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	205185	A. BUILDING _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAINE VETERANS HOME - BANGOR	44 HOGAN RD BANGOR, ME 04401

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F 000	INITIAL COMMENTS From 8/19/24 through 8/22/24, on-site visits were conducted at Maine Veterans Home Bangor for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification and investigating complaints #ME00048548 and #ME00048538. It was determined that Maine Veterans Home Bangor was not in compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 550 SS=D	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. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her	F 550		

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

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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 observation and interview the facility failed to promote care to residents in a manner that maintains each resident's dignity for 3 of 4 meal observations in 2 dining rooms on the B Unit.

Findings:

1. On 8/19/24 between 12:30 p.m. - 12:55 p.m., during lunch observation in the East Wing dining room on B Unit, a surveyor observed the following:

A surveyor observed Certified Nursing Assistant #1 (CNA1) assisting Resident (R46) with eating at 12:43 p.m. The surveyor observed R46 in his/her chair with CNA1 standing up as she was feeding R46. During an interview with a surveyor, CNA1 stated that she was standing because there were no extra chairs to sit in, in the dining room. R46's tablemate did not receive his/her meal tray until 12:53 p.m.

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Resident #79 (R79) was observed eating at 12:35 p.m., but his/her tablemate(s) did not receive their food until 12:49 p.m.

There was a table with 6 residents, R65 received his/her lunch at 12:43 p.m. The surveyor left the dining room at 12:55 p.m., and 3 of 6 tablemates had not received their lunch by this time.

On 8/19/24 at 12:51 p.m., a surveyor asked CNA2 how the meal service is supposed to be delivered. CNA2 stated that they are supposed to serve by table. CNA3 stated that typically we give the kitchen our tickets so they know where the residents are but they wanted to do it themselves today. The kitchen staff was observed bringing the trays into the dining room but with no direction of whose trays were coming in and when.

2. On 8/19/24 at 12:49 p.m., during lunch observation in the West wing dining room, a surveyor observed R6 request a sliced turkey sandwich. R6 stopped eating when he/she did not receive one. The Licensed Practical Nurse publicly provided education to R6 regarding their medication, diagnosis, and dietary restrictions.

3. On 8/20/24 at 8:40 a.m., during breakfast observation in the West Wing dining room, a surveyor observed R94 and R41 sitting at a table with 4 other residents. All residents at the table were served except R94 and R41. Staff observed serving other tables. At 8:46 a.m., R94 was served, staff then served other tables. At 8:52 a.m., R41 was the last resident served in the dining room

On 8/22/24 at approximately 10:30 a.m., the above observations were reviewed and confirmed with the Administrator.

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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 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	F 578		

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the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on facility policy review, record reviews, and interviews, the facility failed to ensure that the resident and/or resident representative written information, concerning the right to accept or refuse medical or surgical treatment and/or formulate and advanced directive, was completed for 9 of 32 residents reviewed for advanced directives. (Resident [R] [R9], R27, R30, R37, R19, R49, R45, R76, and R87).

Findings:

Review of facility policy "Advance Directives ... dated "4/26/23" states "...policy to provide to all residents at the time of their admission, and subsequently upon request, written information concerning their rights under Maine law to make decisions concerning their health care, including the right to accept or refuse medical treatment and health care services."

1. Resident #45 was admitted to the facility on 7/12/18. Review of R45's clinical record lacked evidence that the facility provided/obtained resident and/or resident representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive.

2. Resident #76 was admitted to the facility on 12/13/23. Review of R76's clinical record lacked evidence that the facility provided/obtained resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and/or

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formulate an advance directive.

3. Resident #87 was admitted to the facility on 8/13/23. Review of R87's clinical record lacked evidence that the facility provided/obtained resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive.
4. Resident #19 was admitted on 4/18/24. A review of R19's clinical record lacked evidence that the facility followed up and/or assisted the resident/resident representative with the written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advanced directive.

5. Resident #49 was admitted on 10/1/19 . A review of R49's clinical record lacked evidence that the facility followed up and/or assisted the resident/resident representative with the written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advanced directive.

6. Resident #9 was admitted on 1/16/24. A review of R9's clinical record lacked evidence that the facility followed up and/or assisted the resident/resident representative with the written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advanced directive.

