STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205070	A. BUILDING ______ B. WING ______	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE POINT CENTER	67 PINE POINT RD SCARBOROUGH, ME 04074

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS From 4/6/25 through 4/9/25, on-site visits were conducted at Pine Point Center for the purpose of a Recertification Survey and investigating complaints #ME00047847, #ME00047913, #ME00048496, #ME00049078, #ME00050057, #ME00050346, #ME00051109, and #ME00051115. It was determined that Pine Point Center was not in substantial compliance with 42 CFR 483, Sub-part B Requirements for Long Term Care Facilities.	F 000		
F 578 SS=B	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still	F 578		5/24/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: , ED
TITLE
(X6) DATE: 5/1/2025

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F 578	Continued From page 1 legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record reviews, and interviews, the facility failed to provide evidence to show Advance Directives were offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an Advance Directive, for 4 of 14 residents reviewed for Advance Directives. (Resident#12, #18, #2 and #19) Findings: 1. Resident #12 was admitted to the facility in February 2025. A review of the residents electronic medical record and their paper medical record lacked evidence that the facility offered, reviewed, or provided written information concerning the right to formulate an advanced directive to the resident and/or resident representative. 2. Resident #18 was admitted to the facility in	F 578	Resident #12 Discharged on 4/10/2025. Resident #18 offered material to formulate advanced directives. Resident #2 offered material to formulate advanced directives. Resident #19 Discharged on 4/7/2025 The SSD/ Designee will conduct a facility wide audit to ensure all residents have been provided written information concerning the right to formulate an advanced directive. Additionally identified residents will be provided with written information concerning the right to formulate an advanced directive. The CNE/ Designee will provide education to the social service department on the right to formulate an advanced directive. The SSD/ Designee will audit social service assessments weekly x4 weeks, monthly x3 months, to ensure residents are provided written information concerning the right to formulate an advanced directive and bring results to the monthly QAPI meeting for further review and recommendations	5/24/2025

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F 578	Continued From page 2 December 2024. A review of the residents electronic medical record and their paper medical record lacked evidence that the facility offered, reviewed, or provided written information concerning the right to formulate an advanced directive to the resident and/or resident representative. On 4/6/25 at 3:00 p.m., the above information was Discussed with the Market Clinical Advisor. 3. Resident #2 was admitted in December 2024. A review of the entire medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. 4. Resident #19 was admitted in December 2024. A review of the entire medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. On 4/8/25 at 4:15 p.m., the above findings were reviewed with the Market Clinical Advisor.	F 578		5/24/2025
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.	F 610		5/24/2025

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F 610	Continued From page 3 §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 review, interviews, and facility policy, the facility failed to thoroughly investigate an Injury of Unknown Origin for 1 of 1 resident reviewed for Injuries of Unknown Origin. (Resident #57) Findings: On 10/5/24 the Division of Licensing and Certification received a report that Resident #57 obtained an injury to his/her left ankle, while an unknown Certified Nursing Assistant was putting on the resident's shoe. Review of Resident #57 medical record contained a provider note, dated 10/4/24 of an evaluation of his/her left ankle, which resulted in the provider ordering an X-Ray. On 10/5/24 an X-Ray was obtained and showed no evidence of a fracture but showed soft tissue swelling. Further review of the medical record lacked evidence of any nursing documentation of an injury occurring or monitoring of his/her left foot. Review of the facility's investigation dated	F 610	Resident #57 was discharged on 10/15/2025. CNE/Designee will audit all current investigations to ensure compliance with the facility policy under Abuse Prohibition. CNE/ Designee will ensure that the facility policy Abuse Prohibition last revised on 10/24/22 will "Initiate an investigation within 24 hours of an allegation of abuse that focuses on whether abuse or neglect occurred and to what extent, clinical examination of signs and symptoms of injuries, if indicated, causative factors, and interventions to prevent further injury"... "The investigation will be thoroughly documented within the Risk Management Portal and Ensure that documentation of witnesses is included". Licensed staff have been re-educated to this process. CNE/ Designee will complete random weekly audits x4 weeks and monthly x3 months to ensure policy and procedures are being met regarding the process for Abuse Prohibition. That there is an investigation initiated within 24 hours and thoroughly documented within the Risk Managment Portal and ensure the witnesses are included. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	5/24/2025

