STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205120	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVILLE CENTER FOR HEALTH AND REHAB	7 HIGHWOOD ST , WATERVILLE, Maine, 04901

(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
F0000	INITIAL COMMENTS From 8/25/25 through 8/28/25, on-site visits were conducted at Waterville Center for Health and Rehabilitation for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification and to investigate incident(s) #2588932, #2560464, #211351, #212083, #212057, #212056, 212052, #212015, and complaint(s) #2561140, #212049, #212028, #212036, #212033, #212009, and #212002. It was determined that Waterville Center for Health and Rehabilitation is not in compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F0000	Waterville Center for Health and Rehabilitation provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed as evidence of the facility's continued compliance with state and federal regulations.	
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still	F0578	Resident #43, Resident # 74, Resident # 73, Resident # 58, and/or resident's representative will be provided with written information concerning the right to formulate an Advance Directive. Social Services will conduct an audit of current resident records to determine if the resident has been provided with written information concerning the right to formulate an Advance Directive. Any resident identified as not receiving will be provided information. The Administrator and/or designee will provide re-education to Social Service and Admission Staff concerning the resident's right to formulate an Advance Directive. The Administrator and/or designee will conduct random audits for three (3) months of New Admissions to ensure written information has been provided. The audit results will be reported to the facility's QAPI committee for further review and recommendations.	10/6/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christine L. Yanni	Administrator	9/23/2025

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F0578 SS = D	Continued from page 1 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 ensure that the resident and/or resident representative was provided with written information concerning the right to formulate an advanced directive for 4 of 33 residents reviewed (Residents R43, R74, R73 and R58). Findings: 1. Resident #43 was admitted in July of 2025. A review of the entire electronic record lacked evidence that the facility offered or provided the resident and/or resident representative with written information concerning the right to formulate an advanced directive. 2. Resident #74 was admitted in July of 2025. A review of the entire electronic record lacked evidence that the facility offered or provided the resident and/or resident representative with written information concerning the right to formulate an advanced directive. On 8/26/25 at 1:35 p.m., in an interview with 5 surveyors present, the Social Services Director confirmed that the residents did not have and/or did not decline an Advance Directives. 3. On 8/26/25 the clinical record for R73 was reviewed. The clinical record lacked evidence that the facility offered or provided the resident and/or resident representative with written information concerning the right to formulate an advanced directive. 4. On 8/26/25 the clinical record for R58 was reviewed.	F0578		

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F0578 SS = D	Continued from page 2 The clinical record lacked evidence that the facility offered or provided the resident and/or resident representative with written information concerning the right to formulate an advanced directive. On 8/26/25 at 2:03 p.m., during an interview with the Social Services Director, the surveyor confirmed the facility failed to offer or provide the residents and/or resident representatives with written information concerning the right to formulate an advanced directive.	F0578		
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or	F0580	Resident 111 is no longer a resident at the facility. This occurred in the past. It is facility policy to notify provider of discontinuation of a medical device. Director of Nursing and/or designee will provide re-education regarding physician notification of the discontinuation of a medical device to licensed nursing staff. Director of Nursing and/or designee will conduct random weekly audits times four (4) weeks and thereafter monthly times two (2) months, of change of condition assessments to ensure physician notification occurred. Audit results will be reported to the facility's QAPI committee for review and further recommendations	10/6/2025

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F0580 SS = D	Continued from page 3 (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews, the facility failed to ensure that a resident's physician was notified of the discontinuance of a medical device that uses negative pressure to promote wound healing (Wound Vacuum-Assisted Closure [Wound VAC]) for 1 of 1 resident reviewed for notification of change. (Resident #111 [R111]). Finding: On 8/27/25, during a clinical record review for R111, Documentation indicates he/she was admitted with an order for a wound vac. Review of a Health Status Note, dated 7/9/25 at midnight, shows documentation that at 11:30 p.m. on 7/8/25, R111's wound vac canister was full and needed to be changed. The nurse was unable to replace the canister and discontinued the wound vac. She then applied a wet to dry dressing, covered it with an abdominal pad, and secured it with Kerlix. Upon further review of R111's clinical record there is no evidence that his/her physician was made aware of the discontinuation of the wound vac and did not provide an order for the wet to dry dressing that was applied. A Provider's progress note, dated 7/9/25, indicated the wound vac was still applied when it was documented as being removed at 11:30 p.m. on 7/8/25. This shows the Provider was not aware of the discontinuation of the wound vac treatment.	F0580		