7. Resident #27 was admitted on 8/23/23. A review of R27's clinical record lacked evidence that the facility followed up and/or assisted the resident/resident representative with the written information concerning the right to accept or refuse medical or surgical treatment and/or

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F 578	Continued From page 6 formulate an advanced directive. 8. Resident #30 was admitted on 4/9/24. A review of R30's clinical record lacked evidence that the facility followed up and/or assisted the resident/resident representative with the written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advanced directive. 9. 3. Resident #37 was admitted on 2/21/24. A review of R37's clinical record lacked evidence that the facility followed up and/or assisted the resident/resident representative with the written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advanced directive. During an interview on 8/20/24 from 10:09 a.m. to 10:12 a.m., in presence of 3 surveyors, the Licensed Social Worker confirmed residents/representatives were not asked/offered the opportunity to form an advanced directive, and that she did not follow up with resident and/or resident's representatives to assist with completing advanced directives.	F 578		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations	F 644		

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from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.

§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure that the State mental health authority for Pre-Admission Screening and Resident Review (PASRR) was notified after a resident was admitted with a diagnosed and/or experienced symptoms related to a mental disorder or trauma event to determine if a change in level of service was required for 1 of 5 sampled residents reviewed for PASRR (Resident #30 [R30]).

Finding:

On 8/21/24, R30's clinical record was reviewed which included a PASRR evaluation completed by the hospital, dated 4/4/24, that indicated no PASRR level II was required and there was a mental health diagnosis of anxiety. A review of R30's diagnosis list included in the clinical record: Post-traumatic stress disorder (PTSD), and anxiety disorder, all added to the clinical record on 4/9/24, the date of admission.

On 8/21/24 at 12:43 p.m., in an interview with the surveyor, the Licensed Social Worker confirmed that the PASRR should have been updated to include the diagnosis of PTSD and the State

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F 644	Continued From page 8 mental health authority should have been notified.	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 656		

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local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on record review and interviews, the facility failed to update/implement a care plan in the area of communication for 1 of 1 resident reviewed for communication (Resident #76).

Finding:

Resident #76 was admitted on 12/13/23 and has diagnoses to include a hearing deficit requiring use of hearing aids.

Review of Resident #76's care plan updated 6/21/24 states "communication: Impaired communication. Goal: 3 months Approach: assess for unmet needs such as pain, toileting, hunger, thirst. allow extra time to respond. validate understanding. Allow time to respond face resident, speak clearly .... Further review of Resident #76's care plan lacked evidence that goals and interventions were put into place for his/her hearing needs.

Review of Minimum Data Set (MDS) dated 6/17/24 revealed Resident #76 is hard of hearing and requires hearing aids.

Review of Resident #76 clinical record revealed

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F 656	Continued From page 10 "Physician Order Sheet" dated "7/12/24" for "ENT referral for [right] ear pain/clear drainage/ruptured tm [tympanic membrane] ..." During an interview on 8/22/24 at 11:38 a.m., the Director of Nursing reviewed Resident #76 care plan and confirmed he/she does depend on hearing aids and care plan does not include goals and interventions for hearing loss / hearing aids.	F 656		
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, facility policy review, and interviews, the facility failed to complete post fall assessments for 1 of 4 residents reviewed for falls (Resident #7 [R7]). Finding: Clinical Record Review indicated R7 was admitted on 3/14/24 with a diagnosis of Vascular Dementia. According to the Minimum Data Set (a standardized assessment tool) on 6/19/24, R7 had a Brief Interview for Mental Status (BIMS) score of 1, and a BIMS of 3 on 8/16/24 (a score of 0-7 suggests severe cognitive impairment). Nurse documentation indicated R7 had two	F 684		

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unwitnessed falls on 8/14/24. The clinical record lacked evidence that follow-up assessments were completed after the unwitnessed falls.

The Fall Prevention policy (dated 4/24/23) indicates "a fall may be witnessed, reported by the resident or an observer, or identified when a resident is found on the floor or ground", and "An Occurrence Report will be completed in ECS following a resident fall."

The Neurological Assessments policy (dated 5/8/24) indicated, "In the case of an unwitnessed fall, the resident will be considered to have hit their head unless he/she can reliably state that he/she did not", and "Assessments will be completed every 15 minutes for the first hour after the fall; every 30 minutes for the subsequent 4 hours; every shift for the next 72 hours."

