STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205124	A. BUILDING ______ B. WING ______	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BREAKWATER COMMONS	**100 COMMONS DRIVE ROCKLAND, ME 04841**

(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 1/21/25 through 1/23/2025, on-site visits were conducted at Breakwater Commons for the purpose conducting the annual Long Term Care Survey Process and investigating complaints #ME00049100, #ME00049194, #ME00049577, #ME00049659 and facility reported incident #ME00049102. It was determined that Breakwater Commons was not in substantial compliance with 42 CFR 483, Sub-part B Requirements for Long Term Care Facilities.	F 000	March 4, 2025	
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still	F 578	A house audit of POLST and advance directives was completed on all residents to identify other residents affected by this practice. Several residents did not have advanced directives. The DNS educated nursing staff and implemented the POLST form in the admissions packet. An Advanced Directive Acknowledgement form and packet has been added to the admission packet to be completed upon admission to the facility. The Administrator/DNS educated the management team on the new process of initiating POLST/AD upon admission and reviewing quarterly at IDT meetings. The Community Residential Coordinators will complete weekly audits of their unit charts x60 days to ensure every resident has a completed POLST and AD acknowledgement form or AD. The Administrator/DNS are responsible for compliance. The results will be reviewed at QAPI for 3 months.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: FEB 14, 2025

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F 578	Continued From page 1	F 578		

legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on facility policy review, record reviews, and interviews, the facility failed to ensure that the resident and/or resident representative was provided with written information, concerning the right to accept or refuse medical or surgical treatment and/or formulate an advanced directive, or appoint a surrogate, was completed for 11 of 13 residents reviewed for advanced directives. (Resident #13, #79, #16, #84, #17, #83, #86, #54, #85, #37, #33).

Findings:

Review of facility policy "Advanced Directives" dated 10/18 states " ...The resident has the right and the facility will assist the resident to formulate an advanced directive at their option. Upon admission, the facility will inform and provide the resident and/or resident's representative with information about advance directives. ... Upon admission, identify if the resident has an advance directive and if not, determine if the resident

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F 578	Continued From page 2 wishes to formulate an advanced directive. a resident has the option to execute an advance directive but will not be required to do so. 1.Resident #13 was admitted on 12/19/24. A review of the entire electronic medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. 2. Resident #79 was admitted on 2/20/24. A review of the entire medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. 3. Resident #16 was admitted on 7/26/23. A review of the entire medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. 4. Resident #84 was admitted on 7/10/24. A review of the entire medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive.	F 578		

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F 578	Continued From page 3 5. Resident #17 was admitted on 11/18/24. A review of the entire medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. 6. Resident #83 was admitted on 8/7/24. A review of the entire medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. 7. Resident #86 was admitted on 10/11/24. A review of the entire medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. 8. Resident #54 was admitted on 9/16/24. A review of the entire medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. 9. Resident #85 was admitted on 12/13/24. A review of the entire medical record lacked evidence that the facility offered or reviewed with	F 578		

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F 578	Continued From page 4 the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. 10. Resident #37 was admitted on 3/18/24. A review of the entire electronic medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representative, or that the resident and/or resident representative were provided, written information concerning the right to formulate an advanced directive. 11. Resident #33 was admitted on 12/6/24. A review of the entire electronic medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representative, or that the resident and/or resident representatives were provided, written information concerning the right to formulate an advanced directive. During an interview on 1/22/25 at 9:54 a.m., the Quality Improvement Specialist confirmed that the above residents and/or resident representatives were not offered/reviewed or provided with written information concerning the right to formulate an advanced directive.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-	F 580	All residents have the potential to be affected by the cited deficient practice. No residents were identified as being negatively impacted. The DNS/designee has educated staff on communicating change in condition to POA/emergency contacts.	

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F 580	Continued From page 5 (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various	F 580	Nurse managers will review the 24-hour report daily in clinical huddle to identify any change in condition and follow up with unit nurses to ensure communication has occurred. Nurse managers will review incident reports daily to ensure communication is documented. The DNS is responsible for compliance. This will be reviewed at QAPI for 6 months. March 4, 2025	

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F 580	Continued From page 6	F 580		

locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure that a medical provider and the resident's representative were notified of a significant change in medical condition for 1 of 2 residents reviewed for death (Resident #243).

Finding:

Upon review of Resident #243's clinical record, a hospice "Discharge Summary" dated 10/16/24 stated during a telephone call, the resident's representative "reports anger with the facility that she was not notified of [Resident #243's] change in status from transitioning to active and was not given the opportunity to be present when [Resident #243] died".

Review of all the Nursing notes from 10/2/24 through 10/5/24 included all of the following:
Nursing note on 10/2/24 at 1:37 p.m. stated, "Alert but not swallowing well and pocketing of food noted at lunch. [Doctor] notified. New orders received and noted to downgrade to puree texture diet. Notified [resident representative] of new order."

Nursing note on 10/2/24 at 6:11 p.m. stated, "Had eaten all of (his/her) mashed potatoes for lunch today, however at dinner resident has been holding puree food and fluids in (his/her) mouth and not swallowing. Lots of encouragement required for resident to swallow. Also groaning and yelling out during dinner, PRN morphine

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F 580	Continued From page 7 administered."	F 580		

administered."

Nursing note on 10/2/24 at 8:20 p.m. stated, "HS meds held due to lethargy and not awake enough to swallow medications. Resident had difficulty swallowing at supper this evening and was holding (his/her) food and drinks in (his/her) mouth. Charge nurse notified. Hospice was in this evening and nurse notified her of the above and resident's difficulty swallowing."

Nursing note on 10/5/24 at 10:27 a.m. stated, "Writer was called to assess patient, upon exam death was noted to be at 1007 on 10/05/2024. Exam: upon auscultation there were no heart sounds and breath sounds were noted after 1 minute. Eyes were fixed and dilated without pupillary light reflex, no palpable central pulse was noted, no response to painful stimuli noted. Provider notified ... Family notified by phone and is traveling here to see [Resident #243], staff was notified postmortem care was provided. Hospice was called ..."

On 1/23/25 at 10:09 a.m., during an interview, Registered Nurse #3 (RN#3) stated she was working on a different unit the day Resident #243 passed. She was asked by the Licensed Practical Nurse to come over to pronounce the death. The surveyor asked if Resident #243 had family present. RN#3 stated, "Nobody, I had to call the daughter myself to have her come".

