STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205067	A. BUILDING B. WING	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVE'S EDGE INC	26 SCHOONER STREET , DAMARISCOTTA, Maine, 04543

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F0000	INITIAL COMMENTS From 1/5/26 through 1/7/26 on-site visits were conducted at Cove's Edge for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification and investigating complaint #2642596, #2664475, #2692657 & #2697681. It was determined that Cove's Edge was not in compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F0000	Please see attached plan of corrections.	
F0550 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 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	F0550		

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F0550 SS = D	Continued from page 1 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observations and interviews, the facility failed to provide care for a resident in a dignified manner when a Certified Nursing Assistant (CNA#1) was observed transporting a resident in a shower chair when a resident wasn't provided a cover in a dignified manner exposing their bottom in a facility hallway (Resident #3). Findings: On 1/5/26 at 11:39 a.m., observation of CNA #1 transporting Resident #3 in a shower chair from Periwinkle Place unit, past the front entrance of the facility and nurses station down onto the adjacent unit shower room. Resident #3 had a sheet over his/her lap; however, his/her bottom was visible/exposed, hanging out from under the commode seat as well as his/her foley catheter. At this time, the surveyor intervened, discussing that Resident #3 was left exposed during the transport. CNA #1 stated he/she must have moved the sheet from his/her lap. On 1/5/26 at approx.11:45 a.m., the above observation was discussed with the Director of Nursing.	F0550		
F0656 SS = E	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 -	F0656		

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F0656 SS = E	Continued from page 2 (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 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 observations, interviews, and record reviews, the facility failed to ensure a resident's care plan was developed to reflect the current needs of the resident for 2 of 16 residents reviewed for care planning (Resident #3, #35). Findings: 1. Resident #3 was admitted in January 2025 with diagnoses to include complete heart block and presence of cardiac pacemaker.	F0656		

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F0656 SS = E	Continued from page 3 Review of Resident #3's Quarterly Minimum Data Set (MDS) assessment, dated 10/19/25, indicates presence of cardiac pacemaker. Review of Resident #3's physician orders revealed an order with a start date of 7/31/25 for "St. Jude pacemaker..." A review of Resident #3's care plan, revised on 11/3/25, lacked evidence that goals and interventions were developed and implemented for the pacemaker. On 1/7/2025 at 12:07 p.m. during an interview, Registered Nurse (RN) #5 reviewed Resident #3's care plan and confirmed that it had not been developed or implemented in the area of the pacemaker. 2. Resident #35 was admitted in November 2025 with diagnoses to include chronic obstructive pulmonary disease (COPD), heart failure, and chronic lower extremity edema. On 1/5/26 at 9:05 a.m. observation of Resident #35 seated in his/her recliner chair located next to his/her bed. Resident #35's bed was neatly made, and the surface of the bed was covered with various personal belongings. During an interview at this time, Resident #35 stated he/she needs help from the staff applying his/her compression socks each day because he/she loses his/her balance easily. On 1/7/26 at 11:40 a.m., a surveyor observed Resident #35 seated in his/her recliner with Tubigrips (a tubular bandage that provides compression for swelling) in place on his/her bilateral lower legs. During a follow-up interview at this time, Resident #35 stated that he/she wears the Tubigrips every day and that the Certified Nursing Assistant (CNA) helps him/her apply them each morning and remove them before bed. On 1/7/26 at 11:44 a.m. during an interview, CNA #6 stated Resident #35 sleeps in his/her recliner and that he/she wears compression stockings every day. On 1/7/26 at 11:50 a.m. during an interview, Registered Nurse (RN) #8 and CNA #5 stated that Resident #35 wears Tubigrips daily. Review of Resident #35's clinical record revealed a Quality Review progress note dated 12/4/25 that states, "... chooses to sleep in [his/her] recliner..." Review of Resident #35's care plan states, "I have an ADL [Activities of Daily Living] self-care performance	F0656		

