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| | 205116 | A. BUILDING ______ B. WING ______ | 01/16/2025 |

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| F 000 | INITIAL COMMENTS<br><br>From 1/13/25 through 1/16/25, unannounced on-site visits were conducted at Stillwater Health Care for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification and to investigate complaints #ME00047605, #ME00047766, #ME00050177. It was determined that Stillwater Health Care is not in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. | F 000 | This plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the POC is not an admission that a deficiency exists or that one was cited correctly. This POC is submitted to meet requirements established by State and Federal Law. | |
| F 584 SS=E | Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>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.<br><br>The facility must provide-<br>§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.<br>(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.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are | F 584 | F584<br><br>This incident happened in the past and cannot be undone.<br><br>All residents have the potential to be affected by this incident<br><br>Temperature in the building will be maintained between 71 -81 degrees F.<br><br>Maintenance Director will audit facility temperature 4 times per week to ensure temperature is staying within comfortable and safe temperature levels.<br><br>Will review during QAPI X 3 months | 2/6/25 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE NHA | (X6) DATE 1/30/25

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

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| F 584 | Continued From page 1<br>in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§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<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and interviews, the facility failed to maintain a comfortable air temperature for 3 of 4 days of survey.<br><br>Findings:<br><br>On 1/13/25, during an initial tour of A-Wing and B-Wing, the air temperature was observed to be chilly.<br><br>On 1/13/25, between 11:15 a.m. and 12:00 p.m., in an interview with the surveyor, Resident #5 (R5), R10, R11, R17 and R36 stated they feel cold and at night, it is colder.<br><br>On 1/14/25, the facility air temperature was observed to be chilly on A-Wing.<br><br>On 1/15/25 at 12:30 p.m., the air temperature was observed to be chilly on A-Wing. The thermostats on A and B-Wing and in the main dining room were observed to be set at 70 | F 584 | | |

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| F 584 | Continued From page 2<br>degrees Fahrenheit (F).<br><br>On 1/15/25 at 1:00 p.m., the air temperature was taken in front of the nurse's station on A-Wing and registered at 69.9 Degrees F; in front of Room 7 the air temperature was 70.1 degrees F, in front of Room 13 the air temperature was 70.1 degrees F, and in front of Room 17 the air temperature was 70.1 degrees F.<br><br>On 1/15/25 at 2:00 p.m., in an interview with the Maintenance Director (and observation of thermostats), he confirmed he was unaware that the regulation indicated the air temperature must be maintained between 71 degrees F and 81 degrees F. He turned the thermostats up to 73 degrees F at the time of the interview.<br><br>On 1/15/25 at 2:30 p.m., the air temperature at A-Wing nurse's station registered at 73 F, in front of Room 7 the air temperature was 73.5 F, and in front of Room 16 the air temperature was 73.4 F.<br><br>On 1/15/25, while taking the air temperatures, random residents on A-wing were asked if they could feel a difference in the air temperature and they answered that they felt warmer.<br><br>, | F 584 | | |
| F 657 SS=E | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment. | F 657 | F 657<br><br>This incident happened in the past and cannot be undone.<br><br>All residents with a falls care plan have the potential to be affected by this incident | 2/6/25 |

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| F 657 | Continued From page 3<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(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.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, review of the facility's 'Fall Policy and Procedure' and interview, the facility failed to re-evaluate fall interventions and the relevance of the current fall interventions for 1 of 2 sampled residents (Resident #30 [R30]) reviewed for 7 falls within 8 months timeframe.<br><br>Finding:<br><br>On 1/15/25, a review of R30's clinical record was completed. R30 is diagnosed with Alzheimer's Disease/Dementia. Nurse's notes indicated that from 6/3/24 through 1/3/25, R30 has had several unwitnessed falls, mostly in the late afternoon and evening time, in his/her bedroom. | F 657 | All staff who participate in writing and updating care plans will be re-educated to our Fall P&P.<br><br>DON or designee will audit all residents who have a fall care plan to ensure the clinical team has re-evaluated their fall intervention to ensure relevance. If the interventions are not relevant, an updated fall care plan will be implemented.<br><br>QAPI Fall Pip has been started and will be reviewed or 3 months and the quarterly for 6 months. | |

