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	205083	A. BUILDING _____ B. WING _____	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADIGAN ESTATES	93 MILITARY STREET HOULTON, ME 04730

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F 000	INITIAL COMMENTS From 5/19/25 through 5/22/25, on-site visits were conducted at Madigan Estates for the purpose of completing the annual Survey Process for Federal Recertification and investigating complaint #ME00051618 and Facility Reported Incident #ME00050902. It was determined that Madiagn Estates is not in compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 605 SS=D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical	F 605		

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

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F 605	Continued From page 1	F 605		

symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure an as needed (prn) psychotropic medication met the required 14-day limit for 1 of 5 Resident's reviewed for unnecessary medications (Resident #5 [R5]).

Finding:

On 5/20/25, during a review of R5's current Physician Orders, it showed that R5 was using the facility's Palliative care end of life order set. The order set included an order for Haldol (a psychotropic medication), with directions that if a resident is less than or equal to 60 kilograms (kg) or greater than 70 years of age to give Haldol 0.5 milligrams(mg) to 1 mg intramuscularly (IM) prn for agitation every hour until calm, then every 6 hours prn with no stop date. The medical record lacked evidence of clinical rational to continue the prn psychotropic medication with an extended time frame.

Review of the electronic Treatment Administration Record (TAR) revealed that R5 received a prn Haldol dose of 1 mg on 4/16/25, and a prn Haldol dose of 1 mg on 4/18/25. On 4/19/25 the prn Haldol order was reentered with no stop date, the 14-day limit would be on 5/2/25. R5 required a Provider visit to reevaluate the use or need of the prn Haldol medication. Review of R5's clinical record and TAR revealed that after the date of 5/2/25, R5 received 17 doses of the prn Haldol at

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F 605	Continued From page 2 1 mg IM after the 14-day limit. On 5/21/25 at 1:00 p.m., during an interview with the Nurse Manager/Supervisor, a surveyor confirmed that the clinical record lacked the required documentation or the rational for continuing the prn Haldol, and that the Provider had not evaluated R5 for the continued use of the prn Haldol. Review of R5's physician progress notes indicated that R5 was seen by the Provider on 5/20/25, but the use of the prn Haldol was not reviewed by the Provider.	F 605		
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		

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F 609	Continued From page 3	F 609		

designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:
Based on facility policy review and interviews, the facility failed to ensure an alleged allegation of physical and verbal abuse was reported to the Division of Licensing and Certification for 1 of 2 residents reviewed (Resident #13 [R13]).

Finding:

A review of the facility's policy, "Abuse Prevention Program: Policy Statement", states, "7. Investigate and report any allegations of abuse within timeframes as required by federal requirements".

On 5/11/25, the Division of Licensing and Certification received from Adult Protective services an allegation of verbal and physical abuse toward R13 by Certified Nursing Assistant #2 (CNA2) who was witnessed raising his/her voice, in a derogatory manner and using profanity while working with R13.

A review of a facility-provided written statement from Licensed Practical Nurse [LPN] states, " ...R13 was having a hard time catching his/her breath and that it felt like [CNA2] was trying to "pull his/her catheter out of his/her [insertion site] and was being extremely rough with him/her. As I was walking in, I hear CNA2 say to R13, I'm not being mean you're just a [profanity] jerk."

A review of a facility-provided letter, dated

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F 609	Continued From page 4 5/13/25, addressed to [CNA2], from [Human Resource Manager] states that, "This letter services as formal notice that your per diem status with [facility] is terminated effective immediately due to your use of unacceptable language with a resident and your decision to walk off your shift ..." and a review of "DISCIPLINE" notice, "The following infractions will result in immediate discharge: ... H. Abusive treatment toward a resident. I. Leaving duty station before relief arrives.", and "The following infractions will result in a written warning: H. Discourteous conducts toward any resident, visitor or employee". A review of a facility-provided email, dated 5/16/25 at 10:57 a.m., addressed to [Director of Nursing (DON)], from [CNA2] states that " ... all I simply said was you're a jerk nothing more ..." to R13. On 5/21/25 at 12:35 p.m., in an interview with the Director of Nursing (DON), a surveyor confirmed that staff reported an allegation of verbal and physical abuse of R13 by CNA2 to the DON, and the surveyor confirmed that the facility did not notify the Division of Licensing and Certification of the allegation of alleged physical and verbal abuse.	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.	F 610		

