STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205168	A. BUILDING ______ B. WING ______	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD PARK REHAB & LIVING	**107 ORCHARD ST FARMINGTON, ME 04938**

(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 000	INITIAL COMMENTS From 12/9/24 through 12/11/24 on-site visits were conducted at Orchard Park Rehabilitation and Living Center for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification and to investigate complaint #ME00049096 It was determined that Orchard Park Rehabilitation and Living Center was not in compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	F 584	Please See Attached POC Completion Date: January 17, 2025	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ja Somerlay for MA Fac Ops Manager
TITLE
(X6) DATE: 12/30/2024

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 584	Continued From page 1 in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to adequately maintain maintenance and housekeeping services necessary to maintain the facility in good repair and sanitary conditions for 3 of 3 units (Northern Spy, Cortland and McIntosh) and the laundry room for 1 of 1 environmental tour (12/11/24). Findings: 1. On 11/19/24, from 10:05 a.m. to 10:30 a.m., an environmental tour was conducted with the Administrator, the Maintenance Director and the Housekeeping Account Manager, in which the following findings were observed: - The shower room across her nursing station had a missing ceiling tile and a broken shelf which was missing laminate on the edge exposing bare wood. - -The whirlpool room had ripped/torn flooring at the corners of the sink cabinet and had a large split-apart seam in the middle of the floor which	F 584	Please See Attached POC Completion Date: January 17, 2025	

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F 584	Continued From page 2 was full of dirt. The bottom edge of the sink cabinet was broke and missing laminate. The walls had chipped/missing paint and holes in them. - Resident Room 101 - On 12/09/24 at 9:54 a.m., a surveyor tested the hot water and found it to be cool to the touch and at 86 degrees Fahrenheit (F). The surveyor let the water run until 10:00 a.m. and the water was still cool to the touch.. On 12/9/24 at 10:49 a.m., in an interview, the Maintenance Director stated that the furnace was acting up after being looked at a while ago. He stated that the water temperature fluctuates hot to cold. It never goes above 120 (F). - Resident Room 102- The baseboard heater had chipped/missing paint, was broken apart lying on the floor and in disrepair. The bathroom floor was soiled with dirt and the caulking around the base of the toilet was dirty. - Resident Room 104 - The baseboard heater had chipped/missing paint and was rusting. The bathroom floor dirty around the edges. The caulking around the base of the toilet was dirty. The cold water faucet was broken and ran all the time. The toilet fill water line escutcheon was rusty. - Resident Room 105 - The room walls were marked/marred with black marks. The baseboard heater was broken apart and rusty. - Resident Room 106 - On 12/09/24 at 9:52 a.m., a surveyor tested the hot water. After running for 5 minutes the water was not over 100 (F). The baseboard heater in room had chipped/missing paint and was rusty. - Resident Room 110 - Resident #16 Broda chair was dirty with dried foods. The baseboard heater was broken apart and had chipped/missing paint. The bathroom door had chipped/missing laminate on the bottom left corner creating an uncleanable	F 584	Please See Attached POC Completion Date: January 17, 2025	

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F 584	Continued From page 3 surface. - Resident Room 111 - The room walls were marked/marred with black marks and had chipped/missing paint exposing sheetrock and a metal corner. The paint was missing from above the baseboard heater exposing sheetrock and the heater was broken exposing fins and pipes. The bathroom had a dusty/dirty fan on the floor. - There was a broken hallway ceiling tile outside of resident room 112. - Resident Room 116 - The room walls were marked/marred with black marks and there was unpainted spackle behind and around the book shelf. There was missing paint above baseboard heater exposing sheetrock. - Resident Room 122- The bathroom baseboard heater had chipped/missing paint and was rusty. The room baseboard heater was broken, lying on the floor and in disrepair. - Therapy/Rehab Room - The floor is heavily soiled with dirt. - The Northern Spy Unit hallway floor had 35 cracked/broken floor tiles. - The laundry room wall air conditioning unit was dusty/dirty. 2 of the 3 dryers were not operational. #1 has been inoperable for 2 years and #3 broke down a week ago with no timeframe on getting it fixed. On 12/10/24 at 1:19 p.m., observation of laundry rooms with the Housekeeping Account Manager. Dryer #3 has sign "do not use" and the Housekeeping Account Manager stated laundry sometimes needs to be prioritized due to having one dryer. She stated Dryer #3 has been out of order since about last Friday. On 12/10/24 at 1:28 p.m., in an interview with the Maintenance Director, he stated Dryer #1 has been out of order for over 2 years. Dryer #3 drum is slightly off balance due to a bearing. He had a company come out for a quote but is now having Yankee	F 584	Please See Attached POC Completion Date: January 17, 2025	

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F 584	Continued From page 4 equipment come to take a look for a second opinion. A surveyor requested the initial quote and no quote was made available the surveyor. On 11/19/24 at 10:30 a.m., in an interview, the Administrator, the Maintenance Director and the Housekeeping Account Manager confirmed the findings. 2. On 12/9/24 at 9:54 a.m. and on 12/10/24 at 10:12 a.m., observation of a strong smelling urine odor coming from Resident #21's room. On 12/10/24 at 10:20 a.m., during an interview, the above information was confirmed with the Director of Nursing (DON). The DON states that Resident #21's foley bag is frequently not screwed on all the way causing it leaks on the floor. The DON believes that the urine has absorbed into the flooring. When follow up question about what they are doing to counteract the odor, the DON states that housekeeping is cleaning the room daily but it is not helping. 3. On 12/9/24 at 9:45 a.m. and on12/10/24 at 10:12 a.m., observation of 2 wash basins on the bathroom floor, under the sink. On 12/10/24 at 10:27 a.m., the above information was confirmed with the DON.	F 584	Please See Attached POC Completion Date: January 17, 2025	
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care	F 655	Please See Attached POC Completion Date: January 17, 2025	

