STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205124	A. BUILDING _____ B. WING _____	C 09/26/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 9/25/24 and 9/26/24 unannounced on site visits were conducted at Breakwater Commons to investigate complaint's #ME00048322, #ME00048820, #ME00048836 & #ME00048788 . It was determined that Breakwater Commons was not in substantial compliance with 42 CFR Part 483, Subpart B - Requirements for Long Term Care Facilities.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584	F584-The facility has requested an Informal Dispute Resolution In separate correspondence. Education and reminders were provided to nursing staff regarding appropriate room temperatures for Facility staff inspected room thermostats on the Memory Care Unit to assure appropriate temperature settings were in place prior to conclusion of survey. Locking thermostat covers were purchased and installed following proper temperature setting by Maintenance Staff. Families and residents may choose to have the covers removed upon request. Maintenance Department, Administrator, DNS and Charge nurses have keys to the thermostat covers to adjust temperatures as needed or requested. Success or concerns with this process will be Documented and reviewed during the facility's quarterly QAPI meetings and as needed x 90 days.	9/17/2024 9/26/2024 10/9/2024

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

Administrator 10/20/2024

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

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F 584	Continued From page 1 §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 interviews, the facility failed to maintain a comfortable homelike environment for 1 of 2 units reviewed during a complaint investigation (Memory). Findings: On 9/11/24 at 8:00 a.m., the Department of Licensing received an anonymous compliant indicating on 9/8/24 at 10:30 a.m., indicating on multiple times when [family member] has visited her mother/father in the morning, his/her room has been very cold. Resident #1 was admitted on 11/28/1930 and has diagnoses to include dementia, anxiety, depression, and is receiving Hospice services for end of life care and resided on the Memory Care unit. Review of quarterly Minimum Data Set (MDS) dated 5/29/24 revealed Resident 1 had a Brief Interview for Mental Status (BIMS) of 0 of 15 indicating he/she is not cognitively intact.	F 584		

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F 584	Continued From page 2 During an interview with 2 surveyors on 9/26/24 at 10:30 a.m., Memory Care Unit Manager (UM) indicated a couple of weeks ago he/she came to work in the am and observed a resident coming out of his/ her room and they looked cold, UM went over to see if he/she wanted a sweater and brought resident back into their room and noted it was very cold. UM looked at the thermostat and the air conditioning (AC) was on and set to 68F. UM turned the heat on and went around to check other rooms and found that there were multiple other rooms that also had their AC on at 68F as well. During a confidential interview with 2 surveyors on 9/26/24 at 10:45 a.m. a SM #2 indicated that some CNA's on the overnight shift have been turning the AC on in the Memory Unit at night to try to keep the residents in bed, so they don't wander. Has come in multiple times to AC on in rooms, very cold. (most recently 2-3 days ago [9/23/24]). not comfortable giving names, but it continues to happen. During an interview with 2 surveyors on 9/26/24 at 2:26 p.m., Director of Nursing confirmed she was aware that staff were turning ac on at night and addressed it in a CNA meeting on 9/17/24 and is not sure if it is still happening or not.	F 584		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or	F 585		

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F 585	Continued From page 3	F 585		

reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey

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F 585	Continued From page 4 Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as	F 585	F585 The facility will review and adopt a singular Grievance Policy as to be accepted by the facility QAPI Committee which will enforce timely response to resolve grievances This policy will be included in future facility admission packets to educate all residents and families. The Administrator or appointed "official" will assume the role of Grievance Officer as to be accepted by the facility QAPI Committee. Department managers will be educated on the Grievanc Policy and processes following final adaptation by the facility's QAPI Committee. Grievance data and policy compliance will be Reviewed during the facility's quarterly QAPI meetings and as needed x 6 months.	10/22/2024 10/22/2024 11/8/2024