On 1/23/25 at 10:55 a.m. the lack of nursing documentation of the resident decline with medical provider and family representative being notified from 10/2/24 through 10/5/24 was discussed with the Vice President of Quality Improvement and Nursing Services.

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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 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	F 584		

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F 584	Continued From page 9 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable environment on 2 of 3 units (East and South) for 3 of 3 days of survey. Findings: East Unit: 1. On 1/21/25 at 11:28 a.m., observations of room 123's, shared bathroom with 2 basins stored on the floor under the sink. One of the basins had a commode bucket stored in it. Room 124's bathroom had a wash basin on the floor with commode bucket stored inside of it. 2. On 1/22/25 at 8:41 a.m., observations of room 124's bathroom had a commode bucket on the floor with the basin stored inside of it. Room 127's bathroom had a commode bucket stored on the floor. 3. On 1/23/25 from 8:13 a.m. to 8:21 a.m., the Surveyor and the Director of Nursing discussed the above observations and observed both rooms 124 and 127's bathrooms with commode buckets stored on the floor. South Unit: 4. On 1/21/25 at 9:23 a.m., and on 1/22/25 at	F 584	A house environmental audit was completed to ensure no other areas were affected by this practice. No other residents were identified by this practice. The Administrator/designee has educated the maintenance department, housekeeping department, and nursing on environmental rounding policies and procedures. The CRCs will complete walking audits of each unit biweekly for 30 days, and weekly for 60 days. This will be reviewed at QAPI for 6 months. The Administrator is responsible for compliance. March 4, 2025	

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F 584	Continued From page 10 7:31 a.m., observations of room 203's bathroom with an uncovered bed pan stored on shelf in between 2 wash basins. 5. On 1/21/25 at 9:37 a.m., and on 1/22/25 at 7:35 a.m., observations of room 207's bathroom with an uncovered bed pan on shower shelf with 3 briefs stored inside it. On 1/23/25 at 9:20 a.m., during an interview with 4 surveyors, the Director of Nursing confirmed the bed pans were not stored properly.	F 584		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that a Minimum Data Set, Version 3.0 (MDS) Significant Change in Status Assessment was completed within 14 days from the effective date of the Hospice election, for 1 of 2 sampled residents reviewed for hospice (Resident#243).	F 637	A house audit was completed on residents on hospice to ensure MDS dates were accurate for significant changes to ensure no other residents were affected by this practice. No other residents were idenitifed as being affected. DNS/designee has educated the nursing staff on the requirements of a comprehensive assessment after significant change. During daily clinical huddle (participants include unit nurses, unit nurse managers, MDS nurses, DON) any change of condition, change to hospice, skilled needs will be discussed. Administrator communicated with hospice agencies utilized in house requesting an email sent to Admin/DNS for any new residents signed onto hospice or any residents coming off of hospice. The results will be reviewed with the QAPI committee for 6 months. March 4, 2025	

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F 637	Continued From page 11 Finding: The Resident Assessment Instrument (RAI) Version 3.0 Manual, Chapter 2, page 2-23 reads that "a Significant Change in Status Assessment (SCSA) is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The Assessment Reference date (ARD) must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). A SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place." Resident #243's clinical record indicated the resident was receiving hospice services, with the admission date into hospice as 6/19/24. Further review showed a Significant Change in Status Assessment completed on 9/17/24, 76 days later than required. On 1/23/25 at 10:55 a.m. the above was discussed with the Vice President of Quality Improvement and Nursing Services.	F 637		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656		

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F 656	Continued From page 12 §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 care plan, must-	F 656	A house audit of in-house residents' care plans was completed to ensure no other residents are affected by this practice. Plan to review and update all resident care plans over the next 90 days. The DNS/designee has educated the nursing department on the care plan process. The DNS will audit care plans weekly x60 days. The DNS is responsible for compliance. This will be reviewed at QAPI for 6 months. March 4, 2025	

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	205124	A. BUILDING ______ B. WING ______	01/23/2025

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F 656	Continued From page 13	F 656		

(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview, the facility failed to ensure that a care plan was developed in the area of cardiac pacemaker (Resident #86, #83), hospice services (#243), respiratory needs (#54, #16) and psychoactive medications (#71) for 6 of 26 sampled residents reviewed for comprehensive care plans.

Findings:

1. On 1/21/25 at 9:56 a.m., during an interview, Resident #86 stated he/she had a pacemaker placed about 1 year ago and is followed by cardiology. Review of Resident #86's medical record states he/she was admitted on 10/11/24 with a diagnosis of sick sinus syndrome, chronic atrial fibrillation and nonrheumatic aortic insufficiency with the presence of cardiac pacemaker. The medical record lacked evidence that a comprehensive care plan had been developed in the area of a cardiac pacemaker.
On 1/22/25 at 11:32 a.m., during an interview, the Vice President of Quality Improvement and Nursing Services the care plan lacks pacemaker.

2. Resident #83 was admitted on 8/7/24 with diagnosis of Atrial fibrillation with the presence of cardiac pacemaker. The medical record lacked evidence that a comprehensive care plan had been developed in the area of a cardiac pacemaker.
On 1/22/25 at 2:29 p.m., during an interview, the above was confirmed with the Vice President of Quality Improvement and Nursing Services and the Quality Improvement Specialists.

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F 656	Continued From page 14 3. Resident #243 was admitted to Hospice services on 6/19/24 for primary diagnosis of senile degeneration of brain and passed away on 10/5/24. The medical record lacked evidence that a comprehensive care plan had been developed in the area of hospice/end of life care. On 1/23/25 at 10:00 a.m., the above was discussed with the Director of Nursing and the Vice President of Quality Improvement and Nursing Services. 4. Resident #54 was admitted to the facility on 9/16/24. Review of the residents physican orders indicates that he/she has been recieving oxygen since 11/20/24 with the diagnosis of Hypoxia. Further review of the his/her medical record lacks evidence of a care plan for oxygen usage. On 1/22/25 at 1:50 p.m., the above information was confirmed with the Quality Improvement Specialist. 5. Resident #16's physician orders indicates that he/she has been recieving oxygen since 11/11/24 with the diagnosis of an Upper Respiratory Infection. Resident #16's medical record lacks evidence of a care plan for oxygen usage. On 1/23/25 at 9:30 a..m., the above information was confirmed with the Director of Nursing. 6. Resident #71's Minimum Data Set (MDS) 3.0 Admission Assessment dated 8/14/23, under Care Area Assessment Summary, noted Resident #71 would be care planned for Psychotropic Drug use. As of 1/23/25, Resident #71's medical record	F 656		

