STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205154	A. BUILDING _____ B. WING _____	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN REHABILITATION & NURSING CENTER	59 WEST FRONT ST SKOWHEGAN, ME 04976

(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 On 8/26/24 through 8/28/24, on-site visits were conducted at Woodlawn Rehabilitation & Nursing Center for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification, facility reported incidents #ME00048427, #ME00048386, #ME00048054, and complaints #ME00048283, #ME00048202, #ME00048122, and #ME00047698. It was determined that Woodlawn Rehabilitation & Nursing Center was not in substantial compliance with 42 CFR Part 483, Subpart B - Requirements for Long Term Care Facilities.	F 000	This Plan of Correction constitutes my written allegation of compliance for deficiencies during the recent survey on August 27th 2024. However, submission of this Plan of Correction is not the admission that a deficiency exists or that it is cited correctly. This Plan of Correction is submitted to meet the requirements established by State and Federal Law.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;FormIte 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.	F 578	Two residents were affected by this practice. All residents have the potential to be affected by this practice. Resident R20 Advanced Directive was completed on 9/4/2024 Resident R31 had a POLST in her chart dated for 8/25/23. All current resident charts were audited to ensure they all contained advanced Directive/POLTS. All new admissions will meet with Social Service Director regarding Advanced Directives/POLST at first scheduled Care Plan meeting to ensure completion. Social Services Director will review Advanced Directive/POLST at quarterly care plan meeting and document current code status with confirmation that advanced Directive/POLST is in resident chart. Social Service will ensure that Advanced Directive/POLST will match code status order.	9/4/2024 8/29/24

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

Veronica Hopkins | Administrator | 9/30/2024

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

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F 578	Continued From page 1 (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 reviews and interviews the facility failed to provide residents/representatives written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive for 2 of 3 residents reviewed for advanced directives (Resident #20 [R20] and R31). Findings: 1. Review of R20's entire clinical record lacked evidence that [he/she] was offered/refused the opportunity to formulate an advanced directive upon [his/her] admission on 4/18/23. 2. Review of R31's entire clinical record lacked evidence that [he/she] was offered/refused the opportunity to formulate an advanced directive upon [his/her] admission on 7/24/24.	F 578	Social Service will provide QAPI the list of all new admissions confirming Advanced Directives/POLST were offered at time of admission. Social Service will provide quarterly progress notes confirming Advanced Directive/POLST was discussed at care plan meeting. QAPI will review monthly for the next 3 months.	

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F 578	Continued From page 2 During an interview on 8/27/24 at 9:53 a.m. with a surveyor, the Social Worker confirmed that she has not asked/offered advanced directive information for R20 and R31 upon their admission.	F 578		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and facility policy, the facility failed to ensure an injury of unknown origin was investigated and reported to appropriate state agencies timely for 1 of 3 facility reported incidents reviewed (Resident #12 [R12]). Findings: On 7/8/24 at 8:40 a.m. the Division of Licensing and Certification for the State of Maine (DLC)	F 610	One resident was affected by this practice. All resident have the potential to be affected by this practice. When R12 is laying on the couch she will be observed for having her glasses on and her glasses will be removed to help prevent pressure areas to face. Care Plan updated accordingly. Education will be provided to all clinical staff regarding importance of completing STOP and WATCH when there is any change of color or condition of skin. Re-Education was provided to all nursing staff regarding the self identified incident regarding a bruise of unknown origin. Re-education explained the importance of timely reporting of bruise/injuries of unknown origin. 7/10/24 See attached education. All newly hired nursing employees will receive education on timely reporting of bruises/injuries of unknown origin. All incident reports were reviewed to ensure all other incidents were reported in a timely manner. All incidents will be reviewed at morning meeting utilizing our Dashboard in risk managment in PCC. QAPI will review all incidents each month for the next three months to ensure compliance and reviewed for timely reporting.	7/16/24 10/12/2024 7/10/24