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F 585	Continued From page 5 the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on policy review, record reviews, and interviews the facility failed to establish/implement their own grievance policy reviewed for 1 of 4 records reviewed during a complaint investigation (Resident #3). Findings: On 7/29/24 at 9:24 a.m., the Department of Licensing received a complaint indicating they filed a grievance on behalf of their family member (Resident #3) on 7/25/24 and did not receive a response for 30 days, even though [complainant] kept inquiring. Complainant further indicated [he/she] was informed the Grievance Officer was the Director of Nursing (DON) and the facility provided [him/her] with 2 different grievance policies, one policy states a response will be received in 15 days, and the other says they will respond in a reasonable amount of time, but they never told [him/her] what a reasonable amount of time was. Review of facility provided "Grievance Policy" dated 10/18 states "The facility will ensure prompt resolution to all grievances, keeping the resident and resident representative informed through the investigation and resolution process. The facility grievance process will be overseen by a	F 585		

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F 585	Continued From page 6 Grievance Official who will be responsible for receiving and tracking grievances through their conclusion ... Resident and Resident Representative Notification: The notice shall include. Reasonable time frame for completing the review of a complaint ... Upon receipt of a grievance or concerns, the Grievance Official will initiate the appropriate notification and investigation processes per indicial and facility policies. Resolution: The facility will strive for a prompt resolution outcome for grievances or complaints rendered. A reasonable time frame will be agreed upon with involved parties." Review of "Resident Admission Packet" revealed "Notice of Resident Grievance Procedure" undated, states " ... The Administrator will respond to a written grievance within 15 days. The response will include actions taken ..." Review of facility provided "Grievance" packet dated 7/29/24 states: "Care being provide by [cna] [staff member], UTI concern, decline and hospice needing to do a "sternal rub; getting out of bed; drinks." Further review of Grievance packet revealed response was dated 8/26/24. During an interview with 2 surveyors on 9/25/24 at 1:16 p.m., Social Worker (SW) indicated she used to be the Grievance Officer, but the responsibility was transferred to the Director of Nursing in April (2024). SW indicated she does encourage residents and families to try to settle things without a grievance, but when that's not possible they are encouraged to file a grievance with the Director of Nursing and the facility has 15 days to get back to the person that filed it. At this time SW confirmed Resident #3's family member filed the grievance on 7/25/24.	F 585		

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F 585	Continued From page 7 During an interview on 9/26/24 at 2:26 p.m., DON indicated that the SW was the Grievance Officer, but it was the responsibility of whatever department to investigate the grievance. When asked how long it takes to respond to a grievance, the DON replied 30 days and that she felt that was a reasonable time frame. At this time DON confirmed she received complainants' grievance on 7/25/24 but DON didn't file it until the 26 because she had a few questions she needed answered first.	F 585		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 609	F609- The facility has requested an Informal Dispute Resolution In separate correspondence. A facility incident report was completed following the fall to resident #1 per protocol. 9/8/2024 There are currently no outstanding unreported incidents 10/18/2024 The Administrator and Director of Nursing have been further educated on reporting requirements for injuries of known and unknown origin. The facility Falls Committee is scheduled monthly to review internally reported falls and will assist to determine that reporting requirements have been met. monthly Falls Committee data will be shared with the facility QAPI Committee on a quarterly basis x 6 months.	

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F 609	Continued From page 8 designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that an injury of unknown origin was reported to the State Agency after a resident was found on the floor and bleeding from a head laceration for 1 of 4 complaint investigations reviewed (Resident #1). Findings: On 9/11/24 at 8:00 a.m., the Department of Licensing received a compliant indicating on 9/8/24 at 10:30 a.m., Resident #1, who is a high fall risk was left in his/her room unattended in a Broda chair and was found face down on the floor, sustaining head and right hand laceration requiring transfer to and acute care hospital for evaluation and treatment. Resident #1 has diagnoses to include dementia, anxiety, depression, is dependent on staff for all Activities of Daily Living (ADL)'s and is receiving Hospice services for end of life care. Review of quarterly Minimum Data Set (MDS) dated 5/29/24 revealed Resident 1 had a Brief Interview for Mental Status (BIMS) of 0 of 15 indicating he/she is not cognitively intact. Review of facility "Resident Incident Reporting Form" dated 9/7/23 states " ...This nurse was notified that resident was on the floor in [his/her] room and the broad chair was lying on its side ...	F 609		