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§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 facility policy review, record review, and interview, the facility failed to ensure an allegation of physical and verbal abuse was investigated for 1 of 2 complaints reviewed (Resident #13 [R13]).

Finding:

A review of the facility's policy, "Abuse Prevention Program: Policy Statement", states, "7. Investigate and report any allegations of abuse within timeframes as required by federal requirements".

On 5/11/25, the Division of Licensing and Certification received from Adult Protective services an allegation of verbal and physical abuse toward Resident #13 by Certified Nursing Assistant #2 (CNA2) who was witnessed raising his/her voice, in a derogatory manner and using profanity while working with R13.

A review of a facility-provided written statement from Licensed Practical Nurse [LPN] states, " ...R13 was having a hard time catching his/her

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F 610	Continued From page 6 breath and that it felt like [CNA2] was trying to "pull his/her catheter out of his/her [insertion site] and was being extremely rough with him/her. As I was walking in, I hear CNA2 say to R13, I'm not being mean you're just a [profanity] jerk." During the facility's recertification survey and this investigation, the facility was not able to provide evidence that this allegation of abuse was investigated. On 5/21/25 at 12:35 p.m., in an interview with the Director of Nursing (DON), a surveyor confirmed that the facility did not complete an abuse investigation for the allegation that was brought to their attention by facility staff of physical and verbal abuse of R13 by CNA2.	F 610		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure that the Minimum Data Set (MDS) 3.0 was coded accurately on a Significant Change MDS assessment to indicate that a resident had a State Level II Preadmission Screening and Resident Review (PASRR) for 1 of 3 residents reviewed for PASRR (Resident #60 [R60]). Finding: On 5/19/25, R60's clinical record was reviewed and included a Level I PASRR, dated 4/2/24, that	F 641		

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F 641	Continued From page 7 indicated that R60 needed a face to face review. On 5/21/25 at 10:09 a.m., the Director of Nursing (DON) provided a surveyor with R60's PASRR Level II, dated 4/15/24. Review of R60's Significant Change MDS, dated 12/4/24, was coded under Section: A1500 to indicate that R60 did not have a Level II PASRR. On 5/21/25 at 11:10 a.m., the surveyor confirmed with the DON that R60's Significant Change MDS 3.0, dated 12/11/24, was coded incorrectly under section A 1500 for the question, "Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition" as it was answered "no".	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services.	F 655		

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F 655	Continued From page 8 (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours, that included the instructions needed to provide minimum healthcare information necessary to properly care for 1 of 5 newly admitted residents (Resident #26 [R26]). Finding: On 5/21/25, R26's clinical record was reviewed and indicated that R26 was admitted to the facility in April of 2025 with a Foley catheter in place. The baseline care plan lacked evidence for the	F 655		

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F 655	Continued From page 9 use of a Foley catheter. On 5/21/25 at 1:32 p.m., during an interview with a surveyor, the Director of Nursing stated that she could not find the Foley catheter addressed in the baseline care plan. The surveyor confirmed this finding during this interview.	F 655		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (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	F 657		