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F0656 SS = E	Continued from page 4 deficit…Will have no injuries from use of side/enabler rail device…BED MOBILITY: I use an enabler to maximize independence repositioning in bed…" and "I have potent [potential] for skin integrity r/t [related to] decreased mobility…pressure relieving device on bed…" Further review of the care plan revealed, "Altered cardiovascular status r/t CHF…chronic lower leg edema…" and lacked evidence of Resident #35's daily use of Tubigrips. On 1/7/26 at 12:37 p.m. during an interview, the above finding was discussed with RN #5 and the DON. At this time, RN #5 reviewed Resident #35's care plan and stated that Resident #35 has slept in his/her recliner since admission and confirmed that the bed mobility and side/enabler rail interventions on Resident #35's care plan do not reflect his/her current care needs. RN #5 then stated that the Tubigrips should have been included on Resident #35's care plan.	F0656		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F0657		

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F0657 SS = D	Continued from page 5 (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews and interview, the facility failed to review and revise the care plan by an interdisciplinary team (IDT), that included, to the extent possible, participation of the resident and/or his/her representative after each Minimum Data Set (MDS) assessment for 1 of 16 residents reviewed for care planning (Resident #35). Finding: Review of Resident #35's clinical record revealed an MDS Admission Assessment was completed on 11/25/25. Further review of Resident #35's clinical record lacked evidence that an IDT meeting was held within 7 days following the assessment. On 1/7/26 at 12:46 p.m. the above finding was discussed during an interview with the Director of Nursing (DON) and Registered Nurse (RN) #5. At this time, RN #5 stated that she documents the IDT meeting notes in the resident's electronic medical record (EMR). RN #5 then reviewed Resident #35's EMR and confirmed that an IDT meeting was not held following the above assessment.	F0657		
F0684 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 observations, interviews, and record reviews, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice in the area of medication administration and treatments for 2 of 19 sampled residents (Residents #35 and #2). 1. On 1/6/26 at 11:56 a.m. observed Registered Nurse	F0684		

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F0684 SS = D	Continued from page 6 (RN#3) push the medication cart to R#2's room, proceeded to pull the medications out of the cart and then crushed them without verifying the medications to the resident's chart. The surveyor questioned the practice, but RN#3 stated she did it by memory and that the order is on the resident's Treatment Administration Record (TAR). Even after surveyor intervention RN#3 did not review the TAR before giving the resident the medications. On 1/6/26 at 12:00 p.m. the above finding was confirmed with RN#3. 2. Resident #35 was admitted in November 2025 with diagnoses to include heart failure and chronic lower extremity edema. On 1/5/26 at 9:05 a.m. during an interview, Resident #35 stated he/she needs help from the staff applying his/her compression socks each day because he/she loses his/her balance easily. On 1/7/26 at 11:40 a.m., a surveyor observed Resident #35 seated in his/her recliner with Tubigrips (a tubular bandage that provides compression for swelling) in place on his/her bilateral lower legs. During a follow-up interview at this time, Resident #35 stated that he/she wears the Tubigrips every day and that the Certified Nursing Assistant (CNA) helps him/her apply them each morning and remove them before bed. On 1/7/26 at 11:44 a.m. during an interview, CNA #6 stated Resident #35 wears compression stockings every day. On 1/7/26 at 11:50 a.m. during an interview, Registered Nurse (RN) #8 and CNA #5 stated that Resident #35 wears Tubigrips daily. A review of Resident #35's active physician orders lacked evidence of an order for the Tubigrips. On 1/7/26 at 12:44 p.m., the above finding was discussed with the Director of Nursing (DON).	F0684		
F0695 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	F0695		

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F0695 SS = D	Continued from page 7 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 maintain a sanitary environment to help prevent the development and transmission of disease and infection related to respiratory care for 3 of 4 residents reviewed for respiratory care (Residents #24, #35, and #41). In addition, the facility failed to ensure physician orders were obtained and provided proper monitoring for 1 of 5 residents (Resident #6) receiving oxygen therapy and failed to ensure that physician orders were followed for 1 of 4 residents (Resident #24) receiving oxygen therapy. 2. On 1/5/26 at 9:33 a.m. and on 1/6/26 at 8:14 a.m. a surveyor observed the following: Resident #24 seated in his/her recliner chair, wearing nasal cannula (NC) oxygen tubing, dated 1/3/26, with the oxygen concentrator set to 2.5 liters per minute (L/min). Resident #24's unbagged, undated NC oxygen tubing attached to a portable oxygen tank stored in the pocket on the back of his/her wheelchair. The nasal cannula prongs were in direct contact with the surface of the wheelchair. A review of Resident #24's clinical record revealed the following active orders: An order with a start date of 2/25/25 for "Oxygen: Continuous Oxygen via NC, 1-2 L/ min Maintain 02 [oxygen] Sat [saturation] > 92% Check 02 SAT: Q shift Titrate: SP02 [oxygen saturation] greater than 92% every shift for Dyspnea [shortness of breath]" An order with a start date of 9/5/25 for "Change oxygen tubing... once weekly on Friday per facility protocol... *REMEMBER TO DATE TUBING..." On 1/5/26 at 9:35 a.m., during an interview, Resident #24 stated that he/she uses oxygen continuously and uses the portable oxygen quite often when he/she goes to the bathroom or leaves his/her room.	F0695		