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F 610	Continued From page 4 10/7/24, consisted of the Director of Nursing's interview with Resident #57 and a family member, and a note from an Occupational Therapy (OT) student dated 10/7/24. The OT students note states that Resident #57 "Reported to the OT student that his/her left leg hurt very badly and was bruised and swollen. Patient showed OT his/her left lower extremity, there was bruising on the anterior aspect of his/her knee and swelling with slight bruising on his/her left ankle. Patient reported that the injury occurred from an "aid" that was trying to help him/her put his/her shoes on but was painfully twisting his/her leg." Further review of the facilities investigation lacked evidence that the Director of Nursing thoroughly investigated Resident #57 injury of unknown origin by completing observations and interviews with staff who was working with Resident #57. The facility policy "Abuse Prohibition", last revised on 10/24/22 states in Section 7, subsection 7.7 "Initiate an investigation within 24 hours of an allegation of abuse that focuses on whether abuse or neglect occurred and to what extent, clinical examination of signs and symptoms of injuries, if indicated, causative factors, and interventions to prevent further injury"... "The investigation will be thoroughly documented within the Risk Management Portal. Ensure that documentation of witnesses is included". On 4/8/25 at 11:20 p.m., during an interview, the Market Clinical Advisor was unable to find any additional documentation in the risk management portal or further investigations.	F 610		5/24/2025
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		5/24/2025

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F 657	Continued From page 5 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to review and revise the care plan by an interdisciplinary team (IDT) meeting, which included the participation of the resident and resident's representative, after each Minimum Data Set (MDS) 3.0 assessment, for 3 of 10 residents whose care plans were reviewed. (Resident #22, #40, #11) Findings:	F 657	Resident #22 had CP meetings completed 4/29/2025. Resident #40 left voice mail for family to schedule IDT on 4/29/2025 awaiting call back. Resident #11 had CP meeting completed 4/29/2025 An audit of resident's records was done to confirm a CP meeting was completed and/ or scheduled following the completion of the most recent MDS. SSD/ Designee and the IDT staff will review and revises the care plan which includes the participation of the resident and resident s representative, after each Minimum Data Set (MDS)3.0 assessments, facility IDT staff will be re-educated to this process. SSD/ Designee will complete random weekly audits x4 weeks, then monthly x 3 months of completed MDS to validate CP meetings are completed and to ensure policy and procedures are being followed. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	5/24/2025

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F 657	Continued From page 6	F 657		5/24/2025

1. Resident #22's medical record contained a Significant Change MDS, dated 5/25/24, and Quarterly MDS' dated 8/9/24, 11/7/24, and 1/29/25. The record lacked evidence of IDT meetings being held within 7 days of the above MDS assessments. The medical record stated the last IDT meeting was held on 3/12/24.

On 4/8/25 at 11:20 p.m., the above information was discussed with the Market Clinical Advisor.

2. Resident #40's clinical record contained Quarterly MDS' dated 12/13/24 and 3/15/25. The record lacked evidence of IDT meetings being held within 7 days of the MDS assessment. In addition, the Admission MDS dated 9/12/24 had a IDT meeting held on 9/16/24 with the resident in attendance, but not the family representative.

On 4/8/25 at 2:27 p.m., during an interview, the Market Clinical Advisor confirmed that IDT meetings had not been held and there was no evidence that Resident #40's representative had been invited or had been provided with a copy of the resident care plan.

3. Resident #11's clinical record contained a Quarterly MDS Assessment, dated 1/11/25. The record lacked evidence of IDT meetings being held within 7 days of the MDS assessment.

On 4/9/25 at 10:21 a.m., during an interview, the Social Services Director confirmed she does not have a process for scheduling IDT meetings and does not usually provide residents or their representatives advance notification of the

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F 657	Continued From page 7 meeting(s).	F 657	Resident #106 discharged on 4/8/2025.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to provide Activities of Daily Living (ADL) care in the area of showers/bathing for 1 of 4 residents reviewed (#106). Finding: 1. On 4/06/25 at 11:44 a.m., in an interview with a surveyor, Resident #106 stated he/she had not received a shower and was "washing" him/herself up by hand. A review of the clinical record for Resident #106 revealed an admission date of 4/2/25. The baseline care plan, initiated on 4/2/25, indicated staff were to provide partial/moderate assist of 1 for bathing. A review of CNA documentation noted no shower had been provided since admission. On 4/7/25 at 1:30 p.m., in an interview with a surveyor, CNA#1 was asked to explain the process for assigning a resident a shower/bath day. CNA#1 stated the unit uses a shower book and residents are scheduled based on room number. Resident #106 was presently scheduled for Friday, second shift.	F 677	An audit of resident s shower schedule was completed to validate residents are being offered shower unless contraindicated and the results of this offering are recorded on the POC ADL documentation record and/or unit shower book.. The facility offers residents showers weekly or at intervals appropriate based on preference unless contraindicated. The facility records the results of this offering on the POC ADL documentation record. Staff will be re-educated in this process. The CNE/designee will complete random weekly audits of ADL documentation will complete random weekly audits x4 weeks, then monthly x 3 months to validate that staff have offered residents showers as scheduled. This audit will include monitoring of documentation of that offering in the POC documentation record. The results of the audits will be brought to the monthly QAPI Committee for further review and recommendations	5/24/2025

