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	205134	A. BUILDING _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH'S REHABILITATION AND RESIDENCE	**1133 WASHINGTON AVE PORTLAND, ME 04103**

(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 8/19/2024 through 8/22/2024, on-site visits were conducted at St. Joseph's Rehabilitation and Residence for the purpose of conducting the annual Long-Term Care Survey Process and investigating complaints #ME00046926; #ME00048355; and facility reported incident #ME00047744. It was determined that St. Joseph's Rehabilitation and Residence was not in substantial compliance with 42 CFR 483, Sub-part B Requirements for Long Term Care Facilities.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		

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

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that residents who required feeding assistance were aided with feeding in a dignified manner for 2 of 3 dining observations. (#42) Findings: 1. On 8/19/24 between 12:27 p. m. and 12:34 p.m., a surveyor observed the lunch meal service in the C - Unit dining room. A surveyor observed Certified Nursing Assistant #3 (CNA#3) standing over Resident #42 while feeding him/her. In addition, the CNA did not engage in any conversation with the resident while feeding him/her. In an interview, a surveyor confirmed the above findings with CNA #3 on 8/19/24 at 12:34 p.m., and also confirmed the above findings on 8/19/24 at 1:45 p.m. with the Director of Nursing (DON).	F 550		

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F 550	Continued From page 2 2. On 8/20/24 at 8:15 a.m. a surveyor observed CNA#1 in Unit C dining room, standing over a resident while aiding him/her feeding. A surveyor observed CNA #2 in the hallway at the nurse's station, standing over a resident while aiding him/her with feeding. This was confirmed with the Unit Manager at the time.	F 550		
F 577 SS=B	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying	F 577		

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F 577	Continued From page 3 information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to post, in a place readily accessible to residents, family members, and legal representatives, the results of the most recent survey of the facility in the survey folder (located in the entrance foyer). Finding: On 8/22/24 at 9:05 a.m. a surveyor went to the main lobby to review the book that contained the Latest Survey Results and the book was empty. The Director of Clinical Services was asked where the results are and she stated that she did not know and did not know how long it had been empty.	F 577		
F 578 SS=E	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	F 578		

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F 578	Continued From page 4	F 578		

residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's 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 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 review, and interviews, the facility failed to inform and provide written information concerning the right to formulate an advance directive for 4 of 16 residents reviewed for advanced directives. (#62, #65, #40, #21)
Findings:
1. On 8/20/24 at 9:22 a.m. a surveyor reviewed Resident #62's clinical record and was unable to locate an advance directive. Also, documentation was not found that the resident was informed and provided information they had the right to formulate an advance directive. An "Advance Care Planning Tracking form" was located in Resident #62's clinical record but the document

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F 578	Continued From page 5	F 578		

was unsigned and blank other than "Full Code" being selected.

On 8/20/24 at 9:34 a.m. a surveyor reviewed Resident #65's clinical record and was unable to locate an advance directive. Also, documentation was not found that the resident was informed and provided information they had the right to formulate an advance directive. A form was located in Resident #65's clinical record titled "Advance Care Planning Tracking form" This form was signed by their representative but in the section "Date of Discussion" the representative had written "was none." The rest of the form was blank other than "Do Not Resuscitate" ("DNR") being selected.

On 8/20/24 at 1:55 p.m. a surveyor reviewed Resident #40's clinical record and was unable to locate an advance directive. Also, documentation was not found that the resident was informed and provided information they had the right to formulate an advance directive.

On 8/21/24 at 2:45 p.m. a surveyor met and discussed the above findings with the Director of Nursing who was also unable to locate the requested documentation.

2. On 08/19/24 at 1:38 p.m., a surveyor was unable to locate documentation of an Advanced Directive discussion with Resident #21.