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| F 657 | Continued From page 4 | F 657 | | |

On 6/12/24 at 12:23 p.m., R30 was found on their bedroom floor and had sustained a fracture of the right femur.
On 8/19/24, R30 found in bedroom and apparently had slid from their wheelchair onto their bedroom floor.
On 9/14/24, R30 fell to the bedroom floor. When found, R30 told staff they were reaching for the TV remote.
On 10/25/24, R30 found on floor next to the bed.
On 11/13/24, R30 found on bedroom floor, slid to the floor from his/her bed while staff in room.
On 12/11/24, R30 found on bedroom floor after falling from wheelchair.
On 1/3/25, R30 found on bedroom floor after getting up from his/her wheelchair and falling to the bedroom floor.

A review of R30's care plan, dated 6/13/24, indicated for the problem of safety and the potential for falls, interventions were to use non-skid footwear, monitor for medication side effects, report behaviors, and keep call bell in reach.

A review of R30's care plan, dated 9/7/24, indicated for the problem of at risk for falls, interventions were to keep call bell in reach, use non-skid footwear, fall mat to each side of bed and use fall risk strategies. The highlighted fall strategies for R30 were to use fall mats, low bed, call light in reach, personal items in reach.

On 1/16/25, a review of the facility's Fall policy and Procedure (Clinical Protocol) indicated under Cause Identification: Number 3. The staff and physician will continue to collect and evaluate information until either the cause of the falling is

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| F 657 | Continued From page 5<br>identified, or it is determined that the cause cannot be found or is not correctable.<br><br>Under Treatment/Management:<br>Number 1: Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling.<br>2. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continued (for example, if the individual continues to try to get up and walk without waiting for assistance).<br><br>Under Monitoring and Follow-Up:<br>Number 2. The staff and physician will monitor and document the interventions intended to reduce falling or the consequences of falling.<br>4. If the individual continues to fall, the staff and physician will re-evaluate the situation and consider other possible reasons for the resident's falling (bedsides those that have already been identified) and will re-evaluate the continued relevance of current interventions.<br><br>On 1/16/25 at 10:20 a.m., in an interview with the surveyor, the Director of Nursing confirmed that R30 continues to have unwitnessed falls. He stated has not re-evaluated the effectiveness of the current fall interventions, has not tried other interventions to attempt to reduce the falls, and confirmed that he has not followed the facility's fall policy and procedures. | F 657 | | |
| F 689 SS=G | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2) | F 689 | | |

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| F 689 | Continued From page 6<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interviews, the facility failed to provide interventions outlined in the resident's care plan to ensure that two-person assist was provided during activities of daily living (ADL) for 1 of 2 sampled residents (Resident #12 [R12]), reviewed for falls. The failure to have supervision (two-person assist) as directed by the care plan resulted in an avoidable accident; R12 falling out of bed during evening ADL care, requiring transfer to the emergency room [ER] with admission to the hospital, sustaining a laceration to the head, and rib fractures with increased pain.<br>In addition, based on record review, and interview, the facility failed to adequately supervise a fall risk resident for 1 of 2 sampled residents (R30), reviewed for falls.<br><br>Findings:<br><br>R12 was admitted on 5/24/24 with diagnosis to include diabetes mellitus, peripheral vascular disease with history of right above-the knee amputation, most recently a left toe amputation, and history of deep vein thrombosis on Coumadin (a blood thinner).<br><br>Review of R12's "Report a Facility Incident or | F 689 | F 689<br><br>This incident happened in the past and cannot be undone.<br><br>All residents have the potential to be affected by this incident<br><br>All staff who provide direct patient care will be re-educated on safe resident handling.<br><br>All staff who provide direct patient care will be re-educated on the importance of utilizing the Kardex in Point Click Care to ensure that the correct assistance is being provided to our residents during ADLs.<br><br>DON or designee will review the Care Plan Kardex in Point Click Care (PCC) on each resident to ensure they are current and accurate for all residents.<br><br>DON or designee will randomly audit 6 instances of ADL care per week to ensure that staff are assisting residents per PCC Kardex.<br><br>Will review during QAPI for 3 months and the quarterly for 6 months. | 2/6/25 |