Between 8/19/24 through 8/22/24, during an interview with a surveyor, regarding R7's falls on 8/14/24, Anonymous (A) staff members (A1, A2, A3, and A4) stated:

A1 stated, "I couldn't see, but I heard it. [R7] has a habit of coming out in the morning, I heard the crash. We ran right to [R7]."

A2 stated, he/she observed the staff and heard the fall, "the nurse ran, all the staff ran."

A4 "I hear a loud bang in the dining room. Staff got up and went over there, and I heard a yelp. [R7] was laying on [their] left side, on the floor. There was no one there to witness it."

A3 stated, R7 was found on the floor after an unwitnessed fall, fall assessments were started

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F 684	Continued From page 12 but then discarded without being recorded in the electronic medical record (ECS). On 8/22/24 at 11:22 a.m., in an interview with a surveyor, the Director of Nursing stated, within 20 minutes a post fall investigation has to be filled out. It includes multiple staff members input (medication technician, charge nurse, certified nursing assistants, and supervisors) The information is used to for a mini root cause analysis. The provider and family are supposed to be called, and it should be documented. Care plans are reviewed to see if new interventions need to be put in place. If a resident puts themself on the floor, the need to complete a post fall evaluation varies. If a noise is heard from outside the room, and they are found on the floor. It's considered a fall, no matter what, and the post fall investigation needs to be completed. On 8/22/24 at 12:06 p.m., in an interview with the Director of Nursing and the Unit B Manager, a surveyor confirmed R7's clinical record lacked evidence that the assessments were completed after the two unwitnessed falls.	F 684		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or	F 692		

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desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to recognize a potential significant weight loss for 1 of 1 sampled residents reviewed for nutrition (Resident #101 [R101]).

Finding:

On 8/20/24 at 9:59 a.m., clinical record review indicated R101 was admitted on 4/17/24 with a diagnosis of dementia and abnormal weight loss. R101's weight on admission was 111.4 pounds (lbs). On 4/18/24, the Baseline Care Plan for R101's dementia included the dietary intervention "Provide ordered diet, Identify likes/dislikes, Offer substitute foods, Dietary consult PRN". On 7/25/24, the "Potential for Unintended weight loss" was added to the Care Plan, including "request for dietary evaluation." Monthly weight documentation indicated:
On 4/19/24 the resident weighed 112 pounds (lbs).
On 5/7/24 the resident weighed 111.1 lbs.
On 6/4/24 the resident weighed 106.7 lbs
On 7/2/24 the resident weighed 108.7 lbs
On 8/6/24 the resident weighed 100.0 lbs (8% weight loss in 1 month and 10.23% in 4 months)

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F 692	Continued From page 14 On 8/21/24 at 8:10 a.m., in an interview with the Unit B Manager, a surveyor confirmed the clinical record lacked evidence that nursing staff had notified the medical provider or the registered dietitian, and had not initiated nutritional interventions, such as requesting supplements, to address the weight loss.	F 692		
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a resident's physician supervised and evaluated weight loss for 1 of 1 residents reviewed with significant weight loss (Resident #101 [R101]). Finding:	F 710		

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F 710	Continued From page 15 On 8/20/24 at 9:59 a.m., R101's clinical record was reviewed. On 4/17/24 the resident's admission weight was 111.4 pounds (lbs). On 7/2/24 the resident weighed 108.7 lbs. On 8/6/24 the resident weighed 100.0 lbs (an 8% weight loss in one month, and a 10.23% weight loss in 4 months). On 8/21/24 at 8:10 a.m., in an interview with the Unit B Manager, a surveyor confirmed that the clinical record lacks evidence the provider was notified of significant weight loss, nor were there any Provider Progress notes that addressed the significant weight loss.	F 710		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a	F 756		

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minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to follow up on pharmacist recommendations timely, for 1 of 5 residents reviewed for unnecessary medications (Resident #19 [R19]).