On 8/20/24 at 12:40 p.m. After an extensive search of the electronic record and the hard copy of the clinical record, the charge nurse of Unit A

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F 578	Continued From page 6 stated that she could find no documentation that advanced directive documentation was ever given to the resident. She confirmed, "You are correct, I do not see it anywhere."	F 578		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the	F 582		

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facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and interview, the facility failed to ensure the Notice of Medicare Provider Non-Coverage (CMS-10123-NOMNC) form was provided for 2 of 3 sampled residents whose Medicare Part A Skilled services were discontinued. In addition, the facility failed to ensure the Skilled Nursing Facility Advance Beneficiary Notice (CMS-10055-SNF ABN), which included appeal rights and liability of payment was provided for 2 of 2 sampled residents who remained in the facility after Medicare Part A benefits ended.

Findings:

On 8/20/2024 a surveyor reviewed a random sample of 3 residents who had been discharged from Medicare Part A and found:

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F 582	Continued From page 8 1. A resident's last covered day was 3/3/24 and they remained in the facility. This resident should have received a CMS-10123-NOMNC form and a CMS-10055-SNF ABN form. They received neither. 2. A resident's last day of coverage was 2/28/24 and were discharged to home on 2/29/24. They should have received a CMS-10123-NOMNC form. They did not. 3. A resident's last day of coverage was 3/29/24 and they remained in the facility. They should have received a CMS-10123-NOMNC form and CMS-10055-SNF ABN form. They did not receive a CMS-10055-SNF ABN form. On 8/20/2024 at 9:30 a.m. a surveyor discussed the missing forms with the Director of Nursing.	F 582		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F 600		

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This REQUIREMENT is not met as evidenced by:
Based on a review of the Nursing Facility Reportable Incident Form submitted to the Division of Licensing and Certification on 6/11/24, written statements by staff, facility policy, clinical record review, and interviews, the facility failed to protect residents from physical abuse for 1 of 34 sampled residents. (#91)

Finding:

The facility's "Abuse, Neglect, Misappropriation of Resident Property and Exploitation", Effective 10/2022 .....each resident will be free from abuse. Abuse can include verbal, mental, sexual or physical abuse. Corporal punishment or involuntary seclusion. The resident will also be free from physical or chemical restraints imposed for purposes of discipline or convenience. And that are not required to treat the residents' medical symptoms. Additionally, residents will be protected from abuse, neglect and harm while they are residing at the facility. No abuse or harm of any type will be tolerated, and residents and staff will be monitored for protection.

On 6/11/24, the Division of Licensing and Certification received from the facility a Reportable Incident Form which indicated an allegation of abuse of a resident (Resident #91) by Certified Nursing Assistant #4. (CNA #4) While CNA #4 was providing 1:1 care to Resident #91. CNA #5 observed Resident #91 grabbing CNA #4's arm and CNA #4 slapping the resident's arm/hand and stating: "How do you like it?"

A Clinical record review indicates that Resident #91 was admitted to the facility on 8/4/23 for long

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term care. Resident #91 has a diagnosis of Down Syndrome, Conduct Disorder, Alzheimer's disease and dementia with behavioral disturbance.

On 8/21/24 at 3:17 p.m. a surveyor conducted a telephone interview with CNA #4. CNA #4 stated "Resident #91 was being very combative, and he/she had a lot of feces on his/her hands because he/she kept digging all day long. I took him/her in the room, I cleaned him/her up, brought him/her back outside, and he/she tried to reach out to give me a hug. I took his/her hand and placed his/her hands by his/her side, and I attempted to fix his/her pants zipper at one point, and he/she kicked me, and he/she punched me. The other caregivers saw and rushed over to help."

On 8/21/24 at 3:24 p.m., a surveyor conducted a telephone interview with CNA #5. CNA #5 stated she observed Resident #91 grab CNA #4's arm. She then observed CNA #4 hit Resident #91 and say, "How does it feel?"

A statement written by CNA #5 states "Resident #91 became agitated from being followed by his 1:1 (CNA #4). When Resident #91 tried to walk away from CNA #4. CNA #4 grabbed Resident #91 to redirect him/her. Resident #91 grabbed and squeezed CNA #4's arm. CNA #4 pushed Resident #91's arm away and slapped Resident #91's arm hard and said "How do you like it?