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F 677	Continued From page 8 On 4/7/25 at 1:45 p.m., in an interview with the Oak Hill House Unit Nurse Manager, the surveyor discussed that Resident #106 was unaware he/she was scheduled for a shower and had not been offered a shower on the scheduled day. The Nurse Manager stated sometimes therapies offer to assist residents with showers. The Nurse Manager confirmed the shower was scheduled for Friday but would talk with the resident and have one offered today. On 4/7/25 at 2:15 p.m., in a discussion with Resident #106, the surveyor advised he/she was scheduled for a shower on Friday evenings. Resident #106 stated he/she had not been offered a shower last Friday or at any time since admission. On 4/7/25 at 2:30 p.m., the surveyor discussed with the Market Clinical Advisor that Resident #106 had not been informed of her scheduled shower day and had missed the opportunity last Friday. She had not been offered the opportunity to take a shower since admission.	F 677		5/24/2025
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		5/24/2025

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F 684	Continued From page 9 Based on record review and interviews, the facility failed to assess and monitor a surgical wound (Resident#57), failed to follow physician orders for a wound care (Resident#27) for 2 of 2 resident reviewed for wounds. In additon, the facility failed to obtain physician orders for 1 of 1 resident reviewed for positioning. (Resident #4) Findings: 1. Resident #57 was admitted to the facility in September of 2024, after having a left intertrochanteric femur fracture operation leaving him/her with a surgical wound. Review of the Treatment Administration Record indicated that he/she had "Suture/staple removal one time only for Post op left proximal femur" on 10/6/24. Upon further review, the medical record lacked evidence of an initial nursing assessment, continued monitoring, and assessments of the surgical site throughout his/her stay. On 4/8/25 at 11:20 p.m., the above information was confirmed with the Market Clinical Advisor. 2. On 4/6/25 at 10:02 a.m., and on 4/7/25 at 12:16 p.m., Resident #27 was observed with an uncovered, open wound on his/her right forearm. Resident #27's clinical record contained a physician order dated 4/3/25 for, "Mupirocin External Ointment 2 % (Mupirocin) Apply to Right forearm topically every evening shift for Biopsy for 11 Days. Cover with Band aid, Per dermatology" On 4/9/25 at 10:30 a.m., during an interview, the Registered Nurse #2 stated Resident #27's right forearm wound is supposed to be covered with a bandage at all times. At this time, the finding was	F 684	Resident # 57 discharged on 4/8/2025. Resident #27 current order completed on 4/14/2025. Resident #4 current order in place/ care plan updated. An audit of residents records was completed to determine initial skin assessments and monitoring of wounds following physician orders for a wound, obtaining orders for positioning of a resident with a brace. Staff will be re-educated to this policy and procedure. CNE/Designee will ensure physicians orders are obtained and implemented for monitoring of wounds, following physician orders for a wound, and obtaining orders for positioning of a resident with a brace. CNE/Designee will complete random weekly audits x4 weeks and monthly x 3 months to ensure policy and procedures are being met regarding monitoring of wounds following physician orders for a wound, obtaining orders for positioning of a resident with a brace. The results of these audits will be brought to the Monthly QAPI Committee for further review and recommendations.	5/24/2025

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F 684	Continued From page 10	F 684		5/24/2025

reviewed with the Unit Manager, and she stated Resident #27 does not typically refuse treatments or remove his/her wound dressing.

3. Resident #4 has diagnoses to include hemiparesis (paralysis) following cerebral infarction (stroke).

On 4/6/25 at 11:49 a.m., a surveyor observed a brace on Resident #4's left wrist. At this time, Resident #4 stated he/she has had the brace since his/her stroke and that the nursing staff helps him/her put the brace on first thing in morning and take it off at night.