Finding:

On 8/20/24 at approximately 2:03 p.m., a surveyor and the B Unit Manager reviewed R19's clinical record which included an order, dated 4/18/24, for Trazodone 50 milligrams as needed (PRN) at bedtime with no duration of the order. The surveyor reviewed the pharmacist recommendations, dated 4/19/24 and 5/16/24, for the medication Trazodone, with both of the recommendations indicating "use of PRN (as needed) antidepressants must be limited to 14 days with the exception that the prescriber documents their rationale in the patient's medical

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F 756	Continued From page 17 record and indicates the duration for that PRN order." This order was not discontinued until 6/11/24. The surveyor confirmed with the B Unit Manager this finding.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758		

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F 758	Continued From page 18 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on facility policy review, interviews, and record reviews, the facility failed to ensure an Abnormal Involuntary Movement Scale (AIMS), used to monitor for potentially irreversible side effects of antipsychotic medications, was completed when an antipsychotic medication was started, when a dose changed, or every 6 months, for 2 of 4 sampled residents reviewed (Resident [R] 19. R74). In addition, the facility failed to ensure the physician wrote a rationale and/or order with a duration to extend an as needed (PRN) psychotropic medication beyond the 14-day limit, for 1 of 1 resident reviewed (R19) . Findings: The facility's policy, "Antipsychotic Medications", last reviewed 5/27/22, defines that an AIMS test will be done at the initiation of the antipsychotic (medication) or with a change in dosage and at least every 6 months there after.	F 758		

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On 8/21/24 2:35 p.m. During an interview with a surveyor the Director of Nursing (DON) and Assistant DON (ADON) stated that an AIMS test should be completed as a baseline, with a dosage change and at least every 6 months.

1. On 8/20/24, R19's clinical record was reviewed and included a physician order for Risperidone (antipsychotic medication). At 2:45 p.m., the ADON and surveyor reviewed R19's physician orders and noted that R19 had a dose increase of Risperidone 0.5 milligrams (mg) on 6/18/24, from twice a day to three times a day. The most recent AIMS test in the clinical record was completed on 4/20/24. The surveyor confirmed that an AIMS test was not completed when the Risperidone increased with the ADON during this review.

On 8/20/24 at approximately 2:03 p.m., a surveyor and the B Unit Manager reviewed R19's clinical record which included an order, dated 4/18/24, for Trazodone 50 mg as needed (PRN) at bedtime with no duration of the order. The surveyor reviewed the pharmacist recommendations, dated 4/19/24 and 5/16/24, for the medication Trazodone, with both of the recommendations indicating "use of PRN (as needed) antidepressants must be limited to 14 days with the exception that the prescriber documents their rationale in the patient's medical record and indicates the duration for that PRN order." The surveyor reviewed with the B Unit Manager noting that R19 received the PRN dose on 5/8/24 but the order was not active because it expired on 5/2/24.

2. On 8/21/24, R74's clinical record was reviewed

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F 758	Continued From page 20 and included a physician order for Seroquel (antipsychotic medication). At 2:45 p.m., the ADON and surveyor reviewed R74's clinical record. R74 was admitted to the facility on 12/22/23 with orders for Seroquel (anti-psychotic medication) for 25 mg daily; on 7/29/24, this dose was increased to 50 mg daily. There was no baseline AIMS in the clinical record and the most recent AIMS test was completed on 5/7/24. The surveyor confirmed this finding with the ADON during this review.	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, and interviews, the facility failed to ensure that bowls were dried properly and failed to ensure the kitchen was free	F 812		

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F 812	Continued From page 21 from insects for 1 of 2 kitchen tour (8/19/24). In addition, the facility failed to ensure that milk was not expired during 1 of 2 meal observations on the B Unit (8/19/24). Findings: 1. On 8/19/24 at 10:20 a.m. an initial tour of the kitchen was done with the Nutrition Manager. Observed on a shelf, available for use, were 30 cereal bowl and 30 small white bowls that were wet stacked/nestled. Near the baking station area, fruit flies were observed coming from and around the floor drain. These findings were confirmed at the time of the observation. 2. On 8/19/24 at 12:39 p.m., during a lunch observation in the East Wing dining room on B Unit, a surveyor observed in the beverage trays with ice, 2 unopened 1% milk with an expiration date of 8/18/24. The surveyor confirmed this with the Registered Nurse.	F 812		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility	F 842		

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F 842	Continued From page 22 must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.	F 842		

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§483.70(h)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on facility policy review, record reviews and interviews, the facility failed to ensure that resident records contained accurate and complete information for 3 of 5 resident records reviewed for falls (Resident #84 [R84], R74 and R7).

