Stillwater HEALTH CARE
335 Stillwater Avenue, Bangor, Maine 04401
Tel: (207) 947-1111 • Fax: (207) 947-4184

March 3rd, 2026

Celine Donohue, RN
Long-Term Care Supervisor
Division of Licensing and Certification
11 State House Station
41 Anthony Ave.
Augusta, ME 04333-0011

Dear Ms. Donohue,

Please find the attached plan of correction for the alleged deficiencies cited from the survey that took place on February 27th, 2026 at Stillwater Health Care.

Submission of the plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet the requirements established by State and Federal Law.

Respectfully Submitted,

Amanda Young, MSEd, MLA, QCP
Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205116	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STILLWATER HEALTH CARE	335 STILLWATER AVE , BANGOR, Maine, 04401

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F0000	INITIAL COMMENTS From 2/24/26 through 2/26/26, unannounced on-site visits were conducted at Stillwater Health Care for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification and to investigate complaints #2720619, #2698228, #2686552, and #2661359. It was determined that Stillwater Health Care is not in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F0000	This plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the POC is not an admission that a deficiency exists or that one was cited correctly. This POC is submitted to meet requirements established by State and Federal Law.	
F0610 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 facility policy review, record review, and interviews, the facility failed to ensure allegations of abuse and neglect was investigated for 1 of 4 complaints reviewed. Findings: A review of the facility's policy, "Abuse, Neglect,	F0610	F0610 This incident happened in the past and cannot be undone. Going forward investigations will be initiated by the DON or Designee within 24 hours of when the incident was reported. Investigations will be reviewed and signed off on by the Administrator to ensure completion within 72 hours of reported incident. Administrator and DON are registered for the MHCA Conducting Workplace Personnel Investigations on 4/15/26-4/16/26 for education. Will review in QAPI x 3 months	3/24/26

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	NHA	3/13/26

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F0610 SS = D	Continued from page 1 Exploitation and Misappropriation Prevention Program" effective: 6/2016, revised 03/2025 states, "8. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property." A review of a facility-provided written statement that the Director of Nursing (DON) received from a staff member dated 9/25/25 states, "...a handful of residents are scared..." and "... has neglected some residents care.", referring to another staff member. A review of a facility-provided written statement that the DON received, not signed, or dated states, "resident looked so scared... ...(he's/she's) so rough and mean to me", referring to another staff member. On 2/25/26 at 4:47 p. m. in an interview with the DON, a surveyor confirmed that during the facility's recertification survey and this investigation, the facility was not able to provide evidence that the allegations of abuse or neglect was investigated. On 2/25/26 at 7:00 p.m., in an interview with the Administrator, a surveyor confirmed that the facility did not complete investigations for the allegations of abuse and neglect that was brought to their attention by facility staff.	F0610		
F0628 SS = B	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information	F0628	F0628 This incident happened in the past and cannot be undone. All transfer/discharges will be reviewed at morning meeting to ensure the resident and/or representative were given a copy of the notice and the means in which that copy was delivered. Ombudsman has been notified of all discharges that happened in the month of February 2026. The report was emailed on 3/2/2026 and will be sent the first of each month going forward.	3/24/26

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F0628 SS = B	Continued from page 2 (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under	F0628	Will review in QAPI x 2 months	

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F0628 SS = B	Continued from page 3 paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to	F0628		

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F0628 SS = B	Continued from page 4 effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident	F0628		

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F0628 SS = B	Continued from page 5 must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on record reviews and interviews, the facility failed to notify (at least monthly) the Ombudsman office of transfer/discharges for 1 of 1 resident reviewed for discharge (Resident #63 [R63]), and the facility failed to issue a written transfer/bed hold notice to a resident and their legal representative for a facility-initiated transfer/discharge for 1 of 1 resident reviewed for hospitalization (R61). Findings: 1. On 2/26/26, a review of R63's clinical record was completed. Documentation indicated R63 was transferred home with services on 12/29/25. On 2/26/26 at 8:42 a.m., in an interview with the surveyor, the Licensed Social Worker stated she has not been sending notifications to the Ombudsman's office for any transfers or discharges. 2. On 2/26/26, a review of R61's clinical record was completed. Documentation indicated R61 was transferred to the hospital on 12/30/25 for respiratory distress. There was no evidence that the resident or resident representative had been provided a written copy of the transfer/discharge notice. In addition, the Ombudsman Program was not notified of the transfer/discharge. On 2/26/26 at 9:55 a.m., in an interview with the surveyor, the Director of Nursing confirmed that the resident/resident representative did not receive a copy	F0628		