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F 655	Continued From page 5 Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting	F 655	Please See Attached POC Completion Date: January 17, 2025	

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F 655	Continued From page 6 on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and facility policy, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours that included the problems, interventions, and initial goals needed to provide minimum healthcare information necessary to properly care for 4 of 4 residents reviewed for baseline care plans. (Resident's #23, #27, #80 & #181). Findings: Review of policy "48 Hour Baseline Care Plan" dated 10/18 sates "...A baseline care plan will be created within 48 hours of admission ..., the Care Plan will contain the following 6 key elements: initial goals based on admission orders, all physician orders, including medications and administration schedule; dietary orders, therapy services to be provided; social service needs' PASRR recommendations (if any). 1. Resident #180 was admitted on 11/20/24 with diagnoses to include chronic obstructive pulmonary disease (COPD), Respiratory failure, anxiety, and shortness of breath. Review of Resident 180's clinical record revealed active order dated 11/20/24 for 'Trelegy Ellipta 200 mcg-62.5 mcg-25 mcg powder for inhalation 1 Time Daily for COPD", and order dated 12/2/24 for "Oxygen - see notes Continuous: Oxygen (O2) at 3 L/min per nasal cannula Continuous." Review of Resident #180's care plan initiated 11/20/24 lacked evidence that goals and interventions were put into place for his/her	F 655	Please See Attached POC Completion Date: January 17, 2025	

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F 655	Continued From page 7 respiratory needs. During an interview in presence of 4 surveyors on 12/9/24 at 2:21 p.m., with the Infection Preventionist (IP) indicated that she does care plans on date of admission, and she includes necessary documentation, states that the Minimum Data Set Coordinator (MDS) will let her know if she forgot something. At this time IP confirmed above findings. 2. Resident #80 was admitted on 11/22/24 with diagnoses to include sleep apnea. Review of Resident #80's clinical record revealed active order dated 11/30/24 for "CPAP (Continuous Positive Airway Pressure) 2 Times Daily 11/30/2024. If refuses CPAP, may use PRN order for oxygen at 2 LPM (Liters Per Minute) via nasal cannula." " Oxygen - see notes PRN. If refuses CPAP use 2 LPM oxygen via nasal cannula during night time sleep hours." Review of Resident #80's baseline care plan, initiated 11/22/24, lacked evidence that goals and interventions were put into place for his/her respiratory needs. On 12/10/24 at 10:12 a.m., in an interview, the Quality Improvement Specialist confirmed that the baseline care plan lacked evidence that goals and interventions were put into place for his/her respiratory needs. 3. Resident #23 was admitted on 10/10/24 with diagnosis of dementia with behavioral disturbance. Physician History and physical states resident has diagnosis of dementia with	F 655	Please See Attached POC Completion Date: January 17, 2025	

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F 655	Continued From page 8 behavioral disturbances. Review of Residents #23's care plan initiated on 10/10/24 lacked evidence of goals and interventions were put into place for his/her dementia needs. On 12/9/24 at 2:01 p.m., the above was discussed with the Vice Presisent of Clinical Operations. 4. Resident #27 was admitted to the facility on 10/24/24 with the diagnosis' of Chronic heart failure, Chronic respiratory failure, hypertension, and Chronic obstructive pulmonary disease. Review of his/her clinical record lacked evidence of a baseline care plan being initiated. On 12/11/24 at 9:26 a.m., during an interview, the above information was confirmed with the Quality Improvement Specialist.	F 655	Please See Attached POC Completion Date: January 17, 2025	
F 677	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and family interview, the facility failed to provide dental care and dress a resident in clean clothes for 2 of 2 residents sampled for activities of daily living (ADL) (Resident's #7 & # 10). Findings:	F 677	Please See Attached POC Completion Date: January 17, 2025	

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F 677	Continued From page 9 1. Resident 10 was admitted on 1/22/24 and has diagnoses to include dementia. Review of Minimum Data Set (MDS) dated revealed Resident #10 had a Brief Interview for Mental Status (BIMS) of 0 of 10 indicating he/she is not cognitively intact. During an initial tour of facility on 12/9/24 at 10:15 a.m., Resident #10 was observed walking down the hall with a family member, passing 4 other residents with an excessive amount of what appeared to be food/tartar build up on his/her teeth. At this time the family member indicated that he was bringing his mother/father to the dentist to have his/her teeth cleaned because they were really bad. Resident #10 returned to facility at approximately 12:25 p.m. Review of Resident 10 care plan updated 8/23/24 states: Problem: [Resident 10] requires extensive assistance with self-care secondary to dementia ..." Review of Resident 10's Activities of Daily Living (ADL) documentation from 12/1/24 through 12/10/24 on 12/10/24 at 2:55 p.m., Quality Improvement Specialist (QIP) confirmed Resident 10 was not receiving mouth care at least twice a day. During an interview on 12/10/24 at 1:11 p.m., Certified Nursing Assistant (CNA)2 indicated staff were supposed to do mouth care twice a day and document it in the Electronic Medical Record (EMR) CNA 2 further indicated Resident #10 never re fuses care but is confused. During an observation on 12/11/24 at 8:30 a.m.,	F 677	Please See Attached POC Completion Date: January 17, 2025	

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F 677	Continued From page 10 Resident 10 was observed sitting in a chair across from the nursing station, with obvious food build up visible on the right side of his/her teeth. During an interview on 12/11/24 at 8:43 a.m., CNA3 indicated she was responsible for Resident 10 today and mouthcare is part of daily care, and it would be done when they get up and before they go to bed. At this time CNA 3 indicated that she did not brush Resident 10's teeth this morning, but did rinse his/her mouth out. During an observation on 12/11/24 at 8:54 a.m., a surveyor and QIS observed Resident 10's teeth and confirmed they were not brushed. At this time QIS assisted Resident 10 to his/her room to assist him/her with mouth care. During a follow-up interview at 9:09 a.m., QIS indicated that all she had to do was set up the toothbrush and toothpaste and Resident 10 was able to brush his/her teeth independently. 2. Resident #7 was admitted on 6/7/23 and has diagnoses to include dementia. Review of Minimum Data Set (MDS) dated revealed Resident #7 had a Brief Interview for Mental Status (BIMS) of 3 of 10 indicating severe cognitive impairment. Review of Resident #7's current care plan states: Problem: [Resident 7] requires extensive assistance with self-care secondary to dementia ..." On 12/9/24 at 9:56 a.m., a surveyor observed Resident #7 sitting in his/her wheelchair in her room. Resident #7 had black pants on and a red	F 677	Please See Attached POC Completion Date: January 17, 2025	