A statement written by CNA #6 states "Resident #91 was agitated walking around the common area. CNA #6 states she heard the 1:1 (CNA #4) yell loudly at Resident #91. She then observed Resident #91 grab the 1:1's (CNA #4) arm and

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F 600	Continued From page 11 the 1:1 (CNA #4) removed Resident #91's hand off her arm and reached up and smacked Resident #91 in the right arm and said, "How do you like it?" loudly. A care plan dated 4/25/23 indicates when resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. If resisting care, stop care, ensure he/she is safe and retry care in 5-10 minutes. Attempt care 3 times, if he/she continues to refuse care, alert charge nurse for further. Observe and Document observed behavior and attempted interventions. Provide 1:1 supervision as needed. On 8/20/24 at 3:05 p.m. a surveyor discussed this finding in an interview with the Director of Nursing (DON). The DON stated that CNA #4 was immediately sent home, and the facility terminated her contract with the agency.	F 600		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in	F 623		

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accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which

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ST JOSEPH'S REHABILITATION AND RESIDENCE	1133 WASHINGTON AVE PORTLAND, ME 04103

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receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as

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well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k).
This REQUIREMENT is not met as evidenced by:
Based on record reviews and interviews, the facility failed to issue a written transfer/discharge notice to a resident or their legal representative for a facility-initiated transfer/discharge for 5 of 5 sampled residents transferred/discharged to an acute care facility. (#75, #40, #65, #78 and #88)

Findings:

1. Documentation in Resident #75's clinical record indicated that he/she was transferred to an acute hospital on 7/14/24 and subsequently admitted. The clinical record lacked evidence that the facility issued a written transfer/discharge notice to the resident and/or legal representative.

On 8/21/24 at 3:30 p.m., in an interview with the surveyor, the Director of Nursing (DON) and confirmed that she was unable to locate evidence that a transfer/discharge form for Resident #75 was completed and provided to the resident or resident representative at the time of transfer to the hospital.

2. Documentation in Resident #40's clinical record indicated that he/she was transferred to an acute hospital on 10/31/23 and subsequently admitted. The clinical record lacked evidence that the facility issued a written transfer/discharge notice to the resident and/or legal representative.

3. Documentation in Resident #65's clinical record indicated that he/she was transferred to an acute hospital on 11/2/23 and subsequently

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F 623	Continued From page 15 admitted. The clinical record lacked evidence that the facility issued a written transfer/discharge notice to the resident and/or legal representative. 4. Documentation in Resident #78's clincial record indicated that he/she was transferred to an acute hospital on 4/11/24 and subsequently admitted. The clinical record lacked evidence that the facility issued a written transfer/discharge notice to the resident and/or legal representative. 5. Documentation in Resident #88's clinical record indicated that he/she was transferred to an acute hospital on 4/11/24 and subsequently admitted. The clinical record lacked evidence that the facility issued a written transfer/discharge notice to the resident and/or legal representative. On 8/22/24 at 9:40 a.m. a surveyor interviewed RN #4 and learned a written transfer/discharge notice for the resident and/or representative is not used in this facility but he/she remembers using it at other facilities. On 8/22/24 at 2:50 p.m. a surveyor discussed the above findings with the DON and confirmed the facility does not provide a transfer/discharge form to residents and/or representatives and they were unaware this was necessary.	F 623		
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to	F 625		

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the resident or resident representative that specifies-
(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;
(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and interviews, the facility failed to issue a written bed hold notice to a resident, a family member or legal representative for 5 of 5 sampled residents who had been transferred to an acute care facility (#75, #40, #65, #78 and #88).

Findings:

1. Documentation in Resident #75's clinical record indicated that he/she transferred to an acute care hospital on 7/14/24 and subsequently admitted. The clinical record lacked evidence that the facility issued a written bed hold notice to the resident, a family member, or legal representative

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upon transfer.

On 8/21/24 at 3:30 p.m., in an interview with the Director of Nursing (DON) confirmed that she was unable to locate evidence that the facility issued a written bed hold notice to the resident, a family member, or a legal representative upon transfer for Resident #75.

2. Documentation in Resident #40's clinical record indicated that he/she transferred to an acute care hospital on 10/31/23 and subsequently admitted. The clinical record lacked evidence that the facility issued a written bed hold notice to the resident, a family member, or legal representative upon transfer.