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F 609	Continued From page 9 Upon entering residents' room this nurse noted resident lying face down but more on [his/her] right side ... noticed there was blood on the floor by [his/her] head. Upon checking resident over[he/she] had a laceration to [his/her] outer eye at the end of her eyebrow ..." During an interview on 9/26/24 at 7:52 a.m., Administrator confirmed the facility did not report this injury of unknown origin to the state. In front of 2 surveyors.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to investigate an injury of unknown origin after a resident was found on the floor, bleeding from a head laceration for 1 of 4 complaint investigations reviewed (Resident #1).	F 610	F610- The facility has requested an Informal Dispute Resolution In separate correspondence. A facility incident report was completed following the fall to resident #1 per protocol. 9/8/2024 There are currently no outstanding incidents requiring further investigation of injury origin. 10/18/2024 The Administrator and Director of Nursing have been further educated on investigation requirements for injuries of known and unknown origin. The facility Falls Committee is scheduled monthly to Review internally reported falls and will assist to determine that reporting requirements have been met. monthly Falls Committee data will be shared with the facility QAPI Committee on a quarterly basis x 6 months.	

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F 610	Continued From page 11 During an interview with 2 surveyors on 9/26/24 at 7:52 a.m., Administrator confirmed the facility did not investigate this injury of unknown origin.	F 610		
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 (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	F 656	F656- The facility has requested an Informal Dispute Resolution In separate correspondence. Resident #1, #2, and #3 had orders for psychotropic side effect monitoring at time of survey (see IDR request letter). Resident #2 care plan has identified bed against wall and floor mat being used. Education provided to nursing managers. Psychotropic medications reviewed for compliance of side effect monitoring and reported at QAPI at least on a quarterly basis x 6 months. Monthly audit for beds against wall and floor mats being used will be reviewed for Compliance in care plan and reported out to QAPI at least on a quarterly basis x 6 months.	9/26/24 10/17/24 monthly monthly

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F 610	Continued From page 10 Findings: On 9/11/24 at 8:00 a.m., the Department of Licensing received a compliant indicating on 9/8/24 at 10:30 a.m., Resident #1 who is a high fall risk was left in his/her room unattended in a Broda chair and was found face down on the floor, sustaining head and right hand laceration requiring transfer to and acute care hospital for evaluation and treatment. Resident #1 has diagnoses to include dementia, anxiety, depression, and is receiving Hospice services for end of life care. Review of quarterly Minimum Data Set (MDS) dated 5/29/24 revealed Resident 1 had a Brief Interview for Mental Status (BIMS) of 0 of 15 indicating he/she is not cognitively intact. Review of Resident 1's clinical record revealed that he/she is dependent on staff for Activities of Daily Living (ADL)'s and has had multiple falls since admission. Review of facility "Resident Incident Reporting Form" dated 9/7/23 states " ...This nurse was notified that resident was on the floor in [his/her] room and the broad chair was lying on its side ... Upon entering residents' room this nurse noted resident lying face down but more on [his/her] right side ... noticed there was blood on the floor by [his/her] head. Upon checking resident over[he/she] had a laceration to [his/her] outer eye at the end of her eyebrow ..." Further review of Resident 1's clinical record lacked evidence that an investigation was conducted after this incident.	F 610		

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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 656	Continued From page 12 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, observations, and facility policy, the facility failed to update and include goals and interventions on the resident's current comprehensive care plan for the areas of falls for 1 of 3 residents reviewed (Resident #2), incontinent care for 1 of 3 residents (Resident #3), and psychotropic medication use for 3 of 3 residents reviewed during a complaint investigation. Findings: Review of facility policy "Psychoactive Medication Use Policy" dated 9/18 states "Psychoactive medications will only be used in conjunction with the Individual Care Plan ..." 1. Resident #1 has diagnoses to include hypertension (HTN), kidney disease, dementia, anxiety, and depression and is receiving Hospice for end of life care. Review of active medication orders dated September 2024 revealed Resident #1 was	F 656		