Review of Resident #4's care plan stated, " ...Patient will tolerate left upper extremity wrist brace for no more than 4 hours daily to improve wrist range of motion..." A physician progress note, dated 4/1/25, stated, "Left hemiparesis ...wearing [his/her] brace today...."

Further review of the clinical record lacked evidence of a physician order for the left wrist brace.

On 4/9/25 at approximately 1:00 p.m., during an interview, the Director of Rehabilitation and the Occupation Therapist stated their department provided Resident #4's left wrist brace while he/she was receiving therapy, and they would expect to see a physician order for the brace, but that is driven by nursing.

On 4/9/25 at 2:10 p.m., the above finding was reviewed with the Market Clinical Advisor and the Director of Nursing.

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F 689	Continued From page 11	F 689		
F 689 SS=D	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 on 1 of 5 units (Pleasant Hill House) for 1 of 4 days of survey (4/6/25). Findings: 1. On 4/6/25 at 10:07 a.m., observation of Room 4 on Pleasant Hill House to have an unsecured container of Micro-Kill One Germicidal Alcohol Wipes and a bottle of toilet bowl cleaner. At this time, Registered Nurse #2 confirmed the chemicals should not be stored in a resident's bathroom and removed the chemicals. 2. On 4/6/25 at 11:47 a.m., observation of Room 1 on Pleasant Hill House to have an unsecured container of Micro-Kill One Germicidal Alcohol Wipes. At this time, Registered Nurse #2 again confirmed that chemicals should not be stored in a resident's bathroom and removed the chemicals.	F 689	All chemicals were removed from the resident's room on unit Pleasant Hill House and stored properly. The CNE/ Designee did a whole house audit to ensure residents do not have access to chemicals. The CNE/ Designee will ensure that chemicals are properly stored and that the resident's environment is free of accident hazards relating to the storage of chemicals being properly secured The CNE/ Designee will complete random weekly audits x4 weeks and monthly x 3 months to ensure policy and procedures are being met regarding resident's environment free of accident hazards relating to their storage of chemicals being properly stored. The results of these audits will be brought to the Monthly QAPI Committee for further review and recommendations.	5/24/2025

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	205070	A. BUILDING ______ B. WING ______	04/09/2025

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PINE POINT CENTER	67 PINE POINT RD SCARBOROUGH, ME 04074

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F 689	Continued From page 12 The Safety Data Sheet for Micro-Kill One Germicidal Alcohol Wipes states in Section 4: First Aid Measures. "If inhaled: remove person to fresh air and keep comfortable for breathing. Call Poison control center/doctor is you feel unwell" ... "If on skin (or hair): take off immediately all contaminated clothing. Rinse skin with water" ... "If in eyes: Rinse continuously with water for several minutes. Remove contact lenses, if present and easy to do. Continue rinsing. If eye irritation persists, get medical advice/attention" ... "Indigestion: Rinse mouth. Do not induce vomiting. Get medical attention if symptoms occur. Never give anything by mouth if the victim is unconscious or is convulsing. Obtain medical attention. The Safety Data Sheet for 3M Bathroom Disinfectant Cleaner Ready-to-Use states in Section 4: First Aid Measures. "Inhalation: Remove person to fresh air. If you feel unwell, get medical attention" ... "Skin Contact: Wash with soap and water. If signs/symptoms develop, get medical attention" ... "Eye contact: Flush with large amounts of water. Remove contact lenses if easy to do. Continue rinsing. If signs/symptoms persist, get medical attention" ... "If swallowed: Rinse mouth. If you feel unwell get medical attention". On 4/9/25 at approx 4:15 p.m., the above information was discussed during exit with the Administer, Director of Nursing and the Market Clinical Advisor	F 689		5/24/2025
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care	F 699		5/24/2025