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F0580 SS = D	Continued from page 4 On 8/28/25, during an interview with a surveyor, R111's primary Provider stated that she was not made aware of the wound vac being removed until she saw R111 on 7/11/25. Her progress note dated 7/11/25 documents the wound vac was reapplied the evening prior on 7/10/25. On 8/28/25 at 12:00 p.m. during an interview with the Director of Nursing and the Unit Manager for Cove and Harbor units, the surveyor confirmed that the facility did not have the needed wound vac supplies to continue with a wound vac treatment for R111, the Provider was not made aware of the discontinuance of the wound vac, and a nurse started a treatment for the wet to dry dressing without a physician order.	F0580		
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F0584	1.Resident #86 wedge cushion was cleaned and wheelchair armrests replaced. 2.Kitchenette on Cove unit lower cabinets were cleaned 3. Harbor Unit-resident room 200-two wall fans were cleaned. Room 216 wall fan was cleaned. 4.Bathroom floor tiles in room 223 were cleaned. Room 223-baseboard heater cover was fixed. Resident #81 wheelchair tape was removed. The Director of Facilities Operations and/or designee will conduct an audit of resident areas to ensure kitchenette cabinets are cleaned, wall fans are cleaned, bathroom tiles are cleaned, baseboard heater covers are in place and in good repair, and no rips/tears on wheelchair armrests. Any identified areas will be fixed/repaired The Director of Facilities Operations and/or designee will provide training to the Enironmental service and clinical staff regarding reporting of items that need follow up and repair into TELS (Maintenance Software Program) The Director of Facilities Operations and/or designee will conduct random, monthly audits for three (3) months of resident areas.	10/6/2025

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F0584 SS = E	Continued from page 5 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observations and interviews, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable environment on 3 of 4 Units (Harbor, Cove and Memory Care). Findings: 1. On 8/25/25 at 12:09 p.m., a surveyor and the Memory Unit Manager observed, in Resident room 331-R, a soiled wedge cushion against the wall across from Resident #86's bed and that both Resident #86's wheelchair armrests were ripped. At this time, in an interview with a surveyor, the Memory Unit Manager confirmed the findings. 2. On 8/25/25 at 12:15 p.m., two surveyors observed food particles and debris in two lower cabinets in the kitchenette on Cove Unit. On 8/25/25 at 12:20 p.m., in an interview with two surveyors present, the Cove Unit Manager confirmed the findings. 3. On 8/27/25 at 3:04 p.m., a surveyor and the Harbor Unit Manager observed the following findings: - Resident Room 200 - There were two wall fans that were heavily soiled with dust and were both blowing on Resident #10. - Resident Room 216 – There was a wall fan at the foot of Resident #6's bed that was heavily soiled with dust. At this time, in an interview with a surveyor, the Harbor Unit Manager confirmed the findings.	F0584	Audit results will be reported to the facility's QAPI committee for review and further recommendations.	10/6/2025

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F0584 SS = E	Continued from page 6 4. On 8/28/25 from 10:50 a.m. to 11:20 a.m., a surveyor did an Environmental Tour with the Administrator and the Director of Facility Operations in which the following findings were observed/discussed: - Resident Room 223 – The bathroom floor had six floor tiles that were dirty and stained under the toilet. The room's metal baseboard heater cover was broken apart and hanging down. Resident #81's wheelchair brakes, where they hook to the wheelchair, had white tape on them that was dirty and stained a brownish color. On 8/28/25 at 11:20 a.m., in an interview with a surveyor, the Administrator and the Director of Facility Operations confirmed the findings.	F0584		
F0627 SS = D	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered; (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for	F0627	Resident #88's care plan will be updated to reflect her discharge planning goals and preferences. It is facility policy to develop and/or implement an effective discharge planning process, which will include timely referrals if appropriate, involvement of the IDT in the discharge planning process and the comprehensive care plan will be updated with goals and preferences regarding discharge. Administrator and/or designee will provide re-education regarding discharge planning policy to the Interdisciplinary team. Social Service Director and/or designee will conduct an audit of current resident records to ensure the care plan reflects discharge planning goals and preferences. Any resident's care plan identified as not having discharge planning goals and preferences will be updated. The Social Services Director and/or designee will conduct random weekly audits, including new admissions, times four (4) weeks and thereafter monthly times two (2) months to ensure compliance. Audit results will be shared with the facility's QAPI committee for review and further recommendations.	10/06/2025