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| F 689 | Continued From page 7<br>Complaint" form, dated 5/29/24 at 12:22 p.m. from the facility, indicates that on 5/28/24 at 21:00 (9:00 p.m.), "while providing incontinent care to R12, Certified Nursing Assistant #4 (CNA4) had to change his gloves, while he stepped away to get clean gloves R12 rolled out of bed". "R12 had laceration above left eye. Pain reported in left torso/rib area". "R12 was admitted for follow-up and reported rib fracture per imaging report".<br><br>Review of R12's follow-up report "Report of Facility Incident or Complaint" form, dated 5/31/24 at 3:28 p.m. from the facility, indicates that, "CNA4 tasked with R12's care did not follow his/her plan of care. It is noted that R12 was a 2 person assist in bed and for incontinence care. CNA4 provided care on his own". "CNA4 will go back on orientation to ensure that he is providing safe resident care to our residents. This same CNA will also be receiving a disciplinary write up for this infraction. He will also be required to complete safe resident handling education". "R12 received a laceration above his/her left eye, and fractured ribs 2 - 6 on the left side". R12 was admitted to the hospital.<br><br>Review of R12's Baseline Care Plan (CP) dated 5/24/24, indicates under "Baseline CP: I NEED: some assistance can't complete my cares on my own; BECAUSE I: have below knee amputation; I REPOSITION IN BED: with 2 helpers providing more than half the effort".<br><br>Review of R12's Kardex "Guidelines for Daily Care" indicates under "MOBILITY: I reposition in bed: with 2 helpers providing more than half the effort".<br><br>Review of R12's fall charting indicates on | F 689 | | |

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| F 689 | Continued From page 8 | F 689 | | |

"5/28/24: 21:00 (9:00 p.m.) "resident room. Laceration left forehead c/o (complain of) pain left side torso hit head".

Review of R12's injury report indicates that on "5/28/24 21:00 (9:00 p.m.) R [12], (CNA4), lac (laceration) left forehead c/o (complain of) pain left side torso hit head, ER ... Bed height: higher for hygiene, incontinence care ...CNA [4] cleaning resident for incontinence care, he stepped away for a second to grab a clean pair of gloves. R [12] yelled; I'm going. CNA [4] saw R [12] roll out of bed. - ran for additional staff assistance. Resident found on the right side of the bed (on floor, per Administrator interview on 1/15/25). Small amount of blood coming from his/her left eyebrow and forehead area. Vitals taken; ems [emergency medical services] called. c/o (complain of) pain on left side of his/her torso (rib area) and left arm more than c/o pain in his/her head".

On 1/16/25 at 8:35 a.m. in an interview with a surveyor via telephone, CNA4 states, "R12 rolled out of bed. I was performing care, patient care hygiene. R12 couldn't hold his/her balance, he/she only has one leg, and his/her weight got to him/her." CNA4 states, "I think R12 was a two person assist". CNA4 did admit to caring for R12 by himself when the care plan and Kardex states R12 is a 2 person assist.

On 1/15/24 at 12:23 p.m. in an interview with a surveyor, CNA7 stated that R12 needs 2-person assistance, and stated that this can be found in the Kardex, and pointed to a binder in the nurses station on A wing where the Kardex, "Guidelines for daily care", on each resident is kept.

Review of CT Abdomen and Pelvis with Contrast

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| F 689 | Continued From page 9 | F 689 | | |

report findings on 5/29/24 at 1:31 a.m., Chest Findings: "Displaced acute appearing fractures of the left anterior lateral 2nd through 6th ribs."