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F0695 SS = D	Continued from page 8 On 1/6/26 at 9:01 a.m. during an interview, Registered Nurse (RN) #2 stated nursing staff apply Resident #24's portable oxygen when he/she transfers to his/her wheelchair and that Resident #24 just used the portable oxygen last night when he/she went to the dining room for the evening meal. On 1/6/26 at 1:20 p.m. during a follow-up observation, Resident #24 was asleep in his/her recliner, and his/her oxygen tubing was draped behind the oxygen concentrator, with the nasal cannula in direct contact with the floor. The oxygen concentrator was off. On 1/6/26 at 1:21 p.m. during an interview, RN #3 stated that Resident #24 needs continuous oxygen at 2L/min and that his/her oxygen saturation drops to 88% without it. At this time, the surveyor discussed the above observation with RN #3. At 1:24 p.m., the surveyor, RN #3, and CNA #8 entered Resident #24's room and observed his/her nasal cannula touching the floor. RN #3 proceeded to pick up the oxygen tubing and turn on the oxygen concentrator. Despite surveyor intervention, RN #3 continued to place the nasal cannula in Resident #24's nose. The surveyor then asked how oxygen tubing is stored when it is not in use. RN #3 stated that she usually just hangs it on the concentrator. CNA #8 stated she wraps the tubing with a tissue. On 1/6/25 at 2:05 p.m. the above concerns, including the oxygen flow rate being set outside of the physician's order parameters, the unbagged and undated tubing, and RN #3 placing the nasal cannula on Resident #24 after it was in direct contact with the floor, were discussed with the Director of Nursing (DON). At this time, the surveyor and the DON observed Resident #24's concentrator set to 2.5 L/min and his/her unbagged oxygen tubing connected to the portable tank on the back of the wheelchair, and the DON stated that to her knowledge, the facility does not have a process in place for storing oxygen tubing when it is not in use. 3. On 1/5/26 at 9:09 a.m., a surveyor observed Resident #35's unbagged nebulizer tubing and mouthpiece connected to a nebulizer machine, stored on top of Resident #35's bed. The mouthpiece was in direct contact with a pile of papers on top of the bed. On 1/6/26 at 1:16 p.m. during a follow-up observation, Resident #35's nebulizer machine with attached tubing and mouthpiece was stored on top of Resident #35's bed, and the mouthpiece was in direct contact with his/her bed linens.	F0695		

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F0695 SS = D	Continued from page 9 Review of Resident #35's clinical record revealed active physician orders for "Ipratropium-Albuterol Inhalation Solution… inhale orally every 6 hours as needed for wheezing" and "Nebulizer Disinfect daily: in clean container/ bowl, soak items in three parts hot water, to one part white vinegar for 30 mins. [minutes] remove items from disinfectant sol. [solution], rinse under hot tap water. air dry, store" Review of Resident #35's January 2026 Medication Administration Record and Treatment Administration Record (MAR/TAR) lacked evidence that the Nebulizer is disinfected and stored according to the above order. On 1/6/26 at 1:20 p.m. during an interview, the above observations were discussed with RN #6. At this time, RN #6 stated Resident #35 has Chronic Obstructive Pulmonary Disease and has used nebulizer treatments since he/she was admitted to the facility and that his/her nebulizer machine and mouthpiece should not be stored on his/her bed. RN #6 then stated that after use, the mouthpiece should be cleaned and air dried and stored on a surface but that she is not sure exactly how it should be stored. On 1/6/26 at 2:00 p.m., the surveyor discussed the finding with the DON. At this time, the DON stated she thinks nebulizer tubing and mouthpieces may have been stored in a plastic bag at one point but that she is not sure if the facility has a consistent practice now. 4. On 1/5/26 at 9:42 a.m. a surveyor observed Resident #41's oxygen concentrator next to his/her bed with unbagged and undated nasal cannula oxygen tubing coiled up with the nasal cannula prongs in direct contact with the surface of the concentrator. On 1/6/26 at 1:23 p.m., a surveyor observed Resident #41 seated in his/her wheelchair in the hall, and a portable oxygen tank was stored in the pocket on the back of his/her wheelchair with unbagged, undated nasal cannula oxygen tubing coiled up on top of the tank. At this time, Resident #41 stated that he/she stated never uses the concentrator anymore but sometimes uses "this tank," gesturing toward the tank stored in the back of his/her wheelchair. Review of Resident #41's clinical record revealed documented vital signs indicating the last time Resident #41 used oxygen was 11/19/25. Review of Resident #41's November Medication	F0695		