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F 657	Continued From page 10 by: Based on record reviews and interview, the facility failed to revise a care plan after a resident qualfied for Preadmission Screening and Resident Review (PASRR) Level II services for 1 of 3 residents reviewed for PASRR (Resident #60 [R60]). Finding: On 5/19/25, R60's clinical record was reviewed. The surveyor noted that the PASRR, dated 4/2/24, stated to "Refer for Level II face to face onsite" but the surveyor was unable to locate this document. On 5/21/25 at 10:09 a.m., the Director of Nursing provided a surveyor with R60's PASRR Level II, dated 4/15/24. At 11:10 a.m., the surveyor confirmed with the DON that R60's care plan lacked evidence of a care area for the PASRR Level II services.	F 657		
F 684 SS=D	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: Based on record reviews, policy review, and interviews, the facility failed to follow a policy for completing neurological assessments after a fall for 1 of 2 sampled residents who had fallen and	F 684		

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hit their head (Resident #66 [R66]).

Finding:

The facility's policy, "Neurological Post-fall Assessment Protocol", undated, directed staff to assess the resident immediately after a fall. If a resident is believe to have hit his/her head, the Neurological Post-fall Assessment Protocol will be initiated which included assessing the blood pressure, pulse, respiratory rate, pupil assessment, level of consciousness, speech and motor response.

The Neurological assessment will be performed as follows:
-As soon as it is safe to do so following the incident
- Every 15 minutes times (x) 1 hour (hr)
- Every 30 minutes x 1 hr
- Every 60 minutes x 2 hr
- Once per 12 hr shift x 24 hrs
- Continue x 72 hrs total if any changes from baseline are observed.

On 5/20/25, R66's clinical record was reviewed and indicated the resident had a witnessed fall on 3/6/25 at 10:29 p.m., hitting his/her head on the edge of the bed.

On 5/20/25 at 10:48 a.m., during an interview with a surveyor, the Assistant Director of Nursing (ADON) stated that neurological assessments are done on paper; she will look for them for this fall. At 11:07 a.m., during an interview with a surveyor, the ADON stated that R66 was sent to the hospital and had a negative Computed Tomography (CT) scan. At 11:12 a.m., during an interview with a surveyor with the Director of

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F 684	Continued From page 12 Nursing (DON) present, the ADON stated that R66 was sent to the hospital because they thought R66 was having stroke like symptoms. At this time, the Director of Nursing stated that if the Provider felt that neurological assessments were not needed, then an order should have been received to discontinue them. The surveyor confirmed that neurological assessments were not completed and there was no order to discontinue them for R66's fall on 3/6/25.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore	F 690		

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F 690	Continued From page 13 continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure the physician orders included an order for the use of a Foley catheter for 1 of 2 residents (Resident #26 [R26]). Finding: On 5/21/25, R26's clinical record was reviewed and indicated that R26 was admitted to the facility in April of 2025 with a Foley catheter in place. A review of the physician orders thru 5/7/25 lacked evidence of an order for the use of a Foley catheter, noting that the Foley catheter was removed on 5/8/25. On 5/21/25 at 1:32 p.m., during an interview with a surveyor, the Director of Nursing stated that she could not find an order for the use of a Foley catheter. The surveyor confirmed this finding during this interview.	F 690		
F 812 SS=D	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	F 812		

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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 that dented cans were removed from use, the facility failed to ensure products in the reach-in refrigerator located in the kitchens back room were labeled, in addition the facility failed to ensure all kitchen staff were wearing facial hair restraints on 1 of 4 days of survey (5/19/25)

Findings:

On 5/19/25 at 10:50 a.m., during the initial tour of the kitchen, a surveyor observed in the dry food storage area the following dented cans, on the shelf and available for use:
1 6.56 pounds (lbs.) of diced peaches with a dent on the top seal of the can
2 50-ounce (oz) cans of tomato soup with a dent on the top seal of the can
1 112 oz can of apple filling with a dent on the bottom seal of the can

