DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205006	A. BUILDING _____ B. WING _____	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTELLO MANOR	540 COLLEGE ST LEWISTON, ME 04240

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F 000	INITIAL COMMENTS From 2/18/25 through 2/20/25, on-site visits were conducted at Montello Manor for the purpose of completing the Annual Long Term Care Recertification Survey and investigating complaints #ME00050590, #ME00048847 and #ME00048824 . It was determined that Montello Manor is not in substantial compliance with 42 CFR 483, Sub-part B Requirements for Long Term Care Facilities.	F 000	This plan of correction constitutes my written allegation of compliance for deficiencies cited during the recent survey on 02-18-2025. However, submission of this plan of correction is not the admission that a deficiency exists or that was cited correctly. This plan of correction is submitted to meet the requirement established by State and Federal Law.	
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a residents call bell was within reach for 4 of 15 sampled residents for 2 of 3 days of survey with multiple observations. (Resident #24, #7, #15, #188) Findings: 1. On 2/18/25 at 10:11 a.m., observation of Resident #24 sitting in a wheelchair beside the middle of the bed. The call bell was at the head of the bed hanging down. At this time, Resident #24 attempted to move the wheelchair and was unable to twist his/her body to reach the call bell. 2. On 2/18/25 at 10:54 a.m., observation of Resident #7 sitting up in a broda chair with a	F 558		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Luddy | TITLE: Administrator | (X6) DATE: 3-13-25

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 558	Continued From page 1 hoyer pad underneath him/her and the broda chair positioned at the foot of the bed. The call bell was wrapped up on the side rail at the head of the bed, not within reach. On 2/18/25 at 12:57 p.m., an additional observation of Resident #7, sitting in a broda chair at the foot of the bed, with a tray table in front of resident. The call bell was placed on the bed behind the broda chair, not within reach. 3. On 2/18/25 at 11:05 a.m. and at 12:57 p.m., observations of Resident #15, sitting in a broda chair placed at the end of the bed with pressure-relieving booties on both feet and the foot of the broda chair elevated. The call bell was not visible anywhere around the resident. 4. On 2/18/25 at 10:56 a.m. and at 12:57 p.m., observations of Resident #188 lying in bed with the call bell wrapped around the call box on the wall behind the bed. 5. On 2/18/25 at 2:10 p.m., 2 surveyors observed Residents #7, #15 and #188 with their call bells out of reach. On 2/18/25 at 2:14 p.m., during an interview, both the surveyor and the Licensed Practical Nurse #4 (LPN) observed Residents #7, #15 and #188 with their call bells out of reach. At this time, the LPN found Resident #15's call bell on the floor under the head of the bed and placed the call bells within reach for each resident. On 2/18/25 at 2:33 p.m., the above was discussed with the Administrator. 6. On 2/19/25 at 8:20 a.m., an additional	F 558	**F558- Reasonable accommodation of needs** The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. • Residents # 24, #7, #15, and # 188 were affected by this finding. • All residents have the potential to be affected by this finding. • Review of all residents' preferences and accommodations needed and/or preferred by the residents were reviewed and care plans revised to assure care plan reflects resident's needs for accommodations. • Staff re-educated immediately and ongoing on the accommodation of needs and preferences and assure that all call bells are in place for access by the residents to assure ability to notify staff of needs and wants. • Staff instruction provided on assuring call bell was accessible at all times before leaving the room and to perform observations as when walking through the units to assure all residents in room have direct access to their call bell at all times. • Director of nursing or designee will complete random weekly audits to assure all call bells are in place when residents are in their rooms and compliance is being maintained. • All audits will be reviewed within the QAPI meeting until 100 percent compliance is achieved for 8 weeks and then audit time frames will be revaluated by the committee to assure sustainability is maintained ongoing. **Correction date 3/28/2025**	

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F 558	Continued From page 2 observation of Resident #7 sitting up in the broda chair positioned at the end of the bed with a breakfast tray in front of the resident. The call bell was on the side of the bed lying on the floor. At 8:24 a.m., a certified nurse's aide (CNA) entered the room and made his/her bed then exited the room leaving the call bell on the floor. At 2/19/25 at 8:28 a.m., the breakfast tray was picked up and the call bell remained on the floor. At 8:54 a.m., CNA #2 entered the room, lowered the resident's bed and moved the broda chair to the side of the bed and gave him/her the call bell. At this time, CNA #2 confirmed Resident #7 did not have the call bell. On 2/19/25 at 9:04 a.m., the above was again discussed the above with the Administrator.	F 558		
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.	F 584		

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F 584	Continued From page 3 §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 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interview, 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 2 wings (North and East) and the Laundry room for 1 of 1 facility tour. Findings: On 2/20/25 from 9:05 a.m. to 10:00 a.m., a surveyor conducted an Environmental Tour with the Maintenance Director in which the following findings were observed: North Wing: - Resident Room 43 - The wooden board to the	F 584		

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F 584	Continued From page 4 right of the bed holding the metal base board heating unit, had chipped/gouged paint exposing untreated wood. The metal base board heating unit had chipped/gouged paint creating an uncleanable surface. - Resident Room 49 - The wheelchair right arm rest had a ripped/torn/peeling plastic surface and the wheelchair was visibly dirty with food debris and dust. The bathroom floor had three stained and broken floor tiles around the toilet. - Resident Room 60 - There was a bed pan and wash basin on the floor next to the toilet. - The exit area vestibule on the North Wing had four bags of trash stored on the floor and not secured in a sealed container. East Wing: - Resident Room 61 - The cove base around the room was visibly soiled and dirty. - The ceiling vent in the hallway outside resident room 64 was dirty and dusty. - Resident Room 68 - There were three cracked/broken floor tiles in the bathroom. - Resident room 71 - There was a large crack in the sheetrock wall by the window. Laundry Room: - The cement floor had chipped/missing paint creating an uncleanable surface. - The large folding table had chipped/missing paint and had duct tape on the top edges creating uncleanable surfaces. On 2/20/25 at 10:00 a.m., in an interview, the Environmental Services Director confirmed the findings.	F 584	• No resident was directly affected by these findings. Rooms # 43,49,60, 61 and laundry room were identified to have areas in need of cleaning and or equipment in need of repair. • All resident rooms have the potential to be affected by these findings. • Resident care items, heaters, and dusty surfaces were cleaned and items repaired to assure all areas are safe and clean at this time and surfaces are cleanable. • All identified equipment and floors, heaters, have been repaired and or painted at this time. • Bed wedge added to the bed that did not have one. • Garbage receptacle to be used for all garbage with closed contained lid. • All units audited for any repairs needed. • All staff responsible for cleaning and maintenance of items educated on policy and procedures to assure all areas of concern were addressed and compliance can be maintained and sustained moving forward beginning 3/5/25 and ongoing • Rooms were repaired and were all cleaned and all broken, chipped or dented areas were repaired. • Noted floor tiles identified as broken have been replaced. • Environmental Service Director or designee to complete weekly audits starting 3/5/25 for 4 weeks to assure areas of concern remain corrected and resident care areas are clean and comfortable. • Audits to be completed by Environmental Service Director or designee will to be reviewed in monthly QAPI until 100 percent compliance is achieved for 3 consecutive months. Frequencies of audits will be revaluated and revised by QAPI committee as appropriate.	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623	**Correction date 3-28-2025**	

