STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205158	A. BUILDING _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREGORY WING OF ST ANDREWS VILLAGE	145 EMERY LANE BOOTHBAY HARBOR, ME 04538

(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 5/13/24 through 5/15/2024, on-site visits were conducted at Gregory Wing of St. Andrews Village for the purpose of a Recertification Survey and investigating facility reported incident # ME00046853. It was determined that Gregory Wing of St. Andrews Village was not in substantial compliance with 42 CFR 483, Sub-part B Requirements for Long Term Care Facilities.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;FormIte 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 legally responsible for ensuring that the	F 578		

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

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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, record reviews and interviews, the facility failed to provide residents/representatives written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive for 2 of 6 residents reviewed for advanced directives (Resident's #24 and #26).

Findings:

Review of facility policy titled "Advance Directives" effective date 10/1991 states " .... Purpose: To comply with Federal and Critical access hospitals conditions of participation, the "Federal Patient Self-Determination Act", the "Main Uniform Health Care Decisions Act" and to provide the community with a method for healthcare decision making, Lincoln health has adopted this Advance Directive Policy to provide: 1. B. Written information to patients and or their support person concerning their right to make decisions about medical care. C. Documentation of patients declaration of an advanced healthcare

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F 578	Continued From page 2 directive form. 2.B.1. Lincoln health will provide written information to all adult patients, emancipated minors, persons authorized to make medical decisions on behalf of patients and or the patient support person during every inpatient admission, at time of registration, to outpatients or their representative, to those who are in in emergency department, those undergoing same day surgery, are those who are in observation status. C.4. Any employee or medical staff were receives a copy of Advanced Healthcare Directive form will submit it as part of the patient's medical record .....". 1. Resident #24 was admitted to the facility on 11/21/23. A review of Resident #24's clinical record lacked evidence that the facility provided resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. 2. Resident #26 was admitted to the facility on 8/9/23. A review of Resident #26's clinical record lacked evidence that the facility provided resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. On 5/13 24 at 11:50 a.m., during an interview, the Registered Nurse (RN #2) confirmed the above findings.	F 578		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility	F 609		

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must:

§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on facility policy, record review and interviews, the facility failed to report in a timely manner, an injury of unknown origin with serious injury to the Division of Licensing and Certification (DLC) (State Survey Agency) and to Adult Protective Services (APS) (State Agency) for 1 of 1 residents sampled for injuries/accidents. (#27)

Finding:

Review of the facility's Abuse. Neglect, and/or

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F 609	Continued From page 4	F 609		

Exploitation Reporting" Policy # 02-7080-246, effective date: 05/1999, noted in 1. Policy Statement: 2. All personnel who suspect any incident of resident abuse, neglect or exploitation, including injuries of an unknown source or misappropriation of resident property, must promptly report the incident to (the Department of Health and Human Services)DHHS through the Division of Licensing and Regulatory Services(DLRS) within 24 hours of the incident and to Adult Protective Services.
Attachment one: 1. All incidents: All incidents must be reported to DHS through the division of licensing and regulatory services DSLRs ..... Within 24 hours of the incident or the next working day, when the incident occurs or on a holiday or weekend.) ...

On 3/18/24 at 3:09 p.m., the Division of Licensing and Certification received from the facility a fax which indicated an injury of unknown origin to Resident #27 which was discovered during morning care.

A review of Resident #27's clinical record noted a nursing note written by Nursing n 3/15/24 a 10:59 indicating
"Resident with some right shoulder swelling noted this am during am care/dressing. When sitting on edge of bed, right shoulder is not symmetric, right shoulder appears lower/? dropped compared to left. Resident winces when assisted with dressing. No eventer fall has happened with resident recently. Small rash area noted on right chest and irregular bruise noted on right inner upper arm, non tender. Will try ice and Tylenol and monitor."