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	205124	A. BUILDING _____ B. WING _____	C 09/26/2024

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F 656	Continued From page 13 taking anti-anxiety medications Ativan and Lorazepam, antidepressant Sertraline, and antipsychotic Risperdal. Review of Resident #1 Care plan most recently reviewed on 9/24/24 revealed "Mood: I have Depression, Anxiety and Dementia. I use psychoactive medications for management of symptoms of striking out physically, paranoid thoughts, depression, trying to stand on my own. I will have no adverse drug reactions from psychotropic medications over the next 90 days. Monitor, report, and document changes in mentation: Anti- anxiety: sedation, drowsiness, ataxia, dizziness, nausea, vomiting, confusion, headache, blurred vision, skin rash ..." Further review of Resident #1's clinical record lacked documented evidence that he/she was being monitored for the above medication side effects. During an interview with 2 surveyors on 9/26/24 at 3:09 p.m., the Director of Nursing reviewed the entire clinical record and confirmed Resident #1 was not being monitored for side effects of the above medications. 2. Resident #2 was admitted on 9/29/22 and has diagnoses to include heart failure, Alzheimer's disease, anxiety, depression and is receiving Hospice for end of life care. Review of active orders dated September 2024 revealed Resident #2 was taking antidepressant medication Sertraline, and Lorazepam for anxiety. Observations of Resident #2 on 9/25/24 at 2:38 p.m., and 9/26/24 at 1:02 p.m., revealed Resident	F 656		

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F 656	Continued From page 14 #2 in bed, bed was located against the wall, with fall mat at bedside. Review of Resident #2's care plan, most recently reviewed 8/5/24 revealed: "FALL: I have a potential for falls r/t poor safety awareness. I will not have any falls over the next 90 days. anticipate and meet needs. keep personal space clutter free. Unable to use call bell due to cognitive impairment. Mobility: extensive assistance required with mobility; Hoyer lift for transferring; COGNITION: Cognition: [Resident #2] has an alteration in mood state related to Alzheimer's dementia with anxiety: Goal: Medications and treatments per physician orders. Monitor for side effects and effectiveness, Medications and treatments per physician orders. Monitor for side effects and effectiveness. Further review of Resident #2's clinical record lacked documented evidence he/she was being monitored for side effects of psychotropic medication use. Further review of Resident #2's care plan lacked evidence of goals and interventions for locating the bed against the wall or fall mat use. In addition, Resident #2's clinical record laced documented evidence he/she was being monitored for side effects of psychotropic medication use. During an interview with 2 surveyors on 9/26/24 at 3:10 p.m., Director of Nursing (DON) reviewed Resident #2's entire clinical record and confirmed it lacked evidence Resident #2 was being monitored for signs and symptoms for psychotropic medication use, and the care plan was not updated with goals and interventions to have the bed against the wall or fall mat use.	F 656		

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F 656	Continued From page 15	F 656		

3. Resident #3 was originally admitted on 6/18/24 and has diagnoses to include neurogenic bladder, arthritis, heart failure, dementia, anxiety, depression and is receiving Hospice services for end of life care.

Review of Resident #3 Care plan initiated on 6/18/24 revealed "Urinary Continence: I am incontinent of urine. I require your total assist for incontinence care. ...Check for incontinence at times such as before or after meals, HS, and prn; change if wet/soiled [minimum of 6 times daily]; Mood and Behavior: ...I take medication for my moods/behaviors... will have no adverse drug reactions from psychotropic medications over the next 90 days. Monitor Anti- anxiety: sedation, drowsiness, ataxia, dizziness, nausea, vomiting, confusion, headache, blurred vision, skin rash. Antidepressant: sedation, drowsiness, dry mouth, blurred vision, urinary retention, tachycardia, muscle tremor, agitation, headache, skin rash, photosensitivity, excessive weight gain. Antipsychotics: sedation, drowsiness, dry mouth, constipation, blurred vision, EPS, weight gain, edema, postural hypotension, seizures, glaucoma, jaundice. Hypnotic/Sedative: Sedation, drowsiness, ataxia ..."