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F 677	Continued From page 11 full sleeve sweater on which had dried food particles on the residence shirt and pants. On 12/9/24 at 11:48 a.m., a surveyor and CNA #1 observed Resident #7 lying in bed and CNA #1 stated Resident #7 refused to go to the dining room for lunch. A surveyor and CNA #1 observed dried food particles and on Resident #7's shirt and pants. When asked about the dirty clothes on Resident #7, CNA #1 confirmed at this time that it was a dignity issue and her clothes should have been changed in the morning after breakfast before she was laid down. On 12/10/24 at 10:20 a.m., the surveyor discussed the finding with the Quality Improvement Specialist who confirmed this was a dignity issue and Resident #7 shouldn't have been left in dirty clothes and put in bed.	F 677	Please See Attached POC Completion Date: January 17, 2025	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in 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 facility policy, record review and interviews, the facility failed to adequately monitor a resident after an unwitnessed fall for 1 of 2 residents reviewed for falls (#5).	F 684	Please See Attached POC Completion Date: January 17, 2025	

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F 684	Continued From page 12 Findings: The facilities "Fall Management Policy", last revised 7/19 subsection D states, "A fall incident report will be completed after a resident has had a fall, whether it is a witnessed or not", subsection E states, "Complete Post Fall Observation tool, following a fall, to help identify if the cause of the fall is related to mental status changes, physical limitations or environmental factors" and subsection F states, "Documentation must be completed in the nurse's note on each shift X3 following the fall". The 'Neurological Assessment Policy", last revised 1/2019 states, "Residents with suspected neurological compromise will have a neurological sign monitored and recorded for a minimum of 12 hours". Subsection III Procedures states "A neurological assessment following resident head injury will be completed for all residents sustaining head trauma or suspected head trauma. In EMR: Neuro Checks will be conducted-every 15 minutes x4, every 30 minutes x4, every 1 hr. x4, every 4 hr. x2, and every 8 hr. x1. Frequency of neuro checks after 24 hours is determined by resident's observed signs and symptoms of neurological compromise." Resident #5 was admitted on 9/7/23 with a diagnosis of Dementia and has a Brief Interview of Mental Status (BIMS) score of 4, indicating severe cognitive impairment. Nurse documentation on 9/25/24 at 3:18 a.m., states, "At approximately 2130 resident came to the nurses station in [his/her] wheelchair to self-report "I fell in my bathroom", when asked how [he/she] got up resident states 'I pulled myself up with the bar', reported incident was unwitnessed and it's	F 684	Please See Attached POC Completion Date: January 17, 2025	

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F 684	Continued From page 13 unknown if resident actually fell or not, resident is often confused at baseline related to dementia ... resident states [he/she] has mild pain in her left knee ..." Further review of Resident #5's medical record lacked evidence of the facility completing a fall incident report, a post fall observation tool or continued monitoring of him/her for further injuries and/or neurological changes after the unwitnessed fall. On 12/10/24 at 10:08 a.m., during an interview, the Quality improvement Specialists confirmed the facility failed to complete the required documentation and further monitoring of Resident #5's unwitnessed fall.	F 684	Please See Attached POC Completion Date: January 17, 2025	
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and a review of Safety Data Sheets (SDS), the facility failed to ensure that the resident's environment was free of accident hazards relating to the storage of chemicals being properly secured for 2 of 3 days of survey (12/9/24 and 12/11/24). Findings: The Safety Data Sheet for Rapid Multi Surface	F 689	Please See Attached POC Completion Date: January 17, 2025	

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Disinfectant Cleaner noted the following:
4. First Aid Measures
In case of eye contact: Rinse immediately with plenty of water, also under the eyelids, for at least 15 minutes. Remove contact lenses, if present and easy to do. Continue rinsing. Get medical attention immediately.
In case of skin contact: Wash off immediately with plenty of water for at least 15 minutes. Wash clothing before reuse. Thoroughly clean shoes before reuse. Get medical attention immediately.
If swallowed: Rinse mouth with water. Do not induce vomiting. Never give anything by mouth to an unconscious person. Get medical attention immediately.
If inhaled: Remove to fresh air. Treat symptomatically. Get medical attention.

The Safety Data Sheet for Enzymatic Foul Odor Digester noted the following:
4. First Aid Measures
Eyes: Rinse with water for a few minutes. Consult physician if symptoms occur.
Skin: Rinse with water. Consult physician if symptoms occur.
Ingestion: Get medical attention if symptoms occur.
Inhalation: Treat symptomatically.

The Safety Data Sheet for Germs Be Gone Hand Sanitizer Gel noted the following:
4. First Aid Measures
Danger. Flammable. May be harmful if swallowed. Causes serious eye irritation.
Eyes: rinse cautiously with water for several minutes. Remove contact lenses if present and easy to do. Continue rinsing. If irritation persists, get medical attention.
Skin: rinse with water. Ingestion: may be harmful

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if swallowed. Seek medical attention immediately.
Inhalation: remove person to fresh air and keep comfortable for breathing. Call a poison center or a doctor if you feel unwell

The Safety Data Sheet for GelRite Instant Hand Sanitizer (with vitamin E) noted the following:
4. First Aid Measures
Skin contact: If skin irritation develops, stop use and consult a physician.
Skin absorption: If exposed to large quantities as in a spill, removed clothing and wash skin with soap and water.
Eye Contact: Flush eyes with clear running water for 15 minutes. If irritation persists, seek medical attention.
Inhalation: If exposed to large amounts of vapor as in large spills, watch for signs of intoxication and move to fresh air.
Ingestion: If swallowed, rinse mouth with water, get medical attention.