Findings:

The facility's policy, "Neurological Assessments", (neuro checks) last reviewed 5/8/24, indicates that a neurological assessment will be completed and documented in ECS (electronic medical record) after any incident or fall in which a head injury is suspected. In the case of an unwitnessed fall, the resident will be considered to have hit their head unless he/she can reliably state he/she did not. Assessments will be completed every 15 minutes for the first hour after the fall, every 30 minutes for the subsequent 4 hours, every shift for the next 72 hours.

1. On 8/21/24, R84's clinical record was reviewed and indicated that on 8/15/24 at 12:00 p.m., R84 was observed on the floor in the dining room and

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neuro checks were started. A review of R84's Treatment Administration Record (TAR) and documented neurological assessments indicated the following:

On 8/9/24, the TAR indicated when the 15 and 30 minute neuro checks were to be completed but upon review of the clinical record, the neurological assessments were not documented at the time the assessment occurred. The assessment that was completed for a 15 minute check at 12:00 p.m., was not documented in the clinical record until 5:53 p.m.;
The assessment that was completed for a 15 minute check at 12:15 p.m., was not documented in the clinical record until 5:54 p.m.;
The assessment that was completed for a 15 minute check at 12:30 p.m., was not documented in the clinical record until 5:55 p.m.;
The assessment that was completed for a 15 minute check at 12:45 p.m., was not documented in the clinical record until 5:56 p.m.;
The assessment that was completed for a 15 minute check at 1:00 p.m., was not documented in the clinical record until 5:58 p.m.;
The assessment that was completed for a 30 minute check at 1:30 p.m., was not documented in the clinical record until 5:59 p.m.;
The assessment that was completed for a 30 minute check at 2:00 p.m., was not documented in the clinical record until 5:59 p.m.;
The assessment that was completed for a 30 minute check at 2:30 p.m., was not documented in the clinical record until 6:00 p.m.;
The assessment that was completed for a 30 minute check at 3:00 p.m., was not documented in the clinical record until 6:01 p.m.;
The assessment that was completed for a 30 minute check at 3:15 p.m., was not documented

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in the clinical record until 6:02 p.m.;
The assessment that was completed for a 30 minute check at 4:00 p.m., was not documented in the clinical record until 6:03 p.m.: and
The assessment that was completed for a 30 minute check at 4:30 p.m., was not documented in the clinical record until 6:04 p.m.

The above documentation does not indicate a late entry or mention of what time the documented assessment actually was completed.

2. On 8/21/24, R74's clinical record was reviewed and indicated that on 8/9/24 at 5:45 p.m., R74 was observed on the floor in his/her room and neuro checks were started. A review of R74's Treatment Administration Record (TAR) and documented neurological assessments indicated the following:

On 8/9/24, the TAR indicated when the 15 and 30 minute neuro checks were to be completed but upon review of the clinical record, the neurological assessments were not documented at the time the assessment occurred.

The assessment that was completed for a 15 minute check at 6:00 p.m., was not documented in the clinical record until 9:51 p.m., and did not include vitals;
The assessment that was completed for a 15 minute check at 6:15 p.m., was not documented in the clinical record until 9:51 p.m. and did not include vitals;
The assessment that was completed for a 15 minute check at 6:30 p.m., was not documented in the clinical record until 9:51 p.m., and indicated refusing vitals;
The assessment that was completed for a 15

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minute check at 6:45 p.m., was not documented in the clinical record until 9:52 p.m., and indicated refusing vitals;
There was an extra 15 minute check documented at 10:00 p.m. per assessment (not listed on the TAR), and indicated refusing vitals;
The assessment that was completed for a 30 minute check at 7:15 p.m., was not documented in the clinical record until 10:01 p.m., and indicated refusing vitals;
The assessment that was completed for a 30 minute check at 7:45 p.m., was not documented in the clinical record until 10:02 p.m.,
The assessment that was completed for a 30 minute check at 8:15 p.m., was not documented in the clinical record until 10:02 p.m., and indicated refusing vitals;
The assessment that was completed for a 30 minute check at 8:45 p.m., was not documented in the clinical record until 10:02 p.m., and indicated refusing vitals;
The assessment that was completed for a 30 minute check at 9:15 p.m., was not documented in the clinical record until 10:47 p.m., and indicated refusing vitals;
The assessment that was completed for a 30 minute check at 9:45 p.m., was not documented in the clinical record until 10:47 p.m., and indicated refusing vitals; and
The assessment that was completed for a 30 minute check at 10:15 p.m., was not documented in the clinical record until 10:47 p.m., and indicated refusing vitals.