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F 699	Continued From page 13 The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to identify a resident's past history of Post-Traumatic Stress Disorder (PTSD)/trauma to determine what trigger(s) might cause re-traumatization and failed to revise the care plan to include those triggers and interventions to prevent re-traumatization for 1 of 2 residents reviewed with a diagnosis of PTSD. (Resident #22) Finding: On 4/6/25 a review of Resident #22's medical record showed he/she was admitted in 2018 and had a current diagnosis of PTSD. Further review including assessments and the current care plan lacked evidence that the facility assessed the resident for what triggers might cause re-traumatization and failed to revise the care plan to include those triggers and interventions to prevent re-traumatization. On 4/7/25 at 3:30 p.m., during an interview, the Market Clinical Advisor confirmed the above and stated that nursing completed a trauma assessment today on Resident #22 which included triggers that may cause re-traumatization.	F 699	Resident #22 trauma care plan was updated and completed with triggers to prevent re-traumatization. CNE/ Designee will review resident care plans for history of trauma diagnosis and review that resident care plans reflect trauma informed care with triggers to prevent re-traumatization. CNE/ Designee will provide education to Social Worker regarding updating trauma informed care plans if there is a diagnosis history of trauma per facility policy SS100 Social Services Assessment. CNE/ Designee will complete weekly audit of care plans for those with a trauma diagnosis weekly x4 weeks and monthly x3 months. This audit will include monitoring of documentation of those care plans. The results of the audits will be brought to the monthly QAPI Committee for further review and recommendations.	5/24/2025
F 725 SS=E	Sufficient Nursing Staff	F 725		5/24/2025

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F 725	Continued From page 14 CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. 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)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews, the facility failed to ensure sufficient direct care staff were scheduled and on duty to meet the needs of residents that reside in the facility for weekends of the first quarter (October 1, 2024 - December 31, 2024). This has the potential to affect all residents needing assistance with Activities of Daily Living (ADLs).	F 725	The scheduler is confirming sufficient direct care staff is scheduled to meet minimum daily requirements. CNE reviewed with the resident's the sufficient daily requirements/ census requirements to meet direct care needs on 4/29/2025 when asked to attend resident council. Resident #13 was asked during resident counsel on 4/29/2025 and confirmed call-lights are now being answered in a timely manner per resident. CNE/ Designee will ensure sufficient direct care staff are scheduled and on duty to meet the needs of residents that reside in the facility for weekends. The facility has a two tier on call program to ensure staffing back up in the event of a call out or emergency. Facility staff will be re-educated to this process. The CNE/Designee will complete weekly audits x4 and monthly audits x3 months to validate the facility has sufficient direct care staff scheduled weekends and is using the services of a two tier on call program for weekends in the event of a call out or emergency. The results of these audits will be brought to the Monthly QAPI Committee for further review and recommendations.	5/24/2025

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Findings:

1. Review of Payroll Based Journal staffing report revealed the facility triggered for low weekend staffing during the first quarter of 2025 (October 1, 2024 - December 31, 2024).

On 4/9/25 at 1:56 p.m., both the surveyor and the Director of Nursing reviewed the weekend staffing from October 1, through December 31, 2024. The Director of Nursing confirmed the facility did not ensure enough staff were on duty to meet resident needs on the weekends.

2. A review of the Resident Council Meeting Minutes revealed the following:
-meeting minutes dated 2/26/25 stated "Residents are concerned that staffing ratios aren't consistent. Especially 2nd shift, long waits noted ...Residents are concerned that call lights are not consistently being responded to timely.
-meeting minutes dated 3/26/25 stated, "Residents are concerned that there is only one aide per unit on the second shift and they are not consistently available.
On 4/6/25 at 10:54 a.m., during an interview, Resident #13 stated the lack of staff is a regular concern at Resident Council meetings and that he/she lets the Administrator know about the complaints about staffing.

3. Review of grievances filed by the Resident Council revealed the following:
-a grievance filed 8/12/24 stated, " Residents are concerned that call lights aren't consistently being responded to timely."
- a grievance filed 9/23/24 stated, "Residents are concerned that call lights aren't consistently being

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F 725	Continued From page 16 responded to timely."	F 725	All expired vacutainers in lab room on long term care side have been discarded.	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to properly secure medications on 1 of 2 (Short Stay Unit) units for 2 of 4 days of survey, failed to ensure expired medications were removed from the supply available for use in 2 of 4 treatment/medication carts reviewed and failed to ensure expired lab supplies were removed	F 761	All short stay expired meds were discarded including the expired Guaifenesin XR and routine rounding is done daily to ensure med carts are staying locked when not in use by nurse. All expired meds on long term care side have been discarded. An audit of all med rooms, lab room and medication were completed to validate expiration dates of drugs and vacutainers, expired drugs and vacutainers are being discarded timely, and medication/ treatment carts are locked when not in use. The facility, in accordance with accepted professional standards of practices, will maintain valid drug and vacutainers and ensure treatment/ medication carts are reviewed to ensure expired medication/ lab supplies are removed and carts are locked. Staff will be re-educated on the policy and procedures. CNE/ Designee audit to be done on each unit weekly x4 weeks and monthly x3 months on treatment/ medications carts to ensure policy and procedure is being met with removal of expired drugs/ treatment supplies, and lab supplies. The results of these audits will be brought to the Monthly QAPI Committee for further review and recommendations	5/24/2025

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F 761	Continued From page 17	F 761		5/24/2025

from supply available for use on 2 of 2 units (Short Stay and Long Term Units).