On 3/15/24 a 2:05p.m., the resident was

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F 609	Continued From page 5 transported to an acute care hospital emergency room for evaluation. Resident #27 was found to have right humeral head fracture and fracture Compression Thoracic 5, 6,and 7. On 5/13/24 at 10:50 a.m., in an interview, the Director of Nursing stated this injury was discovered on Friday 3/15/24. She went on to state that the facility knew about the serious injury the same evening in a report from the hospital. She further stated that the facility report to the state was not sent in until 3/18/24. On 5/13/24 at 12:10 p.m., in an additional interview, the Director of Nursing confirmed that the facility did not send a report timely to the Division of Licensing and Certification (DLC) (State Survey Agency) and to Adult Protective Services (APS) (State Agency) regarding this injury of unknown origin.	F 609		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care 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.	F 655		

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F 655	Continued From page 6 (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 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 and record reviews, 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 1 of 3 residents that were reviewed for new admissions. (#189) Finding:	F 655		

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F 655	Continued From page 7 On 5/13/24 at 10:25 a.m., During an interview, Resident #189 stated, he/she has a pacemaker which is checked via his/her phone. Resident #189 was admitted to the facility on 5/7/24. The hospital history and physical included information that the resident had a pacemaker placed for tachybradycardia syndrome and heart block. Further review indicates resident #189's code status as Do Not Resuscitate. Review of the clinical record lacked evidence of a baseline care plan completed within 48 hours to include the instructions necessary to properly care for Resident #189's immediate health and safety needs for the above concerns. On 5/14/24 at 10:19 a.m., during an interview, the Registered Nurse Admission Coordinator confirmed the above and stated she will add the presence of a cardiac pacemaker immediately.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 656		

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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-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on record reviews, interviews and facility policy, the facility failed to update/implement goals and interventions in the area of antibiotic medication use for 1 of 6 residents reviewed for medications (Resident #15).

Findings:

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F 656	Continued From page 9 Review of facility policy "Care Planning/Interdisciplinary Team/Family Participation" dated 3/98 states " ...A comprehensive care plan is developed within seven days of completion of the resident comprehensive assessment (MDS). ...Reviewing care plans to assure that: They reflect the resident's actual needs ..." Review of Resident 15's care plan initiated 3/22/23 revealed "...Focus: I have a Urinary Tract Infection; Goal: UTI will resolve without complications; Interventions: Administer antibiotic as prescribed by Provider.." Review of Resident 15's clinical record revealed order with start date of 2/23/24 for Amoxicillin-Pot Clavulanate 875-125 mg tablet. Give 1 tab by mouth twice daily for 7 days for UTI [Urinary Tract Infection]. Further review of Resident #15's clinical record lacked evidence his/her care plan was updated after this medication was completed. On 5/14/23 at 11:26 a.m., during an interview, the Director of Nursing indicated that Resident #15's care plan should have been updated within 7 days of the antibiotic completion and confirmed the above findings.	F 656		
F 657 SS=D	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.	F 657		

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(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:
Based on interview, record review and facility policy, the facility failed to review and revise the care plan by an interdisciplinary team (IDT) that included, to the extent possible, participation of the resident and/or his/her representative after each assessment for 1 of 7 sampled residents (Resident #17).

Findings:

Review of facility policy "Care Planning/Interdisciplinary Team/Family Participation" dated 3/98 states " ...A comprehensive care plan is developed within seven days of completion of the resident

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F 657	Continued From page 11 comprehensive assessment (MDS). ...Reviewing care plans to assure that: They reflect the resident's actual needs..." Resident #17 was admitted to the facility on 10/30/23. During review of Resident #17's medical record, the surveyor noted quarterly Minimum Data Set (MDS) Assessments dated 2/6/24. The clinical record lacked evidence that a care plan meeting was held by the IDT, resident and/or representative for this assessment. In addition, the last documented IDT meeting was held on 11/14/23. On 5/14/24 at 2:32 p.m., during an interview, the Social Worker reviewed Resident #17's entire clinical record and confirmed there was no evidence that an IDT was held. On 5/14/24 at 2:54 p.m., the above was discussed with Director of Nursing.	F 657		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's	F 661		