On 1/15/25 at 10:34 a.m. in an interview with the Director of Nursing (DON), a surveyor confirmed that the baseline care plan for R12 states he/she needs 2-person assistance with repositioning. The failure to have two staff members present during care for R12 resulted in the resident falling out of bed and sustaining injuries.
2. On 1/15/25, a review of R30's clinical record was completed. R30 is diagnosed with Alzheimer's Disease/Dementia. Nurse's notes indicated that R30 had several unwitnessed falls, mostly in the late afternoon and evening time;

On 6/12/24 at 12:23 p.m., R30 was found on their bedroom floor and had sustained a fracture of the right femur.
On 8/19/24, R30 found in bedroom and apparently had slid from their wheelchair onto their bedroom floor.
On 9/14/24, R30 fell to the bedroom floor. When found, R30 told staff they were reaching for the TV remote.
On 10/25/24, R30 found on floor next to the bed.
On 11/13/24, R30 found on bedroom floor, slid to the floor from his/her bed while staff in room.
On 12/11/24, R30 found on bedroom floor after falling from wheelchair.
On 1/3/25, R30 found on bedroom floor after getting up from his/her wheelchair and falling to the bedroom floor.

A review of R30's care plan, dated 6/13/24, indicated for the problem of safety and the potential for falls, interventions were to use non-skid footwear, monitor for medication side

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| F 689 | Continued From page 10<br>effects, report behaviors, and keep call bell in reach.<br>A review of R30's care plan, dated 9/7/24, indicated for the problem of at risk for falls, interventions were to keep call bell in reach, use non-skid footwear, fall mat to each side of bed and use fall risk strategies. The highlighted fall strategies for R30 were to use fall mats, low bed, call light in reach, personal items in reach.<br><br>On 1/16/25 at 7:15 a.m., in an interview with Certified Nurse Assistant-Medication (C.N.A.-M), she stated she works from 6 a.m. to 6 p.m. She stated she most always works on the A-Wing, where R30 lives. CNA-M stated R30 is a 'sun downer'. [R30] gets more agitated and anxious in the late afternoon and evening. The C.N.A.-M stated they try to keep an eye on R30, but they aren't always able too. C.N.A.-M stated most of the falls occur during late afternoons, dinner time and evening in R30's room and are unwitnessed.<br><br>On 1/16/25 at 10:20 a.m., in an interview with the surveyor, the Director of Nursing confirmed that he has not evaluated the times and causes for R30's falls and has not put in place a plan for supervision and monitoring of R30 during the times of day that the resident experiences greater anxiety and is at a higher risk for falls. | F 689 | | |
| F 695 SS=E | Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of | F 695 | F695<br><br>This incident happened in the past and cannot be undone.<br><br>All residents who use portable oxygen, utilize an oxygen concentrator or use a CPAP machine have the potential to be affected by this incident | 2/6/25 |

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| F 695 | Continued From page 11<br>practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, and interviews, the facility failed to maintain oxygen filled tanks while in use, failed to maintain a physician ordered oxygen setting on an air concentrator, and failed to maintain respiratory equipment in a sanitary manner to help prevent the development and transmission of disease and infection related to respiratory care for 3 of 4 residents reviewed for respiratory care (Resident #10 [R10], R15 and R1).<br><br>Findings:<br><br>1. On 1/13/25 at 12:10 p.m., the surveyor observed Resident #10 (R10) in his/her wheelchair that held a portable oxygen tank on the back of the wheelchair. R10 was using a nasal cannula to receive the extra oxygen. Upon observation of the oxygen tank, it registered empty.<br>After the observation, the surveyor reviewed R10's clinical record under the physician order section. R10 had a physician order for continuous oxygen to be kept at a range between 2-5 liters per minute (LPM) to maintain an oxygen saturation of 90%. At 12:25 p.m., RN1 was observed changing the oxygen tank. At 12:25 p.m., in an interview with the surveyor, R1 confirmed that the oxygen tank had been empty.<br><br>2. On 1/16/25 at 8:20 a.m., a surveyor observed R10 in the front lobby sitting in his/her wheel chair. Upon observation, R10's portable oxygen tank registered empty. A Nurse showed up at | F 695 | All residents who utilize portable oxygen will have a task on the TAR for nurses to check O2 tank q 3 hours during waking hours and to change if need be.<br><br>DON or designee will do a random audit 3 times per week to ensure tanks are not empty and that nurses are signing task in the TAR.<br><br>DON or designee will do a complete audit of all residents who utilize concentrators to ensure O2 settings are correct per order<br><br>DON or designee will do a complete audit of all concentrators to ensure air intake filters have been changed.<br><br>A weekly task will be added to the TAR for those residents who utilize concentrators to ensure that concentrator filters are being changed or cleaned weekly.<br><br>DON or designee will do a compete audit of all residents who utilize CPAP machine to ensure that all CPAP machines have an order in the TAR to ensure cleaning is happening each week.<br><br>DON or designee will audit CPAP cleaning on a weekly basis to ensure cleaning is taking place.<br><br>Will review during QAPI for 3 months. | |