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F 656	Continued From page 15 lacked evidence of a comprehensive care plan in the area of psychotropic drug use. On 1/23/25 at 1:45 p.m., in an interview, the Vice President of Quality Improvement and Nursing Services confirmed the above finding.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657	A house audit of in-house residents' last care plan meetings was completed to ensure no other residents are affected by this practice. The Administrator/designee has educated the social services department and the IDT team on the care plan meeting process. MDS nurse will do a weekly audit x60 days to ensure care plan timing aligns appropriately with the MDS. The Administrator/DNS are responsible for compliance and will review results with the QAPI committee for 6 months. March 4, 2025	

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F 657	Continued From page 16	F 657		

Based on interviews, record reviews, and facility policy, the facility failed to review and revise the care plan by an interdisciplinary team (IDT) meeting, which included the participation of the resident and resident's representative, after each Minimum Data Set (MDS) 3.0 assessments, for 10 of 26 residents whose care plans were reviewed (#73, #79, #90, #28, #51, #54, #67, #71, #37, #40).

Findings:

Review of policy "Comprehensive Person Centered Care Planning." Dated 119 states" The comprehensive person-centered care plan must be consistent with resident rights, developed with the resident/representative input; Include resident goals and desired discharge plans; The facility must develop and implement a comprehensive person centered care plan for each resident, which includes measurable objectives and time frames to meet a residence medical, nursing, and mental/ psychosocial needs identified in the comprehensive assessment/evaluation. A comprehensive care plan must be: Developed within seven days after completion of the comprehensive assessment ..."

1. Resident #73 was admitted on 10/10/23 and has diagnoses to include Parkinson's Disease. Review of Resident #73's clinical record revealed he/she had a Brief Interview for Mental Status of 15 of 15 indicating he/she is cognitively intact.

Further review of Resident #73's clinical record revealed that an Interdisciplinary Team Meeting (IDT) was held on 1/20/2025. The clinical record lacked evidence that Resident #73 was invited to attend the IDT meeting.

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F 657	Continued From page 17	F 657		

During an interview on 1/23/25 Resident #73 stated he/she was not invited to the IDT meeting but would have gone if invited.

2. Review of Resident #79 clinical record revealed quarterly MDS dated 11/28/24. Further review of Resident #79's clinical record lacked evidence that an IDT meeting was held within 7 days of this assessment.

During an interview on 1/23/25 at 1:35 p.m., Vice President of Quality Improvement and Nursing Services confirmed she reviewed clinical record and there was no evidence that and IDT meeting was held after MDS 11/28/24.

During an interview on 1/23/25 at 12:00 p.m. Social Worker Trainee stated IDT meetings should be held withing 1 week of comprehensive assessments and residents and their representatives are supposed to be invited, and all invitations should be documented in the clinical record. At this time confirmed IDT meetings were not held on time, and residents have not been invited to attend.

3. On 1/21/25 at 9:07 a.m., during an interview, Resident #90 stated he/she was not sure if he/she had an IDT meeting.

Resident #90 was admitted on 12/23/24 and had an Admission MDS completed on 1/1/25. The medical record lacks evidence that an IDT meeting, which included the participation of the resident and resident's representative, was held within 7 days of this assessment.

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F 657	Continued From page 18 On 1/21/25 at 2:29 p.m., during an interview, the Vice President of Quality Improvement and Nursing Services stated social services believes they had one on either the 7th or the 14th but they failed to have anyone sign for attendance or document their meeting. 4. Review of Resident #28 medical record indicates that he/she was admitted to the facility on 6/18/24. The quarterly MDS dated 12/9/24 with an IDT meeting taking place on 12/30/24, indicated the IDT meeting was not completed within 7 days of the MDS. On 1/23/25 at 12:00 p.m., the above information was confirmed with the Social Worker. 5. Review of Resident #51's medical record shows he/she was admitted to the facility on 1/2/25 with the diagnosis of Post Operative Left Femur Fracture. On 1/13/25 an Admission MDS revealed Resident had a BIMS of 13 of 15, indicating he/she is cognitively intact. During an interview on 1/21/25 at 9:16 a.m., the resident states he/she did not think his/her care plan meeting occurred. Further review of the resident's medical record showed a care plan meeting took place on 1/14/25 however, lacked evidence that the resident was invited and/or attended the care plan meetng. 6. Review of Resident #54's medical record indicates that he/she was admitted to the facility on 9/16/24 with the diagnosis of Chronic Respiratory Failure. On 1/7/25 Resident #54 had a BIMS of 15 of 15, indicating he/she is cognitively intact. Further review shows the resident had a MDS completed on 1/3/25 and an IDT meeting held on 1/24/25, indicating the IDT	F 657		

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F 657	Continued From page 19	F 657		

meeting was not completed within 7 days of the MDS.

On 1/23/25 at 12:00 p.m., the above information was confirmed with the Social Worker.

7. Review of Resident #67's medical record shows he/she was admitted to the facility on 7/19/23 with the diagnosis of Dementia. On 1/7/25 Resident #67 had a BIMS of 13 of 15, indicating he/she is cognitively intact. During an interview on 1/21/25 at 1:00 p.m., the resident stated he/she is unsure if he/she was invited to the care plan meetings. Further review of the residents medical record shows that a care plan meeting took place on 1/7/25 however, lacked evidence that the resident was invited and/or attended the care plan meetng

On 1/23/25 at 8:37 a.m., during an interview with 3 surveyors present, the Administrator stated, he was not sure if residents were being invited to their meetings but he created a form to make sure residents are being invited.

8. Resident #71's medical record, surveyor noted two MDS Significant change assessments, dated 2/15/24 and 5/1/24 and two MDS Quarterly assessments dated 7/1/24 and 9/4/24. The clinical record lacked evidence that a care plan meeting was held by the IDT for the 2/15/24, 5/1/24, 7/1/24 and 9/4/24 assessments.