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F 623	Continued From page 5 §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623	**F623 Notice before Transfer/Discharge** • Residents # 11 was affected by this deficient practice with no harm. • All residents who are transferred or discharged can be affected by this practice • No resident was harmed by this practice • Transfer discharge notifications will be completed with each transfer or discharge • Social worker or designee to check daily for prior day transfers to hospital and validate completion of transfer/discharge notification and follow up on any variances to assure compliance is sustained • Appropriate staff being re-educated on process for notification of all transfer and discharge to prevent non-compliance Date: 3/06/25 and ongoing • Nurse Managers will review each transfer/ discharge for evidence of notification and report findings within the Monthly QAPI committee meeting and the committee will evaluate effectiveness of education and compliance for next three months. Once 100% compliance is achieved the committee will reevaluate time frames of audits and revise as needed to assure compliance is sustained. **Correction date 3-28-2025**	

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F 623	Continued From page 6 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F 623		

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F 623	Continued From page 7	F 623		

If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k).
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to issue a written transfer/discharge notice to a resident or their legal representative for a facility-initiated transfer/discharge for 1 of 2 Resident's reviewed for hospitalization (Resident #11).

Findings:

Review of Resident 11's clinical record revealed that on 7/12/24 resident was transferred to an acute care hospital and subsequently admitted.

Further review of Resident 11's clinical record lacked evidence that the resident and/or resident representative and the Ombudsman's office were provided a written transfer/discharge notice.

On 2/19/25 at 12:45 p.m., in an interview, the Administrator confirmed the clinical record lacked evidence that a transfer notice was provided in

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F 623	Continued From page 8 writing to the resident and/or resident representative and the Ombudsman's office.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to issue a written bed hold notice to include cost of care to the Resident and/or resident	F 625	**F625 Bed Hold policy before/upon transfer** • Resident #11 was affected by this deficient practice with no harm. • All residents who require a bed hold can be affected by this practice • No resident was harmed by this practice • Bed hold notifications will be completed with each transfer to hospital by the nurse on duty. • Appropriate nursing staff and social worker being re-educated on completing bed hold notification. Date: 3/06//25 and ongoing • Social worker or designee to check daily for prior day transfers to hospital and validate completion of bed-hold notification and follow up on any variances to assure compliance is sustained • Nurse Managers will review each transfer/ discharge for evidence of notification and report findings within the Monthly QAPI committee meeting and the committee will evaluate effectiveness of education and compliance for next three months. Once 100% compliance is achieved the committee will reevaluate time frames of audits and revise as needed to assure compliance is sustained. **Correction date 3-28-2025**	

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F 625	Continued From page 9 representative for 1 of 2 sampled Resident's reviewed for transfer to an acute care hospital (Residents #11). Finding: Review of Resident 11's clinical record revealed that on 7/12/24 resident was transferred to an acute care hospital and subsequently admitted. Review of Resident 11's clinical record lacked evidence that the resident and/or resident representative was provided a written bed hold notice upon this transfer. On 2/19/25 at 12:45 p.m., in an interview, the Administrator confirmed the clinical record lacked evidence that a bed hold notice was provided in writing to the resident and/or resident representative.	F 625		
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 §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	F 656		

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F 656	Continued From page 10 (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 observation, interviews and record review, the facility failed to ensure a person-centered comprehensive care plan was developed in the area of Chronic Obstructive Pulmonary Disease (COPD) and failed to implement the care plan in the area of ADL (Activities of Living) and oxygen maintenance for 4 of 15 residents care plans reviewed (#8, #7,	F 656	**F656 Care Plan** • Residents # 8, #7, #10 and #24 had an incomplete care plan to meet current needs. No resident was harmed by this finding. • All residents have the potential to be affected by these findings. • The comprehensive care plans and physician orders were reviewed and revised as appropriate to reflect resident's current status and needs. • All residents' plans of care were reviewed and compared to physician's orders and diagnosis to assure they reflect current status and were updated to reflect current level of care if indicated. • Process and procedure for timely completion of the care plan to include diagnosis, ADL assistance needs, and any health and safety needs being reviewed with the MDS and admission nurse. • Nursing staff aware of need to review changes in resident plans of care and report any changes in condition to the charge nurse to assure plans are updated in a timely manner. • MDS nurse or designee to review care plans for accuracy at time of any new orders and with each MDS completion to assure care plan is always up to date to current level of needs. • MDS/designee will complete audits of all new orders and admissions to assure care plans are completed timely and reviewed with resident and family timely to identify any changes needed and revise to assure current baseline care represents up to date needs. • The Director of Nursing or designee will report audit results for review within the Monthly QAPI until 100% compliance is achieved and sustained. The QAPI committee will review and revise audit time frames based on compliance achieved ongoing. **Correction date 03-28-2025**	

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	205006	A. BUILDING _____ B. WING _____	02/20/2025

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F 656	Continued From page 11 #10 and #24) Findings: 1. Review of Resident #8's current physician orders noted "Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) mg(milligram)/3ml(milliliter)-1 application Inhale orally four times a day for COPD- start date- 1/15/25 1100, morning(am) 06, noon, evening(pm) 15, night(hs)18." Resident #8's current care plan was reviewed and it lacked evidence that the care plan was updated to include goals and interventions for the care area of COPD/Nebulizer use. On 2/20/25 at 2:00 p.m., in an interview, the Administrator confirmed that Resident #8's care plan was not updated to include goals and interventions for the care area of COPD/Nebulizer use. 2. On 2/18/25 at 10:54 a.m., and on 2/18/25 at 12:57 p.m., Resident #7 was observed sitting up in a broda with the call bell out of his/her reach. On 2/19/25 at 8:20 a.m., an additional observation of Resident #7 sitting up in the broda chair positioned at the end of the bed with a breakfast tray in front of the resident. The call bell was on the side of the bed lying on the floor. He/she was eating breakfast independently, no staff supervision and using a metal spoon, scooping up egg yolk. At 8:24 a.m., a certified nurse's aide (CNA) entered the room and made his/her bed then exited the room leaving the call bell on the floor. At 2/19/25 at 8:28 a.m., the breakfast tray was picked up. At 8:54 a.m., CNA #2 entered the room, lowered the resident's bed and moved the broda chair to the side of the bed	F 656		

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F 656	Continued From page 12	F 656		

and gave him/her the call bell. At this time, during a brief interview, CNA #2 confirmed Resident #7 did not have the call bell available. The surveyor asked what eating assistance is required for Resident #7, she stated "you have to sit with [him/her], [he/she's] supervision". At this time, the surveyor discussed the lack of supervision while he/she ate breakfast using a metal spoon.

Review of Resident #7's care plan for "ADL (Activities of Living) self-care performance deficit r/t dementia" revised on 12/8/23 has an intervention of "Eating: [Resident] requires total assist by 1 staff to eat; Should use small plastic spoon and give small bites to promote increased intake."

The care plan for "swallowing problem r/t dementia, coughing or choking during meals or swallowing med, difficulty with thin liquids" revised on 12/4/23 has an intervention of "Resident to eat only with supervision".

The care plan for "communication problem r/t Alzheimer's dementia" revised on 6/26/24 has an intervention of "Ensure/provide a safe environment: call light in reach".