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F0695 SS = D	Continued from page 10 Administration and Treatment Administration Record (MAR/TAR) indicated, "Check O2 sat every shift. Titrate oxygen to be >91% every shift for was on oxygen at the hospital. The MAR/TAR indicated this order was discontinued 12/9/25. On 1/6/26 at approximately 2:10 p.m., the surveyor and the DON observed Resident #41's oxygen concentrator and the surveyor discussed the above finding. At this time, the DON stated Resident #41's oxygen concentrator and tank should have been removed when the oxygen was discontinued. On 1/6/26 at 2:44 p.m., the above findings were discussed with the Administrator. Findings: On 1/06/2026 at 9:52 a.m., a surveyor observed Resident #6 wearing oxygen via nasal cannula (n/c) during a medication administration observation. On 1/06/2026 at 12:11 p.m., during an interview with Resident #6, a surveyor observed an oxygen concentrator set at 2 liters and the nasal cannula tubing dated 1/1/26. Resident #6 stated he/she wears oxygen all the time. Record review for Resident #6 revealed an admission in November, 2025, with diagnoses that included COPD (Chronic Obstructive Pulmonary Disease). On 1/3/25, Resident #6 was evaluated in the emergency department for difficulty breathing and diagnosed with COPD exacerbation and pneumonia. A review of provider orders lacked a current order for oxygen use. Admission orders, dated 10/24/25, included PRN (as needed) Orders, which stated "Oxygen 2 liters per minute via nasal cannula as needed for dyspnea, comfort and/or an oxygen saturation below 90." Resident #6's record did not specify the amount of oxygen in use or staff documentation of regular monitoring of oxygen saturation. On 1/6/25 at 12:50 p.m., in an interview with the Director of Nursing and the Long Term Care Unit Manager, a surveyor discussed that Resident #6 has worn oxygen continuously since his/her return from the emergency room on 1/3/25. The surveyor discussed the clinical record lacked a current provider's order for	F0695		

"ATEMENT OF DEFICIENCIES .ND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205067	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/07/2026

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F0695 SS = D	Continued from page 11 oxygen use. In addition, the clinical record lacked evidence of staff documentation of amount of oxygen in use and the results of oxygen saturation monitoring. The Director of Nursing acknowledged the findings and stated she would have the provider clarify the orders.	F0695		
F0812 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, interviews and facility policy, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner and failed to ensure foods were labeled and dated in the reach in refrigerator for 2 of 2 kitchen tours. (1/5/26 and 1/5/26) Findings: 1. On 1/5/26 at 9:06 a.m., observation of the kitchen with the Dietician and the Food Service Director (FSD) the following findings were observed and confirmed. - The walk-in freezer ceiling had built up ice in front of the fans, the floor was littered with food and bagged food/packages including French fries, frozen	F0812		