Findings:

1. On 4/6/25 at 9:02 a.m., observation of the Short Stay unit to have an unlocked and unattended treatment cart containing 4 residents insulin pens, pen needles and lancets, during this time 2 residents were present. At 9:05 a.m., the Certified Nurses Aid #1 confirmed the unlock treatment cart and locked it.

2. On 4/6/25 at 11:52 a.m., observation of the Short Stay unit medication room with the Licensed Practical Nurse #3 (LPN#3). The surveyor asked if nursing draws their own labs. The LPN#3 stated, "We can, yes. I haven't for a while, we have a guy who comes in, he usually brings his own supplies. We will be next week; our guy goes on vacation". On the counter was a plastic tote containing 13 butterfly needles with expiration date of 9/21/24, 5 blue top blood vacutainers with expiration date of 10/31/23 and 6 yellow top vacutainers with expiration date of 1/31/25. The LPN#3 confirmed the supplies available for use were expired and stated there is a lab room on the other unit with additional supplies.

3. On 4/6/25 at 12:10 p.m., observation of the lab room on the long-term care units with the Registered Nurse #3 (RN#3) which contained 46 red top blood vacutainers with expiration date of 4/1/25, 41 white top vacutainers with exp. of 12/1/23, 175 green top vacutainers with exp. date of 12/3/23, 3 dark blue top vacutainers with exp. date of 11/30/24, 34 small yellow vacutainers with exp. date of 3/31/25, 100 gray top vacutainers

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F 761	Continued From page 18 with exp. date of 11/30/23, and 99 blue top vacutainers with exp. date 4/30/23. At this time, the RN#3 notified the Director of Nursing (DON) who observed the expired vacutainers. The DON stated nurses can draw labs, but they do have a guy who comes in to draw labs and brings his own supplies and will not be available the next week. 4. On 4/7/25 at 6:47 a.m., observation of the Short Stay medication cart unlocked and unattended. The surveyor was able to open and go through the medication cart which contained a bottle of Fish oil 1000 milligram (mg) with and expiration date of 1/11/25 and 21 tabs of Guaifenesin Extended Release tabs with expiration date of 2/25. During this time, 2 staff walked by and observed the surveyor in the medication cart, a Registered Nurse (RN) and Certified Nurses Aid (CNA) neither addressed the unlocked medication cart. At 6:53 a.m., the surveyor asked RN#1, who returned to the area, to lock the medication cart. On 4/7/25 at 6:55 a.m., the above was discussed with the Market Clinical Advisor 5. On 4/7/25 at 9:49 a.m., observation of Dunstan House medication cart with the LPN #2 which contained a blister pack of Fexofenadine 60mg with an expiration date of 10/2024. At this time, the LPN#2 confirmed and removed the expired medication.	F 761		5/24/2025
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides-	F 804		5/24/2025

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F 804	Continued From page 19 §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and a lunch meal test tray, the facility failed to serve food at an appetizing and palpable temperature for 1 of 2 meals observed. Findings: On 4/6/25 at 9:53 a.m., during an interview, Resident #10 discussed concerns of the food not being hot when it gets to resident. On 4/7/25 at 10:50 a.m., a surveyor requested a sample tray,sample tray. During the observation, both Certified Nursing Assistant (CNA) #2 and CNA #3 started to serve the lunch trays for the 20 residents at 12:19 p.m. During this meal pass, both CNA's had to boost and turn 2 residents and one CNA had to take a resident to the bathroom. The last meal was served at 12:50 p.m., 31 minutes after the first tray was passed. At 12:51 p.m., the food on the sample tray food was tempted, in which the BBQ pulled pork sandwich was 121.7 degrees Fahrenheit and the seasoned potato wedges were 85 degrees Fahrenheit. On 4/7/25 at 1:20 p.m., during an interview, CNA #3 stated they occasionally get more help with passing trays, but it usually ends up being just 2 CNA's which results in cold food.	F 804	Resident #10 was present at resident council on 4/29/2025 resident confirmed that since metal hot plates were put in place on that unit the temperatures have no longer been an issue. The surveyor requested a sample tray to test and kitchen advised there is only enough room on meal cart for the amount of rooms on unit, at 12:19 pm lunch began being served, the sample tray came to the unit on top of the meal cart as the surveyor requested it come to the unit even though she was informed that it would not hold a temp due to not fitting in the meal cart, surveyor then did not temp the sample tray for over 31 minutes from being sent down from the kitchen while it sat on top of the meal cart. CNE/ Designee will review meal pass length of time on each unit to ensure meals are proper temperature when served to residents. CNE/ Designee will provide education to all staff regarding proper served meal temperatures and review facility policy HCSG Policy 006: Food: Quality and Palatability. CNE/Designee will provide and re-educate staff regarding length of time of meal pass CNE/ Designee will audit meal pass and sample meal tray temperatures weekly x4 weeks and month x3 months or until resolved ensuring sample meal tray temperatures are appropriate and report results to QAPI Committee for further review and recommendations.	5/24/2025