On 12/9/24 at 10:00 a.m., a surveyor observed in the unlocked soiled utility room a 12 fluid ounce bottle of Rapid Multi Surface Disinfectant Cleaner, a 12 fluid ounce bottle of Enzymatic Foul Odor Digester, a 16 fluid ounce bottle of Germs Be Gone Hand Sanitizer Gel and two 16 fluid ounce bottles of GelRite Instant Hand Sanitizer with vitamin E.

On 12/9/24 at 10:14 a.m., in an interview with the Acting Director of Nursing and Infection Preventionist confirmed the chemicals were not stored safely behind a locked door. When asked if the facility had confused, compromised and vulnerable residents that can move around the facility, she answered yes.

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F 689	Continued From page 16 On 12/11/24 at 10:00 a.m., a surveyor observed in the unlocked soiled utility room a 12 fluid ounce bottle of Rapid Multi Surface Disinfectant Cleaner. On 12/11/24 at 10:05 a.m., in an interview, the Quality Improvement Specialist confirmed the finding.	F 689	Please See Attached POC Completion Date: January 17, 2025	
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews, policy review, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to respiratory care for 2 of 3 residents reviewed for respiratory care (Resident's #14, and #180). In addition, the facility failed to follow provider orders for 2 of 3 residents reviewed for respiratory care. (Resident 's #80 & #180) Findings: Review of facilty policy "CPAP/BIPAP/AVAP Management" dated 8/6/24 states "...keep out of direct sunlight. Store in clean zip lock or string-tie	F 695	Please See Attached POC Completion Date: January 17, 2025	

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F 695	Continued From page 17 plastic bag. The storage bag should be changed weekly..." 1. Resident 180 was admitted on 11/20/24 with diagnoses to include chronic obstructive pulmonary disease (COPD), respiratory failure, anxiety, and shortness of breath. Observations of Resident #180 on 12/9/24 at 10:20 a.m., and 2:28 p.m., and 12/10/24 at 10:25 a.m., a nebulizer was observed on bedside table with tubing connected to mask lying on top of table not bagged. Resident #180 states he/she has not used it in a couple of days. Review of Resident 180's clinical record revealed active order dated 11/20/24 for "Trelegy Ellipta 200 mcg-62.5 mcg-25 mcg powder for inhalation 1 Time Daily for COPD." On 12/9/24 10:40 a.m., During an observation of Resident #180 with Acting Director of Nursing/Infection Preventionist (DON/IP) confirmed nebulizer tubing should be bagged when not in use. At this time IP retrieved a bag and was observed placing nebulizer tubing in bag. At this time DON/IP indicated the facility follows the same policy for all respirtory equipment. During an observation with 2 surveyors on 12/10/24 at 10:27 a.m., Quality Improvement Specialist (QIP) confirmed Resident #180's nebulizer was not bagged. On 12/9/24 at 10:20 a.m., and 2:28 p.m., and 12/10/24 at 10:25 a.m., Resident #180 was observed in a wheelchair with oxygen concentrator running continuous at 1.5 liters per	F 695	Please See Attached POC Completion Date: January 17, 2025	

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F 695	Continued From page 18 minute (lpm) via nasal canula. Review of Resident #180's clinical record revealed order dated 12/2/24 for "Oxygen - see notes Continuous: Oxygen (O2) at 3 L/min per nasal cannula Continuous." During an observation with 2 surveyors on 12/10/24 at 10:27 a.m., Quality Improvement Specialist (QIP) confirmed Resident #180's oxygen was set at 1.5 liters per minute. 2. Resident #14 was admitted has diagnoses to include chronic obstructive pulmonary disease (COPD), asthma, heart failure, chest pain, hypoxemia, obstructive sleep apnea, and wheezing. A review of Resident #14's clinical record revealed an active order, dated 5/31/24, for "Oxygen (O2) at 3L/min per nasal cannula continuous." A review of Resident #14's care plan, updated 9/19/24, revealed, "Problems: HOSPICE/PAIN/RESPIRATORY DISTRESS: ...Dx end stage COPD w/ oxygen dependence...Interventions: Oxygen will be delivered via nasal cannula ...Oxygen per MD orders..." On 12/9/24 at 9:43 a.m. and on 12/10/24 at 10:32 a.m., Resident #14 was observed lying in bed receiving continuous oxygen via a nasal cannula that was connected to an oxygen concentrator, with the oxygen flow rate set to 2.5 liters (L) per minute. During an observation with a surveyor on 12/10/24 at 10:39 a.m., the Quality Improvement	F 695	Please See Attached POC Completion Date: January 17, 2025	

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F 695	Continued From page 19 Specialist (QIS) confirmed that Resident #14's oxygen concentrator was set at 2.5 liters per minute. 3. Resident #80 was admitted on 11/22/24 with diagnoses to include sleep apnea. Review of Resident #80's clinical record revealed active order dated 11/30/24 for "CPAP (Continuous Positive Airway Pressure) 2 Times Daily 11/30/2024. If refuses CPAP, may use PRN order for oxygen at 2 LPM (Liters Per Minute) via nasal cannula." " Oxygen - see notes PRN. If refuses CPAP use 2 LPM oxygen via nasal cannula during night time sleep hours." On 12/9/24 at 10:28 a.m., a surveyor observed Resident #80's CPAP machine stored on the nightstand and the face mask was stored in the open top drawer of the nightstand and was not bagged. On 12/9/24 at 10:40 a.m., in an observation with a surveyor and interview, the Acting Director of Nursing/Infection Preventionist (DON/IP) confirmed that Resident #80's CPAP face mask was stored inappropriately and should be bagged when not in use.	F 695	Please See Attached POC Completion Date: January 17, 2025	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F 757	Please See Attached POC Completion Date: January 17, 2025	