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F 610	Continued From page 3 received an initial "Facility Incident or Complaint" report, from the facility, that R12 was found to have injuries of unknown origin with small bruise on left temple area, date incident 7/4/24, time of incident 16:00 (4:00 p.m.). R12 has dementia and unable to say what happened. On 7/10/24 at 9:21 a.m. DLC received a follow-up "Facility Incident or Complaint" report, from the facility, that R12 was noted to have a small spot, nickel sized on 7/3(/24) on the left temple area that developed into a bruise noted on 7/4(/24). Bruise initially was size of quarter. During review of R12's clinical record, nursing note on 7/4/24 at 4:22 p.m. by Registered Nurse #2 [RN2] states R12 presents with large bruising on the left side of his/her head/face. Nursing note on 7/4/24 at 4:27 p.m. by RN2 states R12 was discovered to have bruising on left side of his/her face. Origins are unknown and resident cannot recall due to dementia. Nursing note on 7/4/24 at 4:28 p.m. by RN2 states R12 left side of face - date of incident unknown, possible fall. On 8/28/24 at 11:45 a.m. in an interview with a surveyor, RN2 stated that she was told by other staff, certified nursing assistants, that R12's bruising happened a couple of days prior to her nursing notes of 7/4/24 and didn't report it because she thought it was already reported. The Director of Nursing was not made aware. During R12's clinical record review, there is no evidence that the incident noted on 7/4/24 was investigated and reported until 7/8/24. On 8/28/24 at 11:31 a.m. in an interview with the Administrator, a surveyor confirmed that R12's	F 610		

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F 610	Continued From page 4 injury of unknown origin wasn't investigated or reported until 7/8/24.	F 610		
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	F 656	All residents have the potential to be affected by this practice. No resident was affected by this practice. Care Plans will reflect intervention specific to residents care. Re-Education will be provided to all clinical staff on how to manage a resident who is non-compliant with COVID-19 precautions. All newly hired nursing employees will receive education on how to manage a resident who is non-compliant with Covid-19 precautions. Care plans will be reviewed weekly by RAI/designee for appropriateness for care provided and will be updated to reflect compliance with identified needs. Our new software system triggers for care plans to be triggered for infections/precautions with their start and end dates. Monthly audits of care plans will be conducted by RAI/designee to ensure accuracy of care plans.	9/27/24

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F 656	Continued From page 5 community was assessed and any referrals to 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 interviews, observations and record reviews, the facility failed to update/implement care plans for a resident diagnosed with Coronavirus (COVID-19) (Resident #191 [R191]). Findings: R191 was admitted on 7/19/24 and tested positive for Coronavirus (COVID-19) on 8/24/24 requiring quarantine isolation precautions. Observation of R191 on 8/27/24 at 11:01 a.m., self-propelling down West Unit, unmasked and passing 3 residents and 1 staff member in the hall. During an interview on 8/27/24 at 11:01 a.m., Certified Nursing Assistant #1 indicated that R191 won't stay in the room, and she doesn't know what to do with him/her because he/she comes out of his/her room all the time, and no one has given her any direction on what to do if he/she is not following quarantine precautions. Review of R191's care plan updated 8/16/24 lacked evidence that goals and interventions	F 656		

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F 657	Continued From page 7 assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to update/implement care plans for isolation precautions for 1 of 1 care plans reviewed for isolation precautions (Resident #26 [R26]). In addition, the facility failed to update/implement goals and interventions for 1 of 1 resident reviewed for a cardiac pacemaker (R37). Findings: R26 was admitted on 12/28/22 and tested positive for Coronavirus (COVID-19) on 8/10/24 and was placed on isolation precautions. Observation of R26 on 8/26/24 at 11:30 a.m., in hallway outside room 210. There were no precaution signs or personal protective equipment (PPE) observed outside of room 210. During an interview on 8/28/24 at 7:14 a.m. Registered Nurse #1 [RN1] confirmed that R26 had been off quarantine precautions quite a while. Review of R26's care plan updated 8/12/24 states "COVID 19 I have tested positive ... Maintain my isolation with droplet and contact precautions administer oxygen as needed turn, cough and deep breath administer antipyretics as ordered evaluate me for dehydration (moist mucous membranes, urine color, skin turgor etc.) I need my aides to maintain my isolation with droplet and contact precautions. Report s/s [signs/symptoms] of pain to my nurse Provide or assist me with oral care, I need everyone to maintain my isolation with droplet and contact precautions. My goal is	F 657		