3. Documentation in Resident #65's clinical record indicated that he/she transferred to an acute care hospital on 11/2/23 and subsequently admitted. The clinical record lacked evidence that the facility issued a written bed hold notice to the resident, a family member, or legal representative upon transfer.

4. Documentation in Resident #78's clinical record indicated that he/she transferred to an acute care hospital on 4/11/24 and subsequently admitted. The clinical record lacked evidence that the facility issued a written bed hold notice to the resident, a family member, or legal representative upon transfer.

5. Documentation in Resident #88's clinical record indicated that he/she transferred to an acute care hospital on 4/11/24 and subsequently admitted. The clinical record lacked evidence that the facility issued a written bed hold notice to the resident, a family member, or legal representative

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F 625	Continued From page 18 upon transfer. On 8/21/24 at 1:27 p.m.a surveyor discussed the findings with the DON and confirmed that she was unable to locate evidence that the facility had issued completed bed hold notices for Resident #40, Resident #65, Resident #78 and Resident #88.	F 625		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and	F 645		

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(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.
This REQUIREMENT is not met as evidenced by:

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F 645	Continued From page 20 Based on record reviews and interview, the facility failed to ensure that 1 of 5 residents reviewed with a specialized mental health diagnosis, whose stay went beyond the expected 30 days, had been referred to the appropriate state-designated authority for Pre-Admission Screening & Resident Review Level II (PASRR) evaluation and determination (Residents #55). Finding: Resident #55 was admitted to the facility on 11/25/21 with diagnosis of bipolar disorder. Resident #55's clinical record contained a PASRR Level I determination letter dated 10/18/21 that stated further PASRR evaluation was not required due to Resident #55 met the criteria for a short-term convalescence admission. Resident #55 was not discharged after a short stay and was assessed to be Nursing Facility level of care and continued to reside in the facility. The clinical record lacked evidence to indicate that the PASRR Level I was forwarded again to the State Mental Health Authority to determine if a PASRR Level II evaluation and determination was needed after the Residents stay changed from short-term to long-term. On 8/21/24 at 12:38 p.m., in an interview, the Director of Clinical Services confirmed the findings.	F 645		
F 657 SS=E	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	F 657		

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F 657	Continued From page 21 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), that included but is not limited to, the attending physician, a registered nurse and Certified Nurses Aid (CNA) with responsibility for the resident, a member of nutrition services and to the extent possible, include the participation of the resident and/or resident's representative, after each Minimum Data Set (MDS) assessment for 16 of 29 residents whose care plans were reviewed (#9, #13, #18, #30, #31, #40, #54, #55, #62, #65, #67, #71, #75 #78, #88, #93 and #95).	F 657		

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Findings:

1. Review of Resident #9's medical record, the surveyor noted IDT meetings held on 7/13/23, and 4/11/24 where the only IDT members in attendance were a registered nurse and nutrition services. The IDT held on 7/13/23 and 10/11/23 only had nutrition services in attendance.

2. Review of Resident #13's medical record, the surveyor noted an IDT meetings held on 1/4/2024, with only Dietary & Nursing in attendance. No documentation of resident or family invitation or attendance.

Review of Resident #13's medical record, the surveyor noted an IDT on 3/27/2024, with only Dietary & Nursing
in attendance. A note stated "resident has no complaints or concerns. goes to dialysis x3 wk scheduled for cataract surgery 4/22/24. dialysis is concerned with residents eating consumption (high K+/Ca+ foods & fluid intake) resident has been educated numerous times. No documentation of resident or family invitation or attendance.

Review of Resident #13's medical record, the surveyor noted an IDT on 7/2/2024 with only Dietary in attendance. A note stated, "Renal, large portions protein tid with meals, regular consistency (level 4) thin liquids, 1500cc fluid restriction. Allergic to raw carrots, celery and peaches." No documentation of resident or family invitation or attendance

3. Review of Resident #18's medical record, the surveyor noted IDT meetings held on 11/3/23, 2/3/24, and 5/3/24 where the only IDT members

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in attendance were a registered nurse and nutrition services. The IDT held on 8/3/24 only had a registered nurse in attendance.