Review of entire clinical record laced evidence lacked documented evidence Resident #3 received/refused incontinent care per care plan and lacked evidence he/she was being monitored for side effects of psychotropic medication use.

During an interview with 2 surveyors on 9/26/24 at 2:50 p.m., the Director of Nursing reviewed the entire clinical record and confirmed Resident #3

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F 656	Continued From page 16 is not being monitored for side effects of psychotropic medication, and was not receiving incontinent care per care plan interventions.	F 656		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and policy review, the facility failed to obtain informed consent for use of psychotropic medication use, and failed to monitor for side effects of psychotropic medications for 3 of 3 residents reviewed during a complaint investigation (Residents #1, #2 and #3).	F 757	F757- The facility has requested an Informal Dispute Resolution In separate correspondence. Resident #1, #3 had informed consent in place at time of survey. Resident #2 is deceased. Education provided to nursing managers. Audit for psychotropic medications will be reviewed for compliance. Of informed consent and reported out to QAPI at least on a quarterly basis x 6 months.	10/17/24. monthly

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F 757	Continued From page 17 Findings: Review of facility policy "Psychotropic Medication Use Policy" dated 9/18 states "It is the goal for North Country Associates to ensure proper use, evaluation, and monitoring of psychoactive medications ...Informed consent for psychoactive medications will be obtained; ...Side effect monitoring and documentation will be collected and documented on a daily basis;...Psychoactive medication use must be monitored closely, in conjunction with the physician and the pharmacist, for effectiveness, side effects, and contraindications for use ..." 1. Resident #1 has diagnoses to include dementia, anxiety, and depression and is receiving Hospice for end of life care. Review of Resident #1's active orders dated September 2024 revealed: -Order with start date of 9/20/24 for Morphine concentrate 20mg/ml oral syringe (for oral use only) (0.25ml) syringe (ML) oral every eight hours for thirty days spinal stenosis. -Order with start date of 9/13/24 for anti-anxiety medication Ativan 0.5mg tablet (0.5 mg) tablet 2 times daily for 30 days for dementia -Order with start date of 9/24/24 for anti-anxiety medication, lorazepam 0.5 mg tablet (1 tab) as needed every 6 hours. -Order with start date of 9/20/24 for antidepressant medication Sertraline 50 mg tablet (1.5 tabs) one time daily. -Order with start date of 6/5/24 for antipsychotic medication Risperdal 0.5 mg tablet (1) tablet by mouth three times daily. Further review of Resident #1's clinical record	F 757		

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F 757	Continued From page 18	F 757		

lacked documentation that informed consents were obtained for above psychotropic medications, and lacked evidence Resident #1 was being monitored for side effects of the above psychotropic medications.
During an interview with 2 surveyors on 9/26/24 at 3:10 p.m., Director of Nursing (DON) reviewed Resident #1's entire clinical record and confirmed it lacked evidence Resident #1 was being monitored for signs and symptoms for psychotropic medication use and lacked evidence informed consents were obtained for use of above psychotropic medications.

2. Resident #2 was admitted on 9/29/22 and has diagnoses to include heart failure, Alzheimer's Disease, anxiety, depression and is receiving Hospice for end of life care.

Review of Resident #2's active orders dated September 2024 revealed:
-Order with start date of 3/8/24 for Sertraline 50mg tablet, 1 tab oral 1 time daily for depression.
-Order with start date of 9/4/24 Lorazepam 0.5mg tablet, ½ tablet oral 2 times daily for 30 days for dementia, anxiety.