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F0627 SS = D	Continued from page 7 Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F)The facility ceases to operate. §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §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. (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(7) Orientation for transfer or discharge.	F0627		

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F0627 SS = D	Continued from page 8 A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services (ii)If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process	F0627		

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F0627 SS = D	Continued from page 9 must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the	F0627		

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F0627 SS = D	Continued from page 10 post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and record review, the facility failed to develop and/or implement an effective discharge planning process by failing to send referrals to appropriate entities timely, to involve the interdisciplinary team in discharge planning process, and to update the comprehensive care plan with goals and preferences regarding discharge, with referrals to appropriate entities made for this purpose and /or responses to information received from referrals to appropriate entities, for 1 of 4 residents reviewed for Discharge (Resident #88 [R88]). Findings: On 8/25/25 at 2:24 p.m., during an interview with a surveyor, R88 stated he/she has wanted to transfer to another facility for the past 3 years but has not had the help he/she needs to achieve this goal.	F0627		

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F0627 SS = D	Continued from page 11 On 8/27/25, R88's clinical record was reviewed and revealed the following: -Review of the R88's Care Plan indicated the focus "Discharge: [R88 will] remain in the facility through the next review date", revised on "12/01/2022". The intervention for this focus stated, "Discuss with [R88] appropriate options through the next review date", revised on "06/16/23". The clinical record lacks evidence that R88's comprehensive care plan was updated to address R88's goals and preferences regarding discharge, documentation of referrals to appropriate entities made for this purpose and /or response to information received from referrals to appropriate entities. - On 9/13/24, A Social Service Note stated that R88 was anxious to hear if he/she was approved to transfer to another facility. The clinical record lacks evidence that R88's comprehensive care plan was updated in response to information received from the referral. -On 9/24/24, R88's Interdisciplinary Care Meeting indicated that R88's Care Plan was reviewed and updated. The summary note states "[R88] has an incentive to move to a new placement." The clinical record lacked evidence that the Interdisciplinary Team was involved in the process of developing the discharge plan, or that R88's comprehensive care plan was updated to include R88's goals and preferences regarding discharge, referrals to appropriate entities made for this purpose and /or updated in response to information received from referrals to appropriate entities. -On 12/23/24, R88's Interdisciplinary Care Meeting indicated that R88's Care Plan was reviewed and updated. The clinical record lacked evidence that the Interdisciplinary Team was involved in the process of developing the discharge plan, or that R88's comprehensive care plan was updated to include R88's goals and preferences regarding discharge, referrals to appropriate entities made for this purpose and /or updated in response to information received from referrals to appropriate entities. -On 3/13/25, a social service note indicates a Social Worker sent R88's Case Manager (not employed by the facility) a list of referrals to facilities already explored and indicated the Case Manager would help make referrals. The clinical record lacked evidence that the Interdisciplinary Team was involved in the process of developing the discharge plan, or that R88's	F0627		