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| F 695 | Continued From page 12<br>8:28 a.m., with new tank and exchanged them. On 1/16/25 at 8:28 a.m., in an interview with the surveyor, the Director of Nursing confirmed that the oxygen tank had been empty.<br><br>3. On 1/15/25 at 2:45 p.m., a surveyor observed R10's oxygen concentrator and the air intake filter located on the back on the concentrator was heavily soiled with dust. On the front of the concentrator was the manufacturer's directions that directed the air intake filter needed to be cleaned weekly. On 1/15/25 at 2:50 p.m., in an interview with the Director of Nursing, a surveyor confirmed this finding.<br><br>4. On 1/14/25 at 8:45 a.m., a surveyor observed R15's oxygen concentrator set on 1.5 liters per minute (LPM); the front of the oxygen concentrator was dusty and the intake filter located on the back on the concentrator was dusty. On the front of the concentrator was the manufacturer's directions that directed the air intake filter needed to be cleaned weekly. R15's physician order indicated that the oxygen order was for 2-4 LPM. On 1/14/25 at 3:07 p.m., during an interview with a surveyor, Licensed Practical Nurse (LPN) stated that R15's oxygen should be at 2 LPM. During this interview, the surveyor confirmed that the concentrator setting was not per physician order and that the front of the concentrator and the filter in the back was dusty.<br><br>5. R1 was admitted on 10/10/24 and has an order dated 10/11/24 for a continuous positive airway pressure (CPAP) machine (used to treat obstructive sleep apnea, uses mild pressure to keep the breathing airways open during sleep) for | F 695 | | |

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| F 695 | Continued From page 13<br>evening use.<br><br>On 1/13/25 at 11:58 a.m., a surveyor observed R1's CPAP machine on the table beside his/her bed. R1 states that staff set it up for him/her at night, but nobody has come in to clean it or order new supplies for it, and R1 states he/she's been here for three months and knows some supplies need to be replaced.<br><br>On 1/14/25 at 3:03 p.m. in an interview with a surveyor, RN3 states she doesn't know if R1's CPAP has been cleaned because she doesn't work nights. She states it would be on the Treatment Administration Record (TAR), usually scheduled cleaning once a week. RN4 looked on the TAR and on the physician orders and did not see any orders for cleaning R1's CPAP. During this interview, the surveyor confirmed that the CPAP machine does not have an order or treatment scheduled for cleaning the CPAP machine.<br><br>On 1/14/25 at 3:09 p.m., during an interview with the RN-Nurse Manager, a surveyor confirmed that there is no order for R1's CPAP machine, tubing, and mask for cleaning or replacing supplies. | F 695 | | |
| F 725 SS=E | Sufficient Nursing Staff<br>CFR(s): 483.35(a)(1)(2)<br><br>§483.35(a) Sufficient Staff.<br>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 | F 725 | F 725<br><br>This incident happened in the past and cannot be undone.<br><br>All residents have the potential to be affected by this incident | 2/6/25 |

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| F 725 | Continued From page 14<br>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.<br><br>§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:<br>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br>(ii) Other nursing personnel, including but not limited to nurse aides.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review 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. This has the potential to affect all residents needing assistance with Activities of Daily Living (ADL's).<br><br>Findings:<br><br>Review of Payroll Based Journal staffing report revealed the facility triggered for low weekend staffing during the fourth quarter of 2024 (July 1 - September 30).<br><br>On 1/14/25 at 2:35 p.m., in an interview with a surveyor and review of weekend staffing for July 1, 2024, through September 30, 2024, the | F 725 | Weekend staffing will be monitored daily to ensure the center is meeting the needs of the residents.<br><br>DON or designee will call the center on the weekend to evaluate call outs and to assist with staffing needs. Center will have the on-call nurse for weekends, be ready to come in if there is potential that we will not be able to meet the needs of our residents.<br><br>Will review during QAPI x 3 months. | |