On 2/19/25 at 9:04 a.m., the above failure to have the call bell available, the lack of supervision while eating and the use of a metal spoon was discussed with the Administrator.

3. On 2/18/25 at 10:33 a.m., and at 2:10 p.m., Resident #10 was observed using a nasal cannula for his/her oxygen administration with the tubing dated 1/28/25.

Review of Resident #10's care plan for "Altered

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F 656	Continued From page 13 cardiovascular status r/t CHF (congestive heart failure) Hypertension, AFIB (atrial fibrillation), Aortic stenosis, revised on 10/25/23 has an intervention of "change O2 (oxygen) tubing weekly and PRN (as needed)" 4. On 2/18/25 at 10:11 a.m., Resident #24 was observed sitting in a wheelchair bedside the middle of the bed. The call bell is at the head of the bed hanging down. At this time, resident #24 attempted to move the wheelchair and was unable to twist his/her body to reach the call bell. Review of Resident #24's care plan for "ADL self-care performance deficit r/t Alzheimer's dementia, impaired balance/unsteady gait, arthritis", revised on 5/2/23 has an intervention of "Encourage [Resident] to use the call bell for assistance" and the care plan for "high-moderate risk for falls relating to confusion, gait/balance problems, psychoactive drug use and unaware of safety needs", has an intervention of "be sure the residents call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance." On 2/18/25 at 2:33 p.m., the above was discussed with the Administrator.	F 656		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684		

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F 684	Continued From page 14 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to follow physician orders in the area of urinary care, activities of daily living, and respiratory care for 3 of 15 residents sampled (Resident #12, #7, and #10). 1. Review of Resident #12's clinical record contained a physician order dated 1/8/25 instructing nursing to flush resident's foley catheter with 60 cc (cubic centimeter) of normal saline every day for obstructive uropathy. The clinical record lacked evidence of this was being completed. On 2/19/25 at 9:59 a.m., during an interview, the Administrator confirmed the above physician order was not completed daily by staff. 2. Review of Resident #7's provider order, dated 9/14/24 instructs nursing to provide, "Minced and Moist diet, minced texture, Nectar consistency, Fed by Staff, use plastic spoon." On 2/19/25 at 8:20 a.m., observation of Resident #7 eating breakfast independently, no staff supervision and using a metal spoon, scooping up egg yolk. At 8:24 a.m., a certified nurse's aide (CNA) entered the room and made his/her bed then exited the room. At 2/19/25 at 8:28 a.m., the breakfast tray was picked up. At 8:54 a.m., during a brief interview, the surveyor asked what eating assistance is required for Resident #7, she stated "you have to sit with [him/her], [he/she's] supervision". At this time, the surveyor discussed	F 684	**F684 Quality of Care** • Residents #12, #7 and #10 were affected by this finding. No resident was harmed by this finding. • All residents with these findings have potential to be affected. • Resident #7 current status reviewed and plastic spoon has been discontinued due to biting the plastic and now eating better with metal spoon and staff re-educated to assure all supervision with eating is maintained for all residents that require the supervision based on written care plan. • Resident # 12 plan of care reviewed by physician and Foley catheter flush order will remain as a prn order, no scheduled flushes are ordered at this time. • All appropriate staff to be reeducated on the process to prevent these outcomes in quality of care identified related to accommodation of care and following physician's orders in EMR system related to medication order entry, oxygen management, and assistive devices. Date: 3/6/25 and ongoing • All residents who receive oxygen/ nebulizer reviewed and each resident has orders for cleaning, labeling and changing of the respiratory tubing and equipment, filter cleaning on a scheduled weekly basis. • All areas identified to be reviewed and corrected with process and procedure reviews to assure compliance is achieved and maintain within each area listed within Quality of Care deficiencies. All audits per schedules and compliance reviews for reported deficiencies to be reported within the monthly QAPI committee meetings until 100% is achieved and sustained for three months. • The Director of Nursing or designee will report audit results for review within the Monthly QAPI until 100% compliance is achieved and sustained. The QAPI committee will review and revise audit time frames based on compliance achieved ongoing. **Correction Date: 3/28/2025**	

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F 684	Continued From page 15 the lack of supervision while Resident #7 ate breakfast using a metal spoon. 3. Review of the Resident #10's provider order, dated 12/2/24 instructs nursing to, "change and date O2 and C-pap tubing Clean concentrator filter every night shift every Mon". On 2/18/25 at 10:33 a.m., and at 2:10 p.m., observations of Resident #10 using a nasal cannula for his/her oxygen (O2) administration with the tubing dated 1/28/25. On 2/19/25 at 2:20 p.m., the above was discussed with the Administrator.	F 684		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and a review of Safety Data Sheets (SDS), the facility failed to ensure that the resident's environment was free of accident hazards relating to the storage of chemicals being properly secured for 4 of 4 observations for 2 of 3 days of survey (2/18/25 and 2/20/25). Findings:	F 689		

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F 689	Continued From page 16 1. On 2/18/25 at 10:28 a.m., a surveyor observed an unsecured 40 oz bottle of Ajax laundry detergent on the back of the toilet in Resident Room 71's bathroom, which is shared with occupied resident Room 69. 2. On 2/18/25 at 11:08 a.m., 2 surveyors observed an unsecured 40 oz bottle of Ajax laundry detergent on the back of the toilet in Resident Room 71's bathroom, which is shared with resident Room 69 and occupied. 3. Resident #4, who occupies Room 69, stated in an interview that he/she accesses the bathroom for use. On 2/18/25 at 12:36 p.m., , in an observation and interview, the Environmental Services Director confirmed there was an unsecured 40 oz bottle of Ajax laundry detergent on the back of the toilet in Resident Room 71's bathroom. The Safety Data Sheet for Ajax Classic Heavy Duty Liquid Laundry Detergent noted the following: 4. First Aid Measures Eye contact: flush affected areas with water for at least 15 minutes. Seek medical assistance if required. Skin contact: Rinse with water. If skin irritation occurs in use, seek medical assistance. Inhalation: Give the subject access to fresh air. If symptoms do not resolve quickly, seek medical assistance. Ingestion: may be harmful if swallowed and large quantities. On 2/18/25 at 12:44 p.m., in an interview, a surveyor discussed the findings with the	F 689	**F689 Free of Accident Hazards/Supervision/Devices.** • Resident # 4 had potential to be affected by finding of Ajax in the bathroom. Resident #4 was not harmed by this finding. • All residents who have access to the ajax have potential to be affected by this finding. • All resident with access to the metal pieces that were on the floor had potential to be affected by the metal being left on floor. No residents were harmed by this finding. • All resident areas were audited to assure no items were left within the resident care areas that could be considered a risk for accident hazard. • All hazardous products will be kept in a locked container when in use of resident's room. • One resident utilizing laundry detergent in room caused potential for all confused residents to be affected by unlocked detergent when wandering. • Laundry detergent used by resident #4 has been discontinued and replaced with bar soap when resident washes her ted stockings. • Environmental services to complete facility rounds and audits to assure no hazard risks exist • Weekly environmental services and rounds and audits by Director of Environmental services/Designee will note any potential hazardous items, remove them, educate staff as needed, and report to QAPI meeting monthly for review and will continue until 100 percent compliance is achieved for three consecutive months. **Correction date 3-28-2025**	