4. Review of Resident #30's medical record, the surveyor noted IDT meetings held on 11/23/23 and 2/14/24 where the only IDT members in attendance were a registered nurse and nutrition services. The IDT held on 5/15/24 only had a registered nurse and activities in attendance. The IDT held on 8/14/24 only had a registered nurse in attendance.

5. On 8/19/24 at 1:53 p.m., during an interview, Resident #31 was asked if he/she was invited or participated in their plan of care meetings with the IDT team, he/she stated, not sure if he/she was invited. Review of Resident #31's medical record, the surveyor noted IDT meetings held on 10/30/23 and 1/29/24 where the only IDT members in attendance were a registered nurse and nutrition services. An MDS Quarterly assessment was completed on 5/20/24. The medical record lacked evidence that a care plan meeting had been held by the IDT after the 5/20/24 assessment. All past 3 IDT meetings lacked documentation of resident #31 being invited or attending his/her IDT.

6. Review of Resident #40's medical record, the surveyor noted IDT meetings held 3/6/24 and 2/27/24 where only dietary attended. An IDT meeting held 11/21/23 where only nursing and dietary attended.

7. Review of Resident #54's medical record, the surveyor noted IDT meetings held on 1/26/24 and 7/23/24 where the only IDT members in attendance were a registered nurse and nutrition

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services. The IDT held on 7/27/23, 10/26/23 and 4/25/24, only had nutrition services in attendance.

8. Review of Resident #55's medical record, the surveyor noted IDT meetings held on 9/7/23 and 12/7/23 where the only IDT member in attendance was nutrition services. The IDT held on 3/6/24 only had a registered nurse, activities and nutritional services in attendance and the IDT held on 6/5/24 only had a registered nurse and nutritional services in attendance.

9. Review of Resident #62's medical record, the surveyor noted IDT meetings held 10/4/23, 1/30/24, 4/26/24 and 7/29/24 where only nursing and dietary attended.

10. Review of Resident #65's medical record, the surveyor noted IDT meetings held 2/10/23, 8/10/23, 11/9/23, 3/15/24 where only nursing and dietary attended. An IDT meeting held 5/12/23 where nursing, dietary, wife and resident attended. A meeting held 6/13/24 where only activities attended.

11. Review of Resident #67's medical record, the surveyor noted IDT meetings held on 3/21/24 and 6/11/24 where the only IDT members in attendance were a registered nurse and nutrition services.

12. On 8/19/24 at 10:14 a.m., during an interview, Resident #71 was asked if he/she was invited or participated in their plan of care meetings with the IDT team, he/she stated, "No, nobody said anything about it". Review of Resident #71's medical record, the surveyor noted IDT meetings held on 11/6/23 and 2/2/24 where the only IDT members in attendance was a registered nurse

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and nutrition services. The IDT held on 5/10/24 only had nutrition services in attendance and the IDT on 8/7/24 only had a registered nurse in attendance. All past 4 IDT meetings lacked documentation of resident #71 being invited or attending his/her IDT.

13. Review of Resident #75's medical record, the surveyor noted IDT meetings held on 6/29/23 where the only IDT members in attendance were a registered nurse and nutrition services. The IDT held on 6/29/23 and 9/14/23 only had nutrition services in attendance.

14. Review of Resident #78's medical record, the surveyor noted IDT meetings held 9/21/23 where only dietary attended. IDT meetings held 6/22/23, 12/21/23, 3/26/24 where only nursing and dietary attended.

15. Review of Resident #88's medical record, the surveyor noted IDT meetings held 5/1/24 and 8/1/24 where only dietary attended. IDT meetings held 8/4/23, 11/3/23 and 2/1/24 where only nursing and dietary attended.

16. Review of Resident #93's medical record, the surveyor noted IDT meetings held on 4/17/24 and 7/24/24 where the only IDT member in attendance was a registered nurse and nutrition services.