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F 812	Continued From page 15 At 10:55 a.m., the surveyor observed that in the reach in cooler near the steam table, on the top shelf was a steamtable pan covered in plastic wrap that was not labeled or dated. At 11:00 a.m., the surveyor observed the reach in cooler that was in the back storage room/break room area that had 4 trays each with dishes of food that were out of their original containers. The trays had a paper towel indicating what meal the trays were to be used for 5/19 supper, breakfast 5/20, lunch 5/20 and dinner 5/20 but were not labeled with what was in the individual dishes. On 5/19/25 at 11:05 a.m. the surveyor confirmed the above findings with the Food Service Director (FSD) At 11:08 a.m., the surveyor observed the cook and another staff member who had facial hair that was not restrained while in the food preparation area. This finding was confirmed at the time of the observation.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records.	F 842		

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F 842	Continued From page 16 §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- (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	F 842		

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F 842	Continued From page 17 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 interview, the facility failed to ensure that a resident's record contained the Power of Attorney paperwork for 1 of 6 residents reviewed for Advance Directives (Resident #60 [R60]). Finding: On 5/20/25, R60's clinical record was reviewed and indicated on the profile section of the electronic record that R60 had a Power of Attorney (POA) but the surveyor was unable to locate this document. On 5/21/25 at 11:10 a.m., during an interview with a surveyor, the Director of Nursing stated they did not have a copy of R60's POA paperwork on file. The surveyor confirmed this finding during this interview.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

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F 880	Continued From page 18 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (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,	F 880		

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depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

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

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

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to maintain an Infection Control Program designed to help prevent the development and spread of infection related to Enhanced Barrier Precautions (EBP) for 1 of 2 sampled residents reviewed on EBP (Resident #42 [R42]).

Finding:

A review of the sign posted on R42's room indicated the following: staff were required to

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wear personal protective equipment (PPE), a gown, and gloves when providing care.

Review of facility policy "Enhanced Barrier Precautions, ... 3. Contact precautions apply when: ... b. A resident is NOT known to be infected or colonized with any MDRO [multi-drug-resistant organisms], has ... indwelling medical device ..., ... indicates that EBP are required for any residents with an indwelling catheter ... 8. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: ... h. prolonged, high-contact with items in the resident's room, resident's equipment, or with resident's clothing or skin."

On 5/20/25 at 11:13 a.m., a surveyor observed CNA3 sitting on R42's bed, not wearing a gown, or gloves.

Review of the Electronic Medical Record (EMR) for R42 revealed that he/she is on EBP due to a catheter.

On 5/20/25 at 11:16 a.m., in an interview with CNA3, a surveyor confirmed that he was sitting on R42's bed with no PPE for a resident that is on EBPs.

On 5/22/25 at 8:17 a.m., in an interview with a surveyor, Registered Nurse (RN) stated that R42 is on EBPs because of a catheter. RN states that she observed CNA3 sitting on R42's bed without gown, or gloves on 5/20/25, and she stated after the observation she asked CNA3 if the linens had been cleaned or if the floor aid changed the bed prior to him sitting on R42's bed. He did not know. RN spoke with CNA3 about using PPE's if

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F 880	Continued From page 21 completing high contact care or sitting on a bed of a resident that is on EBPs. RN said to the surveyor that CNA3 is aware that R42 is on EBP and what PPE he should have been wearing.	F 880		
F 947	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on Certified Nursing Assistant (CNA) employee education record review and interview, the facility failed to implement and maintain an effective training program to ensure that a CNA attended the required 12 hours of annual in-service education training, and annual dementia training for 1 of 4 randomly selected CNAs reviewed on survey (CNA #1 [CNA1]).	F 947		

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F 947	Continued From page 22 Finding: On 5/22/25, review of CNA1's employee record indicated the date of hire to be 8/16/21. The education file lacked evidence of annual education in the areas of dementia training, resident rights, infection control, and/or the 12 required hours for continuing education annually. On 5/22/25 at 12:45 p.m., during an interview with a surveyor and the Payroll and Resident Accounts Manager, the employee education record was reviewed. At this time the surveyor confirmed that CNA1 had not completed the required 12 hours of annual in-service education.	F 947		