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F 689	Continued From page 17 Administrator. 4. On 2/20/25 at 9:33 a.m., a surveyor and the Environmental Services Director observed 5 pieces of metal approximately 2 feet long, which appeared to be brackets laying on the floor in the North wing staff exit vestibule. At this time this was confirmed by the Environmental Services Director that the metal brackets were on the floor, creating an accident hazard, and that residents had access to this area.	F 689		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to maintain a respiratory program to help prevent the development and transmission of disease and infection related to respiratory equipment care for 4 of 4 residents reviewed for respiratory care (Resident #19, #7, #10, and #187) for 3 of 3 days of survey. (2/18/25, 2/19/25 and 2/20/25) Findings: 1. On 2/18/25 at 11:02 a.m., a surveyor observed an unbagged oxygen tubing and a nasal canula	F 695	**F 695 Respiratory** • Residents # 7, # 187, #10, #19 were not harmed by this finding. • All residents receiving respiratory therapy have the potential to be affected by this practice. • All resident with oxygen, nebulizers, CPAP have order to clean, check and change tubing weekly • All licensed staff educated on the respiratory equipment management and cleaning policy. Date: 3/6/25 and ongoing • Weekly audits by Director of Nursing/Designee will note any variances in respiratory equipment cleaning and dating and any variances will be addressed and reported to QAPI meeting monthly for review and will continue until 100 percent compliance is achieved for three consecutive months • The Director of Nursing or designee will report audit results for review within the Monthly QAPI until 100% compliance is achieved and sustained. The QAPI committee will review and revise audit time frames based on compliance achieved ongoing **Correction Date 03-28-2025**	

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F 695	Continued From page 18 hanging on an oxygen tank that was secured to the back of Resident #19's wheelchair which was stored in the hallway outside of the resident's room. The oxygen tubing was not dated. 2. On 2/18/25 at 2:20 p.m., 2 surveyors observed an unbagged oxygen tubing and a nasal canula hanging on an oxygen tank that was secured to the back of Resident #19's wheelchair which was stored in the hallway outside of the resident's room. The oxygen tubing was not dated. 3. On 2/19/25 at 8:20 a.m., Observation of Resident #7's nebulizer machine with an unlabeled mask and tubing stored on the dresser next to the television. Review of the Resident #7's Medication Administration Record states, a nebulizer treatment was last administered on 2/13/25. The Medical record lacked evidence of orders for, or the changing of the nebulizer mask and tubing weekly. 4. On 2/18/25 at 10:33 a.m., and 2:10 p.m., observations of Resident #10's oxygen nasal cannula tubing labeled with the date of 1/28/25. On 2/19/25 at 8:24 a.m., and 12:21 p.m., observations of a nasal cannula tubing draped over personal belongings on the bedside dresser, not hooked to the oxygen concentrator. Review of Resident #10's medication administration record for January 2025 has documentation of the O2 nasal canula tubing being changed on 1/27. February 2025 record has documentation of the O2 nasal cannula tubing being changed on 2/3, 2/10 and 2/17. 5. On 2/18/25 at 9:47 a.m., and on 2/19/25 at	F 695		

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F 695	Continued From page 19 12:35 p.m., Resident #187's oxygen nasal cannula tubing was wrapped up and stored under the oxygen concentrator handle On 2/19/25 at 2:20 p.m., the above findings were discussed and observed by the administrator and the surveyor. 6. On 2/20/25 at 7:49 a.m., an additional observation of Resident #187's nasal cannula tubing wrapped up and stored under the oxygen concentrator handle. At 8:02 a.m., Resident #7's nebulizer mask and tubing, undated and still stored on the dresser and available for use. On 2/20/25 at 9:00 a.m., during an interview with the Administrator, the surveyor again the confirmed the oxygen and nebulizer mask/tubing were still being stored improperly and available for use. The facilities Policy: "Respiratory Therapy" last revised on 2/2022 states, "The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff." Infection control considerations related to oxygen administration" states, "Change the oxygen cannula and tubing every seven (7) days, or as needed" and "Keep the oxygen cannula and tubing used PRN in a plastic bag when not in use." " "Infection control considerations related to medication nebulizers continuous aerosol" states, "Store the circuit in plastic bag, marked with date and resident's name, between uses" and "Discard the administration "set up" every seven (7) days."	F 695		

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F 726	Continued From page 20	F 726		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and the facilities Medication Administration Policy, the facility failed to ensure that licensed staff are provided with training and are assessed for	F 726	**F726 Competent Nursing** • All licensed nurses have the potential to be affected by this practice. • All licensed nurses have been reeducated on entering physician orders within PCC correctly. Date: 3/06/25 and ongoing • Licensed nurses will perform first and second checks on all new orders to assure accuracy of new orders in PCC to prevent medication errors. • Weekly audits by Director of Nursing/Designee will note any variances in training of licensed nurses and or any errors. Noted variances will be addressed and reported to QAPI meeting monthly for review and will continue until 100 percent compliance is achieved for three consecutive months. • The Director of Nursing or designee will report audit results for review within the Monthly QAPI until 100% compliance is achieved and sustained. The QAPI committee will review and revise audit time frames based on compliance achieved ongoing **Correction date 03-28-2025**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 21	F 726		

competency which includes transcription of physician orders in the facilities electronic clinical documentation program Point Click Care (PCC) the facility utilizes for 2 of 7 residents reviewed for medications. (Resident #1 & Resident #34)

Findings:

1. A Nursing Progress note dated 9/12/24 indicating Resident #1 was seen by the provider regarding increased delusions and complaints of visual hallucinations. The progress notes further indicated the resident had received Bupropion 300 milligrams (mg) and Bupropion 450 mg daily for 4 days. Physicians' orders were obtained to immediately discontinue the Bupropion ER 450 mg, hold the Bupropion ER 300 mg for 4 days and hold the antidepressant medication Duloxetine for 4 days. Continue to monitor resident and send to the emergency room for evaluation or deterioration of condition.

A review of the September 2024 Medication Administration Record (MAR) for Resident #1 indicates that he/she received Bupropion ER 300 mg at 6:00 a.m. on 9/9/24, 9/10/24, 9/11/24 & 9/12/24 and Bupropion ER 450 mg at 6:00 a.m. on 9/9/24, 9/10/24, 9/11/24, 9/12/24.