On 1/23/25 at 1:41 p.m., the above finding was confirmed with the Vice President of Quality Improvement and Nursing Services
9. Review of Resident #37's clinical record revealed a Minimimum Data Set (MDS) Significant Change Assessment was completed

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F 657	Continued From page 20 on 7/26/24. Further review of the clinical record lacked evidence that an interdisciplinary team (IDT) meeting was held following the assessment. During an interview on 1/23/25 at 3:27 p.m., the Vice President of Clinical Services and Quality Assurance confirmed that she reviewed Resident #37's clinical record and that there was no evidence an IDT meeting was held after the 7/26/24 MDS assessment. 10. Review of Resident #40's clinical record revealed a Comprehensive MDS Assessment was completed on 8/23/24 and an MDS Quarterly Assessment was completed on 12/5/24. Further review of the clinical record lacked evidence that an IDT meeting was held within 7 days of the assessments. During an interview on 1/23/25 at 3:27 p.m., the Vice President of Clinical Services and Quality Assurance confirmed that she reviewed Resident #40's clinical record and that there was no evidence an IDT meeting was held after the 8/23/24 or 12/5/24 MDS assessments.	F 657		
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.	F 684	All residents have the potential to be affected by this practice. No residents were identified to be affected. The DNS/designee has educated nursing staff on physical orders for self-administration of medications, insulin administration policy and procedures, and side rail assessment and orders. Side rail orders have been added to the admissions order set to be populated after the side rail assessment is completed.	

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F 684	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews, facility policy, and manufacturer directions, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice in the area of nutrition for 1 of 2 residents reviewed (Resident #60) and in the area of falls for 2 of 3 residents reviewed (Residents #79, #37). Additionally, the facility failed to obtain physician orders for medications located at a resident's bedside, for 2 of 2 sampled residents (Residents #40, #70). Findings: 1. Review of manufacturer directions dated November 2024 states "NovoLog® is a rapid-acting insulin that helps lower mealtime blood sugar spikes in adults ... with diabetes ...NovoLog® starts acting fast. Eat a meal within 5 to 10 minutes after taking it ..." Resident #60 was admitted on 10/13/23 and has diagnosis to Diabetes Mellitus II. Review of Resident #60 active orders dated January 2025 reveled order with state date of 11/30/24 for" Novolog U-100 Insulin; Aspart 100 unit/mL subcutaneous solution Before Meals for Type II diabetes mellitus; Sliding Scale Insulin: Insulin Units <70 or > 400 Notify MD; MD; 151-200, 2Units; 201-250, 4Units; 251-300, 6Units; 301-350, 8Units; 351-400, 10Units; 401-450, 12 units." During a medication observation pass on 1/22/25 at 7:20 a.m., a surveyor observed Registered Nure #1 (RN#1) administering 4 units of Novolog	F 684	Nursing unit managers will complete random room audits for beside medications biweekly x 60 days. The DNS is responsible for compliance. This will be reviewed at QAPI for 6 months. March 4, 2025	

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F 684	Continued From page 22 to Resident #30 for blood sugar of 206, per provider order. Observation of breakfast meal on 1/22/25 revealed Resident #60 did not receive his/her breakfast tray until 8:45 a.m., which is 1 hour and 25 minutes after receiving Novolog. During an interview on 1/22/25 at 9:15 a.m., RN #1stated he administered sliding scale insulin to Resident #30 earlier this morning but could not specifically remember what time it was as he did not write it down. RN#1 further stated he did not know how to look back in the Electronic Medical Record to see what it was, but was aware that Resident #30 had not received his/her breakfast until 8:45 a.m. During an interview with 4 surveyors on 1/22/25 at 10:08 a.m., Quality Improvement Specialists stated that Residents that received short acting insulin before a meal should eat as soon as possible after insulin was administered. At this time a surveyor discussed the above findings. 2. Review of provided "Side Rails/Grab Bars Policy" dated 11/18 states" ...Whenever side rails or grab bars are considered ...A physician's order will be obtained to include the reason for use. ...The nurse will provide and review "A Guide to Bed Rail Safety for Patients" with resident/resident representative; Informed consent for Use of Side Rails/Grab Bars will be obtained. Side rail and grab bar use will be screened quarterly and with any significant change in the resident's condition or behavior." Resident #79 was admitted on 2/20/24 and had diagnoses to include hemiplegia, dementia, and history of falls.	F 684		

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F 684	Continued From page 23 Observations of Resident #79 on 1/22/25 at 7:15 a.m., he/she was observed lying in bed with bilateral side rails in use. Review of Resident #79's care plan updated 9/20/24 states "enablers to promote independent bed mobility. Falls: I am at risk for falls r/t impaired mobility, poor safety awareness, impulse control, secondary to a stroke and dementia Fall without injury 8/12/24 ..." Review of Resident #79's clinical record revealed a "Fall Risk Assessment" completed 11/24/24, and "Side Rail Screen" dated 11/24/24. Further review of Resident #79's clinical record lacked evidence that side rail assessments/screens were conducted prior to 11/24/24. Review of Resident #79's clinical record lacked evidence that a provider order was obtained for bed rail use, that the resident/representative was presented with copy of "A Guide to Bed Rail Safety for Patients," a signed consent for bed rail use was obtained and quarterly side rail screenings were completed. During an interview on 1/23/25 at 12:31 p.m. the Director of Nursing reviewed Resident #79's entire clinical record and confirmed the above findings. 3. Resident #37 was admitted on 3/18/24 and has diagnoses to include dementia and repeated falls. On 1/21/25 at 10:51 a.m. and 1/22/25 at 11:04 a.m., Resident #37 was observed lying in bed, with bilateral side rails in use.	F 684		

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F 684	Continued From page 24 Review of Resident #37's care plan, updated 11/4/24, revealed, "ADL [Activities of Daily Living] ...Side rails as enablers to promote independent bed mobility ..." and "Falls: I am at risk for falls r/t [related to] impaired mobility ..." Review of Resident #37's clinical record revealed a Fall Risk Screen was completed on 10/21/24 and 1/20/25, and a Side Rail Screen was completed on 10/21/24. Further review of Resident #37's clinical record lacked evidence of a physician's order for side rail use and lacked evidence that informed consent for use of side rails was obtained. During an interview on 1/23/25 at 3:27 p.m., the Vice President of Clinical Services and Quality Assurance reviewed Resident #37's entire clinical record and confirmed the above finding. 4. Review of Facility Policy "Self-Administration of Medications Policy," revealed, "Procedure: A. If the resident has an order to keep a medication at bedside, the facility must complete a Self-Administration of medications screen. B. If outcome ...indicates resident is able to self-administer his/her medications, obtain a physician order to self-administer ... F. If the resident has an order to keep medications at bedside, the medication must be secured in a locked box, to maintain the safety of other residents ..." During observations of room 220 on 01/21/25 at 10:41 a.m. and 1/22/25 at 8:58 a.m., a 0.38 ounce (72 sprays) Flonase 50mcg/spray nasal	F 684		

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F 684	Continued From page 25	F 684		

spray medication device and a 30-pad box of Ocu Soft Lid Scrub eyelid pads were observed on Resident #40's bedside table.