17. On 8/19/24 at 10:32 a.m., during an interview, resident #95 was asked if he/she was invited or participated in their plan of care meetings with the IDT team, he/she stated, "I don't think I've had one for quite a while". Review of Resident #95's medical record, the surveyor noted IDT meetings held on 9/22/23 and 12/22/23 where the only IDT

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F 657	Continued From page 26 member in attendance was a registered nurse and nutrition services. The IDT held on 3/22/24 only had nutrition services in attendance and the IDT on 6/21/24 only had activities and nutritional services in attendance. All past 4 IDT meetings lacked documentation of Resident #95 being invited or attending his/her IDT.	F 657		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.	F 661		

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F 661	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a discharge summary which included a recapitulation of the resident's stay for 1 of 1 residents reviewed for discharge (Resident #105). Findings: Resident #105 was admitted to facility on 2/1/24 for skilled services. On 6/12/24 Resident #105 was discharged to the community. The clinical record lacked evidence a recapitulation of the resident's stay was completed at discharge. On 8/22/24 at 9:41 a.m., during an interview, the Director of Clinical Services indicated that she reviewed Resident #105's clinical record and was unable to find evidence that a recapitulation of stay was completed for this resident.	F 661		
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 review and interview, the facility failed to ensure that physician's orders were followed for 1 of 33 sampled residents (#9).	F 684		

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F 684	Continued From page 28 Finding: Resident #9's Physician Order Summary sheet dated 4/9/24 indicated the resident was to be weighed weekly on Tuesday and Thursday for Congestive Heart Failure. There was no evidence in the resident's clinical record to indicate the resident was weighed on 4/18/24, 5/23/24, 6/6/24, 6/11/24, 7/11/24, 7/18/24 and 7/25/24. On 8/21/24 at 3:30 p.m., the surveyor confirmed this finding in an interview with the Director of Nursing (DON).	F 684		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, facility policy, and interviews, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to respiratory care for 4 of 4 residents reviewed for respiratory care (#30, #60, #93 and #70) Findings:	F 695		

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Facility policy and procedure "Oxygen Use and Storage" effective 3/2023 states under "Respiratory Care, A sanitary environment must be maintained to prevent the transmission of disease and infection. Nasal cannula should be discarded and changed weekly. A label indicating the date and the initials of the staff changing the cannula/tubing should be applied to the nasal cannula. Nebulizer parts should be wrenched after each use and discarded every week. A label indicating the date in the initials of the staff changing the parts/tubing should be applied to the tubing ... Staff changing the tubing should document on the treatment administration record (TAR) when the tubing has been changed following the policy."

1. On 8/19/24 at 9:22 a.m., on 8/20/24 at 2:45 p.m., and on 8/21/24 at 10:02 a.m., observations of Resident #30's oxygen (O2) nasal cannula tubing unlabeled/undated, an oxygen tubing connected to the CPAP (continuous positive airway pressure) machine with the open end hanging of the bedside table and resting on the floor and a nebulizer pipe stored on the bedside table amongst personal belongings unlabeled/undated. Review of the clinical record lacked documentation of both the O2 and nebulizer tubing change weekly.

2. On 8/19/24 at 9:46 a.m., and on 8/21/24 at 10:04 a.m., observations of Resident #60's nebulizer tubing unlabeled/undated with the mouthpiece hanging down the backside of the bedside dresser and wall. Review of the clinical record lacked documentation of the nebulizer tubing change weekly.

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F 695	Continued From page 30 3. On 8/19/24 at 10:30 a.m., and on 8/20/24 at 2:47 p.m., observations of Resident #93's nebulizer tubing unlabeled/undated with the mask stored on the bedside table amongst personal belongings and another nebulizer pipe hanging off the top between the dresser and wall. 08/19/24 at 1:59 p.m., During observation and discussion with Resident #70, a surveyor observed that his Oxygen was running at 2L and that there was no date on the tubing. He stated, " I don't wear it that much." Review of the clinical record lacked documentation of the oxygen tubing change weekly. This was verified with the LPN passing meds and with the charge nurse at that time. On 8/21/24 at 10:08 a.m., during an interview, the Licensed Practical Nurse stated, O2 tubing and nebulizers are changed weekly, should be signed off on the TAR and the tubing should be initialed. On 8/21/24 at 10:35 a.m., both the surveyor and the Director of Clinical Services observed the above O2/nebulizer tubing and storage. The Director of Clinical Services stated the tubing is usually stored coiled up and stored on top of the machines and should be changed weekly and documented on the Treatment Administration Record ("TAR").	F 695		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with	F 699		