2. Resident #34's MAR indicates that a physician's order dated 10/8/24 instructs staff to administer Reglan 5 mg Give one tablet 4 times a day for 14 days. The MAR indicates that the resident received the medication Reglan 5 mg 4 times daily from 10/8/24 - 10/27/24. Resident #34 received 6 additional days of Reglan 5 mg 4 times daily. (24 doses)

A Medication Incident Report dated 10/28/24 for

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F 726	Continued From page 22 Resident #34 indicates that on 10/7/24 Reglan was ordered for 14 days and did not have a stop date entered in the electronic clinical documentation program, Point Click Care (PCC). On 2/20/25 at 10:10 a.m., during an interview with the Director of Nursing (DON), she stated the physicians order for Bupropion ER 450 mg was entered into the electronic clinical charting software, PCC incorrectly. The physicians order for Bupropion ER 450 mg should have been put on hold until the facility received the medication from the pharmacy. The surveyor asked if new staff and agency staff are required to complete training on the Point Click Care system. The DON stated that "It varies. Some nurses do not want any training. Most of them have used PCC because it's so widely used. If we see something amiss, we will do reeducation." Resident #34's physicians order for Reglan 5 mg one tablet four times a day for 14 days did not have a stop date entered in the PCC system. The stop date should have been entered 10/21/24. A review Licensed Nurse Orientation Checklist states All items require the initials of the staff person teaching the skill: Point Click Care Electronic System: - Order entry for medications & treatments - Using MARS & TARs - Medication Error Report I. Medication: - Medication pass - time frames and standards - New medication orders - entry into PCC & communication with the pharmacy II. Documentation - Physician orders, transcription into PCC, noting & 2nd noting - Written & Telephone	F 726		

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F 726	Continued From page 23 - Medication Error Report The facility policy, Administering Medications revised 2/2022, Policy Interpretation and Implementation, 3. Medications must be administered in accordance with the orders, including any required time frame. 7. The individual administering the medication must check the label three (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. On 2/20/25 at 12:08 p.m., a surveyor confirmed that licensed staff are not provided training on the facilities electronic clinical documentation program (PCC) the facility utilizes with the Administrator.	F 726		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on the review of annual evaluations and interviews, the facility failed to complete an annual performance evaluation for Certified Nursing Assistants (CNA) at least every 12 months, for 5 of 5 CNA's reviewed with employment greater than 1 year. (CNA#1, CNA#2, CNA#3, CNA#4, and CNA#5)	F 730		

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F 730	Continued From page 24 Finding: 1. CNA #1 was hired on 11/26/2018. The employee record lacked evidence of an annual performance evaluation being completed for 2024. 2. CNA #2 was hired on 7/31/2023. The employee record lacked evidence of an annual performance evaluation being completed for 2024. 3. CNA #3 was hired on 9/5/1991. The employee record lacked evidence of an annual performance evaluation being completed for 2024. 4. CNA #4 was hired on 7/31/2023. The employee record lacked evidence of an annual performance evaluation being completed for 2024. 5. CNA #5 was hired on 2/6/2017. The employee record lacked evidence of an annual performance evaluation being completed for 2024. On 2/20/25 at 11:47 a.m., during an interview with the Facility Administrator and 2 surveyors present, the above information was confirmed.	F 730	**F 730 Nurse Aide Performance Review** • Staff #'s 1-5 did not have evaluations completed timely. • All CNA's hired are potentially affected by this finding. • A review of all current CNA's to be completed and a current performance evaluation is within the staff record. • Staff managing the CNA's will be educated on the completion of the annual performance evaluations timely. Date: 3/10/25 and ongoing • Department heads/designee will complete monthly audits of all C.N.A hires to assure performance evaluations are completed timely and reviewed and signed by the employee annually. • The Administrator/ designee will report audit results for review within the Monthly QAPI until 100% compliance is achieved and sustained. The QAPI committee will review and revise audit time frames based on compliance achieved ongoing **Correction Date 03-28-2025**	
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on reviews of facility report sent to the Division of Licensing and Certification, record reviews, and interviews, the facility failed to ensure that 2 of 5 sampled residents reviewed for	F 760		

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F 760	Continued From page 25	F 760		

medications was free of significant medication errors. (Resident #1 & Resident #34)

Findings:

1. On 9/18/24 a facility report was submitted to the Division of Licensing and Certification. A review of the facility report and the five day follow-up report stated the following:

Adult Protective Services (APS) received an anonymous report of an overdose. A medication error was discovered on 9/12/24 involving incorrect dosing of the antidepressant Wellbutrin (Bupropion). Provider on-site and evaluate Resident #1. Orders obtained to hold Wellbutrin (Bupropion) and Duloxetine for four days. Monitor for seizures or worsening of condition and send to the emergency room if any decline in status or seizure activity. Resident #1 was removed from the facility by Emergency Medical Services (EMS) shortly after.

A Nursing Progress note dated 9/12/24 indicating Resident #1 was seen by the provider regarding increased delusions and complaints of visual hallucinations. The progress notes further indicated the resident had received Bupropion 300 milligrams (mg) and Bupropion 450 mg daily for 4 days. Physicians' orders were obtained to immediately discontinue the Bupropion ER 450 mg, hold the Bupropion ER 300 mg for 4 days and hold the antidepressant medication Duloxetine for 4 days. Continue to monitor resident and send to the emergency room for evaluation or deterioration of condition.

A review of Emergency Room Documentation indicates that Resident #1 was evaluated for

F760 Significant Medication Error

- Two residents #1 and #34 had potential to be affected by this finding.
- All residents who receive medications and or treatment orders have the potential to be affected
- Licensed staff re-educated on accurate physician order entering within PCC and will complete first and second checks on all new orders to prevent medication errors, education provided on 3/6/25 and is ongoing.
- All staff who administer medications will be re-educated on accurate entering and discontinuing previous order to prevent risk of duplicate medication orders leading to medication errors.
- All staff entering physician orders will assure that order can be visualized on the MAR/TAR to be administered and that order was entered accurately.
- Ongoing review by the nurses and nurse managers to be maintained to assure compliance with parameters of medications is maintained.
- Weekly audits by Director of Nursing/Designee will note any variances and or any errors. Noted variances will be addressed and reported to QAPI meeting monthly for review and will continue until 100 percent compliance is achieved for three consecutive months.
- The Director of Nursing or designee will report audit results for review within the Monthly QAPI until 100% compliance is achieved and sustained 12 weeks. The QAPI committee will review and revise audit time frames based on compliance achieved ongoing

Correction Date 03-28-2025

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F 760	Continued From page 26 complaints of "feeling dry", intermittent visual hallucinations and staff and resident are worried that he/she may be receiving too much Bupropion. Resident #1 had complaints of feeling nauseous for 1 week with occasional vomiting and having trouble with oral intake. Resident #1 was admitted to the hospital on 9/15/24 and discharged from the hospital on 9/16/24 with a diagnosis of Lactic acidemia with elevated anion gap, resolved and a UTI. A review of the September 2024 Medication Administration Record (MAR) for Resident #1 indicates that he/she received Bupropion ER 300 mg at 6:00 a.m. on 9/9/24, 9/10/24, 9/11/24 & 9/12/24 and Bupropion ER 450 mg at 6:00 a.m. on 9/9/24, 9/10/24, 9/11/24, 9/12/24. 2. Resident #34's MAR indicates that a physician's order for Reglan 5 mg, give one tablet 4 times a day for 14 days. The MAR indicates that the resident received the medication Reglan 5 mg 4 times daily from 10/8/24 - 10/27/24. Resident #34 received 6 additional days of Reglan 5 mg 4 times daily. (24 doses) A Medication Incident Report dated 10/28/24 for Resident #34 indicates that on 10/7/24 Reglan was ordered for 14 days and did not have a stop date entered in the electronic clinical charting software, Point Click Care (PCC). On 2/20/25 at 10:10 a.m., during an interview with the Director of Nursing (DON), she stated the physicians order for Bupropion ER 450 mg was entered into the electronic clinical charting software, PCC incorrectly. The physicians order for Bupropion ER 450 mg should have been put on hold until the facility received the medication	F 760		