Review of Resident #40's clinical record lacked evidence of a physician order for the Flonase and Ocu Soft Lid Scrub and lacked evidence of a physician order to self-administer. Further review of the clinical record lacked evidence of a Self-Administration screen.

During an interview on 1/22/25, between 9:14 a.m. and 9:22 a.m., Registered Nurse (RN) #2 stated that if a resident or resident's family brings a medication in from home, there should be a physician order for the medication and an order that the resident may keep the medication at bedside. At this time, RN #2 reviewed Resident #40's clinical record and confirmed that there was no order for the Flonase, the Ocu Soft Lid Scrub, or for resident to keep medications at bedside.

During an interview on 1/22/25 at 9:27 a.m., the South Unit Manager stated it was her expectation that if a resident had medication at the bedside, there would be a physician order for the medication(s) and the order must state it is ok for the medication to be at bedside and for the resident to self-administer. At this time, the above finding was reviewed with the South Unit Manager.

On 1/22/25 at 11:10 a.m., the above finding was reviewed with the Quality Improvement Specialist. On 1/22/25 at 8:30 a.m. and on 1/23/25 at 9:15 a.m., observation of an Albuterol Sulfate HFA 90 mcg aerosol inhaler on the resident's bedside table.

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F 684	Continued From page 26 On 1/22/25 at 8:30 a.m., during an interview, Resident #70 states that he/she uses the inhaler often as needed. In an additional interview on 1/23/25 at 9:15 a.m., Resident #70 states that he/she and their power of attorney requested to keep the inhaler at bedside. During this interview resident proceeded to take 2 puffs of the inhaler for shortness of breath. Review of Resident #70 medical record shows the medication being Albuterol Sulfate HFA 90 mcg aerosol inhaler with instructions to use every 6 hours as needed. Further review of the resident's medical record lacks evidence of an order to keep the medication at bedside. Review of the Medication Administration Record lacks evidence that the resident has received/administered the medication for the month of January. On 1/22/25 at 9:25 a.m., during an interview with the Vice President of Clinical Services and Quality Improvement the above information was confirmed.	F 684		
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	F 695	All residents have the potential to be affected by this practice. DNS/designee educated nursing staff on the policy regarding oxygen and nebulizer cleaning, storage, and labeling. CRC's will audit each unit biweekly x60 days to ensure proper labeling and storage. The DNS is responsible for compliance. Audits will be reviewed at QAPI for 6 months. March 4, 2025	

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F 695	Continued From page 27 by: Based on observations and interviews, the facility failed to maintain a sanitary environment to help prevent the development and transmission of disease and infection related to oxygen and nebulizer use for 5 of 6 residents reviewed for respiratory care. (Resident #54, #70, #17, #13 and #42) Findings: Review of provided "Oxygen Use & Storage Policy" dated 10/24 states: ...when nebulizer parts are not in use; after being air dried, the mask and/or hand held devices should be stored in a plastic bag to the risk of it being contaminated. 1. On 1/21/25 at 8:40 a.m. and on 1/22/25 at 8:50 a.m., observation of Resident #54's oxygen nasal cannula tubing on the floor by his/her bed labeled with the date of 1/6/25. Review of Resident #54 medical record reveals a physician order to change oxygen weekly. Review of the Treatment Administration Record (TAR) stated the tubing was changed on 1/12/25 and on 1/19/25. 2. On 1/21/25 at 9:01 a.m. and on 1/22/25 at 8:30 a.m., observation of Resident #70's unlabeled nebulizer pipe and tubing stored on the nebulizer machine. 3. On 1/21/25 at 9:15 a.m., 1/22/25 at 8:41 a.m., and on 1/23/25 at 8:21 a.m., observations of Resident #17's oxygen nasal cannula tubing dated 1/13 and an undated nebulizer pipe stored on the back of the nebulizer machine and the	F 695		

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F 695	Continued From page 28 bedside dresser. Review of resident #17's medical record had providers orders dated 1/9/25 to "Change Tubing 1 Time Weekly", "Clean/Store oxygen tubing not in use 1 Time Weekly" and provider orders dated 1/4/25 for "ipratropium 0.5 mg (milligram)-albuterol 3 mg (2.5 mg base)/3 mL (milliliter) nebulization solution ...Inhalation Three Times Daily." The most recent care plan for "Impaired Respiratory secondary to Acute on Chronic Respiratory Failure, RLL (right lower lobe) Pneumonia, COPD AEB (chronic obstructive pulmonary disease acute exacerbation) need for hospitalization, respiratory medications/treatments and supplemental Oxygen" with interventions of "Change oxygen tubing weekly; label and date". Review of the January treatment administration records states the oxygen tubing was changed on the 12th and the 19th and lacked evidence of the nebulizer tubing being changed. On 1/23/25 from 8:13 a.m. to 8:21 a.m., both the surveyor and the Director of Nursing conducted a tour of the East unit and observed the above nebulizer tubing and pipe storage, the oxygen tubing dates and discussed the inaccurate documentation in the residents TAR relating to changing the tubing. 4. Observations of Room 203 on 1/21/25 at 9:18 a.m., 1/22/25 at 7:27 a.m., and 1/23/25 at 1:17 p.m., revealed nebulizer located on top of Resident #13's side table with tubing attached with/to facemask/reservoir which is resting/stored	F 695		

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F 695	Continued From page 29	F 695		

on top of the side table without a barrier between the nebulizer mask and the machine allowing potential cross contamination.

During an interview with 4 surveyors on 1/23/25 at 9:20 a.m., the Director of Nursing confirmed Resident #13's nebulizer tubing was not stored appropriately when not in use.