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F 804	Continued From page 20 On 4/7/25 at 1:00 p.m., the above information was discussed with the Market Clinical Advisor.	F 804		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for floors, walls, the dishwasher and fans/vents, failed to ensure staff were wearing proper hair restraints and failed to ensure that canned goods with a compromised seal were not available for use for 1 of 4 days of survey. (4/6/25) Findings: On 4/6/25 at approx. 9:00 a.m., during the initial	F 812	Kitchen floors, walls, the dishwasher and fans/vents were cleaned. Wall fans were removed. Dietary aide #1 and #2 were provided education immediately regarding proper hair restraints. Kitchen stock was audited to ensure all cans were checked for damage and if dented they were placed in the designated area for compromised cans, so they are not available for use. An audit was completed to ensure the kitchen was maintained in a clean and sanitary manner for floors, walls, the dishwasher and fans/vents, failed to ensure staff were wearing proper hair restraints and failed to ensure that canned goods with a compromised seal were not available for use. The facility in accordance with accepted professional standards of practice, will review kitchen floors, walls, dishwasher and fans/vents for dirt/debris/food ensuring the space is clean and that staff use proper hair restraint per facility policy and procedures. Staff will be re-educated on policy and procedures. Administrator/ Designee will audit kitchen environment and the use of hair restraint weekly x4 weeks and monthly x3 months to ensure kitchen environment meets cleanliness standards and hair restraints are properly in use and report results to QAPI Committee for further review and recommendations.	5/24/2025

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F 812	Continued From page 21 tour of the kitchen the following was observed: 1. -The kitchen floor was dirty with food debris and trash around the entire floor and under the equipment and shelving. - The kitchen walls were covered with dirt and food debris. - The dish washer was covered with dirt and debris. - The vent above the grill was coated with dirt and debris. - The vents and fans throughout the kitchen had built up dust 2. Observation of the Dietary Aid #1 and #2 not wearing proper hair restraints while preparing food. After surveyor intervention, both Dietary Aid #1 and #2 applied hair restraints. 3. Observation of 3, #10 cans of peaches with denting along the seal and available for use. At this time, the Cook #1 stated that cans should be checked for damage upon arrival and if dented, placed in the designated area for compromised cans so they are not available for use. On 4/6/25 at 1:14 p.m., the above information was discussed with the Food Service District Manager.	F 812		5/24/2025
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	F 842		5/24/2025

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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
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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 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-

Resident #11 s order was corrected to ensure order showed on the MAR/TAR for accurately charting if being given and/or being refused.

An audit of residents MARs was completed to validate accuracy of the medical record as it related to treatments and medication administration.

The facility, in accordance with accepted professional standards and practices, will maintain medical records on each resident that are complete and accurately documented. Licensed staff will be re-educated on the policy and procedures.

CNE/Designee will complete random weekly x 4 weeks then monthly x 3. These audits will include confirming that orders are in the system accurately to be signed off as being given and/ or refused were completed and the medical record is accurately documented. The results of these audits will be brought to the Monthly QAPI Committee for further review and recommendations.

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	205070	A. BUILDING ______ B. WING ______	04/09/2025

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(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 review, observation, and interviews, the facility failed to ensure that clinical records were complete and contained accurate information for 1 of 2 residents reviewed for nutrition (Resident #11).

Finding:

Resident #11 was admitted in 2024 with diagnoses to include protein-calorie malnutrition.