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F 760	Continued From page 27 from the pharmacy. Staff did not review the medication order completely that would have instructed them to discontinue the Bupropion ER 300 mg when the Bupropion ER 450 mg was received from the pharmacy. The surveyor asked if new staff and agency staff are required to complete training on the Point Click Care software. The DON stated that "It varies. Some nurses do not want any training. A lot of them have used PCC because it's so widely used. The staff orientation consists of "where things are located, the residents and we will get them into the Pyxis system. If we see something amiss, we will do reeducation." Resident #34's physicians order for Reglan 5 mg one tablet four times a day for 14 days did not have a stop date entered in the PCC system. The stop date should have been 10/21/24. On 2/20/25 at 12:08 p.m., a surveyor confirmed the significant medication errors for Resident #1 and Resident #34 with the Administrator.	F 760		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the	F 806		

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F 806	Continued From page 28 facility failed to provide food that accommodates the resident preferences and failed to provide a second-choice meal/alternative that is similar in nutritive value as the first-choice meal for 1 of 1 resident reviewed for food choices (Residents #10), this has the potential to affect all residents who have a "Minced and moist" diet and "Puree" diet. Findings: 1. On 2/18/25 at 10:42 a.m., during an interview, Resident #10 stated, there is "not enough staff to do mechanical soft for just me. I get minced moist. Speech therapist tested me and gave me a list of what I could and could not eat and they still said no." On 2/19/25 at 8:24 a.m., in an additional interview, Resident #10 stated, "Speech ok'd a list of foods that are good but they are not giving them to me because it's too much trouble for the kitchen. All those foods, I can only choose 2 items. I used to have graham crackers" ..."They serve French toast here but I'm not able to have it." He/she then stated, he/she is not able to choose his/her foods and there are no alternatives for his/her meals, stating "I do ask for hot cocoa", "I often have gone without a meal" and "It's unjust, but I don't want to be a burden to the kitchen. I'm working on dealing with the injustice of the situation." At this time, he/she confirmed he/she has not been offered a waiver discussing the potential risks involved with eating the foods of his/her choice. Review of Resident #10's Quarterly Minimum Data Set with the Assessment Reference Date of 11/27/24 revealed he/she had a Brief Interview for	F 806	**F806 Resident Allergies, Preferences, Substitutes** Facility shall accommodate resident food preference. • While resident #10 was affected, any resident has the potential to be affected. • All residents with altered diet have the potential to be affected when an alternative meal is not available to choose. • All appropriate staff who provide meals and snacks to residents are re-educated on resident food preferences and alternatives available at meal time. Date 3/11/25 and ongoing. • FSD to monitor to assure alternatives are available for second choice at meal times and that preferences are reviewed upon admission and notified when updated by staff. Diet plan can then be adjusted to accommodate resident likes and dislikes within diet order. All audits will be brought to QAPI and reviewed. • Audits and preferences will be reviewed in QAPI meeting to determine residents' requests are being honored based on reasonable accommodation and preferences x 3 months then review continued needs. **Correction date 3-28-2025**	

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Mental Status of 14 out of 15 indicating [he/she] is cognitively intact. Further review of the medical record stated he/she is responsible for decision making for him/herself.

Review of the current care plan for Activities of Daily Living self-performance deficit included an intervention of "Eating: [Resident#10] is able to feed [him/herself] after set-up, 1:1 staff supervision for exception foods".

Review of the Speech Therapy recommendations given by the Master's degree in Speech-Language Pathology and the Certificate of Clinical Competence in Speech-Language Pathology (MS CCC-SLP) upon discontinued speech services dated 8/29/24 states: "Response to treatment: patient has made functional gains with [his/her] swallowing and maintained safety on several mechanical soft foods, however the facility is only allowing 2 exceptions to [his/her] minced and moist diet, stating more is too complicated" ... "Impact to daily life: Patient would be most appropriate on a mechanical soft diet which is not offered by [his/her] living facility. Consequently there are several food items [he/she] is judged to be safe on that [he/she] is denied." Short term goal not met with the explanation of: "Patient would be most appropriate on mechanical soft textures, but the facility does not offer that consistency as a meat choice and is only allowed 2 of the foods [he/she] has been cleared for, stating more is too complicated.

Review of Speech Therapy dietary recommendations dated 8/29/24 and signed into order by provider on 9/5/24 states, "Pt now only needs supervision when consuming diet

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F 806	Continued From page 30	F 806		

exceptions."

Review of the resident notes states the following:

A dietary note on 8/16/24 at 10:19 a.m. states, "This writer met with [Resident] to explain that [him/her] diet had indeed been upgraded to ground meat with no raw vegetables, rice or nuts."

A dietary note on 8/16/24 at 2:31 p.m. states, "[Resident's] diet has been downgraded to Minced and Moist. In a conversation with [resident] it was explained by this writer and the DON (Director of Nursing) that [he/she] could choose two items off the diet that had been deemed safe to continue to be offered. [Resident] commented that the raisins [he/she] provides on [his/her] own so they should not count. [Resident] was advised that even though [he/she] purchased them, they were not on [his/her] diet and therefore if [he/she] ate them without choosing them as one of her 2 foods [he/she] wishes to have. It was explained to [him/her] that blended diets was not a good practice so [he/she] would continue to receive speech with the goal of upgraded [him/her] to the next diet, and allowing one food and a time would not be done moving forward."

A dietary note on 8/26/24 states, "when this write was auditing the resident refrigerator in the nourishment kitchen there was a piece of cake with [Resident #10's] name on it dated 8/22/24. This writer took the piece of cake and will inquire tomorrow when [family] visits if [family] brough that to [him/her]."

A dietary note on 9/11/24 during the

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F 806	Continued From page 31	F 806		

Interdisciplinary Team Meeting, Resident #10 stated that [he/she] is allowed to have cornflakes and many other things per speech. [Resident] was remined that ST (Speech) is no longer involved in [his/her] care at this time and when discharged [he/she] was put on a minced and moist diet with only those exceptions noted, with supervision."

A dietary note on 12/11/24 during the Interdisciplinary Team Meeting, Resident #10 stated, "Well if I can manage all these things I should just be able to have regular food." "It was then explained to [Resident] that [he/she] was not safe to have regular food, and that was not going to occur ... [Resident asked to speak with the MD (Doctor) in regards to upgrading [his/her] diet. [He/she] was informed that the MD would be made aware of [his/her] wish, but [his/her] likelihood of ever having a "regular diet" were rare."

A dietary note on 12/27/24 states a discussion with Resident #10's family, "It was explained to [family] the reason behind the diet, and the entire purpose of the diet was to keep [him/her] safe as this was the most appropriate diet for [him/her] as recommended by speech therapy. It was explained to [family] about additional diet textures offered by larger facilities and should [he/she] want to explore that option we would help facilitate that move. [Family] stated he believes [Resident #10] is ordering takeout and having it delivered. I explained that [he/she] should not be doing that, and I would notify the DON (Director of Nursing) so she can educate her staff that any food ordered from outside should be in compliance with [his/her] minced and moist diet, or should not be allowed, due to safety concerns."

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F 806	Continued From page 32	F 806		

Review of a MediTelecare note dated 1/30/25 states, [Resident #10 ...being seen today for an initial evaluation for psychotropic medication management .....[he/she] is a good historian ...Reports depression only when [he/she] cannot eat [his/her] favorite foods ...Reports at times [he/she] does not enjoy [his/her] food."