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F 661	Continued From page 12 representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview and clinical record review, the facility failed to develop a discharge summary which included a recapitulation of the resident's stay for 1 of 1 residents reviewed for discharge (Resident #33). Findings: Resident #33 was admitted to facility on 2/9/24 for skilled services. On 2/24/24 resident #33 was discharged to the community. The clinical record lacked evidence a recapitulation of the resident's stay was completed at discharge. On 5/15/24 at 10:09 a.m., during an interview, the Director of Nursing indicated that she reviewed Resident #33's clinical record and was unable to find evidence that a recapitulation of stay was completed for this resident.	F 661		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		

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F 689	Continued From page 13 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the resident's environment was free of accident hazards relating to a commode for 1 of 3 days of survey. (5/13/24) Finding: On 5/13/24 at 10:05 a.m., two surveyors observed a commode over a toilet in Resident Room 125's bathroom. The left armrest had been worn down and the right armrest was broken open with sharp/jagged plastic edges exposed. On 5/13/24 at 10:13 a.m., in an interview with two surveyors, the Director of Nursing confirmed that the sharp/jagged plastic edges on the armrest was an accident hazard.	F 689		
F 695 SS=D	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	F 695		

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F 695	Continued From page 14 care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure that clinical records were complete and contained accurate documentation for 1 of 3 sampled residents reviewed for Oxygen (#189). Finding: On 5/13/24 at 10:25 a.m. and on 5/14/24 at 9:56 a.m., observations of Resident #189 on Oxygen set at 2 Liters Per Minute (LPM) via nasal cannula. Review of the hospital discharge history and physical states the resident has diagnosis of chronic respiratory failure with hypoxia and obstructive sleep apnea and required oxygen at home at 2LPM continuously. The Assessment and Plan states, "Patient on continuous home oxygen, 2 LPM via nasal cannula". Review of the Physician order dated 5/7/24 states "O2 every day and night shift for ILD (Interstitial Lung Disease)", the order lacked the amount of oxygen / LPM to be administered. On 5/14/24 at 10:19 a.m., during an interview, both the surveyor and the Registered Nurse (RN) Admission Coordinator reviewed the admission orders which indicated the 2LPM. The RN stated she will update the orders immediately to reflect the LPM of oxygen.	F 695		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		

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F 755	Continued From page 15	F 755		

§483.45 Pharmacy Services
The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

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

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

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

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

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on record review, interviews and facility policy, the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation, failed to determine that drug

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records are in order and that an account of all controlled drugs is maintained, failed to ensure that two people who are authorized to administer medications signed the Shift Count page indicating that they counted all controlled substances at the change of shift for 1 of 2 units reviewed for medication storage (Gregory Wing).

Findings:

Review of facility policy "Controlled Substance Storage" dated 5/1/18 states "...At each shift change, or when key are transferred, a physical inventory of all controlled substances, including refrigerated items is conducted by two appropriately licensed/certified personnel and is documented..."

1. Review of controlled substance logbook labeled Gregory Wing Book #16 index revealed page 81 was blank. Further review revealed page 81 belonged to Resident #27 for medication "Lorazepam 2mg [milligram]/ml [milliliter] concentrate take 0.25ml. (5mg) by mouth every hour as needed for anxiety, agitation, nausea. Give 1mg 1hour prn for severe anxiety/SOB/nausea."

2. Review of controlled substance logbook labeled Gregory Wing, Book #16, revealed that oncoming licensed staff failed to sign the shift count page on 5/11/24 at 19:00 and failed to sign out on 5/12/24 at 07:00.