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F 657	Continued From page 8 to: my airway and oxygen exchange will be maintained Goal time: two weeks". Further review of R26's care plan lacked evidence that the care plan was updated after he/she was taken off isolation precautions. During an interview on 8/27/24 at 2:13 p.m., with 2 surveyors the Senior Director of Nursing (SDNS) indicated once a resident tests positive for COVID-19 they are tested again on day 5 and on day 7, and after a negative test on day 7 they can come off precautions. SDNS further indicated that COVID-19 precautions should be care planned when a resident tests positive and should be taken off as soon as the precautions end. At this time SDNS confirmed R26's care plan was not updated appropriately. 2. R37 was admitted on 3/11/24 and has diagnoses to include chronic obstructive pulmonary disease, and chronic heart failure with presence of cardiac pacemaker placed 3/11/24. Observation of R37 on 8/26/27 at 11:31 a.m., revealed a pacemaker monitor at bedside. During an interview on 8/28/24 at 2:34 p.m., in presence of 2 surveyors the Minimum Data Set (MDS) indicated R37 was admitted with the pacemaker and did not come with any orders for its use. MDS further indicated they do not have the serial number or expiration date on file because he/she sees the cardiologist every 2 months or so and didn't know they needed to have it. At this time MDS Coordinator confirmed R37's care plan lacked goals and interventions for R37's pacemaker.	F 657		
F 684 SS=D	Quality of Care	F 684		

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F 684	Continued From page 9 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 3 sampled residents receiving insulin coverage (Resident #19 [R19]). Findings: 1. On 8/28/24, R19's clinical record was reviewed and included a physician order, dated 5/11/24, to administer Insulin Aspart FlexPen 100UNIT/ML Solution Pen-injector, 10 units subcutaneous to [inject medication between skin and muscle, under the skin] daily at 7:30 a.m.. The instructions state, "Hold for blood sugar less than 170". On 8/3/24, R19's blood sugar result at 7:30 a.m. was 119. Documentation indicated that R19 received 10 units and should have been held (not given). On 8/5/24 R19's blood sugar result at 7:30 a.m. was 165. Documentation indicated that R19 received 10 units and should have been held (not given).	F 684	One resident was affected by this practice. All residents have the potential to be affected by this practice. Insulin orders for R19 were reviewed, clarification from Medical Director was provided. We contacted the physician we got the orders updated and corrected and implemented them within our new system. Re-education will be provided by Director of nursing to all nursing staff on holding medication and when to give medication regarding insulin orders. Audits were conducted by Director of nursing on all other sliding scale insulin orders to insure compliance with physician orders. Medical Director was contacted about sliding scale orders to clarify and updated orders. New software system Point Click Care will tell nursing how much insulin to give regarding sliding scale insulin orders so errors in how much insulin to give in a sliding scale should be resolved. All audits of sliding scale insulin orders will be reviewed by QAPI times 3 months to insure compliance	9/27/24 9/3/24

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F 684	Continued From page 10 On 8/25/24 R19's blood sugar result at 7:30 a.m. was 166. Documentation indicated that R19 received 10 units and should have been held (not given). 2. On 8/28/24, R19's clinical record was review and included a physician order, dated 5/11/24, to administer Insulin Aspart FlexPen 100UNIT/ML Solution Pen-injector, 10 units subcutaneous daily at 11:30 a.m.. The instructions state "Hold for blood sugar less than 170". On 8/25/24 R19's blood sugar result at 11:30 a.m. was 161. Documentation indicated that R19 received 10 units and should have been held (not given). 3. On 8/28/24, R19's clinical record was review and included a physician order, dated 3/15/24, to administer Insulin Aspart FlexPen 100UNIT/ML Solution Pen-injector, variable dose subcutaneous q.i.d. (four times per day) 7:30 a.m., 11:30 a.m., 16:30 (4:30 p.m.), 20:30 (8:30 p.m.) for Type 1 Diabetes, "Insulin Directions: 131 -180 = 6 units; 181-240 = 8 units; 241-300 = 10 units; 301-350 = 12 units; >400 = 16 units; ..." On 8/8/24 R19's blood sugar result at 4:30 p.m. was 162. Documentation indicated that R19 received 0 (no) units and should have been given 6 units. On 8/10/24 R19's blood sugar result at 4:30 p.m. was 192. Documentation indicated that R19 received 6 units and should have been given 8 units. On 8/22/24 R19's blood sugar result at 4:30 p.m. was 150. Documentation indicated that R19	F 684		