A review of the admission contract signed on 9/1/23 under section "Dining/Meals/Guest Meals/Diet/Food from outside" states, "Special diets will be prepared if ordered by a physician. Any resident that chooses a diet different from what the physician has ordered, may have a regular diet order if he/she signs a waiver."

The facilities Resident Diet Policy effective 1/1/2017 states: "Should a patient fail to follow the therapeutic diet on a regular basis, the noncompliance will be documented, and the dietary director will advocate for the diet to be changed to regular."

On 2/19/25 at 8:44 a.m., during an interview with 2 surveyors, the Director of food and dietary confirmed there are no residents with a current food waiver stating, they try not to because of their previous immediate Jeopardy (IJ), they don't want to end up in IJ again and the Physician and Nutritionist push everyone to be on a regular diet.

2. Review of the posted "Minced and Moist" and "Puree" menus for the 4-week meal rotation lacks an alternative option for all meals; Breakfast Lunch and Dinner. In addition, both the "Minced and Moist" and "Puree" Breakfast menus have oatmeal and eggs served every day of the week.

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	205006	A. BUILDING _____ B. WING _____	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTELLO MANOR	540 COLLEGE ST LEWISTON, ME 04240

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F 806	Continued From page 33 On 2/19/25 at 11:12 a.m., during an interview with 4 surveyors, the DON stated the doctor had very clear conversation with the resident on the risks involved with eating foods outside of his/her diet. Surveyor asked about staff supervision while the resident is consuming these restricted foods, the DON stated, "I don't have the staff to go in every hour and sit with [him/her] while [he/she] eats a cracker and doesn't dunk it in the milk. [He/she] would not follow Speech recommendations." At this time, the Surveyor discussed the admission contract which states a waiver would be given to residents who choose a different diet, reviewed speech recommendations for the resident to have foods outside of the diet with supervision, the MediTelecare note which states the resident experiences depression for not eating his/her favorite foods and the lack of alternative choices in meals for residents who have a "minced and moist" and "puree" diet. At this time, the DON confirmed resident #10 is his/her own decision maker and had not been offered a waiver for the diet of choice.	F 806		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted	F 842		

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F 842	Continued From page 34 professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.	F 842	**F 842 Resident Records** • Resident # 10 was not harmed by this finding • All residents who require respiratory therapy equipment cleaning and tubing changing have the potential to be affected by this finding. • Resident records reviewed for accurate completion documentation and of all respiratory tube changes and cleaning. • Appropriate staff re-educated on protocol for cleaning, labeling all respiratory equipment in use. Date: 3/6/25 and ongoing • Director of Nursing or designee will complete random weekly audits to assure all respiratory equipment changes were completed and documented accurately within the medical record and compliance is being maintained. • All audits will be reviewed within the QAPI meeting until 100 percent compliance is achieved for 8 weeks and then audit time frames will be re-evaluated by the committee to assure sustainability is maintained. Ongoing **Correction date 3-28-2025**	

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F 842	Continued From page 35 §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that the clinical records were complete and contained accurate documentation for 1 of 4 residents review for respiratory care. (Resident #10) Findings: On 2/18/25 at 10:33 a.m., and at 2:10 p.m., observations of Resident #10 using a nasal cannula for his/her oxygen (O2) administration with the tubing dated 1/28/25. Review of Resident #10's provider order dated 12/2/24 instructs nursing to, "change and date O2 and C-pap tubing Clean concentrator filter every night shift every Mon". Review of the medication administration record for January 2025 has documentation of the O2 nasal canula tubing being changed on 1/27. February 2025 record has documentation of the O2 nasal cannula tubing being changed on 2/3, 2/10 and 2/17.	F 842		

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F 842	Continued From page 36 On 2/19/25 at 2:20 p.m., the above was discussed with the Administrator.	F 842		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will	F 867	**F867 Quality assurance performance improvement** • No residents were harmed by this finding. • All residents have the potential to be affected by this finding. • F584, F623, F625, F689, & F806 were identified as repeat deficiencies. New plan of correction formatted and implemented to achieve compliance in these deficiencies and all other areas identified. • Re-education on all areas for plan of correction listed within this survey will be completed. Date: 3/6/25 and ongoing • Complete plan of correction provided to and reviewed with all department head and QAPI committee members to assure understanding and expectations in achieving compliance and sustaining compliance utilizing the written plan of correction audits completed and reviewing and revising any variances identified. Date: 3/5/25 • Weekly audits by Administrator/Designee will note any variances in each area of the plan of correction to assure compliance is achieved and sustained. Audits will be reviewed within the QAPI meeting monthly for review and will continue until 100 percent compliance is achieved for three consecutive months. • The Administrator will report audit results for review within the Monthly QAPI until 100% compliance is achieved and sustained for three months. The QAPI committee will review and revise audit time frames based on compliance achieved ongoing **Correction date 3-28-2025**	

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F 867	Continued From page 37 systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.	F 867		

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F 867	Continued From page 38 §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §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: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by:	F 867		

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F 867	Continued From page 39 Based on record review and interview, the facility's Quality Assurance Committee failed to ensure that the Plan of Correction for identified deficiencies from the Annual Long Term Care Survey Process for Federal Recertification dated 12/12/23, were effective. The Federal citations F584, F623, F625, F689, and F806 were cited again during the annual Long Term Care Recertification Survey dated 2/20/25. Findings: During the Annual Long Term Care Survey Process for Federal Recertification dated 2/20/25, it was determined that F584, F623, F625, F689, and F806 would be recited for the same reasons: F584 for failure to adequately provide housekeeping and maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable environment; F623 failure to issue a written transfer/discharge notice to a Resident or their legal representative for a facility-initiated transfer/discharge; F625 failure to issue a written bed hold notice to include cost of care to the Resident and/or resident representative; F689 failure to ensure that the resident's environment was free of accident hazards relating to the storage of chemicals being properly secured; and F806 failure to provide food that accommodates the resident preferences and failed to provide a second-choice meal/alternative that is similar in nutritive value as the first-choice meal. On 2/20/25 at 12:28 p.m., during an interview, the above findings were discussed with the Administrator.	F 867		
F 868 SS=D	QAA Committee	F 868		

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F 868	Continued From page 40 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 assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by:	F 868	**F868 QAPI/Committee** • No residents were directly affected by this finding. • Staff re-educated on the expected attendance of the Director of Nursing and ICP at all QAPI meetings to assure compliance is achieved and maintained. Date: 3/5/25 • The administrator will assure that the QAPI meetings have the appropriate staff in attendance to assure compliance is maintained at all meetings. • The signature sheet reflects all staff that were in attendance to all QAPI committee meetings. **Correction Date 03-28-2025**	

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F 868	Continued From page 41 Based on review of the Quality Assessment and Assurance (QAA) attendance sheets and interview, the facility failed to ensure that an Infection Preventionist and the Director of Nursing attended 1 of 4 quarterly QAA meetings. Findings: A review of the quarterly QAA meeting attendance sheets indicated that the Director of Nursing did not attend the February 20, 2024 quarterly QAA meeting and an Infection Preventionist did not attend the June 4, 2024 quarterly QAA meeting. On 2/20/25 at 12:28 p.m., in an interview, the above was confirmed with the Administrator.	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	F 880		