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F 757	Continued From page 20 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to ensure that a resident's drug regimen was free from unnecessary drugs by administering doses of Insulin outside of the physician order parameters and failed to follow the care plan in the area of nutrition for 1 of 5 reviewed for unnecessary medications (#5). Finding: Resident #5's current Physician orders contained an order, dated 9/7/23 for Novolog Insulin 100 unit/mL (milliliter) give 6 units subcutaneous three times daily for type 2 Diabetes Mellitus with Diabetic Polyneuropathy with Instructions to Hold for Blood sugar less than 110. Review of the Electronic Medication Administration Record (EMAR) for October 2024 states, nursing administered Novolog insulin, 6 units on 10/13/24 with a documented blood sugar of 100 and on 10/16/24 with a blood sugar of 98.	F 757	Please See Attached POC Completion Date: January 17, 2025	

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F 757	Continued From page 21 The EMAR for November 2024 states, nursing administered Novolog insulin, 6 units on 11/9/24 with documented blood sugar of 109. In December 2024, nursing administered Novolog insulin, 6 units on 12/1/24 with a blood sugar of 108 and on 12/7/24 with a blood sugar of 96. Resident #5's nutrition care plan initiated on 7/1/24 with a goal of "[resident] will not experience any complications related to Diabetes over the next 90 days, with an intervention instructing nursing to "Medications and treatments per physician orders" On 12/10/24 at 10:52 a.m., during an interview, the Quality Improvement Specialists reviewed the EMAR for October, November and December and confirmed nursing failed to follow physician orders and the care plan by administering excessive doses of NovoLog insulin outside of parameters.	F 757	Please See Attached POC Completion Date: January 17, 2025	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812	Please See Attached POC Completion Date: January 17, 2025	

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F 812	Continued From page 22 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 observation and interview the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for the hood system, 2 wall air conditioning units, a floor fan, a grease trap cover and the ceiling grid hangers for 1 of 1 tour. On 12/9/24 from 9:05 a.m. to 9:35 a.m., an initial kitchen tour was completed with the Food Service Director in which the following findings were observed: - The hood system filers was dusty/dirty. - The wall air conditioning unit and the wall above it, by the 3-bay pot sink, were dusty/dirty. Also, the wall below the air conditioning unit was soiled with dried liquid residue. - The wall air conditioning unit and the wall above it, in the dish room, was dusty/dirty. - The ceiling grid hangers were rusty and stained a yellowish color throughout the kitchen. - The floor fan was dusty/dirty. -The grease trap lid had chipped/missing paint creating an uncleanable surface. On 12/9/24 at 9:35 a.m., in an interview, the Food Service Director confirmed the findings.	F 812	Please See Attached POC Completion Date: January 17, 2025	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880	Please See Attached POC Completion Date: January 17, 2025	

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F 880	Continued From page 23 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 §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 880	Please See Attached POC Completion Date: January 17, 2025	

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F 880	Continued From page 24 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 observation and interview the facility failed to ensure food was served under sanitary conditions during 1 of 3 units observed during lunch meal (Cortland Unit). Findings: Review of Infection Control: Standard Transmission Based Precautions Policy dated 9/18 states: "Hand washing is the single most important seep in infection control. Hands must be washed before and after all resident contact..."	F 880	Please See Attached POC Completion Date: January 17, 2025	

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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 880	Continued From page 25 On 12/9/24 at 12:00 p.m., Licensed Practical Nurse (LPN) was observed coming out of Room 101 holding a lunch tray. LPN was observed walking down the hall to kitchen utility cart located outside of Room 106. LPN then removed trash from the top of the lunch tray with bare hands and placed it in trash can. LPN then placed the lunch tray on the kitchen utility cart, walked past hand sanitizer located outside Room 106, and proceeded to walk across the hall and into Room 105 where she was observed to place her right bare hand on a resident's shoulder, and her left bare hand on the side table located over the bed. LPN then walked out of the room and directly to the lunch cart located outside of the room, opened it with her left hand and reached in to obtain another lunch tray. At this time a surveyor intervened, and LPN confirmed she did not sanitize her hands in between resident contact. During an interview on 12/9/24 at 12:05 p.m., Acting Director of Nursing/Infection Preventionist (DON/IP) stated it was her expectation that staff sanitize their hands before and after resident contact. At this time the above was discussed with DON/IP.	F 880	Please See Attached POC Completion Date: January 17, 2025	
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.	F 881	Please See Attached POC Completion Date: January 17, 2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205168	A. BUILDING ______ B. WING ______	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD PARK REHAB & LIVING	**107 ORCHARD ST FARMINGTON, ME 04938**