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F0812 SS = E	Continued from page 12 yogurt/ice cream single serve cup and several packages of an unknown food product. Under the shelving unit was a built up ice mound in the right back corner. There were open unlabeled/dated bag of waffles and a bag of personal pizzas. - The stand up mixer had dried food/debris on the mixing arm, the protective cage and the shield. At this time the FSD and the cook stated the last time the mixer was used was Friday (3 days ago) for making cinnamon buns. - The 3 bin plastic storage containers for flour, panko and sugar had food/debris particles covering the container and lids. - The Cook's cooler had a pan of sliced deli meat (roast beef) with an orange sticker/label with a used by date of 1/4/26. 2. On 1/6/26 at 8:20 a.m., during a follow up observation of the kitchen with the FSD, the walk-in freezer ceiling had built up ice in front of the fans and under the shelving unit was the built up ice mound in the right back corner. The FSD stated "I didn't realize it was that harsh…We will probably be hitting it by the end of the week." On 1/6/26 at approx. 3:30 p.m., observation of the built up ice in the walk in freezer was removed. The facilities "Food and Supply Storage" policy revised 1/25 states, "All food, non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption. Most, but not all, products contain an expiration date. The words "sell by", "best by", "enjoy by", or "use by" should precede the date. The "sell-by" date is the last date that food can be sold or consumed; do not sell products in retail areas or place on patient trays/resident plates past the date on the product. Foods past the "use-by", "sell-by", "best-by", or "enjoy-by" date should be discarded. Cover, label ad date unused portions and open packages. Use the Medvantage/Freshdate labeling system or complete all sections on the Morrison orange label. Products are good through the close of business on the date noted on the label."	F0812		
F0842 SS = B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5)	F0842		

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F0842 SS = B	Continued from page 13 §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 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	F0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205067	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/07/2026

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F0842 SS = B	Continued from page 14 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. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews, the facility failed to ensure that clinical records were complete and contained accurate information for 1 of 3 sampled residents reviewed for positioning and mobility (Resident #3). Finding: Resident #3 was admitted to the facility in January 2025 with diagnoses to include left hip fracture and left hip surgical repair. A review of Resident #3's clinical record revealed the following active physician orders:An order with a start date of 1/16/25 for "Elevate affected extremity to prevent swelling"An order with a start date of 1/16/25 for "Incentive Spirometer 10 x QH [every hour] while awake" An order with a start date of 1/16/25 for "Call for persistent or worsening drainage..." Review of	F0842		

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F0842 SS = B	Continued from page 15 Resident #3's baseline care plan, initiated 1/17/25 states, "L [left] hip surgical incision r/t [related to] Left femur fracture stryker gamma nail…my surgical incision will heal...by review date…" A review of Resident #3's revised care plan indicated the focus, goal, and interventions were resolved on 7/2/25. On 1/7/26 at 11:59 a.m. during an interview, the above finding was discussed with the Director of Nursing (DON). At this time, the DON stated that the order for persistent drainage should have been discontinued because Resident #3 no longer has a surgical wound but that she is not sure about the other orders and the nurse would know better. On 1/07/2026 at 12:07 p.m. during an interview with Registered Nurse (RN) #5 and RN #6, RN #6 stated Resident #3's left leg is no longer being elevated and that the Incentive spirometer is no longer being used and that the above orders are no longer accurate. At this time, RN #5 stated the nurse should have asked the provider to discontinue the orders.	F0842		
F0880 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	F0880		

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F0880 SS = E	Continued from page 16 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 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 observations, interviews and record review, the facility failed to maintain an Infection Control	F0880		

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F0880 SS = E	Continued from page 17 Program designed to help prevent the development and transmission of disease and infection by failing to apply appropriate interventions including Transmission Based Precautions (TBP) and Enhanced Barrier Precautions (EBP). In addition, facility failed to demonstrate staff competency for Infection Control in the areas of TBP and EBP in 2 of 2 units (Periwinkle and hummingbird). Findings: 1. On 1/6/26 at 9:52 a.m., during a medication administration observation for Resident #6 on the Periwinkle Unit with Certified Nursing Assistant-Medication Tech (CNA-M) #7, a Contact Precautions sign that indicated a gown and gloves are to be worn when entering the room and a Personal Protective Equipment (PPE) storage bag was hanging on the front of the door. At this time, the surveyor asked CNA-M #7 to verify the type of precautions in place, and CNA-M #7 stated Resident #6 is not on precautions but that his/her roommate is on precautions for urine. When the surveyor asked to clarify what type of precautions are in place for Resident #6's roommate, CNA-M #7 sanitized his hands, donned (put on) a mask and gloves and stated he is wearing a mask because Resident #6 is coughing but could not tell the surveyor what type of precautions were in place. The surveyor donned PPE according to the instructions on the Contact sign. On 1/6/26 at 2:13 p.m. the surveyor and the Director of Nursing (DON) observed the contact sign and PPE bag hanging on outside of Resident #6's door. At this time, the DON stated neither Resident #6 or his/her roommate is on Contact precautions and that the Contact sign was placed in error. The DON then stated Resident #6's roommate is on EBP and that the PPE and an EBP sign should have been placed on the back of the door. 2. On 1/6/26 at 11:21 a.m. observation of room 108 with a Personal Protective Equipment (PPE) bag hanging on the back of the room door, there was no visible EBP sign or TBP posted instructing staff on what to wear during care or which resident in the room required the PPE. On 1/6/26 at 11:21 a.m. the above was confirmed with RN#3, who stated that they know who is on EBP or TBP by looking at the Treatment Administration Record (TAR). 3. On 1/5/26 at 12:21 p.m., observation of room 105 with a PPE bag hanging on the back of the room door,	F0880		