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F 880	Continued From page 42 arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism 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	F 880	**F880 Infection Control** • Resident #7, # 187, #10, #19 were not harmed by this finding • All residents receiving respiratory therapy have the potential to be affected by this finding. • All residents on precautions will have sign up when room under precautions until it is cleaned completely after discharge. • All staff re-educated on the management of respiratory equipment checking, cleaning and monitoring and isolation removal process. Date: 3/06/25 and ongoing • ICP / designee will complete weekly audits on respiratory equipment and management of isolation signage and cleaning of room post discharge to assure compliance is achieved and sustained x 12 weeks ICP to report any variances in the audits and corrections and revisions made at the QAPI committee meetings once 100 percent compliance is achieved for 3 months the committee will re-evaluate and adjust audit time periods ongoing... **Correction date 3-28-2025**	

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F 880	Continued From page 43 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, record review, and interview, the facility failed to disinfect reusable resident equipment during medication administration for 2 of 4 residents observed during medication administration. In addition, the facility failed to implement infection prevention measures for 1 of 3 days of survey (2/20/25). Findings: 1. On 2/19/25 at 8:44 a.m., Certified Nursing Assistant (CNA)- Med Tech was observed taking a blood pressure (BP) with a BP cuff for Resident #10 with a reading of 97/60. The CNA-M removed the BP cuff and did not sanitize afterwards. On 2/19/25 at 9:13 a.m., Certified Nursing Assistant - Med Tech was observed taking a blood pressure with a BP cuff for Resident #31 with a reading of 109/79. The CNA-M removed the BP cuff and did not sanitize afterwards. During an interview on 2/19/25 at 9:22 a.m., the CNA-M indicated equipment should be cleaned in between residents with a sanitizing wipe but she forgot today. The facility policy Cleaning and Disinfecting Resident Care Items and Equipment revised 2/2022 Policy Interpretation and Implementation - 4. Reusable resident care equipment will be	F 880		

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F 880	Continued From page 44 decontaminated and/or sterilized between residents. On 2/19/25 at 11:35 a.m., a surveyor discussed the above finding in an interview with the Administrator. 2. On 2/20/25 at 9:40 a.m., during an environmental tour, a surveyor asked to go into Resident room 60 on the North wing and was told by the Maintenance Director that Resident #1 had Norovirus and that room is under contact precaution. The surveyor and the Maintenance Director observed no contact precaution sign stating that there was contact precaution or what staff needs to wear when going into that room. He said the room will not be cleaned until he is told by Nursing administration that the room is no longer on contact precaution. On 2/20/25 at 9:43, the Administrator observed resident room 60 with a surveyor and the Maintenance Director, stated the resident had been sent to the hospital and confirmed that there should be a contact precaution sign on the door. On 2/20/25 at 10:06 a.m., in an interview, the Infection Preventionist(IP0 confirmed that if a resident on Transmission Based Precaution(TBP) was sent to the hospital then the room stays shut with precaution signs on the door and remains on precautions. The IP went on to state that it is still a precaution room and there are germs in side of it and the 48 hours hasn't passed where that resident would be off precaution.	F 880		
F 909 SS=D	Resident Bed CFR(s): 483.90(d)(3)	F 909		

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F 909	Continued From page 45 §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 and mattresses as part of a regular maintenance program to ensure that the mattresses and bed frames are compatible and identify areas of possible entrapment for 1 of 37 beds.(Resident #11's) Finding: On 2/18/25 at 10:28 a.m., a surveyor observed Resident #11's bed and found the mattress was approximately 12 inches to short for the bed and left a large gap between the mattress and the footboard of the bed creating an area of possible entrapment. On 2/18/25 at 11:08 a.m., 2 surveyors observed Resident #11's bed and found the mattress was approximately 12 inches to short for the bed and left a large gap between the mattress and the footboard of the bed creating an area of possible entrapment. On 2/18/25 at 12:36 p.m., in an interview, the Maintenance Director confirmed the mattress was approximately 12 inches to short for the bed and left a large gap between the mattress and the	F 909	**909 Resident Bed** • Resident # 11 was affected by this finding. No harm related to this finding • All residents with a bed have potential to be affected by this finding • Residents bed was corrected the same day it was identified. • All residents' beds were checked by environmental services to assure all beds mattresses were compatible. • Regular inspections on mattresses to be completed weekly by environmental services to assure compliance is maintained. • Inspections to reported by Environmental service director or designee to the QAPI committee monthly and variances identified and corrected immediately. • Environmental services director/designee will report inspections and any variances in the QAPI committee meetings. Once 100 percent compliance is achieved for 3 months the committee will re-evaluate and adjust audit time periods ongoing. **Correction Date: 03-28-2025**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205006	A. BUILDING _____ B. WING _____	02/20/2025

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F 909	Continued From page 46 footboard of the bed creating an area of possible entrapment. On 2/18/25 at 12:44 p.m., in an interview, a surveyor discussed the finding with the Administrator.	F 909		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 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. Furthermore the facility failed to ensure that the	F 947	**F947 Annual C.N.A in-service training** • 5 CNAs did not have the required 12 hours of in-service listed within their record as completed. • All CNAs/staff have the potential to be affected by this finding. • CNAs/staff to receive education to achieve at least the 12 hours annually required to maintain their certifications. • Re-education provided on the expected number of hours required annually to nursing leadership for all CNAs hired. Date: 3/10/25 and ongoing • Tracking system updated to assure that CNA have access to the hours completed each year. • Monthly Inservice calendar is posted to provide the C.NA ample opportunities to complete their 12 in-service hours annually to meet the requirements • Director of Nursing/designee will complete weekly audits on the completion of in-services each month due to assure compliance is achieved and sustained x 8 weeks and report any variances in the QAPI committee meetings. Once 100 percent compliance is achieved for 3 months the committee will re-evaluate and adjust audit time periods ongoing. **Correction date 3-28-2025**	

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F 947	Continued From page 47 CNA attended the mandatory yearly dementia trainings for 3 of 5 CNA's employed greater than 1 year. (CNA#1, CNA#2, CNA#3, CNA#4, and CNA#5). On 2/20/25 a surveyor reviewed the following employee files: 1. CNA #1 was hired on 11/26/2018. Review of CNA #1 Employee In-service/attendance Records lacked evidence of dementia training along with the required 12 hours for continuing education for the year of 2024. 2. CNA #2 was hired on 7/31/2023. Review of CNA #2 Employee In-service/attendance Records lacked evidence of dementia training along with the required 12 hours for continuing education for the year of 2024. 3. CNA #3 was hired on 9/5/1991. Review of CNA #3 Employee In-service/attendance Records lacked evidence of the required 12 hours for continuing education for the year of 2024. 4. CNA #4 was hired on 7/31/2023. Review of CNA #4 Employee In-service/attendance Records lacked evidence of dementia training along with the required 12 hours for continuing education for the year of 2024. 5. CNA #5 was hired on 2/6/2017. Review of CNA #5 Employee In-service/attendance Records lacked evidence of the required 12 hours for continuing education for the year of 2024. On 2/20/25 at 11:47 a.m., During an interview with the Facility Administrator and 2 surveyors present, the above information was confirmed.	F 947		

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