The above documentation does not indicate a late entry or mention of what time the documented assessment actually was completed.

On 8/22/24 at 10:23 a.m., a surveyor reviewed

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documentation of the neuro checks with the Director of Nursing. The Treatment Administration Record (TAR) was reviewed and the time on the TAR included the time that an assessment was done but the documentation of the assessment in the clinical record does not correlate with the time on the TAR. The surveyor confirmed that the documentation of the assessments are not reflective of the time that they were completed.

On 8/22/24 at 11:14 a.m., in an interview with a surveyor, a Certified Nursing Assistant (CNA) #5 stated vitals are completed as part of the post fall packet. The CNAs take the vitals and keep them with the packet and the nurses are responsible for entering them into the ECS (electronic medical record) when the packet is completed.
3. On 8/20/24 at 10:38 a.m., R7's clinical record was reviewed. Nursing notes indicated the resident had 2 falls on 8/14/24. The clinical record lacked evidence the post fall assessments and vitals were completed.

On 8/19/24 through 8/22/24, in an interview with an anonymous staff member (A4), regarding R7's fall on the morning of 8/14/24, A4 stated, "I hear a loud bang in the dining room. Staff got up and went over there, and I heard a yelp. [R7] was laying on [their] left side, on the floor. There was no one there to witness it." A4 stated post fall assessments and vitals were started on R7 for a fall on the morning of 8/14/24, but they were directed by management to discard them.

On 8/19/24 through 8/22/24, in an interview with an anonymous staff member (A3), regarding R7's fall second fall on 8/14/24, A3 stated, R7 was found on the floor after an unwitnessed fall, fall

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assessments were started but then discarded without being recorded in the electronic medical record (ECS).

On 8/22/24 at 11:14 a.m., in an interview with a surveyor, a Certified Nursing Assistant (CNA) #5 stated vitals are completed as part of the post fall packet. The CNAs take the vitals and keep them with the packet and the nurses are responsible for entering them into the ECS (electronic medical record) when the packet is completed.

On 8/22/24 at 11:22 a.m., in an interview with a surveyor, the Director of Nursing stated, within 20 minutes a post fall investigation has to be filled out. It includes multiple staff members input (medication technician, charge nurse, certified nursing assistants, and supervisors) The information is used to for a mini root cause analysis. The provider and family are supposed to be called, and it should be documented. Care plans are reviewed to see if new interventions need to be put in place. If a resident puts themself on the floor, the need to complete a post fall evaluation varies. If a noise is heard from outside the room, and they are found on the floor. It's considered a fall, no matter what, and the post fall investigation needs to be completed.

On 8/22/24 at 12:06 p.m., in an interview with the Unit B Manager and the Director of Nursing, the Unit B Manager stated, post fall assessments may be discarded after step 4 if staff feel it was not a fall based on assessments. At this time the surveyor confirmed that resident medical records are not retained when assessments and vitals are discarded before being entered into the electronic record.

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F 880	Continued From page 29	F 880		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		

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F 880	Continued From page 30 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on facility policy review, record review, and interview, the facility failed maintain an effective infection control program, and failed to analyze and follow-up on known infections in the facility. This has the potential to affect all residents receiving an antibiotic in the facility. In addition, the facility failed to ensure a shared glucometer was cleaned after each use for 1 of 2 observations (8/20/24),	F 880		

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Findings:

Review of facility policy "Infection Prevention and Control Program" dated 9/25/23 states " .... will establish, implement and maintain an infection prevention and control program that will provide safe, sanitary and comfortable environment to help prevent, recognize, and control, the onset, development and transmission of communicable disease and infection to residents... Surveillance and investigation to prevent and control the onset and spread of infection within the facility.
...Program Record Keeping maintains records of incidents and corrective actions related to infections..."

1. Review of facility provided "Infection Report" revealed the following:
-During the month of 6/2024, there were 25 documented facility acquired infections that were prescribed antibiotics.
-During the month of 7/2024, there were 20 documented facility acquired infections that were prescribed antibiotics.
-From 8/1/24 through 8/29/2024 there were 15 documented facility acquired infections that were prescribed antibiotics. Further review of infection report lacked evidence the facility analyzed and followed up on known infections in facility.