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F 684	Continued From page 11 received 5 units and should have been given 6 units. 4. On 8/28/24, R19's clinical record was review and included a physician order, dated 5/11/24, to administer Insulin Aspart FlexPen 100UNIT/ML Solution Pen-injector, 4 units subcutaneous daily at 1630 (4:30 p.m.). The instructions state "Hold for blood sugar less than 170". On 8/2/24 R19's blood sugar result at 4:30 p.m. was 144. Documentation indicated that R19 received 4 units and should have been held (not given). On 8/15/24 R19's blood sugar result at 4:30 p.m. was 115. Documentation indicated that R19 received 4 units and should have been held (not given). On 8/28/24 at approximately 5:15 p.m. in an interview with the Quality Improvement Manager, a surveyor confirmed the above findings.	F 684		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (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)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was	F 693	One resident was affected by this practice. All resident have the potential to be affected by this practice. When RN1 became aware of incomplete feeding of Enteral Nutrition. RN1 restarted Enteral feeding to complete required Enteral Nutrition order. RN1 labeled bag with pertinent information. The policy regarding Enteral Nutrition will be reviewed by all nursing staff. Director of Nursing or designee will provide re-education on Enteral Nutrition. All newly hired nursing employees will receive education regarding Enteral Nutrition administration.	9/27/24 9/27/24

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F 693	Continued From page 12 clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that tube feedings were administered according to provider orders for 1 of 1 resident observed for tube feeding (Resident #9 [R9]). Findings: R9 was admitted on 7/16/24 with diagnose to include failure to thrive. Review of R9 Minimum Data Set dated 7/22/24 revealed a Basic Interview for Mental Status (BIMS) score of 4 of 15 indicating he/she is not cognitively intact. Review of R9's active orders "August 2024" revealed order for "Osmolyte 1.2 Cal/Nutritional Supplements. Liquid (1430ml [milliliter]) at 89 ml per hour enteral tube continuous rate for 16 hours 1400 (2:00 p.m.-6:00 a.m.) for nutritional support. ... Give 200 ml of water prior to feeding, pause feeding at 10 p.m. to give 200 ml of water. Give 200 ml of water after feeding." During an observation on 8/27/24 at 7:00 a.m., R9 was observed sitting in a wheelchair. IV	F 693	Director of Nursing or designee will conduct audits to ensure policy regarding Enteral Nutrition is followed. Audits will be reviewed by QAPI each month for 3 months to ensure compliance.	

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	205154	A. BUILDING _____ B. WING _____	08/28/2024

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F 693	Continued From page 13 (intravenous) pole/machine was noted next to bed with a bag hanging from the pole containing 300 ml's of an unlabeled/undated liquid substance. The machine was off and connected to R9's abdomen. During a follow up observation on 8/27/24 at 7:09 a.m., Registered Nurse #1 (RN1) indicated she had hung the bag yesterday (8/26/24) at approximately 2-2:30 p.m., and it is supposed to run continuously until 10 p.m., when a water flush is supposed to be done and it should have immediately been started again. At this time RN1 confirmed she did not date or label the tube feed and R9 did not get the entire nutritional support as ordered. During an interview on 8/27/24 at 3:39 p.m., the above concern was discussed with Senior Director of Nursing Services.	F 693		
F 695 SS=D	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, and interviews, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to	F 695	All resident have the potential to be affected by this practice. No resident was affected by this practice. Re-Education was provided by Director of Nursing or designee to staff that respiratory tubing will be properly labeled and stored in plastic bag when not in use. All newly hired nursing employees will receive education on how to properly label and store respiratory tubing. Weekly audits will be conducted by Director of Nursing or designee to ensure proper storage of tubing when not in use. Audits will be reviewed by QAPI monthly times three months to insure compliance.	9/27/24