On 5/13/24 at 11:18 a.m., during an interview, the Certified Medication Technician (CMT) indicated that staff do not use the index when they do shift count and they only need one person to sign controlled medications into the controlled

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F 755	Continued From page 17 substance book. The CMT further indicated that when she does count, she does not use the index and just matches the page numbers in the book with the actual medication cards. On 5/13/24 at11:28 a.m., during an interview, the Registered Nurse (RN2) indicated that staff should be using the index during the shift count, but they had not been. RN2 further indicated that licensed staff were required to sign the controlled logbook at the beginning and end of each shift and anytime the keys were transferred to another person. RN2 further indicated they have one staff member entering controlled medications into the controlled logbook. On 5/13/24 at 12:10 p.m., during an interview with 2 surveyors, the Director of Nursing (DON) reviewed the controlled book, noted index page 81 was blank. At this time, the DON stated the index is the key to reconciliate the controlled medication count, the page should have been filled out, and licensed staff should be signing at the beginning and end of each shift indicating the controlled medication count is correct, confirming the above concerns.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and	F 758		

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F 758	Continued From page 18 (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 758		

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Based on record review, interview and facility policy, the facility failed to show evidence of documentation to justify the use of psychotropic medications for 2 of 5 residents reviewed for unnecessary medications (#17 and #28).

Findings:

Review of facility policy "Restraints, Physical/Chemical" dated 2/98 states"...Psychotropic Medication Implementation: ...The facility will follow pharmacy recommendations for indication, gradual dose reduction and monitoring..."

1. Resident #17 was admitted to on 10/30/23 with a diagnosis of anxiety. Review of Resident #17's clinical record revealed "Pharmacy Review" dated 2/28/24 stating "Patient has an order for Lorazepam 0.5mg [milligram] tab give 1 tab po [by mouth] as needed. [He/she] uses this medication infrequently. According to the regulations this medication is a psychotropic and requires 2 attempts at a gradual dose reduction in the first year and then every year after. If it is not appropriate to attempt a dose decrease at this time, the provider may wish to document rational for contraindication. [Provider response]: Disagree. Further review of Resident #17's clinical record lacked evidence of a rational for the provider's response.

During an interview on 5/14/24 at 3:29 p.m., the Director of Nursing confirmed she had reviewed Resident #17's clinical record and was not able to find any rational for Resident #17's continued use of lorazepam.

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F 758	Continued From page 20 2. Resident #28 was admitted to on 11/2/23 with diagnosis of anxiety and depression. Review of Resident #28's clinical record revealed a "Pharmacy Review - Note to Attending Physician/Prescriber" dated 3/25/24 stating "Patient has order for Sertraline 100mg give one tab po qam [every morning]." According to the regulations a gradual dose reduction should be attempted 2 times in the first year and once a year thereafter. Provider might wish to attempt a GDR or document rationale for contraindication at this time. Physician may wish to consider a dosage reduction at this time to ensure patient is on the lowest effective dose. [Provider response]: Disagree. Further review of Resident #28's clinical record lacked evidence of a rational for the provider's response. On 5/15/24 at 10:50 a.m., during an interview, the surveyor discussed the finding with the Administrator and the Director of Nursing at the survey exit meeting.	F 758		
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	F 812		

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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, interview and the facility's "Storage - Food and Non Food Items" policy effective date: 04/20/12, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for a grease trap base, floor drains, ceiling vents, lights and ceiling tiles; failed to ensure facial hair protection was worn; and failed to ensure foods in the walk-in freezer were dated and/or labeled.