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F0627 SS = D	Continued from page 12 comprehensive care plan was updated to include R88's goals and preferences regarding discharge, referrals to appropriate entities made for this purpose, collaboration with R88's Case Manager, and/or responses to information received from referrals to appropriate entities. -On 3/26/25, R88's Interdisciplinary Care Meeting indicated that R88's Care Plan was reviewed and updated. The summary indicated "Referrals are continuing to be completed for other facility options." The clinical record lacked evidence that R88's comprehensive care plan was updated to include R88's goals and preferences regarding discharge, referrals to appropriate entities made for this purpose and /or updated in response to information received from referrals to appropriate entities. -On 6/24/25, R88's Interdisciplinary Care Meeting indicated that R88's Care Plan was reviewed and updated. The summary indicated "Referrals are continuing to be completed for other facility options." The clinical record lacked evidence that R88's comprehensive care plan was updated to include R88's goals and preferences regarding discharge, referrals to appropriate entities made for this purpose and /or updated in response to information received from referrals to appropriate entities. On 8/27/25, the facility's policy "Discharge of Resident: Home [or] Other Facility" dated "6/12/14" was reviewed. The policy does not address the discharge planning process. On 8/27/25 at 12:40 p.m., during an interview with a surveyor, the Director of Nursing (DON) stated there is not a specific policy for discharge planning regarding a resident's requesting to transfer to another facility. The DON confirmed that it is the expectation that the facility will make referrals to appropriate entities when requested by residents. The DON stated that this was made clear to the Director of Social Services. She stated the Director of Social Services has made referrals to appropriate entities since that discussion (2/24/25). On 8/27/25 at 4:30 p.m., during an interview with the DON and the Administrator, a surveyor confirmed the above findings. The Administrator stated there is a policy within the Care Plan policy to include transfers to other facilities.	F0627		

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F0627 SS = D	Continued from page 13 On 8/28/25, the facility's policy "Care Plans, Comprehensive Person-Centered", "Revised December 2024", was reviewed and stated "8. The comprehensive, person-centered care plan will: … f. include the resident's stated preference and potential for future discharge, including his or her desire to return to the community and any referrals made to local agencies or other entities to support such a desire; … 14. The interdisciplinary team must review and update the care plan: … b. when the desired outcome is not met; … 16. Discharge Planning: a. The facility will develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them post discharge." The clinical record lacks evidence that the comprehensive care plan was updated to include R88's goals and preferences regarding discharge, referrals to appropriate entities made for this purpose and /or updated in response to information received from referrals to appropriate entities. On 8/28/25, the facility's "Discharge Planning Protocol", (undated), was reviewed and stated "4. If a resident is requesting to… be transferred to another facility, initiate referral to… facility of choice." The clinical record lacks evidence that referrals to appropriate entities were made for R88 to transfer to another facility between September 2024 and 2/24/25. On 8/28/25 at 12:15 p.m., during an interview with the Administrator and the Social Services Director, the Social Services Director confirmed that the facility failed to make referrals to appropriate entities after R88's request to transfer, between September 2024 and 2/24/25. At this time the surveyor confirmed the above finding.	F0627		
F0645 SS = D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:	F0645	Resident #81's PASRR has been submitted to the state-designated authority. Social Services will conduct an audit of current residents to ensure all residents have been screened for PASRR Level I determination and submitted to the state-designated authority. Any resident identified as not having been screened will be screened for PASRR Level I determination and will be submitted to the state-designated authority.	10/6/2023

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F0645 SS = D	Continued from page 14 (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility	F0645	The Administrator and/or designee will provide education to social services regarding PASRR's. The Administrator and/or designee will conduct random PASRR audits, including new admissions, for three months of all to ensure compliance. The results of the audits will be reported to the facility's QAPI committee for review and further recommendations.	10/6/2025

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F0645 SS = D	Continued from page 15 services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure a resident with a specialized mental health diagnosis had been referred to the appropriate state-designated authority for Pre-Admission Screening & Resident Review (PASRR) evaluation and determination for 1 of 1 resident reviewed for PASRR evaluation (Resident #81). Finding: On 8/26/25, clinical record review indicated Resident #81 was admitted to the facility in October of 2024 from a hospital, with a specialized mental health diagnosis. The clinical record lacked evidence that that the resident had been screened for a PASRR Level I determination and that it was submitted to the State-designated authority prior to admission. On 8/28/25 at 12:23 p.m., in an interview with five surveyors present, the Social Services Director and the Administrator confirmed that Resident #81's clinical record lacked evidence that that the resident had been screened for a PASRR Level I determination and that it was submitted to the State-designated authority when the resident was admitted in October of 2024.	F0645		
F0656 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	F0656	Resident # 48's care plan will be updated to include anticoagulant use. Resident #45 no longer has COVID-19 It is facility policy to develop and implement comprehensive care plans for each resident, including anticoagulant use and COVID-19/respiratory infections and antibiotic usage.	10/6/2025