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F0880 SS = E	Continued from page 18 there was no visible Enhanced Barrier Precautions sign or TBP posted instructing staff on what to wear during care or which resident in the room required the PPE. At this time, during an interview with the resident, he/she stated he/she has a supra pubic (SP tube) catheter. He/she was asked if staff wear personnel proactive equipment when providing direct care for his/her SP tube. He/she stated "some do some don't". On 1/6/25 at approx. 1:55 p.m., the DON and 3 surveyors discussed the lack of EBP posting on several rooms and a TBP (Contact) posted on a room that was not required. The DON stated that the EBP rooms should all have Contact precaution sign posted, stating EBP is contact precautions.. If the resident did not have an active infection and was on EBP then the PPE bag will be on the inside of the door until the resident is discharged. The surveyor asked if there was posted EBP signage for those residents, the DON stated no. At this time, the DON and the surveyors went to the Hummingbird unit and observed room 105. On the back of the door was the hanging PPE bag now with a Droplet Precaution (TBP) sign posted. At this time, DON was asked which resident was on droplet precautions. The DON stated neither resident was on droplet precautions and that the posted TBP was incorrect. The surveyor asked how does staff or visitors know which resident is on TBP or EBP. The DON stated there is a list at the station. The DON was unable to find the list in the wall hanging station on the Hummingbird unit and then asked the Certified Nurses Aide (CNA#2) where the list of EBP residents is located. After ruffling through papers CNA#2 found an undated paper that contained a list of residents. On this list it had nonpharmacological interventions, which resident required a daily weight, and who was on EBP. At this time CNA #2 stated she doesn't know how old the list is or when it was made but one of the residents on the list was discharged a while ago.	F0880		

Cove's Edge Plan of Correction for Annual Survey conducted on January 05-08, 2026

F0550- Resident Rights/Exercise of Rights

Corrective Action for residents identified in survey:

The affected resident was immediately covered once the Certified Nursing Assistant (CNA) became aware of the issue on 01/05/2026. Staff involved were also reeducated on resident dignity and privacy procedures.

How to identify other residents having the potential to be affected by the same deficient practice:

All residents scheduled to receive showers were reviewed to ensure proper covering procedures are followed during transport. No additional concerns were identified.

Measures put in place to ensure that deficient practice will not recur:

Targeted re-education will be provided to all CNAs and nursing staff by 01/28/2026, emphasizing proper privacy practices and required covering procedures during resident transports for showers.

The facility will monitor corrective actions to ensure deficient practice is being corrected and will not recur:

Director of Nursing, Unit Manager, or designees will complete random weekly observations of shower transportation for a period of three months to ensure compliance. All findings will be submitted to the QAPI committee quarterly for review.

Full compliance by: February 20, 2026

F0656- Develop/Implement Comprehensive Care Plan

Corrective Actions completed:

The care plans for the affected residents were immediately updated to include specific goals and interventions for pacemaker management, compression garment usage, and sleep preferences:

Resident #3: Pacemaker use was added to the individualized plan of care.

Resident #35: Tubigrips were added to the care plan.

Resident #35: Care plan was updated to reflect resident preference to sleep in a recliner.

Missing information was added to care plans by 01/19/2026.

Nursing staff were informed of the changes by 01/19/26.