5. Resident #42 was admitted on 12/29/23 and has diagnoses to include obstructive sleep apnea.

During an observation of room 221 on 1/21/25 at 10:44 a.m., Resident #42's unbagged nasal cannula and oxygen tubing, dated "1/17," was lying on the floor by Resident #42's bed and was connected to an oxygen concentrator, located next to the bed, with an empty black antimicrobial bag, dated 1/8/24, stored on top of the concentrator.

During a follow-up observation of room 221 on 1/22/25 at 9:00 a.m., the oxygen tubing was observed in the black antimicrobial bag, dated 1/8/24, located on top of the oxygen concentrator.

Review of Resident #42's care plan revealed, "Respiratory ...I use O2 [oxygen] at 2L [liters] HS [hour of sleep] r/t [related to] SOB [shortness of breath] ...Change oxygen tubing and antimicrobial bag weekly; label and date ..."

Review of Resident #42's active January Treatment Administration Record (TAR) revealed an order, with a start date of 10/9/24, to "Change O2 tubing and antimicrobial bag Q [every] Sunday night and date both..." Review of the TAR

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F 695	Continued From page 30 indicated the tubing and antimicrobial bag were changed on Wednesday, 1/15/24. During an interview on 1/23/25 at 8:53 a.m., in the presence of 5 surveyors, the above finding was reviewed with the Director of Nursing.	F 695		
F 730 SS=D	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 the review of annual evaluations and interviews, the facility failed to complete a annual performance evaluation for Certified Nursing Assistants (CNA) at least every 12 months, for 1 of 5 CNA's reviewed with employment greater than 1 year. (CNA#4) Finding: CNA #4 was hired on 2/8/21. The employee lacked evidance of a annual preformance evaluaion being completed for 2024. On 1/23/25 at 11:32 a.m.., during an interview, the Vice President of Clinical Services and Qaulity Improvement confirmed CNA #4 did not have a preformace evaluation on file for the year of 2024.	F 730	A house audit of employee performance reviews was completed to identify any overdue performance reviews. The Administrator educated the management team on performance review timing and process. Outstanding performance reviews will be completed for those employees. The DNS educated nursing management on the requirement for annual 12 hours of in-services for CNA's. The DNS and nursing management team will create and implement a performance review and in-service schedule for staff. Nursing unit managers will audit staff attendance and completion of in-services monthly on an ongoing basis. The business office manager will review personnel files for the required education upon completion of the CNA's annual performance review. The Administrator and DNS are responsible for compliance. This will be reviewed at QAPI for 6 months. March 4, 2025	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		

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F 761	Continued From page 31 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure expired medications were removed from the supply available for use and failed to ensure that medications were stored properly as per manufacturers' recommendations for 3 of 5 medication/treatment carts reviewed for medication storage. Findings: 1. On 1/22/25 at 7:30 a.m., observation of the	F 761	A house audit of medication storage rooms and carts was completed on each unit to ensure no other medications were expired. DNS/designee provided education to nursing staff on medication storage policies and procedures. Unit managers will audit carts and storage areas biweekly x60 days. The DNS is responsible for compliance. This will be reviewed at QAPI for 6 months. March 4, 2025	

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F 761	Continued From page 32 South unit nurse treatment cart #2 with the Registered Nurse #2 (RN#2), the cart contained an opened and undated vail of Tuberculin Purified Protein Derivative with manufactures instructions of "Store between 36 degrees - 46 degrees F" and "Once entered vial should be discarded after 30 days". At this time, RN#2 confirmed the Tuberculin vial was not labeled or stored correctly and immediately wasted the vial. 2. On 1/22/25 at 7:36 a.m., observation of the South unit medication cart with the Certified Medication Technician #1 (CNA-M #1), the cart contained an opened bottle of Acidophilus w/Pectin with the manufactures instructions to "refrigerate after opening", one opened bottle of Famotidine 10mg (milligram) with an expiration date of 12/24 and one opened bottle of Loratadine 10mg with an expiration date of 11/24. At this time, the CNA-M#1 removed the expired bottle and acidophilus. On 1/22/25 at 7:40 a.m., the above was discussed with the Vice President of Quality Improvement and Nursing Services. 3. On 1/22/25 at 9:57 a.m., observation of the West unit medication cart with the CNA-M #2, the cart contained an opened bottle of Acidophilus probiotic with the manufacturer's instructions of "refrigerate after opening". At this time, the CNA-M#2 removed the acidophilus. On 1/22/25 at approx. 10:15 a.m., the above was discussed with the Vice President of Quality Improvement and Nursing Services.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		

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F 812	Continued From page 33 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and policy review the facility failed to ensure foods were dated and labeled in, stand up freezer, dry storage room and the walk in freezer. In addition, the facility failed to discard obvious freezer burned food on 1 of 3 survey days. Additionally, the facility failed to ensure a sanitary environment during 1of 2 dining observations of meal service on 1 of 3 units. Findings: Review of policy "Food Storage" undated states " ... All containers must be legible and accurately labeled and dated ...Leftover food will be stored in covered containers or wrapped carefully and securely. Each item will be clearly labeled and	F 812	The facility immediately discarded all food that was not: sealed, dated, labeled and did not have a used by date. All residents have the potential to be affected by this practice. The FSD/designee has educated dietary staff on food storage policies and procedures and handwashing. The IP nurse/designee will complete bi-weekly audits x 60 days on food storage (food dated, labeled, used by date, covered/ sealed within food safety temperatures/ policy, food storage). The IP nurse will complete bi-weekly audits during meal service of employee handwashing. The FSD and Administrator is responsible for compliance. The results of these audits will be reviewed with the QAPI committee for 6 months. March 4, 2025	

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F 812	Continued From page 34 dated before being refrigerated. Leftover food is used within 7 days (4 days or 96 hours per Maine regs) or discarded. During an initial kitchen tour with 2 surveyors and the Dietary Manger on 1/21/25 between 8:22 a.m. and 8:45 a.m., the following was observed: -Dry storage area: A rolled up unlabeled clear bag containing unknown brown crumbly substance with open date of "11/12" available for use. -Stand up freezer: Small undated blue squeezable bag of chocolate icing opened with frosting coming out of it and 3 gallon size bags of bananas with obvious freezer burn. -Walk in refrigerator: Undated and unlabeled, unknown brown substance rolled up with plastic wrap, the Dietary Manger stated it was crumbled bacon, 1 large metal tray with multiple small metal containers containing green and red peppers, one containing pork chops, one containing a sandwich, 1 containing unidentifiable small round brown balls, and 2 small containers of unidentifiable substances, all undated and unlabeled. During an interview with 2 surveyors on 1/21/25 at 8:45 a.m., the Dietary Manger confirmed above findings. 2. Facility policy, "Director of Food and Nutrition Services Responsibilities," states, "Procedure ...6 ...Staff will follow proper sanitation and food handling practices..." and facility policy, "Hazard Analysis Critical Control Points and Food Safety," states, "Procedure: 1. Staff will be aware of the following sources of food borne organisms in food service: a. Humans (nose and throat, hands	F 812		

