists, "wash sacrum with Dermal wound cleanse, apply Lotrisone to peri wound ...". The Wound Clinic order dated 9/12/23 listed under, comments, "to Periwound apply clotrimazole (brand name, Lotrimin, an antifungal)". On 10/23/23 at 3:44 p.m., during an interview with a surveyor, the Registered Nurse completing a dressing change for R33 could not find Lotrisone cream to use on a sacrum wound as ordered on	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205020	A. BUILDING _____ B. WING _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BANGOR NURSING & REHABILITATION CENTER	103 TEXAS AVE BANGOR, ME 04401

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F 842	Continued From page 26 the TAR. He stated he would get more ordered from the pharmacy. On 10/26/23 at 9:33 a.m. in an interview with a surveyor, RN Katie was asked if Lotrisone was used when she changed R33's dressing. RN said that she did a dressing change for R33 and used Lotrisone cream. The surveyor asked to see the cream used, and the RN went to R33's room and showed the surveyor a tube of Clotrimazole (Lotrimin) cream, this surveyor confirmed with the RN at this time that the medication she used was Lotrimin, not Lotrisone as listed on the TAR. On 10/26/23 at 9:45 a.m. in an interview with a surveyor, the Educational Director confirmed the transcription error that Lotrisone was entered in the TAR in error and should have been clotrimazole (Lotrimin) as ordered by the Wound Clinic on 9/12/23.	F 842		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and	F 851		

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	205020	A. BUILDING _____ B. WING _____	10/26/2023

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F 851	Continued From page 27	F 851		

services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).

§483.70(q)(2) Submission requirements.
The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:
(i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);
(ii) Resident census data; and
(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).

§483.70(q)(3) Distinguishing employee from agency and contract staff.
When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.

§483.70(q)(4) Data format.
The facility must submit direct care staffing information in the uniform format specified by CMS.

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F 851	Continued From page 28 §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on record review and interviews related to mandatory submission of staffing information, the facility failed to ensure complete and accurate direct care staffing information based on payroll data was submitted to CMS (Centers for Medicare and Medicaid Services) for fiscal year quarter 3 (April 1 - June 30, 2023). This has the potential to affect all residents (51). Findings: Interview with the Administrator on 10/25/23 at 11:05 a.m. revealed that he/she is the responsible person for the submission to CMS of staffing information based on payroll data. Administrator verbalized, the finance/payroll department used to do this, but he got done in June 2023 and the Employee Experience Coordinator thought she had until the end of August 2023 to submit the data. A document titled "PBJ Staffing Data Report CASPER (Certification and Survey Provider Enhanced Report) 1705D FY (Fiscal Year) Quarter 3 2023 (April 1 - June 30)" states that the facility "Failed to Submit Data for the Quarter" was "triggered". "Triggered' was defined as "no data submitted for quarter". A facility document titled "Detailed Census Report - By Payer", dated 10/23/2023, documented there were 52 residents living in the facility, there were 51 residents living in the facility with 1 bed hold.	F 851		

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F 851	Continued From page 29 On 10/25/23 at 11:05 a.m. with an interview with a surveyor, the Administrator revealed that their expectation is that the Employee Experience Coordinator submit to CMS the staffing information based on payroll data, and that they missed the deadline for the last quarter.	F 851		
F 880 SS=B	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §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	F 880		

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F 880	Continued From page 30	F 880		

infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on review of the facility's Infection Prevention and Control Program (IPCP) and

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F 880	Continued From page 31 interview, the facility failed to ensure that the IPCP was reviewed annually. Finding: On 10/26/23 at 11:00 a.m., the facility's IPCP was reviewed. There was no evidence to indicate that the IPCP was reviewed annually. The Educator/Infection Preventionist did not provide evidence that the IPCP was reviewed annually.	F 880		
F 882 SS=E	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to ensure that the facility's Infection Preventionist (IP) had completed specialized training prior to starting the IP position.	F 882		

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F 882	Continued From page 32 Finding: On 10/25/23 at 1:15 p.m., in an interview with the surveyor, the Educator/Infection Preventionist (Educator/IP) stated she started this position in March 2023 and has enrolled in an on-line training for Infection Control and Prevention but has not completed the training. On 10/25/23 at 1:20 p.m., in an interview with the surveyor, the Educator/IP confirmed that no other staff/IP is overseeing or consistently training her and that she has not completed the specialized training-Certificate in Infection Prevention and Control.	F 882		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.	F 947		

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F 947	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on employee record review and interviews, the facility failed to implement and maintain an effective training program which includes, at a minimum, training on dementia for 4 of 5 licensed staff reviewed (Certified Nursing Assistant #1 [CNA1], CNA2, Certified Nursing Assistant-Medications #1 [CNA-M1], and CNA-M2). Findings: On 10/25/23 the following employee records were reviewed: 1. CNA1 was hired on 3/11/20. There was no documented dementia training. 2. CNA2 was hired on 9/27/22. There was no documented dementia training in over 12 months. 3. CNA-M1 was hired 8/19/11. There was no documented dementia training in over 12 months. 4. CNA-M2 was hired 1/7/22. There was no documented dementia training in over 12 months. On 10/25/23 at 3:15 p.m., in an interview with a surveyor, the Employee Experience Business Partner, Senior Employee Experience Business Partner, and Director of Employee Experience confirmed the above findings.	F 947		