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F 695	Continued From page 14 respiratory care for 1 of 1 resident reviewed for respiratory care (Resident #38 [R38]). Findings: R38 was admitted on 4/3/24 and has diagnoses to include chronic obstructive pulmonary disease. Review of facility Coronavirus (COVID-19) line list revealed R38 tested positive for COVID 19 on 8/9/24. Observations of Room 210-1 on 8/19/24 at 9:22 a.m., 8/20/24 at 2:45 p.m., and 8/21/24 at 10:02 a.m., revealed an oxygen concentrator at bedside with tubing tucked in concentrator handle, dated 8/11/24 and not bagged. A nebulizer machine was observed on the armchair of a recliner with tubing connected to nebulizer pipe, hanging off the side of the recliner. Tubing was not bagged and dated 8/11/24. Review of R38 clinical record revealed nursing note dated 7/13/24 states, "Respirations labored, can't take full breath. SOB [short of breath] w [with] /exertion SOB when sitting at rest HOB [head of bed] needs raising. Oxygen [O2]: 2.0 liter/min [minute] in room via nose to keep 02 sat [saturation] > or equal to 90% tolerating well. No new orders continue to observe[,] Encouraged to rest[,] head of bed elevated. Resident states prior to use of oxygen at home only at bedtime and throughout the night." During an observation of Room 210-1 on 8/28/24 at 7:10 a.m., with a surveyor, Registered Nurse #1 (RN1) indicated that she doesn't know why the oxygen and nebulizer are still in the room as he/she has not used them in a really long time.	F 695		

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F 695	Continued From page 15 During a review of R38's clinical record with RN1 on 8/28/24 at 9:54 a.m., RN1 confirmed R38 last used his/her oxygen on 7/13/24 and last used the nebulizer on 7/13/24. During an interview on 8/28/26 at 8:26 a.m., the above concerns were discussed with Administrator in presence of 2 surveyors. Administrator stated that she had no idea why they would still be in there because he/she did have COVID-19, but it was very mild and didn't think he/she required oxygen or his/her nebulizer.	F 695		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.	F 725	All residents have the potential to be affected by this practice. No residents were affected by this practice. Education was provided by DON to all nurses on procedure to follow when clinical staff callouts occur to make every attempt to cover the call out. Facility has implemented a clinical staffing pool of per-diem staff to help insure state minimum requirements are met on weekends. Schedule will be reviewed weekly by DON, Administrator, and Scheduler to make every effort adequate staffing is provided.	9/27/24

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F 725	Continued From page 16 §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure sufficient direct care staff were scheduled and on duty to meet the needs of residents that reside in the facility. This has the potential to affect all residents needing assistance with Activities of Daily Living (ADL's). Findings: Review of Payroll Based Journal staffing report revealed the facility triggered for low weekend staffing during the second quarter (January1 through March 31, 2024). On 8/28/24 at 6:15 p.m., review of weekend staffing for January 1 through March 31, 2024, the Administrator confirmed the facility did not have enough staff to meet resident needs on the weekends.	F 725		
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	F 732	All resident have the potential to be affected by this practice. No residents were affected by this practice. Nurse Staffing sheets will be swapped out by overnight nurse prior to start of day shift and this will include weekends. Education was provided by Director of Nursing to all nurses to update staffing sheets for any scheduling changes. Weekly audits will be done by Director of Nursing or Designee to insure compliance regarding posting staffing sheets. Audits will be viewed by QAPI times three months to make sure following compliance.	9/27/24

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F 732	Continued From page 17 (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post the nurse staffing information in a prominent place, readily accessible and visible to all residents, for 1 of 3 days of survey (8/26/24). Finding: On 8/26/24, surveyors observed that the nurse staffing information was not posted in an area visible to residents and visitors.	F 732		

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F 732	Continued From page 18 On 8/27/24 at 1:08 p.m., in an interview, the Administrator confirmed that the nurse staffing information was not posted in an area visible to residents and visitors on 8/26/24.	F 732		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to monitor and document targeted behaviors to support the use of psychotropic medications for 1 of 5 residents reviewed for unnecessary medications (Resident #37 [R37]). Findings:	F 757	All resident have the potential to be affected by this practice. No resident was affected by this practice. Education was provided by Director of Nursing or designee regarding monitoring of both side effects and behaviors for psychotropic medications. Our new software system Point Click Care has monitoring of side effects and behaviors of psychotropic medications. Software triggers when these medications are entered into the individual care plan for monitoring and GDR as required. Audits of side effects/and behaviors will be audited by Director of Nursing or designee weekly using the Point Click Care software system and QAPI will review audits times 3 months to insure compliance.	9/3/24