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F0628 SS = B	Continued from page 6 of the transfer/discharge notice.	F0628		
F0655 SS = B	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident.	F0655	F0655 This incident happened in the past and cannot be undone. Baseline care plan will be printed, reviewed and signed by all new admissions. Audit of all new residents will be completed by DON or designee to ensure compliance. Will review in QAPI x2 months	3/24/26

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F0655 SS = B	Continued from page 7 (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews and interviews, the facility failed to provide resident/resident representative's with a summary of their baseline care plan for 3 of 4 residents reviewed for baseline care plans (Resident #3 [R3], R5, R61). Findings: 1. On 2/25/26, a review of R3's clinical record was completed. A baseline care plan was completed within 48 hours of R3's admission. There was no evidence that a summary of the baseline care plan was provided to the resident or the resident representative. On 2/25/2026 at 12:35 p.m., in an interview with the surveyor, the Director of Nursing [DON] stated that they do not provide a copy of the baseline care plan to the resident or the resident representative. The surveyor confirmed at this time that the resident/resident representative did not receive a summary of the baseline care plan. 2. On 2/25/26, a review of R5s clinical record was completed. A baseline care plan was completed within 48 hours of R5's admission. There was no evidence that a summary of the baseline care plan was provided to the resident or the resident representative. On 2/25/26 at 12:35 p.m. in an interview with the surveyor, the DON confirmed that the resident/resident representative did not receive a summary of the baseline care plan. 3. On 2/26/26, a review of R61's clinical record was completed. A baseline care plan was completed within 48 hours of R61's admission. There was no evidence that a summary of the baseline care plan was provided to the resident or the resident representative.	F0655		

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F0655 SS = B	Continued from page 8 On 2/26/26 at 9:55 a.m., in an interview with the surveyor, the DON confirmed that the resident/resident representative did not receive a summary of the baseline care plan.	F0655		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews, the facility failed to ensure that a physician ordered medication was available for use to meet the needs for 1 of 4 residents observed during medication administration pass (Resident #64 [R64]). Finding:	F0755	F0755 This incident happened in the past and cannot be undone. Charge Nurse on duty when medications arrive will ensure all medications have been delivered. Medications that are not delivered will be reviewed by the DON or designee to ensure medication is received in our 3-day window. If a medication cannot be delivered within the 3-day window the DON or designee will look to our local pharmacy to fill. Will review in QAPI x 3 months	3/24/26

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F0755 SS = D	Continued from page 9 On 2/26/26 at 7:56 a.m., a surveyor observed Registered Nurse #1 (RN1) complete a medication administration pass for R64. RN1 stated she could not administer Testosterone Gel (a medication used to treat low testosterone levels not due to normal aging) to R64 because the facility did not have any. On 2/26/26, R64's clinical record review indicated an order, dated 2/20/26, for "Testosterone Transdermal Gel 20.25 [milligram (MG)] per (/) Actuation (ACT)] (1.62%) (Testosterone) Apply 1 pump [applied to the skin (transdermally)] one time a day for [HYPOGONADISM (a condition in which the body doesn't make enough of the hormone testosterone)] APPLY TO UPPER ARM". Review of the Medication Administration Record indicated that R64's Testosterone Gel was not available and R64 had not received Testosterone Gel as physician ordered, from 2/20/26 through 2/26/26, for a total of 7 days (7 missed doses). On 2/26/26 at 10:18 a.m., during an interview with a surveyor and the Director of Nursing (DON), R64's clinical record was reviewed. The DON stated he would have to look into why this medication was not received from pharmacy. At this time, the surveyor confirmed the facility failed to ensure a physician ordered medication was available for use to meet the needs for R64.	F0755		
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately	F0761	F0761 This incident happened in the past and cannot be undone. Insulin will be audited x3 per week to ensure no expired insulin is in the cart. DON or designee will review weekly audit and do 1 random audit per week to ensure compliance. Will review in QAPI x3 months	3/24/26

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F0761 SS = E	Continued from page 10 locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observations and interviews, the facility failed to ensure expired medications were removed from the available for use supply, for 2 of 3 Medication Storage Areas reviewed (A Wing Treatment Cart and B Wing Treatment Cart). Findings: On 2/25/26 at 3:16 p.m., a surveyor and the Director of Nursing Services (DON) observed and confirmed the following were in the A Wing treatment cart and available for use: -1 box of 12 rectal Acetaminophen Suppositories 650 milligrams (mg) with an expiration date of "01/2026" -1 multi-use vial containing 10 milliliter (ml) of Insulin glargine 100 units (u)/10ml, open but unlabeled with an open date or an expiration date. The DON stated insulin is good for 28 days after opening, and was unable to determine when the vial would expire. -2 open vials, 10mL insulin lispro 100u/ml, with an open date of 1/14/26. The insulin expired on 2/11/26 and was available for use 14 days past expiration. On 2/25/26 at 3:35 p.m., a surveyor and the DON observed and confirmed the following were in the B Wing treatment cart and available for use: -1 open vial, 10mL insulin lispro 100u/ml, the box was labeled with an open date of 2/2/26, the vial was labeled as opened on 2/12/26. The DON was unable to determine when the vial would expire. -1 pre-filled 3ml insulin pens containing Lantus Solostar (Insulin Glargine) 100u/mL, open and undated. The DON was unable to determine the expiration date. The DON stated the pre-filled insulin pens expire 28 days after opening. -1 pre-filled 3ml insulin pens containing Lantus Solostar (Insulin Glargine) 100u/mL, the packaging was dated open 2/19/26, the insulin pen was labeled opened	F0761		