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F 881	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on facility policy, record reviews, and interviews, the facility failed to implement its Antibiotic Stewardship Program (ASP) that includes antibiotic use protocols and a system to monitor antibiotic use. This has the potential to affect all residents receiving an antibiotic. Findings: Review of the facility policy "Antibiotic Stewardship Program" last revised on 8/24 states " ...To improve antibiotic use are expected to reduce adverse events, prevent emergence of resistance and lead to better outcomes for residents" ... "Infection Preventionist: Monitors and supports antibiotic activities through rounds, review of providers orders, documentation, and available reports. Tracks antibiotic therapy through use of line listings and pharmacy report. Reviews antibiotic resistance patterns: Monitors HAI (Heath care Acquired Infections) and MDRO's (multi-drug resistant organisms) on Monthly Line listings and Infection Control Report looking for increased rates or trends" and under "Tracking/Reporting: Monitoring measures of antibiotics use by auditing available reports and resident medical records, monitoring if cultures are obtained before antibiotics are initiated" ... and "monitor rates of new antibiotic starts/1,000 resident days through use of line list or [pharmacy report". 1. Review of the facility provided "Safety Meeting, Infection Control Report" revealed the following: -During the month of 9/12/2024, there were 5 documented facility acquired infections that were prescribed antibiotics.	F 881	Please See Attached POC Completion Date: January 17, 2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 881	Continued From page 27 -During the month of 10/10/2024, there were 6 documented facility acquired infections that were prescribed antibiotics. -During the month of 11/21/2024, there were 4 documented facility acquired infections that were prescribed antibiotics. 2. Review of the facility provided Quality Assurance & Performance Improvement Pharmacy quarterly reports for Quarter #4 dated 12/23, Quarter #1 dated 3/24, and Quarter #2 dated 6/24, and Quarter #3 dated 9/24, section "VIII" is the "Antibiotic/Antimicrobial Stewardship Discussion". Further review showed the quarterly reports lacked a section "VIII" failing to provide evidence that the pharmacist/facility reviewed antibiotic use and/or Antibiotic Stewardship program during these meetings. On 12/10/24 at 2:38 p.m., during an interview, the Infection Preventionist, Acting Director of Nursing confirmed the facility does have a lot of frequent urinary track infection's which required antibiotics and that for the most part the physician would review culture results to ensure the correct antibiotic was being prescribed but she has not implemented any tracking systems to identify trends and antibiotic use. In addition, she stated she does not review the monthly pharmacy antibiotic report.	F 881	Please See Attached POC Completion Date: January 17, 2025	
F 887 SS=F	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member	F 887	Please See Attached POC Completion Date: January 17, 2025	

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F 887	Continued From page 28	F 887	Please See Attached POC Completion Date: January 17, 2025	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 887	Continued From page 29 to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on review of the facility's "Infection Control Immunizations - Influenza, Pneumococcal, COVID" and "Employee Immunization/Vaccination Requirements" policy and procedures and interviews the facility failed to develop and implement policy and procedure to ensure all staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine or information on obtaining COVID-19 vaccine. This has the potential to effect all employees. Findings: Review of the "Infection Control Immunizations - Influenza, Pneumococcal, COVID" policy, last revised on 12/24, and the "Employee Immunization/Vaccination Requirements" policy, last revised on 9/5/23 failed to include procedures relating to staff education regarding the benefits and potential risks associated with COVID-19 vaccine or information on obtaining COVID-19 vaccine. 1. On 12/10/24 at 2:38 p.m., during an interview, the Infection Preventionist confirmed that staff are	F 887	Please See Attached POC Completion Date: January 17, 2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 887	Continued From page 30 not provided education regarding the benefits and potential risks associated with COVID-19 vaccine, stating, "No, I haven't since last year", In addition, she confirmed that there is no information relating to COVID-19 in the new employee packet. 2. On 12/11/24 at 7:50 a.m., during an interview with the Maintenance Director, he states that he has not recieved education on the COVID Spikevax within the past year. 3. On 12/11/24 at 7:55 a.m., during an interview with the Licensed Pratical Nurse, who states she has not received education on the COVID spikevax within the past year. 4. On 12/11/24 at 8:00 a.m., during an interview with the facilities Ward Clerk, she discussd that she has never received education on the COVID spikevax.	F 887	Please See Attached POC Completion Date: January 17, 2025	

ORCHARD PARK REHABILITATION & LIVING CENTER
ANNUAL LONG TERM CARE SURVEY PROCESS
FEDERAL RECERTIFICATION &
COMPLAINT INVESTIGATION
PLAN OF CORRECTION
December 30, 2024

Please note the filing of this plan of correction does not constitute an admission of the allegations set forth in the statement of deficiencies. The facility is filing this plan of correction in accordance with applicable law.

F584 - 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment
Finding #'s 1-15: 3 of 3 Units (Northern Spy, Cortland, and McIntosh); Laundry Room and Therapy/Rehab Room

1. **a) SHOWER ROOM ACROSS FROM NURSING STATION:**
    - The missing ceiling tile was replaced; the broken shelf which was missing laminate on the edge exposing bare wood was removed.

   b) WHIRLPOOL ROOM:
    - A quote will be obtained for the flooring where it is ripped/torn at the corners of the sink cabinet, and where there is a large split-apart seam in the middle of the floor to determine if the flooring will be repaired or replaced. The repair or replace will be scheduled, as soon as able, after the quote is received and cost analysis is complete. The laminate on the bottom of the cabinet was repaired.
    - The chipped/missing paint and the holes in the wall, were repaired and repainted.

   c) RESIDENT ROOM 101:
    a. The hot water temperature issue was corrected on December 18, 2024 to have the water temps at acceptable levels, but not to exceed 120 degrees. Water Temps are routinely monitored to ensure they are maintained at acceptable levels but do not exceed 120 degrees.

   d) RESIDENT ROOM 102:
    a. The baseboard heater will be repaired; the chipped/missing paint on the baseboard heater will be repaired.
    b. The dirt was cleaned off the floor in the bathroom.
    c. The caulking around the base of the toilet was replaced.

   e) RESIDENT ROOM 104:
    a. The chipped/missing paint on the baseboard heater was repaired.
    b. The dirt was cleaned from around the edges of the floor in the bathroom.
    c. The caulking around the base of the toilet was replaced.
    d. The cold water faucet was replaced so the water doesn't run constantly.
    e. The rusty escutcheon on the toilet water fill line will be replaced.

   f) RESIDENT ROOM 105:
    a. The black marks were cleaned off the walls/walls re-painted, as indicated.