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F 757	Continued From page 19 R37 was admitted on 3/11/24 and has diagnoses to include depression. Review of R37's active orders for "August 2024" revealed order with start date of 3/12/24 for "Escitalopram oxalate 10 mg [milligram] tablet 1 tablet by mouth daily for depressed mood." Further review of R37's clinical record lacked evidence that he/she was being monitored for side effects of this medication. During an interview on 8/27/24 12:02 p.m., Registered Nurse #1 confirmed that the facility does not monitor for side effects of psychotropic medication. During an interview on 8/27/24 at 2:12 p.m. Senior Director of Nursing indicated that the facility documents for side effects of psychotropic in nursing notes only by exception.	F 757		
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:	F 880	Two residents were affected by this practice. All resident have the potential to be affected by this practice. Personal protective equipment signage was posted 8/26/2024 informing staff of EBP's for R13 and R19. Re-Education was provided by Director of Nursing or designee to all Licensed staff regarding Infection Control policy. Re-Education was provided to all clinical staff on how to manage residents who are non-compliant with COVID-19 precautions. All newly hired nursing employees will receive education on how to manage a resident who is non-compliant with Covid-19 precautions.	9/27/24 9/27/24

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F 880	Continued From page 20 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880	Audits will be conducted by Director of Nursing or designee weekly times 3 months of residents on EBP's. QAPI will review times 3 months to make sure in compliance.	

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F 880	Continued From page 21 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 record review, interviews and observations the facility failed to 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. The facility failed to provide enhanced barrier precautions (EBP's) pertaining to Resident's with urinary Foley catheters, and multi drug resistant organisms [MDRO] for 2 of 3 days of survey (8/26/24, and 8/27/24). Findings: 1. Review of facility provided "Coronavirus (COVID-19) line list" revealed the first resident tested positive for Coronavirus (COVID-19) on 8/9/24. As of 8/24/24 there were a total of 17 residents and 13 staff members tested positive for Coronavirus. Observation of Resident #191 [R191] on 8/27/24 at 11:01 a.m., unmasked and self-propelling down West Unit passing 3 residents. Review of "COVID-19 line list" revealed R191 tested positive	F 880		

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F 880	Continued From page 22 for COVID-19 on 8/9/24. During an interview on 8/27/24 at 11:03 a.m., Certified Nursing Assistant #1 [CNA1] indicated R191 won't stay in his/her room, and she did not offer him/her a mask to wear when in the hall. During an interview on 8/27/24 at 9:12 a.m., Licensed Practical Nurse (LPN) (designated infection preventionist) confirmed the first resident tested positive for COVID-19 on 8/9/24. LPN indicated that she finds out who tested positive when she comes in and runs the infection report but is unaware of how to track/trace how it come into the building because no ones ever shown her how to. During an interview in presence of 4 surveyors on 8/27/24 at 2:44 p.m., Quality Improvement Manager indicated she understands infection control needs some improvement as survey has pointed out and they will be making improvements but feels that the facility has a very low infection rate regardless. 2. On 8/26/24, from 10:30 a.m. to 3:45 p.m., a surveyor observed no signage or personal protective equipment (PPE) notifying of EBP's for R13 who had an MDRO or R19 who had a Foley catheter. On 8/27/24, from 7:30 a.m. to 3:45 p.m., a surveyor observed no signage or personal protective equipment (PPE) notifying of EBP's for R13 who had an MDRO or R19 who had a Foley catheter. On 8/28/24 at 8:24 a.m., a surveyor could not find	F 880		

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F 880	Continued From page 23 any documentation pertaining to the use of EBP's. On 8/28/24 at 8:24 a.m., a surveyor observed EBP signage and PPE equipment outside of the rooms of R13 and R19. At this time, in an interview with the Administrator, a surveyor confirmed that EBP's including signage and PPE equipment was not being used for R13 and R19 and should have been due to Foley catheter with MDRO and MDRO.	F 880	All resident have the potential to be affected by this practice. No residents were affected by this practice.	
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 interviews, and record review the facility failed to implement its 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 facility provided "Infection Report" revealed the following: -During the month of April 2024, there were 3 documented antibiotics prescribed.	F 881	Faciltiy is reviewing and monitoring that appropriate antibiotics are being ordered as well as used per NHSN and McGreers for scoring infections as well as C&S reportrs. D.O.N RN/ICP provides a report at the quartly quaility assurance meeting regarding infections and use of antibiotics which is then reviewed by the QAPI team. See attached ICP certificate. LPN was covering for ICP while on vacation during survey. LPN has completed the ICP class on 9/25/2024. Current Director of Nursing and day shift RN are currently enrolled in ICP certifcate program. Will be completed by 10/12/24. Quailtiy assurance RX reports are discussed in QAPI meetings pharmacist monthly reports do contain recommendations for appropriate antibiotic use. QAPI will review Antibiotic use monthly to insure policy regarding Antibiotic Stewardship is being followed.	9/25/2024 10/12/2024