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F0656 SS = D	Continued from page 16 resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to develop a care plan in the area of anticoagulant (blood thinner) use for 1 of 5 residents reviewed for unnecessary medications (Resident #48 [R48]). In addition, the facility failed to update a care plan for 1 of 1 residents reviewed for Coronavirus 19 (COVID 19) (Resident #45 [R45]).	F0656	Director of Nursing and/or designee will provide re-education to licensed nurses regarding comprehensive care plan policy. Director of Nursing and/or designee will conduct an audit of current resident's comprehensive care plans to ensure care plans are up to date. Director of Nursing and/or designee will conduct random weekly Care plan audits times four (4) weeks and thereafter monthly times two (2) months to ensure compliance. Audit results will be shared with the facility's QAPI committee for review and further recommendations.	10/6/2025

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F0656 SS = D	Continued from page 17 Findings: 1. R48 has diagnoses to include chronic embolism (blockage in a blood vessel) and thrombosis (blood clot formation) of right popliteal vein (a deep vein located behind the knee joint). Review of R48's active physician orders revealed an order for "Eliquis Oral Tablet 5MG [milligram] Give 5mg by mouth two times a day for R/O [rule out] Clot." Review of R48's comprehensive care plan lacked evidence that goals and interventions were developed or implemented for the use of an anticoagulant (Eliquis). On 8/27/25 at 3:00 p.m., during an interview, the Memory Unit Manager reviewed R48's care plan and confirmed it did not include the use of an anticoagulant. 2. Review of facility Covid line listing revealed R45 tested positive for COVID 19 on 2/13/25. Review of R45's care plan updated 7/21/25 states "COVID: [R45] has a Respiratory Infection with a congested cough. (Covid19) Date Initiated: 02/13/2025..." During an interview with the Director of Nursing (DON) and the Infection Preventionist on 8/27/25 at 9:00 a.m., the DON confirmed R45 tested positive for COVID 19 on 2/13/25 and would have been quarantined for up to 10 days. At this time DON confirmed no residents in the facility are COVID 19 positive. During an interview on 8/27/25 at 9:03 a.m., the above was confirmed with DON.	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--	F0657	It is facility policy to develop a comprehensive care plan within 7 days after completion of the comprehensive assessment. Director of Nursing and/or designee will provide re-education to the Interdisciplinary team regarding care plan timing. Director of Nursing and/or designee will conduct random weekly audits times four (4) weeks and thereafter monthly times two (2) to ensure compliance.	10/6/2025

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F0657 SS = D	Continued from page 18 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and record reviews, the facility failed to review and revise the care plans 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 5 of 33 residents reviewed for care planning (Resident #125 [R125], R2, R45, R57, and R1). Findings: 1. Review of R125's clinical record revealed an MDS Admission Assessment was completed on 11/8/24. Further review of R125's clinical record indicated an Interdisciplinary Team (IDT) meeting was held 11/25/24 and lacked evidence that an IDT meeting was held within 7 days following the assessment. On 8/28/25 at 12:22 p.m. during an interview, the above finding was discussed with the Social Services Director. 2. Review of R2's clinical record revealed the quarterly MDS was completed on 5/29/25. Further review of R2's clinical record indicated, the Interdisciplinary Team meeting (IDT) was held on 6/15/25 (19 days after MDS completion).	F0657	The comprehensive care plan is to include/address the monitoring and/or management of medical diagnoses. Director of Nursing and/or designee will provide re-education to IDT and licensed nursing staff. Director of Nursing and/or designee will conduct an audit of current residents to ensure all comprehensive care plans address the monitoring and management of medical diagnoses. Director of Nursing and/or designee will conduct weekly random audits times four (4) weeks and monthly times two (2) months thereafter of residents with newly added diagnosis care plans to ensure the comprehensive care plans address the monitoring and management of the newly added medical diagnoses. All audit results will be reported to the facility's QAPI committee for review and further recommendations.	10/6/2025