Ja Pomelam RN, MHA
Fac. Ops Mgr. 12/30/2024

   b. The baseboard heater was repaired; the chipped/missing paint on the baseboard heater was repaired.

g) RESIDENT ROOM 106:
   a. The hot water temperature issue was corrected on December 18, 2024, to have the water temps at acceptable levels but not to exceed 120 degrees.
   b. The chipped/missing paint on the baseboard heater was repaired.

h) RESIDENT ROOM 110:
   a. The Broda Chair was cleaned of dried food. (Resident D/C'd and chair returned to Hospice)
   b. The baseboard heater will be repaired; the chipped/missing paint on the baseboard heater will be repaired.
   c. The chipped/missing laminate on the bottom left corner of the bathroom door was repaired.

i) RESIDENT ROOM 111:
   a. The black marks were cleaned off the walls/walls will be re-painted, as indicated.
   b. The chips in the walls creating exposed sheetrock, chips in the wall above the baseboard heater, and exposing the metal corner will be repaired. The walls will be repainted, as indicated.
   c. The broken baseboard heater will be repaired.
   d. The dusty fan on the floor was removed.

j) HALLWAY OUTSIDE OF RESIDENT ROOM 112:
   a. The broken ceiling tile was replaced.

k) RESIDENT ROOM 116:
   a. The black marks were cleaned off the walls/walls re-painted, as indicated.
   b. The unpainted spackle area behind and around the bookshelf was painted.
   c. The exposed (missing) sheetrock above the baseboard heater was added and painted.

l) RESIDENT ROOM 122:
   a. The chipped/missing paint on the bathroom baseboard heater will be repaired.
   b. The room baseboard heater was put back together and placed back where it belongs.

m) THERAPY/REHAB ROOM:
   a. The dirt was cleaned off the floor.

n) NORTHERN SPY HALLWAY:
   a. A quote will be obtained to determine if the flooring will be repaired/replaced for the cracked/broken floor tiles. The repair or replace will be scheduled, as soon as able, after the quote is received and cost analysis is complete.

o) LAUNDRY ROOM:
   a. The wall air conditioning unit will be cleaned of dust/dirt.
   Quotes will be obtained to repair one of the inoperable dryers to make a total of 2 operable dryers available for use.

[illegible signature]
Fac Ops Mgr 12/30/2024

2) A quote will be obtained to determine if the flooring in Resident #21's room (Room #120-1) will be repaired/replaced. The repair or replace will be scheduled, as soon as able, after the quote is received and cost analysis is complete. It was recommended that Resident #21 be moved to another resident room from Room #120-1, and the room will not be used as a resident room until the repair/replace can be completed, as indicated. Resident #21's (responsible party) refused this move.

3) Wash basins will not be stored on the floor under bathroom sinks.

- Other Resident Rooms could be affected by the same alleged deficient practice(s).
- Education will be provided to Housekeeping and Maintenance staff regarding environmental issues. Nursing staff will receive education regarding appropriately connecting resident's Foley bags to reduce leakage of urine onto the floor. Nursing and Housekeeping staff will receive education on the proper storage of wash basins.
- The Maintenance Director, or designee(s), will audit these issues weekly x 4 weeks, and then monthly x 3 months to ensure the plan of correction improves the areas of concern and sustains compliant practice(s). The results of the audits will be reported to the facility's Quality Assurance Committee for 3 months, as indicated.
  Date of Completion: January 17, 2025

F655 – 483.21 (a)(1)-(3) Baseline Care Plan
Findings #1-4

1) Resident #180 D/C'd from the facility on 12/18/24.
2) Resident #80 D/C'd from the facility on 12/23/24.
3) Resident #23 does not have a Baseline Care Plan as the timeframe for such has elapsed; the Comprehensive Care Plan contains a Dementia Diagnosis and goals/interventions for his/her Dementia needs.
4) Resident #27 expired on 10/30/2024.
   - Other residents have the potential to be affected by this alleged deficient practice.
   - Staff Education is being provided regarding developing Baseline Care Plans per regulation and facility policy. The Director of Nursing, and/or designee(s) will audit new admission resident records weekly x 4 weeks and then monthly x 3 months to ensure Baseline Care Plans are being developed as required The results of the audits will be reported to the facility's Quality Assurance Committee for 3 months, as indicated.
     Date of Completion: January 17, 2025

F677 – 483.24 (a)(2) ADL Care Provided for Dependent Residents
Findings #1-2

1) Resident #10 was promptly assisted with brushing his/her teeth when the QIS RN was made aware of the issue.
2) Resident #7's clothes were changed promptly upon staff's notification of his/her clothes having dried food particles on them.
   - Other residents have the potential to be affected by these alleged deficient practice(s). There were no other allegations or findings such as these observed.

JLPonceLow RN MHA
FacOpsMgr 12/30/2024

- Staff Education will be provided regarding assisting residents in the area(s) of grooming (brushing teeth) and changing resident clothing when it is noted to be soiled with dried food particles. The Director of Nursing Services, and/or designee(s) will audit residents to ensure they are receiving assistance or encouragement with brushing their teeth, and resident's clothing is being changed when it contains dried food particles weekly x 4 weeks, and then monthly x 3 months. The results of these audits will be reported to the facility's Quality Assurance Committee for 3 months, as indicated.
  Date of Completion: January 17, 2025

F684 - 483.25 Quality of Care
Findings #1

- Res #5's clinical record did not contain a fall incident report, a post observation tool, or a neurological assessment tool s/p a resident self-reporting a fall. The resident did, however receive application of PRN muscle rub, and was sent to the hospital for hip/pelvis and knee x-rays which returned negative results.
- Other residents have the potential to be affected by this alleged deficient practice. There were no other allegations or findings such as this observed.
- Staff Education will be provided regarding completing the required documentation and monitoring of a Resident after an unwitnessed fall.
- The Director of Nursing Services, and/or designee(s) will conduct audits weekly x 4 weeks, and then monthly x 3 months to ensure clinical records of a resident who sustains an unwitnessed fall contain the required documentation and monitoring post an unwitnessed fall. The results of the audits will be reported to the facility's Quality Assurance Committee for 3 months, as indicated.
- **Date of Completion: January 17, 2025**

F689 - 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices
Finding #1

- Chemicals were removed from this room.
- Other residents have the potential to be affected by this alleged deficient practice. No other findings of this nature were observed.
- Staff Education is being provided regarding properly securing chemicals, which could be accident hazards, in a manner where cognitively impaired residents do not have access to them.
- The Maintenance Director, and/or designee(s), will conduct audits weekly x 4 weeks, and then monthly x 3 months to ensure chemicals are properly secured. The results of the audits will be reported to the facility's Quality Assurance Committee for 3 months, as indicated.
  Date of Completion: January 17, 2025

F695 - 483.25(i) Respiratory/Tracheostomy Care and Suctioning
Findings #1-3

1) The nebulizer apparatus for resident #180 was replaced and appropriately placed in a plastic bag. The liter flow for resident #180's oxygen was increased to 3L/minute to match the current order.
2) The liter flow for resident #14's oxygen was increased to 3L/minute to match the current order.