Findings:

On 5/13/24 from 9:10 a.m. to 9:35 a.m., an initial kitchen tour was conducted with the Food Service Director in which the following findings were observed:

> The cement base under the grease trap had chipped/missing paint creating an uncleanable surface.
> There were 3 floor drain grates that had chipped/missing paint creating uncleanable surfaces.
> There were 3 ceiling vents, above food preparation areas, and surrounding ceiling tiles that were moderately soiled with dust.
> The dry storage room had a ceiling vent and a light that were moderately soiled with dust.
> There was a male kitchen worker with facial hair that was not wearing facial hair protection

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F 812	Continued From page 22 while preparing food in the kitchen. > The walk-in freezer had an unlabeled and undated bag of bread and also had a package of unlabeled bacon bits. > The dry storage room had a ceiling vent and a ceiling light that were moderately soiled with dust. On 5/13/24 at 9:35 a.m., in an interview, the Food Service Director confirmed the findings.	F 812		
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure garbage was properly disposed of and contained to prevent the harborage and feeding of pests for 3 of 3 days of survey (5/13/24, 5/14/24 and 5/15/24). Findings: 1. On 5/13/24 at 9:00 a.m., a surveyor observed loose, unbagged trash on the ground around the dumpsters. 2. On 5/14/24 at 8:15 a.m., a surveyor observed loose, unbagged trash on the ground around the dumpsters. 3. On 5/15/24 at 8:15 a.m., a surveyor observed loose, unbagged trash on the ground around the dumpsters. On 5/15/24 at 10:50 a.m., in an interview, the surveyor discussed the findings with the	F 814		

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F 814	Continued From page 23 Administrator and the Director of Nursing at the survey Exit meeting.	F 814		
F 868 SS=B	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. §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	F 868		

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F 868	Continued From page 24	F 868		

assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by:
Based on review of the quarterly Quality Patient Resident Safety Committee meeting attendance sheets and interview, the facility failed to ensure that the Infection Preventionists attended 4 of 4 quarterly meetings.

Finding:

A review of the quarterly Quality Patient Resident Safety Committee meeting attendance sheets indicate that the Infection Preventionists did not attend the 5/24/23, 8/23/23, 11/15/23 and 2/28/24 quarterly meetings.

In addition, the facilities Senior Living Performance Improvement & Safety Plan for 2023/2024 under section "Program Organization" states, "The Senior Living Performance Improvement Committee is a Board Committee ... Membership of the Committee shall consist of representation from the following constituents: Administration, Board of Trustees, Quality and Safety, Medical Director and/or designee if unable to attend, Pharmacist, Risk Management, Director of Nursing Services and/or designee if unable to attend and three others members of the facility staff". The improvement plan lacks the federally required Infection Preventionists as a committee member.

On 5/15/24 at 8:19 a.m., during an interview, the Infection Preventionist stated she has not attended a Quality Patient Resident Safety Committee meeting recently and that she usually does not attend but the Director of Nursing will

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F 868	Continued From page 25 present her information. On 5/15/24 at 8:25 a.m., during an interview, the Director of Nursing confirmed the infection preventionists has not attended any of the meetings. In addition, the DON stated she does not have the infection prevention education as the infection preventionist has. On 5/15/24 at 9:27 a.m., during an interview with the Administrator the surveyor confirmed the above finding.	F 868		
F 909 SS=F	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on interviews, the facility failed to conduct regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment for 37 of 37 beds. Findings: On 5/14/24 at 11:42 a.m., a surveyor met with the Director of Facilities and asked for the bed gap measurements and side rail gap measurement documentation. The Director of Facilities stated that he had never heard of those before and he	F 909		

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would check with the other maintenance men. He came back and stated that they had never heard of them either. At this time, the Director of Facilities confirmed that the facility had never completed bed gap measurements and/or side rail gap measurements at the facility for any of the resident's beds.

On 5/14/24 at 11:50 a.m., in an interview with the Administrator and the Director of Facilities, the Administrator stated that she had never heard of bed gap measurements or side rail gap measurements. At this time, the Administrator confirmed that the facility had never completed bed gap measurements and/or side rail gap measurements at the facility for any of the resident's beds. The surveyor asked for the facility's Bed Safety and Bed Rails policy and procedure.

On 5/14/24 at 1:30 a.m., in an interview with the Administrator, she stated that she can't locate any Bed Safety and Bed Rails policy and procedure documentation and can't provide any to the surveyor.