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| F 725 | Continued From page 15<br>Administrator confirmed the facility did not have enough staff to meet resident needs on the weekends. | F 725 | | |
| F 732 SS=B | Posted Nurse Staffing Information<br>CFR(s): 483.35(g)(1)-(4)<br><br>§483.35(g) Nurse Staffing Information.<br>§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:<br>(i) Facility name.<br>(ii) The current date.<br>(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>(A) Registered nurses.<br>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).<br>(C) Certified nurse aides.<br>(iv) Resident census.<br><br>§483.35(g)(2) Posting requirements.<br>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.<br>(ii) Data must be posted as follows:<br>(A) Clear and readable format.<br>(B) In a prominent place readily accessible to residents and visitors.<br><br>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>§483.35(g)(4) Facility data retention | F 732 | F 732<br><br>This incident happened in the past and cannot be undone.<br><br>All residents have the potential to be affected by this incident<br><br>Holder for daily nurse staffing sheet has been fixed to the wall outside the activities department at eye level for our residents can view it.<br><br>Will review during QAPI x1 month. | 2/6/25 |

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| F 732 | Continued From page 16<br>requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and interview, the facility failed to post the nurse staffing information in an area visible to residents for 4 of 4 days of survey (1/13/25, 1/14/25, 1/15/25, and 1/16/25).<br><br>Finding:<br><br>On 1/14/25 through 1/16/25, a surveyor observed that the nurse staffing information was not posted in an area visible to residents.<br><br>On 1/16/25 at 11:27 a.m., in an interview with a surveyor, the Administrator and Director of Nursing stated the nurse staff information was posted outside of the main entrance door to the facility, and the surveyor confirmed that it was not posted in an area that residents had visible access too. | F 732 | | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility | F 812 | F 812<br><br>This incident happened in the past and cannot be undone.<br><br>All residents have the potential to be affected by this incident<br><br>Dietary Manager or designee will audit 5x per week to ensure that hair nets and beard/mustache nets are being worn properly while in the kitchen. | 2/6/25 |

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| F 812 | Continued From page 17<br>gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and interviews, the facility failed to ensure the proper storage and labeling of foods in the walk-in refrigerator located in the kitchen, failed to ensure a vegetable sink had the proper air gap and failed to ensure kitchen staff properly wore hairnets by leaving hair uncovered and unrestrained for 2 of 4 days of survey (1/13/25, 1/15/25).<br><br>Findings:<br><br>1. On 1/13/25 at 10:30 a.m., during the initial kitchen tour, a surveyor observed the Food Service Director (FSD) with a hairnet that did not contain all her hair. In the walk-in refrigerator there was a large cup of Dunkin Donuts beverage that was not labeled with a name or date, and a 1-pound (lb.) brick of Gold'N'Sweet butter that was noted to have a torn cover exposing the butter and showing marks of scrapes and punctures along the edges and on the top of the butter brick.<br><br>The vegetable sink was observed with an improper air gap on the drainpipe.<br><br>The 10-114 State of Maine Rules Chapter 226, definition Section A, defines an Air-Gap Separation - A physical separation between the | F 812 | Dietary Manager or designee will audit 5x per week that outside beverages are not in walk-in refrigerator.<br><br>Dietary Manager or designee will audit 5x per week that packaged food in the walk-in refrigerator are intact, with no punctures, openings, or scrapes.<br><br>Vegetable sink air gap in the drainpipe has been fixed.<br><br>Will review during QAPI x3 months. | |