Further review of Resident #2's clinical record lacked documentation that informed consents were obtained for above psychotropic medications, and lacked evidence Resident #2 was being monitored for side effects of the above psychotropic medications.

During an interview with 2 surveyors on 9/26/24 at 3:10 p.m. April Director of Nursing (DON) reviewed Resident #2's entire clinical record and confirmed it lacked evidence Resident #2 was

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F 757	Continued From page 19 being monitored for signs and symptoms for psychotropic medication use and lacked evidence informed consents were obtained for use of above psychotropic medications. 3. Resident #3 was originally admitted on 6/18/24 and has diagnoses to include neurogenic bladder, dementia, anxiety, depression and is receiving Hospice services for end of life care. Review of Resident #3's active orders September 20204 revealed: -Order with start date of 6/24/24 for antipsychotic medication Risperidone 1 mg tablet 1 time daily. -Order with start date of 6/18/24 for anti-anxiety medication Lorazepam 0.5 mg tablet PRN every 4 hours. -Order with start date of 6/21/24 for antidepressant medication sertraline 25 mg tablet 1 time daily. Further review of Resident #3's clinical record lacked documentation that informed consents were obtained for above psychotropic medications, and lacked evidence Resident #3 was being monitored for side effects of the above psychotropic medications. During an interview with 2 surveyors on 9/26/24 at 3:10 p.m. Director of Nursing (DON) reviewed Resident #3's entire clinical record and confirmed it lacked evidence Resident #3 was being monitored for signs and symptoms for psychotropic medication use and lacked evidence informed consents were obtained for use of above psychotropic medications.	F 757		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5)	F 842		

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F 842	Continued From page 20 §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 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	F 842	F842 Resident #3s care plan reflects that resident will be checked and changed at times upon rising, meal times, h.s., and as needed when soiled/wet. Education was provided to c.na staff. Resident #3 will be reviewed weekly x 4 weeks and then monthly X 5 for compliance of documentation of incontinence care This will Be reported out to QAPI at least quarterly x 6 months.	9/26/24 10/15/24

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F 842	Continued From page 21 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. §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 clinical records were complete and contained accurate information for 1 of 3 sampled residents reviewed for incontinent care (Resident #1). Findings: Resident #3 was originally admitted on 6/18/24 and has diagnoses to include neurogenic bladder.	F 842		

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F 842	Continued From page 22 Review of Admission Minimum Data Set (MDS) dated 6/24/24 revealed Resident #3 had a Brief Interview for Mental Status (BIMS) of 0 of 15 indicating he/she is not cognitively intact. Further review of MDS revealed he/she is dependent on staff for all Activities of Daily Living (ADL). Review of Resident #3 Care plan initiated on 6/18/24 revealed "Urinary Continence: I am incontinent of urine. I require your total assist for incontinence care. ...Check for incontinence at times such as before or after meals, HS, and prn; change if wet/soiled [minimum of 6 times daily]. Review of "ADL Verification Worksheet" dated July 2024 revealed Resident #3 received incontinent 1 (one) time on 7/10/24, 7/18/24, 7/24/24, 7/25/24, 7/26/24, 7/27/24, 7/28/24, and 7/31/24. 2 (two) times on 7/1/24, 7/2/24, 7/3/24, 7/4/24, 7/8/24, 7/9/24, 7/12/24, 7/15/24, 7/16/24, 7/17/24, 7/19/24, 7/20/24, 7/22/24, 7/23/24, and 7/30/24, and 3 (three times) on 7/5/24, 7/6/24, 7/7/24, 7/11/24, 7/13/24, 7/14/24, and 7/29/24. During a review of Resident #3's clinical record with 2 surveyors on 9/26/24 at 2:55 p.m., the Director of Nursing (DON) indicated that at the time of documents reviewed, residents should have been toileted/changed at each meal time, first thing in the morning, before bed and any other time necessary in between. At this time DON confirmed above findings.	F 842		