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F0761 SS = E	Continued from page 11 2/20/26. The DON was unable to determine when the insulin pen would expire.	F0761		
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 and interviews the facility failed to ensure the kitchen was maintained in a clean manner on 2 of 3 days of survey (2/24/26 and 2/25/26), the facility failed to ensure that dented cans were removed from use and the facility failed to discard expired products in the reach-in refrigerator and the walk in refrigerator located in the kitchen that were available for use on 1 of 3 days of survey (2/24/26), Findings: On 2/24/26 at 10:45 a.m., during the initial tour of the kitchen a surveyor observed a built-in air conditioner that was heavily covered in dirt and grime, also observed were dust webs from the top corners right and left of the air conditioner to the ceiling.	F0812	F0812 This incident happened in the past and cannot be undone. Dented can was removed from circulation. Expired creamer of 1 day was thrown out. AC Unit in the Kitchen has been removed. Dietary Manager or designee will do a second check of all canned items after initial delivery. Dietary Manager or designee will audit creamers x3 per week to ensure expiration date is current. Will review in QAPI x 3 months.	3/24/26

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F0812 SS = E	Continued from page 12 In the dry food storage room on the shelves and in the can rack the surveyor and Food Service Director observed the following dented cans 2 cans of crushed pineapples in juice, 6 pounds, 12-ounce cans that were dented near the bottom seal. 4 cans of mushrooms, pieces and stems 3-pound, 14-ounce cans that were dented near the bottom and top seals. In the reach-in refrigerator there was a carton of half and half that was half empty with a best by date of 2/23/26, next to it there was a full carton of half and half with a best by date of 2/23/26 available for use. In the walk-in refrigerator there were 2 full cartons of half and half available for use on the shelf with a best by date of 2/23/26. These findings were confirmed by the surveyor during the initial tour with the Food Service Director. On 2/25/26 at 8:30 a.m. during a second tour of the kitchen, the surveyor observed the built-in air conditioner that was still heavily covered in dirt and grime, also observed were dust webs from the top corners right and left of the air conditioner to the ceiling. The Food Service Director stated she will have it cleaned today on 2/25/26.	F0812		
F0842 SS = E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F0842	F0842 This incident happened in the past and cannot be undone. An audit of all resident's vital sign orders was reviewed to ensure orders are correct. DON updated the vital sign order in PCC, which will allow staff to only input vitals 1 time and then order will be completed. Will review in QAPI x 3 months	3/24/26

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F0842 SS = E	Continued from page 13 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments;	F0842		

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F0842 SS = E	Continued from page 14 (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 reviews and interviews, the facility failed to ensure that clinical record(s) contained complete and accurate information for 6 of 10 sampled residents reviewed on survey (Resident #7 [R7], R8, R51, R2, R36, and R17). Findings: 1. On 2/25/26, R7's clinical record was reviewed. R7's Order Summary indicated, "Check monthly weights every day shift every 1 month(s) starting on the 1st for 7 day(s) for Monitoring" with a start date of 8/1/25, "Check monthly vital signs every day shift every 1 month(s) starting on the 1st for 7 day(s) for Monitoring" with a start date of 8/1/25, and "Weekly [blood pressure (B/P)] and [heart rate (HR)] checks. every day shift every [Sunday] for [Monitoring] B/P meds" with a start date of 8/17/25. The Treatment Administration Record [TAR] indicated R7's vital signs (weight, blood pressure, temperature, pulse, respiratory rate, and oxygen saturation rate) were identical on 2/1/26, 2/2/26, 2/3/26, 2/4/26, 2/5/26, 2/6/26 and 2/7/26, 7 days. 2. On 2/25/26, R8's clinical record was reviewed. R8's Order Summary Report indicated an order, start dated 11/1/24, "Vital Signs [and] Weights monthly every day shift every 1 month(s) starting on the 1st for 7 day(s) for vital signs." The TAR indicated R8's vital signs (weight, blood pressure, temperature, pulse, respiratory rate, and oxygen saturation rate) were identical on 2/2/26, 2/3/26, 2/4/26, 2/5/26, 2/6/26 and 2/7/26, 7 days. The provider progress note, dated 2/24/26, states "Blood pressures this month [he/she] has had 3 recordings that were all recorded as exactly the same at 152/88, previous numbers were systolics	F0842		