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| F 812 | Continued From page 18<br>free-flowing discharge end of a potable water supply pipeline and an open or non-pressure receiving vessel. An air-gap separation shall be at least twice the diameter of the supply pipe measured vertically above the overflow rim of the vessel - in no case less than one inch (2.54 cm) and the Code of Federal Regulation, Title 21, Part 1250, Section 1250, 30 (d) states "all plumbing shall be so designed, installed, and maintained as to prevent contamination of the water supply, food, and food utensils."<br><br>All the above findings were confirmed with the FSD at the time of the observations.<br><br>2. On 1/15/25 at 7:50 a.m., during a second tour of the kitchen, the surveyor observed that the FSD had a hairnet that did not contain all her hair, and two kitchen aides/cooks did not have a beard/mustache cover on while performing food preparation/distribution tasks. The vegetable sink did not have the proper 1-inch air gap on the drainpipe.<br><br>On 1/15/25 at 8:00 a.m., the surveyor confirmed with the FSD that her hair was not contained in her hairnet and the cook and kitchen aide did not have their facial hair covered and the vegetable sink remained with the improper 1-inch air gap. | F 812 | | |
| F 842 SS=B | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(h)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent | F 842 | F 842<br><br>This incident happened in the past and cannot be undone.<br><br>All residents have the potential to be affected by this incident | 2/6/25 |

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| F 842 | Continued From page 19<br>agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.<br><br>§483.70(h) Medical records.<br>§483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete;<br>(ii) Accurately documented;<br>(iii) Readily accessible; and<br>(iv) Systematically organized<br><br>§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-<br>(i) To the individual, or their resident representative where permitted by applicable law;<br>(ii) Required by Law;<br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br>(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.<br><br>§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.<br><br>§483.70(h)(4) Medical records must be retained | F 842 | LSW or designee will audit all resident files to ensure that all residents with a POA, have the paperwork on file verifying POA.<br><br>LSW will ensure that all new admissions have POA paper work on file in a timely manner if applicable.<br><br>Will review during QAPI x3 months. | |

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| F 842 | Continued From page 20<br>for-<br>(i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(h)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to ensure that a resident's record contained the Power of Attorney paperwork, 2 months after admission, for 1 of 2 residents reviewed for Advance Directives (Resident #55 [R55]).<br><br>Finding:<br><br>On 1/14/25, R55's clinical record was reviewed and noted that R55 was admitted to the facility on 11/15/24 and that a family member was the Power of Attorney.<br><br>The "Acknowledgement of Important Information and Policies" document uploaded in R55's electronic clinical record indicated that R55 has "an Advanced Directive and have provided the | F 842 | | |

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| F 842 | Continued From page 21<br>facility with a copy of the document" but the surveyor could not find this document.<br><br>On 1/15/25 at 11:58 a.m., during an interview with a surveyor, the Licensed Social Worker (LSW) stated that she did not have a copy of an Advance Directive or the Power of Attorney (POA) paperwork. On 1/15/25 at 1:15 p.m., LSW handed the surveyor a copy of the Power of Attorney paperwork that she just received from the hospital. The surveyor confirmed that the POA paperwork has missing from R55's clinical record for 2 months. | F 842 | | |
| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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; | F 880 | F 880<br><br>This incident happened in the past and cannot be undone.<br><br>All residents have the potential to be affected by this incident<br><br>All staff who administer medication have been re-educated to the P&P pertaining to medication administration.<br><br>The CNA-M who was observed during the survey has received re-education on passing medication by an outside RN trainer to ensure these kinds of infection control errors do not continue.<br><br>All staff who provide direct patient care have been re-educated in Enhanced Barrier Precautions (EBP). | 2/6/25 |

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| | 205116 | A. BUILDING ______ B. WING ______ | 01/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 880 | Continued From page 22<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. | F 880 | The CNA observed changing bed linins with no gown on had a documented verbal coaching with the DON on the importance of following EBP.<br><br>The LPN observed doing wound care with no gown on had a documented verbal coaching with the DON on the importance of following EBP.<br><br>Will review during QAPI x3 months. | |

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| F 880 | Continued From page 23<br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on the observations, facility policy reviews, and interviews, the facility failed to maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and during two medication administration observations and for a Resident on Enhanced Barrier Precautions (Resident #25 [R25] on 2 of 4 days of survey (1/14/25 and 1/15/25).<br><br>Findings:<br><br>The facility's policy, "Administering Oral Medications", revised 2/2022, noted that for tablets or capsules from a bottle - "do not touch the medication with your hands."<br><br>1. On 1/14/25 at 6:50 a.m., a surveyor observed Certified Nursing Assistant - Medications #1 (CNA-M1) preparing medications. There were already 2 pills in the plastic cup when the surveyor started the observation. CNA-M1 popped a pill from the medication card into her hands and placed the pill in the plastic cup. The surveyor confirmed during this observation with CNA-M1 that she had touched the medication with her hand at this time.<br><br>2. On 1/15/25 at 6:50 a.m., during a medication pass observation with CNA-M1 for Resident #55 (R55), a surveyor observed that CNA-M1 popped a pill from the medication card and it fell on to the top of the medication cart; CNA-M1 picked up the | F 880 | | |