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F0657 SS = D	Continued from page 19 3. Review of R45's clinical record revealed the quarterly MDS was completed on 6/3/25. Further review of R45's clinical record revealed the IDT was held on 5/29/25 (6 days prior to completed MDS). Review of R45's quarterly MDS completed on 2/18/25. Review of R45's clinical record revealed the IDT was held 2/27/25 (9 days after completed MDS). 4. Review of R57's clinical record revealed quarterly MDS completed on 12/16/24. Further review of R57's clinical record revealed the IDT was held on 1/8/25 (24 days after completed MDS). Review of R57's clinical record revealed significant change MDS completed on 12/16/24. Further review of R57's clinical record revealed the IDT was held on 1/8/25 (23 days after completion of MDS). Review of R57's clinical record revealed quarterly MDS completed on 5/9/25. Further review of R57's clinical record revealed the IDT was held on 5/8/25 (1 day before the completed MDS). During an interview on 8/26/25 at 4:04 p.m., in presence of 5 surveyors Minimum Data Set (MDS) Coordinator stated she uses the Assessment Reference Date (ARD) date to schedule IDT meetings. During an interview with Director of Nursing and Administrator on 8/28/25 at 12:45 p.m., the Director of Nursing stated that the IDT meetings are held within 7 days after the completion of the MDS. 5. On 8/28/25, R1's clinical record was reviewed. R1's diagnosis list includes, atrial fibrillation ([afib] an irregular and often very rapid heart rhythm), Chronic Pain and a history of genital herpes and Methicillin-Resistant Staphylococcus Aureus ([MRSA] bacteria that does not get better with the type of antibiotics that usually cure staph infections). R1's Order Summary states, "Foley [Catheter] wash site with soap and water daily as needed". The Care Plan states, "[R1] has acute/chronic pain [related to (r/t)]", the Care Plan does not identify what the acute/chronic pain is related to or the location of the chronic pain. R1's Care Plan does not address the monitoring and management of afib, or R1's history of genital herpes and MRSA.	F0657		

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F0657 SS = D	Continued from page 20 On 8/28/25 at 2:36 p.m., during an interview with a surveyor, the Director of Nursing (DON) and the Administrator, R1's clinical record was reviewed. The DON stated the last episode of genital herpes resolved in April of 2025 but is unsure why that was removed from the care plan. She also stated R1 had afib in June of 2025. At this time the surveyor confirmed R1's care plan was not updated to address the monitoring and / or management R1's diagnoses including afib, Chronic Pain or R1's history of genital herpes and MRSA.	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 facility policy review, record review, and interview the facility failed to document and adequately assess and monitor a resident after an unwitnessed fall for 1 of 5 residents reviewed for unnecessary medications (Resident #48 [R48]). Finding: Review of the policy, "Fall Prevention and Response Policy", revised 7/14/25, states, "…Immediate Response…Head-to-toe nursing assessment…vitals…anticoagulant use, anticoagulant last dose…Neurological Monitoring Protocol…Unwitnessed fall OR suspected head impact OR ON anticoagulant…Frequency & duration of neuro check…Q [every] 15 min [minutes] x 1h [hour], Q 30 min x 1 h, Q1 h x 4h, Q4 h x 24 h, Q8 h until 72 h total…Record completion of each neuro check in flowsheet…" Resident #48 has diagnoses to include long term use of anticoagulant (blood thinner) and falls. Review of R48's clinical record revealed he/she sustained an unwitnessed fall on 6/3/25. Review of R48's Change in Condition Evaluation, dated 6/3/25 and SBAR [Situation, Background, Assessment,	F0684	This occurred in the past and cannot be corrected. The Director of Nursing and/or designee will provide education to licensed nurses staff regarding Fall Prevention/Response Policy, including change of condition assessments, neuro checks, and physician notification. The Director of Nursing and/or designee will conduct random weekly audits of change of conditions, falls, and neuro checks to ensure completion and provider notification times four (4) and monthly thereafter times two (2) months to ensure completion. The audit results will be reported to the facility's QAPI committee for review and further recommendations.	10/6/2025