During an interview on 8/21/24 at 12:01 p.m., Director of Nursing (DON) confirmed they review antibiotics during the monthly Antibiotic Stewardship meetings but have not looked at trends or root cause of the infections.

During an interview on 8/22/24 at 9:20 a.m., Infection Preventionist indicated the facility does

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F 880	Continued From page 32 have a lot of antibiotic use and realized that there are a lot of antibiotic prescriptions that do not meet McGuires criteria and haven't done any tracing/surveillance to form a root cause of the infections. 2. On 8/20/24 at 8:23 a.m., a surveyor observed Certified Nursing Assistant #4 (CNA4) complete a blood sugar on a resident, using a shared glucometer. At 8:25 a.m., the surveyor then observed CNA4 walk over to another resident and complete another blood sugar, without cleaning the glucometer inbetween use. On 8/20/24 at 8:26 a.m., during an interview with CNA4, the surveyor asked if she cleaned the glucometer after using on one resident, before completing the blood sugar check on the other resident. CNA4 stated that she does have the Sani Cloths to clean the glucometer and that sometimes she cleans it when she remembers. The surveyor confirmed during this interview that the glucometer was no cleaned inbetween resident use.	F 880		
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on facility policy review, record reviews, and interviews, the facility failed to implement its	F 881		

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Antibiotic Stewardship Program (ASP) that includes antibiotic use protocols and a system to monitor antibiotic use. This has the potential to affect all residents receiving an antibiotic.

Findings:

Review of the facility policy "Antibiotic Stewardship Program" dated 2/2/23 states " ...To improve patient safety and assist in the prevention of multi-drug resistant organisms (MDRO) and Clostridium difficile infections (CDI) by optimizing use of antibiotic drugs and to provide continuous improvement by utilizing prescribing and outcomes data to identify opportunities of targeted initiatives and optimal antibiotic prescribing ...Tracking and trending for appropriate antibiotic selection and identification..."

Review of facility policy "Medication Regimen Review" dated 1/2019 states " ...The consultant pharmacist compiles and analyzes data collected from MMR's and presents findings to the Quality Assurance and Process Improvement (QAPI) Committee as part of the facility continuous improvement (CQI) program.

Review of facility provided "Infection Report" revealed the following:

-During the month of 6/2024, there were 25 documented facility acquired infections that were prescribed antibiotics.
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-From 8/1/24 through 8/29/2024 there were 15 documented facility acquired infections that were

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F 881	Continued From page 34 prescribed antibiotics. Further review of infection report lacked evidence these antibiotics were reviewed or discussed. Review of facility provided Quality Pharmacy Report for Quarter #4 dated 1/8/24, Quarter #1 dated 4/1/24, Quarter #2 dated 6/26/24, Quarter #3 dated 10/9/23 lacked evidence that the pharmacist/facility reviewed antibiotic use during these meetings. During an interview on 8/21/24 at 12:01 p.m., Director of Nursing (DON) indicated that for the most part the providers put their own orders in the electronic medical record (EMR) and the infection report is generated through the EMR, and that is what they review during the monthly Antibiotic Stewardship meetings, but they have not looked at trends or root cause. During a follow up interview on 8/21/24 at 3:01 p.m., with 2 surveyors, the DON indicated she spoke with pharmacist confirming the provided pharmacy reports contain everything that is discussed in QAPI, and antibiotic stewardship has not been discussed. During an interview on 8/22/24 at 9:20 a.m., Infection Preventionist (IP) indicated the facility does have a lot of antibiotic use and realized through the survey process that there are a lot of antibiotic prescriptions that do not meet McGuires criteria. IP further indicated that at this point no one had discussed antibiotic use with the providers before and they have not implemented any tracking systems.	F 881		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)	F 883		

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F 883	Continued From page 35 §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has	F 883		

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already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure that 1 of 5 residents reviewed for immunizations included documentation in the medical record to indicate the resident received a pneumococcal immunization (Resident #7).

Finding:

Review of Resident #7's clinical record revealed " ...Pneumococcal Vaccine Consent" signed 11/6/23. Further review of resident's clinical record lacked evidence that this vaccination was administered.

During an interview on 8/20/24 at 10:54 a.m., Education Coordinator reviewed clinical record and confirmed Resident #7 signed pneumococcal immunization consent on 11/6/23 and did not receive the vaccination.