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| F 880 | Continued From page 24 | F 880 | | |

pill using 2 medication cups (not touching with her hands) and placed the pill into the medication cup for administration. The surveyor confirmed that the top of the medication cart is not considered a clean area because you don't know who or what has touched the top of your cart, even if you had cleaned it at the beginning of your shift at this time.

3. The facility's policy, "Enhanced Barrier Precaution", revised 2/2024, directs that Enhanced Barrier Precautions (EBP) are indicated for residents with wounds .....and remain in place for the duration of the stay or until the resolution of the wound. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs included changing linens.

On 1/14/25, before 10:00 a.m., a surveyor observed Certified Nursing Assistant #2 (CNA2) in a resident room changing the bed linen for R25 and was observed not wearing a gown. The surveyor observed an Enhanced Barrier Precaution sign that indicated that staff must wear gloves and gown when changing bed linens. At 10:02 a.m., during an interview with a surveyor, CNA2 stated that R25 has a leg wound that is wrapped; CNA2, Licensed Practical Nurse (LPN), and the surveyor observed the sign on the wall outside of R25's room that indicated gown and gloves much be worn when changing bed linens. The surveyor confirmed that EBP were not followed at this time. On 1/15/25 at 7:37 a.m., during an interview with a surveyor, the Director of Nursing (DON) stated that CNA2 came to him and discussed the above observation; the DON stated that he explained to CNA2 that personal protective equipment (PPE) should be worn when

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| F 880 | Continued From page 25<br>changing bed linens for R25 and that additional education would be provided. | F 880 | | |
| F 947 SS=E | Required In-Service Training for Nurse Aides<br>CFR(s): 483.95(g)(1)-(4)<br><br>§483.95(g) Required in-service training for nurse aides.<br>In-service training must-<br><br>§483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.<br><br>§483.95(g)(2) Include dementia management training and resident abuse prevention training.<br><br>§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.<br><br>§483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.<br>This REQUIREMENT is not met as evidenced by:<br>Based on employee record reviews and interviews, the facility failed to implement and maintain an effective training program which includes, at a minimum, training on abuse, and on dementia management by failing to ensure that 5 of 5 Certified Nursing Assistant (CNA) staff employed completed their required training (CNA1, CNA2, CNA4, CNA5, and CNA6).<br><br>Findings: | F 947 | F 947<br><br>This incident happened in the past and cannot be undone.<br><br>All residents have the potential to be affected by this incident<br><br>Skills fair has been completed and the mandatory training that are required for our CNAs have been received.<br><br>DON or designee will do an audit of all CNAs to ensure they are in compliance with mandatory training.<br><br>Will review during QAPI x3 months. | 2/6/25 |

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| F 947 | Continued From page 26<br>On 1/16/25 the following employee records were reviewed:<br><br>1. CNA1 was hired on 5/17/23. There was no documented training in over 12 months.<br><br>2. CNA2 was hired on 9/25/23. There was no documented training in over 12 months.<br><br>3. CNA4 was hired 2/28/24. There was no documented orientation, or training on dementia, and there is no documented reorientation as outline in a performance correction notice dated 6/11/24.<br><br>5. CNA5 was rehired on 9/26/24. There was no documented training on dementia.<br><br>6. CNA6 was hired on 5/8/23. There was no documented training on dementia.<br><br>On 1/16/25 at 11:27 a.m., in an interview with a surveyor, the Administrator stated that she was unable to find any documented trainings listed above, and a surveyor confirmed that CNA1, CNA2, CNA4, CNA5, and CNA6 lacked evidence that mandatory training was completed. | F 947 | | |