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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 trauma informed care for 1 of 5 sampled residents reviewed for trauma. (#60)

Finding:

Facility policy and procedure, "Trauma Informed Care", revised 11/2023 states, "upon admission to the facility, social services, or designee, will assess each resident using screening question on admit for a history of trauma and or post traumatic stress disorder to ensure identified residents receive appropriate treatment and services. Any additional information may be obtained from the medical record or resident representative. Identified traumatic events and triggers will be reviewed by the interdisciplinary care team, who will work with the resident/resident representative to develop methodologies and approaches to mitigate/eliminate the triggers ... Trauma specific interventions will be placed on the residence care plan, and this will be reviewed quarterly, and updated as necessary.

On 8/19/24 during an interview, Resident #60 stated, the facility is aware that he/she has "PTSD", and he/she is not to have male caregivers. Resident #60's clinical record was

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F 699	Continued From page 32 reviewed and indicated the resident was admitted to the facility on 5/7/22. The history and physical completed on 5/9/22 states under "Past Medical History, Diagnosis: History of sexual abuse in childhood". The Psychosocial Assessment & History completed on 5/9/22 and on 6/6/23 - Section 6 indicates, he/she had Physical/Sexual/Emotional Abuse History. The screening for trauma informed care completed on 6/5/23 and on 5/9/24 indicate "yes" for facing a traumatic event or experience in the past. The clinical record lacked information that indicated what Resident #60's PTSD triggers are or what events might cause re-traumatization. On 8/20/24 at 8:59 a.m., during an interview, the Director of Clinical Services stated she could not find a care plan (goal and trauma interventions) for the above history of trauma other than, "resident does not want male direct care givers (CNAs)" being mentioned as an intervention under "Personalized care". At this time, the Director of Clinical Services confirmed the above.	F 699		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,	F 755		

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dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-

§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on facility policy, observations, record review and interviews the facility failed to ensure controlled drug records are in order and an account of all controlled drugs is maintained to enable reconciliation and failed to ensure that two people who are authorized to administer medications signed the controlled substance cycle count once daily for 1 of 1 Omnicell (automated medication dispensing cabinet) reviewed.

Findings

Facility policy and procedure for Omnicell Inventory & Cycle Count, dated 7/2018 states, "Controlled medications will counted at least once daily by two licenses nurses. This specific count will be signed off as complete using the

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F 755	Continued From page 34 accountability log sheet." On 8/21/24 at 8:14 a.m., observation of the Unit A medication storage room with the Registered Nurse Manager (RN #3) to have an Omnicell machine which contained emergency box medications including controlled drugs. At this time, the RN #3 stated the controlled medications in the Omnicell should be counted daily. The "Daily Omnicell Controlled Substance Cycle Count" log indicated controlled substances are counted once daily by outgoing and incoming nurse. A review of the logs from 1/2024 through 8/21/24 showed the following missing controlled substance count daily: 1/2024 missing count for 9 of 31 days 2/2024 missing count for 11 of 28 days 3/2024 missing count for 14 of 31 days 4/2024 missing count for 12 of 30 days 5/2024 missing count for 17 of 31 days 6/2024 missing count for 22 of 30 days 7/2024 missing count for 20 of 31 days 8/2024 missing count for 14 of 20 days reviewed On 8/21/24 at 8:50 a.m., the above was discussed with the Director of Clinical Services.	F 755		
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.	F 761		

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F 761	Continued From page 35 §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 facility policy, observation, interview and record review the facility failed to ensure biologicals were stored at appropriate temperatures in 2 of 2 refrigerators observed (Unit A, #1 and #2 refrigerators). Findings: Facility policy and procedure for Omnicare Storage and Expiration of Medications, Biologicals, Syringes and Needles, revised 8/24 states, "Facility should ensure that medications and biologicals are stored at their appropriate temperatures... refrigeration: 36° to 46°F." 1. On 8/21/24 at 8:14 a.m., observation of the Unit A medication storage room with the Registered Nurse Manager (RN #3) which contained 2 refrigerators #1 (containing insulin, Ozempic and Tuberculin Purified Protein) and #2	F 761		