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F 812	Continued From page 35 ...clothing) ...poor hand washing practices ..." During an observation of the lunch dining service for the South Kitchen on 1/22/25 between 12:06 p.m., and 12:25 p.m., Dietary Aide #1 walked up to refrigerator and placed his left hand on the freezer door handle and then opened the refrigerator door with right hand. Dietary Aide #1 then removed a container of chocolate milk from the refrigerator and using his right hand, poured chocolate milk into a cup, drank the chocolate milk, proceeded to put the cup into the trash can and then donned (put on) gloves. Dietary Aide #1 then removed the serving spoons from the container on the top of the food truck, removed the plastic wrap from the metal food trays in the food service area, and placed a serving spoon in each tray. Dietary Aide #1 then rested his right hand on the counter and placed his gloved left hand on his left hip and then doffed (took off) the gloves and proceeded to don a new pair of gloves. Dietary Aide then spooned pasta onto a plate and with his gloved right hand, picked up a piece of garlic bread from a metal tray on the counter and placed it on a meal plate. At this time, a surveyor intervened, and Dietary Aide #1 stated he has worked here since November and has not received education on hand hygiene. At this time, Dietary Aide #1 doffed gloves, sanitized his hands and donned new gloves before continuing to plate food. Review of Dietary Aide #1's Orientation Acknowledgement Checklist, dated 12/2/24, included receipt of facility policy, "Infection Control/Exposure Control Plan" but lacked evidence that Dietary Aide #1 received education on hand hygiene or safe food handling practices.	F 812		

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F 812	Continued From page 36 On 1/22/25 at 12:38 p.m., the above finding was reviewed with the Quality Improvement Specialist. On 1/22/25 at 12:53 p.m., the finding was reviewed with the Dietary Manager, who stated new-hire training was conducted but that Dietary Aide #1 has not received formal hand hygiene or safe food handling training.	F 812		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary.	F 868	The facility held a quarterly QAPI meeting on January 28, 2025. Attendance was documented. All required members of the QAPI committee were present including the Infection Preventionist. The facility's QAPI plan was reviewed at this meeting as well as surveyor findings from the annual survey (the Statement of Deficiencies was not yet available). The Administrator is responsible for the meeting of the formal QAPI Committee on a quarterly basis. March 4, 2025	

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F 868	Continued From page 37 §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on an interview and review of the facility's Quality Assurance and Performance Improvement (QAPI) Plan, meeting attendance sheet and Power Points provided, the facility failed to present evidence that the required members attended 3 of 4 quarters provided. Finding: The facilities QAPI Plan under "Governance and leadership" states, "The Administrator is responsible for the successful implementation of the QAPI Program through enforcement of scheduling and education to participants." On 1/22/25 at 11:37 a.m., during an interview with 3 surveyors present, the Administrator was only able to provide an attendance sheet for the 12/19/23 QAPI meeting stating, the previous Director of Nursing put the power point presentations together, and he thought she was taking attendance. He then stated the Medical Director at the time was not at the 3rd quarter QAPI. Review of the QAPI power points from Quarter 1 (4/23/24), Quarter 2 (7/23/24) and Quarter 3 (11/26/24) lacked evidence of the required member's attendance. In addition, the QAPI failed	F 868		

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F 868	Continued From page 38 to include the infection preventionists for 4 of 4 quarterly QAPI meetings reviewed.	F 868		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an 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;	F 880	RN #1 was removed from the floor and contract was terminated. All residents have the potential to be affected by this practice. The DNS/designee educated staff on handwashing and safe medication administration. The IP nurse will complete random audits 2x weekly for 60 days on nursing staff during medication administration. The DNS is responsible for compliance. Results of these audits will be reviewed at QAPI for 6 months. March 4, 2025	

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F 880	Continued From page 39	F 880		

(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 observation, interview and record review, the facility failed to maintain an Infection Control Program designed to help prevent the development of infections related to Subcutaneous injected medication for 1 of 1 resident observed for subcutaneous medication administration (Resident #60).

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F 880	Continued From page 40 Finding: The facilities "Injectable Medication Administration" policy revised 1/2018, states under "Purpose: To administer medications via subcutaneous ...routes in a safe, accurate and effective manner" and "Equipment Required ...Examination gloves" The facilities "Medication Administration - General Guidelines" policy revised 1/2018, states under "Administration ... Hands are washed before putting on examination gloves and upon removal for administration of ... injectable .... medications." On 1/22/25 at 7:20 a.m. during observation of Resident #60's medication administration with a Register Nurse #1(RN#1). The RN#1 prepared the Novolog Insulin for a subcutaneous injection and entered the resident's room, without performing hand hygiene and donning gloves, he immediately cleansed the residents right lower abdomen with the alcohol prep and administered the NovoLog insulin subcutaneously. At this time, the RN#1 confirmed he should have performed hand hygiene and donned gloves prior to the medication administration. On 1/22/25 at 7:40 a.m., the above was discussed with the Vice President of Quality Improvement and Nursing Services.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations	F 883	A house audit was completed on all residents to ensure no other residents were affected by this practice.	