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F0684 SS = D	Continued from page 21 Response] nursing progress note, dated 6/3/25, lacked evidence that vital signs were taken at the time of R48's fall and lacked evidence that the provider was made aware that R48 was on an anticoagulant. Additionally, review of R48's Neurologic Screen Form, dated 6/4/25, lacked evidence that neurological checks were initiated on the date and time of the fall. On 8/28/25 at 9:12 a.m., the above finding was discussed with the Director of Nursing (DON). At this time, the DON stated the facility has a Performance Improvement Plan (PIP) in place for falls. Surveyor review of the PIP Summary indicated that the PIP addressed fall prevention and reduction in falls and lacked evidence that documentation, assessing, and monitoring were included in the PIP.	F0684		
F0689 SS = E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and a review of Safety Data Sheets (SDS), the facility failed to ensure that the resident's environment was free of accident hazards relating to the unsecured storage of a container of germicidal disposable wipes for 1 of 4 days of survey. (8/25/25), In addition the facility failed to provide adequate supervision resulting in a resident elopement for 1 of 1 residents reviewed (Resident #3 [R3]). Findings: 1. The Safety Data Sheet for Sani-Cloth Germicidal Disposable Wipes stated the following: 5. Emergency and First Aid Procedure: Skin Contact: If rash or irritation develops, discontinue use.	F0689	The Sani-Cloth Germicidal Disposable wipe container in the lower cabinet in the kitchenette on the Cove Unit was removed immediately. It is facility policy to secure all Sani-Cloth Germicidal Disposable Wipes in a locked cabinet or locked utility room. The Director of Nursing and/or designee will provide re-education regarding policy to CNA's, and licensed nursing staff. The Director of Nursing and/or designee will conduct random weekly audits times four (4) weeks and monthly times two (2) months thereafter to ensure compliance. Audit results will be reported to the facility's QAPI committee for review and further recommendations. Incident involving Resident #3 was reported to licensing and Certification as required. Investigation and 5 day report completed. A visiting family member exited the elevator without ensuring the doors closed behind him. Resident # 3 entered the elevator and was retrieved in the lobby by staff as he was exiting the elevator.	10/6/2025

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F0689 SS = E	Continued from page 22 Eye Contact: Flush with cool water for 15 minutes. Inhalation: Remove to fresh air. Ingestion: Consult Physician. On 8/25/25 at 12:15 p.m., two surveyors observed a 1 pound 13 ounce container of Sani-Cloth Germicidal Disposable Wipes in a lower, unlocked cabinet in the kitchenette on the Cove Unit. This was accessible to residents. On 8/25/25 at 12:20 p.m., in an interview with two surveyors present, the Cove Unit Manager confirmed the finding. 2. R3 resides on the secured Memory Care Unit and has diagnoses to include dementia, anxiety, and disorganized schizophrenia. During observations on 8/25/25 at 3:45 p.m., and 8/27/25 at 8:28 a.m., R3 was observed aimlessly wandering around the secured Memory Care Unit with a helmet on. Review of R3's care plan updated 8/5/25 states "Focus: R3 is an elopement risk/wander due to dementia, impaired safety awareness and Resident wanders aimlessly. Goal: …safety will be maintained through the next review date. Intervention: Distract me from wandering by offering pleasant diversions, structured activities, food, conversation, television, book… I identify pattern of wandering: is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate… On 8/28/25 at 8:15 a.m., a surveyor pushed the elevator button in the lobby on the first floor. The elevator door opened and the surveyor observed R3 in the elevator, aimlessly walking in circles with no helmet on. At this time surveyor called out for Business Office Manager (BOM) who was at the reception desk to come help get R3 back up to the secured unit. During an interview on 8/28/25 at 9:09 a.m., Certified Nursing Assistant (CNA) stated they were passing breakfast trays this am, and R3 was wandering over by the elevator but he did not notice anyone getting off the elevator and had no idea how R3 got in the elevator.	F0689	Education was provided to the family member. There are signs in the elevator, and a second set of signs will be posted outside of the elevator.	10/6/2025