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F 881	Continued From page 24 -During the month of May 2024, there were 7 documented antibiotics prescribed. -During the month of June 2024, there were 7 antibiotics prescribed. -During the month of July 2024, there were 11 antibiotics prescribed. Review of facility provided "RX Quality Pharmacy Report" dated 1/26/24, 4/26/24 and 7/2/24 lacked evidence of antibiotic use/discussion on these forms. During an interview on 8/27/24 at 9:12 a.m., Licensed Practical Nurse (LPN) (Infection Preventionist) indicated she is currently halfway through the infection Preventionist program and does not know how to track the infections and what to do with the orders she prints out. She does not check for culture and sensitivity results for urinary tract infections and believes the nurses take care of all that stuff. LPN does not receive a quarterly antibiotic use report from pharmacy and doesn't review them at Quality Assurance and Performance Improvement (QAPI) meetings. LPN confirmed 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 9:18 a.m., with 4 surveyors the Administrator confirmed the provided "RX Quality Assurance Report's" provided are what is discussed in QAPI meetings. During an interview in presence of 4 surveyors on 8/27/24 at 2:44 p.m., Quality Improvement Manager (QIM) was asked to provide evidence that the facility was implementing its antibiotic stewardship plan. At this time QIM indicated the facility is consistently using McGuire's criteria for	F 881		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205154	A. BUILDING _____ B. WING _____	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 881	Continued From page 25 antibiotic stewardship and refused to produce supporting documents to indicate their use and was unable to provide supporting evidence indicating review of antibiotic use during its QAPI meetings. At this time QIM indicated she understands infection control needs some improvement as survey has pointed out and they will be making improvements but feels that the facility has a very low infection rate regardless.	F 881		
F 882 SS=E	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to ensure that the facility's Infection Preventionist (IP) had completed specialized training prior to starting the IP position. Findings:	F 882	All resident have the potential to be affected by this practice. No residents were affected by this practice. Please find attached to POC the certificate held by Director of Nursing/ICP for Woodlawn. Current Director of Nursing and day shift RN are currently enrolled in ICP certifcate program. Will be completed by 10/12/24. LPN has completed ICP class with completion date of 9/25/2024. LPN was covering for ICP while out on vacation.	10/12/2024 9/25/2024

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F 882	Continued From page 26 During an interview on 8/27/24 at 9:12 a.m., with 3 surveyors, Licensed Practical Nurse (LPN) indicated she started with the facility in October 2024 for the purpose of becoming the Infection Preventionist but did not start the IP class until February 2024. LPN is currently halfway through the course and has not had any training by anyone and is unsure of what to do. During an interview on 8/27/24 at 2:21 p.m., Senior Director of Nursing Services confirmed that LPN was the facilities designated Infection Preventionist. During an interview on 8/27/24 at 10:27 a.m., with 3 surveyors, Regional Quality Improvement Manager confirmed LPN has been acting as IP since October of 2023 and was not enrolled in IP class until February 2024 and has not yet been completed it.	F 882		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may	F 947	All resident have the potential to be affected by this practice. No residents were affected by this practice. Emailed education regarding CNA 2 to surveyor the following morning showing required education was completed by CNA2. Please see attached education in email. Facility utilizes Relias Learning to ensure all required education is completed annually. QAPI will review all CNA mandatory training for completion.	

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F 947	Continued From page 27 address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on Certified Nurse's Aide (CNA) employee education record reviews and interview, the facility failed to monitor and ensure that a CNA attended the required 12 hours of annual in-service education, for 1 of 5 randomly selected CNA's employed greater than 1 year. (CNA2) Findings: CNA2 was hired on 4/11/23. Review of provided in-service training dated 4/11/23 through 4/11/24 lacked evidence that CNA2 received required in-service training for abuse or resident rights. During an interview on 8/28/24 at 6:24 p.m. with 2 surveyors, the Administrator confirmed CNA2 is missing education on abuse and resident rights for 2023-2024.	F 947		