J Pomerleau RN, MHA
Fac Ops Mgr 12/30/2024

3) The face mask of the CPAP Machine for Resident #80 was placed in a plastic bag promptly when staff were notified it was not appropriately stored.

- Other residents who have oxygen orders, who use nebulizers, and who have CPAP machines have the potential to be affected by the same alleged deficient practice(s).
- Staff education will be provided for staff to verify the correct oxygen liter flow, and to ensure nebulizer apparatus' and CPAP facemasks are being appropriately stored.
- The Director of Nursing, and/or designee(s), will conduct audits weekly x 4 weeks then monthly x 3 months to ensure oxygen liter flow(s) are appropriately set, and nebulizer apparatus'/CPAP masks are being appropriately stored. The results of the audits will be reported to the facility's Quality Assurance Committee for 3 months, as indicated.
Date of Completion: January 17, 2025

F757 – Drug Regimen is Free from Unnecessary Drugs 483.45 (d) (1)-(6)
Finding #1

- Resident #5 received Novolog Insulin outside of the parameters for administration per MD orders.
- Other residents have the potential to be affected by this same alleged deficient practice. No other findings of this nature were observed.
- Staff education will be provided for licensed staff to verify parameters of when to hold insulin based on blood sugar result per MD orders..
- The Director of Nursing, and/or designee(s), will conduct audits weekly x 4 weeks then monthly x 3 months to ensure insulin is being held appropriately based on the parameters the physician order. The results of the audits will be reported to the facility's Quality Assurance Committee for 3 months, as indicated.
Date of Completion: January 17, 2025

F812 – Food Procurement, Store/Prepare/Serve-Sanitary
Findings #1-5

1) The dust and dirt will be cleaned out of the filters in the hood system.
2) The wall air conditioning unit and the wall above it, by the 3 bay sink will be cleaned of dust/dirt. The wall below the air conditioner unit will be cleaned of the dried liquid residue.
3) The ceiling grid hangers will be cleaned/or repainted to remove the rusty and yellowish stained appearance.
4) The floor fan will be cleaned of the dust/dirt.
5) The grease trap lid will be repainted so it has a cleanable surface.

- No residents were affected by these alleged deficient practices.
- Staff education will be provided to Dietary, Housekeeping and Maintenance staff on maintaining the cited areas free of dust/dirt, dried liquid residue and rusty/yellowed appearance.
- The Food Services Director, and/or designee(s), will conduct audits weekly x 4 weeks then monthly x 3 months to ensure the areas cited remain free of dust/dirt, dried liquid residue and rusty/yellowed appearance. The results of the audits will be reported to the facility's Quality Assurance Committee for 3 months, as indicated.
Date of Completion: January 17, 2025

JL Cornelian, Ed MA
Fac Ops Mgr 12/30/2024

F880 - 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control
Finding #1

- The LPN Staff member promptly and appropriately washed his/her hands upon notification of failing to do so in between resident contact.
- No residents were affected by this alleged deficient practice. No other findings of this nature were observed.
- Staff Education is being provided regarding proper handwashing or sanitizing in between resident contact.
- The Director of Nursing Services, and/or designee(s), will conduct audits weekly x 4 weeks, and then monthly x 3 months to ensure proper handwashing and/or sanitizing is being completed in between resident contact. The results of the audits will be reported to the facility's Quality Assurance Committee for 3 months, as indicated.
  Date of Completion: January 17, 2025

F881 – 483.80(a)(3) Antibiotic Stewardship Program
Finding #'s 1-2

- The facility implemented an Antibiotic Stewardship Program (ASP) which includes antibiotic use protocols and a system to monitor antibiotic use.
- Residents have the potential to be affected by this alleged deficient practice.
- The Infection Preventionist received training on 12/23/24 regarding Antibiotic Stewardship. Other staff will receive education regarding the Antibiotic Stewardship Program and what to do when receiving an antibiotic order for a resident. The Consultant Pharmacist will review Antibiotic Use during QA Meetings. The IP nurse will review the monthly pharmacy report.
- The Director of Nursing Services, and/or designee(s), will conduct audits weekly x 4 weeks, and then monthly x 3 months to ensure the Antibiotic Stewardship Program is appropriately monitoring antibiotic use(s). The results of the audits will be reported to the facility's Quality Assurance Committee for 3 months, as indicated.
  Date of Completion: January 17, 2025

F887 – 483.80(d)(3)(i)-(vii) Covid-19 Immunization
Finding #1

- Staff have been provided education regarding the benefits and potential risks associated with Covid-19 vaccine and information about obtaining the Covid-19 vaccine.
- No residents were affected by this alleged deficient practice.
- Staff were educated by being provided with the most current Covid-19 Vaccine Information Sheet.
- The Director of Nursing Services, and/or designee(s), will conduct audits weekly x 4 weeks, and then monthly x 3 months to ensure employees have signed for the Covid-19 VIS form, and have signed a statement indicating their vaccine status. The results of the audits will be reported to the facility's Quality Assurance Committee for 3 months, as indicated.
  Date of Completion: January 17, 2025

JyBoncelan, RN MHA
Fac Ops Mgr 12/30/2024