Resident #11's clinical records contained an active physician order dated 1/17/25 for "Start 8oz whole milk & full fat ice cream milkshake TID w/ meals and at bedtime with meals AND at bedtime."
A physician progress note, dated 2/28/25 which stated, "Did verify with staff that [he/she] is being given whole milk with [his/her] shakes....however,

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F 842	Continued From page 24 unable to find the order for milkshakes on the MAR (Medication Administration Record) or TAR (Treatment Administration Record). Did discuss this with unit manager..." An additional physician progress note, dated 4/1/25 which stated, "Weight loss...still do not see order for milkshakes on MAR or TAR to be signed out, will discuss with nurse manager again..." Resident #11's MAR and TAR for January, February, and March 2025 lacked documentation of the milkshakes being given. On 4/8/25 at 8:51 a.m., during an interview with a surveyor, the unit manager reviewed Resident #11's entire clinical record and confirmed the January, February, and March 2025 MAR/TAR lacked evidence of Resident #11 being given and/or refusing a milkshake. On 4/8/25 at 11:44 a.m., the above was discussed with the Market Clinical Advisor.	F 842		5/24/2025
F 880 SS=E	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	F 880		5/24/2025

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F 880	Continued From page 25 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism 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.	F 880	LPN #2 was re-educated to the policy and procedures for hand hygiene. CNA #2 and 3 were re-educated to the policy and procedures for hand hygiene. PT-A was re-educated on proper donning and doffing of PPE policy and procedures. An audit was completed to validate staff have been re-educated to the hand hygiene and use of PPE to provide a sanitary environment to help prevent the development and transmission of disease and infection. The facility and staff will maintain the Infection Control Program designed per company policy to provide a sanitary environment to help prevent the development and transmission of disease and infection related to hand hygiene during medication administration and meal tray service observations and the use of Personal Protective Equipment (PPE) CNE/Designee will complete weekly audits x4 weeks monthly x 3 months to ensure the Infection Control Program designed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to hand hygiene during medication administration and meal tray service observations and the use of Personal Protective Equipment (PPE). The results of these audits will be brought to the monthly QAPI committee for further review and recommendations.	5/24/2025

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§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to maintain an Infection Control Program designed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to hand hygiene during medication administration and meal tray service observations and the use of Personal Protective Equipment (PPE) for 3 of the 4 days of survey.

Findings:

1. On 4/7/25 at 8:02 a.m., just prior to medication administration observation, the Licensed Practical Nurse #2 (LPN #2) was observed at the nurse's station rubbing his eyes and nose multiple times. He then moved the medication cart onto Pleasant Hill House and without preforming hand hygiene prepared a resident medication, again rubbing eyes and nose, he then entered resident room, removed and applied a Lidoderm patch to the residents back, then administered the resident's medications all without performing hand hygiene. At this time, the LPN#3 stated, due to a condition,

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he frequently rubs his eyes, and he should have performed hand hygiene prior to preparing and administering medications.

On 4/7/25 at approx. 8:30 a.m., the above was discussed with the Market Clinical Advisor

2. On 4/7/25 at 12:25 p.m., during lunch meal pass on the Skilled Unit, a surveyor observed CNA #2 and CNA #3 turning and boosting a resident in his/her bed, both CNA's exited the residents room and without performing hand hygiene, CNA #2 grabbed a meal tray and delivered it to Room 18 and CNA #3 grabbed a meal try and delivered it to Room 13. At 12:27 p.m., at this time the surveyor intervened, both CNA #2 and CNA #3 confirmed they should have performed hand hygiene after providing care to a resident and prior to tray delivery.

On 4/7/25 at 1:00 p.m., the above information was discussed with the Market Clinical Advisor.

3. On 4/8/25 at 4:04 p.m., a Physical Therapy Assistant (PT-A) was observed exiting the Oak Hill unit, wearing a yellow isolation gown. The PT-A proceeded to walk past the surveyor, located next to the nurse's station and enter the main dining room, where she doffed the isolation gown and then exited the dining room. At this time, the surveyor asked where the PT-A was prior to leaving the Oak Hill unit, and the PT-A stated she had been in a room wearing gloves, a gown, an N95 mask, and eye protection because the resident was on transmission-based precautions (TBP). She then stated, while she was in the room with the resident, the nurse came in and informed her that the TBP had just been

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F 880	Continued From page 28 lifted and she removed her gloves, mask, and eye protection before she exited the room and should have removed the gown, but she forgot, so she doffed it in the dining room. On 4/8/25 at 4:11 p.m., the above was discussed with the Market Clinical Advisor.	F 880		5/24/2025