How to identify other residents having the potential to be affected by the same deficient practice:

A full review of all residents' pacemakers, tubigrips, compression stockings and individualized sleep preferences was completed to ensure care plans accurately reflect their needs. Any omissions were added to care plans by 01/19/2026.

Measures put in place to ensure that deficient practice will not recur:

Education regarding comprehensive care plan development and accurate documentation was provided to the interdisciplinary team by 01/28/2026.

The facility will monitor corrective actions to ensure deficient practice is being corrected and will not recur:

Director of Nursing (DON), nurse manager or designee, will ensure care plans referencing sleep preferences, compression devices, and pacemakers will be audited in alignment with the MDS schedule—weekly ×4 weeks, then monthly ×5 months. Audit results will be submitted to the QAPI committee for quarterly review.

Full compliance by: February 20, 2026

F0657- Care Plan Timing and Revision

Corrective Action for deficiency in survey:

For Resident #35, interdisciplinary team (IDT) documentation from the 12/04/2025 meeting was entered in the record as a late entry on 01/21/2026. The care plan was reviewed and updated to reflect the resident's current needs and preferences.

How to identify other residents having the potential to be affected by the same deficient practice:

All newly admitted residents and those requiring comprehensive assessments were audited for timely IDT meeting completion. There were no additional findings.

Measures put in place to ensure that deficient practice will not recur:

MDS Coordinators were re-educated and instructed by 01/21/2026 to schedule IDT meetings within seven days following completion of a comprehensive MDS assessment. Additional re-education regarding regulatory requirements for timely care plan meetings was provided to the interdisciplinary team by 01/28/2026.

The facility will monitor corrective actions to ensure deficient practice is being corrected and will not recur:

Director of Nursing (DON), nurse manager or designee will conduct audits of MDS and IDT meeting schedules weekly ×4 weeks, then monthly ×5 months by reviewing a report of completed assessments and then verifying their subsequent IDT meetings occurred within 7 days. Audit outcomes will be reviewed during quarterly QAPI meetings.

Full compliance by: February 20, 2026

F0684-Quality of Care

Corrective Action for residents identified in survey:

RN #3 was immediately re-educated on 01/06/2026 to ensure medication orders are verified in the resident's room using the electronic record prior to administration. Resident #35's medication administration record was immediately reviewed, and all orders were verified with the prescribing provider. Compression garments were removed until a valid physician order was obtained and documented. A physician order for Tubigrips was obtained on 01/07/2026.

How to identify other residents having the potential to be affected by the same deficient practice:

All residents and their records were audited on 01/23/2026 for the presence and appropriate use of compression devices. Provider orders were also verified as current and accurate, and any discrepancies were corrected promptly.

Measures put in place to ensure that deficient practice will not recur:

The Director of Nursing and Unit Manager will ensure all nurses and CNAs will receive re-education by 01/28/2026 regarding verification of orders during medication preparation and administration. Staff will also be educated on the requirement to secure physician orders for any compression device prior to use.

The facility will monitor corrective actions to ensure deficient practice is being corrected and will not recur:

The Director of Nursing and/or Unit Managers will observe medication administration for three residents weekly ×4 weeks, then monthly ×5 months. New residents and newly introduced compression devices will be audited weekly ×4 weeks, and then monthly ×5 months. All monitoring results will be presented quarterly to the QAPI committee.

Full compliance by: February 20, 2026

Cove's Edge 205067 Plan of Correction for survey year 2025 conducted on January 5-8, 2026

F0695- Respiratory/Tracheostomy Care and Suctioning

Corrective Action completed:

All respiratory equipment for the affected residents was immediately replaced with properly stored and dated supplies. Physician orders were reviewed and treatments administered as prescribed.

For Resident #24: New physician order was obtained on 01/09/2026 permitting oxygen titration up to 4 L/min to maintain oxygen saturation >92%. Oxygen tubing was also replaced on 01/09/2026.

For Resident #35: Nebulizer tubing was replaced on 01/06/2026.

For Resident #41: Oxygen and concentrator were removed on 01/06/2026.

For Resident #6: Physician order for oxygen was obtained on 01/06/2026.

Staff were educated on a new process for handling, storing, and replacing oxygen and nebulizer tubing and process was fully implemented on or before 01/16/2026.