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F0842 SS = E	Continued from page 15 ranging from the 100s to 120s over the last 3 months. Will wait to see ongoing trends before making any changes to [his/her] [blood pressure] medications at this time. Heart rates have been within normal limits, O2 saturations normal on room air and patient has been [without fever (afebrile)]." On 2/26/26 at 10:22 a.m., during an interview with a surveyor and the Director of Nursing (DON), R8's clinical record was reviewed. The DON stated the order directs the vitals to be taken once per month but was unsure why the vitals appear to be replicated over several days. At this time the surveyor confirmed the clinical record contained inaccurate information. 3. On 2/25/26, R51's clinical record was reviewed. R51's TAR, indicated, Check monthly vital signs every day shift starting on the 1st and ending on the 7th of every month with a start date of 9/1/25. The TAR indicated R51's vital signs (temperature, pulse, respiratory rate, and oxygen saturation rate) were identical on 2/2/26, 2/3/26, 2/4/26, 2/5/26, 2/6/26 and 2/7/26, 6 days. 4. On 2/25/26 R2's clinical record was reviewed. R2's TAR indicated, "Vital Signs & Weights monthly every day shift every 1 month(s) starting on the 1st for 7 day(s) for vital signs" with a start date of 11/1/24. The TAR indicated R2's vital signs (weight, blood pressure, temperature, pulse, respiratory rate, and oxygen saturation rate) were identical on 2/4/26, 2/5/26, 2/6/26, and 2/7/26, 4 days. 5. On 2/26/26 R36's clinical record was reviewed. R36's TAR indicated, "Vital Signs & Weights monthly every day shift every 1 month(s) starting on the 1st for 7 day(s) for vital signs - Start Date – 11/01/2024". The TAR indicated R36's vital signs (weight, blood pressure, temperature, pulse, respiratory rate, and oxygen saturation rate) were identical on 2/1/26 through 2/7/26, 7 days. 6. On 2/26/26 R17's clinical record was reviewed. R17's TAR indicated, "Monthly weight and Vitals every day shift every 1 month(s) starting on the 1st for 7 day(s) for vital signs – Start Date – 05/01/2025". The TAR indicated R17's vital signs (weight, blood pressure, temperature, pulse, respiratory rate, and oxygen saturation rate) were identical on 2/2/26 through 2/7/26, 6 days.	F0842		

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F0842 SS = E	Continued from page 16 On 2/26/26 at 10:34 a.m., during an interview with the DON and four surveyors, the DON stated that the computer system is pulling information from the previous results when new data is not entered by staff. At this time a surveyor confirmed the above findings.	F0842		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F0880	F0880 This incident happened in the past and cannot be undone. Infection control policy and procedure manual has been reviewed for annual compliance. Signature page placed in IP manual for annual review. Will review in QAPI x 1 month	3/24/26

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F0880 SS = D	Continued from page 17 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 review of the facility Infection Control Program (ICP) and interview, the facility failed to complete an annual review of the ICP and update/revise the program if needed for 1 of 1 ICP. Finding: On 2/25/26 at 9:00 a.m., in an interview with the Infection Preventionist (IP), she stated she did not know if the ICP had been annually reviewed. A review of the ICP was completed and there was no evidence that an annual review of the ICP had been completed.On 2/25/26 at 9:53 a.m., in an interview with the surveyor, the Administrator, confirmed that the facility has not completed an annual review of the ICP.	F0880		
F0947 SS = D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4)	F0947	F0947 This incident happened in the past and cannot be undone.	3/24/26

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F0947 SS = D	Continued from page 18 §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 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 employee record reviews and interviews, the facility failed to implement and maintain an effective training program which includes, at a minimum, training on dementia management by failing to ensure that 1 of 5 Certified Nursing Assistant (CNA) staff employed completed their required training (CNA3). Finding: On 2/26/26 the following employee record was reviewed: CNA3 was hired on 7/3/23. There was no documented training on dementia in over 12 months. On 2/26/26 at 8:00 a.m., in an interview with a surveyor, the Administrator stated that she was unable to find any documented trainings listed above, and a surveyor confirmed that CNA3 lacked evidence that mandatory training on dementia was completed within the past 12 months.	F0947	An audit was done to see which nurse's aides were not in compliance with their dementia care training for 2025. The nurse's aides who were not in compliance have now completed their dementia training and are current. Will review in QAPI x3 months.	