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F 761	Continued From page 36 (containing insulins). At this time, the RN #3 stated the refrigerators temperatures should be monitored once or twice daily, she could not remember. The "Medication Fridge Temperatures Log" for refrigerators #1 and #2 indicated temperatures are to be monitored twice daily. Review of the temperature logs from 1/2024 through 8/21/24 showed temperatures were only being monitored once daily, with the following daily temperatures missing: 1/2024 missing temp for 6 of 31 days 2/2024 missing temp for 7 of 28 days 3/2024 missing temp for 6 of 31 days 4/2024 missing temp for 4 of 30 days 5/2024 missing temp for 3 of 31 days 6/2024 missing temp for 2 of 30 days 7/2024 missing temp for 6 of 31 days 8/2024 missing temp for 7 of 20 days reviewed On 8/21/24 at 8:50 a.m., the above was discussed with the Director of Clinical Services. 2. On 8/21/24 at 10:24 a.m., both surveyor and Director of Clinical Services observed the vaccine refrigerator in the Infection Control office which contained 22 boxes of influenza vaccine and 3 boxes and 7 syringes of pneumococcal vaccines. Review of the Temperature Logs which were attached to the front of the refrigerator stated July 2024 temperatures were monitored only once daily for 14 out of 31 days and August 2024 temperatures were monitored only once daily for 12 out of 21 days reviewed. At this time, the Director of Clinical Services confirmed the lack of temperature monitoring.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		

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F 812	Continued From page 37 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 serve and store food in a sanitary manner during 1 of 2 observations. Findings: 1. On 8/19/24 at 9:10a.m. during the initial observation of the kitchen, this surveyor found undated and unlabeled pie and other deserts in the reach-in refrigerator. 2. Also, on a cart that the 'person in charge' stated was "the breakfast cart" observed three different packages of cheese with no dates, and a package of French toast with no date.	F 812		

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F 812	Continued From page 38 These were confirmed with the 'person in charge' at the time. 3. On 8/21/24 at 11:30a.m. Observation of Unit A Kitchenet - Observed that the freezer contained a moderate to heavy amount of dirt and the refrigerator contained a light to moderate amount of dirt and it was extremely full. All items observed did have resident names and dates. Observation of Unit B Kitchenet - observed a small to moderate amount of dirt and the temperature log on the outside of the fridge was lacking documentation of temperature checks for 13 of 31 days in July of 24 and for 3 of 21 days in August of 2024. The were confirmed with the "person in charge" of the Dietary Department at 12:45p.m. 4. On 8/21/24 at 3:45p.m. in an interview with the Food Service Consultant, she reviewed the Dish Machine Temp log with this surveyor that showed when the dish machine needed repair and would no longer record the temp of the wash and rinse, the company told them to add bleach and they were doing it, but never recorded the parts per million (ppm) that they added. The log lacks documentation from 6/7/24 - 7/9/24, this was confirmed with her at that time.	F 812		
F 868 SS=E	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:	F 868		

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ST JOSEPH'S REHABILITATION AND RESIDENCE	1133 WASHINGTON AVE PORTLAND, ME 04103

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F 868	Continued From page 39 (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on interviews and reviews of the attendance from the facility Quality Assurance meetings, the facility failed to ensure the Quality assessment and assurance (Qaa) committee consisted of the required members. Findings:	F 868		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205134	A. BUILDING _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 868	Continued From page 40 A review of the signed attendance list for Qaa meetings held on 6/11/24 and 7/2/24 showed that the administrator, owner, board member or other individual in a leadership role did not attend either meeting. On 8/22/24 at 9:15 a.m. a surveyor discussed the above finding with the Director of Nursing (DON) and learned the Qaa committee meets weekly but the Administrator (or owner, board member or other individual in a leadership role) does not ever attend the Qaa meetings.	F 868		