How to identify other residents having the potential to be affected by the same deficient practice:

A facility-wide review of all residents receiving respiratory treatments was completed to verify that equipment was sanitary and orders were current; any discrepancies were corrected immediately. This was completed by 01/28/2026.

Measures put in place to ensure that deficient practice will not recur:

Education will be provided to all clinical staff on proper use, handling, storage, replacement, documentation, administration, and adherence to physician orders for respiratory treatments, including oxygen and nebulizer tubing by 01/28/2026.

The facility will monitor corrective actions to ensure deficient practice is being corrected and will not recur:

The Director of Nursing, Nurse manager, or designee will audit for proper use, handling, storage, replacement, documentation, administration, and adherence to physician orders for respiratory treatments, including oxygen and nebulizer tubing oxygen and nebulizer orders and proper handling of tubing. Audits will be conducted weekly x 4 weeks then monthly x 5 months and findings will be reported to the quarterly QAPI committee.

Full compliance by: February 20, 2026

Cove's Edge 205067 Plan of Correction for survey year 2025 conducted on January 5-8, 2026

F0812- Food Safety

Corrective Action completed:

No residents were directly harmed; however, all improperly stored or unlabeled food was discarded immediately. The walk-in cooler was cleaned and sanitized, and equipment was thoroughly cleaned on 01/06/2026. Maintenance staff removed accumulated ice from the walk-in unit on 01/06/2026.

How to identify other residents having the potential to be affected by the same deficient practice:

All food storage areas were inspected on 01/06/2026 to ensure compliance with proper labeling, storage, and sanitation standards. Any deficiencies were corrected promptly.

Measures put in place to ensure that deficient practice will not recur:

A daily kitchen inspection checklist was implemented to monitor cooler conditions, temperatures, food labeling, and storage practices. Dietary staff were re-educated on January 28, 2026, regarding food safety protocols. A preventive maintenance schedule for the walk-in cooler was established and implemented to prevent ice buildup on January 28, 2026.

The facility will monitor corrective actions to ensure deficient practice is being corrected and will not recur:

The Dietary Manager or designees will conduct daily audits of food storage and labeling for 30 days, then weekly for 2 months. Results will be reported to QAPI committee quarterly.

Full compliance by: February 20, 2026

F0842- Resident Records- Identifiable Information

Corrective Action completed:

Resident # 3's post-operative orders were immediately discontinued, and the medical record was updated to accurately reflect the resident's current condition and care needs on 01/07/2026.

How to identify other residents having the potential to be affected by the same deficient practice:

All resident records were reviewed to identify and remove any outdated or unnecessary orders by 01/25/2026. Any discrepancies were corrected promptly.

Cove's Edge 205067 Plan of Correction for survey year 2025 conducted on January 5-8, 2026

Measures put in place to ensure that deficient practice will not recur:

Orders for all residents will be reviewed quarterly following the MDS schedule to ensure accuracy and appropriateness. Nursing staff were educated by 01/28/2026 regarding timely discontinuation of orders and documentation updates.

The facility will monitor corrective actions to ensure deficient practice is being corrected and will not recur:

The Director of Nursing, Unit Manager, or designees will conduct quarterly audits of all residents' orders, and audit results will be reviewed during subsequent quarterly QAPI meetings.

Full compliance by: February 20, 2026

F0880- Infection Prevention & Control

Corrective Action completed:

Residents identified as requiring TBP (transmission based precautions) and EBP (enhanced barrier precautions) were immediately placed under appropriate precautions. PPE was provided and signage posted at room entrances. Staff were re-educated on proper implementation of TBP and EBP by 01/28/2026.

How to identify other residents having the potential to be affected by the same deficient practice:

A facility-wide audit was completed on 01/23/2026 to confirm appropriate TBP and EBP application and signage.

Measures put in place to ensure that deficient practice will not recur:

Education was provided by 01/28/2026 to all staff regarding precautions and protocols, PPE use, and signage requirements.

The facility will monitor corrective actions to ensure deficient practice is being corrected and will not recur:

The Infection Preventionist, Director of Nursing and/or designees will conduct weekly audits ×4 weeks, followed by monthly audits ×5 months to ensure adherence to TBP and EBP requirements. All findings will be reviewed with the QAPI committee quarterly.

Full compliance by: February 20, 2026.

Cheryl Dobbelsteyn