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F 883	Continued From page 41 §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative	F 883	DNS provided education to the IP nurse and nurse managers on vaccination policies and procedures. Immunization consent was added to the admission packet and education provided to unit nurses. IP nurse will obtain consent and order vaccinations past due for residents to have all residents up to date within 60 days. IP nurse will audit charts weekly for 60 days for new admissions to ensure consents and orders are entered for Influenza and Pneumococcal immunizations. The DNS is responsible for compliance. This will be reviewed at QAPI for 6 months. March 4, 2025	

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F 883	Continued From page 42 has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on immunization record review, review of the facility's immunization policy and interview, the facility failed to implement their Influenza, Pneumococcal, COVID policy for 1 of 5 residents whose immunization records were reviewed (#16) Finding: The facility's "Immunization Policy" indicated in Procedure I: Before offering the Influenza or Pneumococcal vaccine or COVID vaccine, each resident, and/or resident's legal representative will receive the appropriate Vaccine Information Statement (VIS) produced by the Maine and/or Federal Centers for Disease Control regarding the benefits and potential side effects of the vaccines for the current year. The resident's clinical record will include the following documentation: Signature of the person receiving the educational material, designating receipt and understanding of the material. Verbal consent may also be obtained if communication is done via a telephone conversation. Proof the resident either received the Influenza, COVID and/or the Pneumococcal vaccine, the vaccine(s) was	F 883		

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F 883	Continued From page 43 contraindicated for medical reasons, or the resident refused the vaccine(s). ImmPact website can be utilized to see if these vaccines have been administered. Each resident will be offered an Influenza Vaccine October 1 through March 31 annually, unless the immunization is medically contraindicated, or the resident has already been immunized during this time period. Each resident will be offered a COVID Vaccine, upon admission unless the immunization is medically contraindicated, or the resident has already been immunized. VIS will also be provided to educate on risk vs benefit. Each resident will be offered a Pneumococcal Vaccine, upon admission unless the immunization is medically contraindicated, or the resident has already been immunized. Vaccines will be given in accordance with the Maine Center for Disease Control. For Immunocompromised adults aged 65 years or older. A single dose of PCV 20 may be administered or administered 1 dose of PCV 15, if not previously administered, followed by 1 dose of 23 valent pneumococcal polysaccharide vaccine (PPSV23) at a minimum interval of 8 weeks between both doses. The vaccine administration will be documented on the vaccine record in the medication administration record. Resident #16's clinical record indicated that the resident was admitted to the facility on 7/26/23. Resident #16's immunization records lacked evidence that the resident's PCV 20 and Influenza immunization was current or offered and administered as directed by the facility's "Immunization - Influenza, Pneumococcal, COVID Policy. On 1/23/25 at 10:27 a.m., a surveyor confirmed the above findings in an interview with the Quality	F 883		

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F 883	Continued From page 44 Improvement Specialist.	F 883		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education 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	F 887	DNS provided education to the IP nurse and nurse managers on vaccination policies and procedures. Immunization consent was added to the admission packet and education provided to unit nurses. IP nurse will update staff quarterly on COVID-19 vaccination recommendations. IP nurse will obtain consent and order vaccinations past due for residents to have all residents up to date within 60 days. IP nurse will audit charts weekly x30 days for new admissions to ensure consents and orders are entered for COVID-19. The DNS is responsible for compliance. Results of audits will be reviewed with the QAPI committee for 6 months. March 4, 2025	

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F 887	Continued From page 45	F 887		

was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and
(B) Each dose of COVID-19 vaccine administered to the resident; or
(C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and
(vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following:
(A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine;
(B) Staff were offered the COVID-19 vaccine or 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 immunization record review, review of the facility's immunization policy and interview, the facility failed to implement their Influenza, Pneumococcal, COVID policy for 1 of 5 residents whose immunization records were reviewed (#16)

Finding:

The facility's "Immunization Policy" indicated in Procedure I: Before offering the Influenza or Pneumococcal vaccine or COVID vaccine, each resident, and/or resident's legal representative will receive the appropriate Vaccine Information Statement (VIS) produced by the Maine and/or Federal Centers for Disease Control regarding the benefits and potential side effects of the vaccines for the current year. The resident's

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F 887	Continued From page 46 clinical record will include the following documentation: Signature of the person receiving the educational material, designating receipt and understanding of the material. Verbal consent may also be obtained if communication is done via a telephone conversation. Proof the resident either received the Influenza, COVID and/or the Pneumococcal vaccine, the vaccine(s) was contraindicated for medical reasons, or the resident refused the vaccine(s). ImmPact website can be utilized to see if these vaccines have been administered. Each resident will be offered a COVID Vaccine, upon admission unless the immunization is medically contraindicated, or the resident has already been immunized. VIS will also be provided to educate on risk vs benefit. Resident #16's clinical record indicated that the resident was admitted to the facility on 7/26/23. Resident #16's immunization records lacked evidence that the resident's COVID immunization was current or offered and administered as directed by the facility's "Immunization - Influenza, Pneumococcal, COVID Policy. On 1/23/25 at 10:27 a.m., a surveyor confirmed the above findings in an interview with the Quality Improvement Specialist.	F 887		
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.	F 947	All residents have the ability to be affected by this practice. DNS provided education to the nursing management team on the requirements of 12 hours per year of in-service training for CNA's.	

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F 947	Continued From page 47 §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 § 483.71 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. This REQUIREMENT is not met as evidenced by: Based on Certified Nursing Assistant (CNA) employee education record review and interview, the facility failed to monitor and ensure that the CNA attended the required 12 hours of annual in-service education training for 5 of 5 randomly selected CNAs employed greater than 1 year (CNA #1, CNA #2, CNA #3, CNA #4, and CNA #5). Findings On 1/22/25, a surveyor reviewed the following employee education files: 1. CNA #1 was hired 12/5/1994. Review of CNA #1 Employee In-service/attendance Records lacked evidence that she completed the 12 hours of required continuing education for the year of 2024. 2. CNA #2 was hired 8/31/2020. Review of CNA #2 Employee In-service/attendance Records lacked evidence that she completed the 12 hours of required continuing education for the year of	F 947	DNS/designee will create a schedule for annual education/in-services for CNA's to complete. Unit managers will be responsible for tracking education completed by CNA's. DNS is responsible for compliance. In-service requirements will be reviewed at QAPI for 6 months. March 4, 2025	

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F 947	Continued From page 48 2024. 3. CNA #3 was hired 3/18/2013. Review of CNA #3 Employee In-service/attendance Records lacked evidence that she completed the 12 hours of required continuing education for the year of 2024. 4. CNA #4 was hired 2/8/2021. Review of CNA #4 Employee In-service/attendance Records lacked evidence that she completed the 12 hours of required continuing education for the year of 2024. 5. CNA #5 was hired 6/8/2020. Review of CNA #5 Employee In-service/attendance Records lacked evidence that she completed the 12 hours of required continuing education for the year of 2024. On 1/22/25 at 1:34 p.m., during an interview with 4 surveyors present, the Administrator confirmed the above findings.	F 947		