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F0689 SS = E	Continued from page 23 During an interview on 8/28/25 at 9:10 a.m., Licensed Practical Nurse (LPN) stated that R3 did wander a lot and was able to confirm R3 most likely got onto the elevator after another family member came up to the third floor and did not make sure that the elevator doors closed before they walked away. At this time LPN confirmed R3 was most likely stuck in the elevator for approximately 10 minutes before the surveyor noticed him. During an interview on 8/28/25 at 9:11 a.m., a family member stated he/she arrived at the unit around 8:05 a.m., and did notice Resident 3 by the elevators, but did not wait for the elevator doors to close before going to visit with his/her family member. During an interview on 8/28/25 at 8:25 a.m., the Administrator stated she was already aware of the above findings.	F0689		
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action	F0756	It is facility policy to review and respond to Pharmacy recommendations in a timely manner. Director of Nursing and/or designee will provide re-education to licensed nursing staff regarding timely review and response of pharmacy recommendations. Director of Nursing and/or designee will conduct random weekly audits times four (4) weeks and monthly thereafter times two (2) months to ensure timely review of pharmacy recommendations are reviewed. All audit results will be reported to the facility QAPI's committee for review and further recommendations.	10/6/2025

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F0756 SS = D	Continued from page 24 has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews and interviews, the facility failed to respond to the consultant pharmacist's recommendations in a timely manner for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #45 [R45]). Findings: Review of facility policy "Medication Regiment Review (MRR)" dated 6/5/24 states "...Facility should encourage physician/prescriber or other responsible parties receiving the MMR and the director of nursing to act upon the recommendations contained in the MRR for those that require physician/prescriber intervention, facility should encourage physician/prescriber to either accept and act upon the recommendations contained within the MRR or reject all or some of the recommendations contained in the MRR and provide an explanation as to why the recommendation was rejected, as outlined in the State Operations Manual Appendix PP. The attending physician should document in the residents health record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. Facility should alert the Medical Director where MRRs are not addressed by the attending physician in a timely manner... The attending physician should address the consultant pharmacist's recommendation no later than their next scheduled visit to the facility to assess the resident, per facility policy and state or federal regulations..." R45 was originally admitted in 2023 and has diagnoses to include dementia, anxiety, and a major depressive disorder. Review of Pharmacy Consultant Report dated 5/22/25 states "...please attempt a gradual dose reduction (GDR) to Sertraline 12.5 mg [milligram] daily..." Review of	F0756		

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F0756 SS = D	Continued from page 25 provider response dated 7/20/25 (182 days after Pharmacy review) states "Not clinically appropriate at this time due to increase anxiety/agitation…". The provider failed to respond to pharmacy recommendation in a timely manner. Review of facility policy "Psychotropic Medication Use" dated 3/1/25 states "....The physician shall respond appropriately by changing or stopping problematic doses or medications, or clearly documenting (based on assessing the situation) why the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences..." Review of pharmacy consultant report dated 1/19/25 states, "…recently began receiving Haloperidol 2 mg twice daily for dementia with behavioral disturbance. This first generation antipsychotic has an unfavorable risk profile. [He/She] has experienced more than one fall since initiation of haloperidol. A resident to resident interaction is attributed as the precipitating factor per facility progress note. Please consider a gradual dose reduction of Haloperidol to 2 mg once daily, with the end goal of discontinuation. Perhaps non-pharmacological interventions could be used to minimize or eliminate precipitating factors?" Review of provider response dated 4/30/25 (108 days after Pharmacy review) states "D/c Haldol, I have removed it from the med list…" Review of R45's "Orders" revealed Haldol was discontinued on 4/30/25. Review of R45's care plan updated 5/17/25 states "[R45] uses psychotropic medications [related to (r/t)] management of her aggressive behavior and agitation…Consult with pharmacy, MD to consider dosage reduction when clinically appropriate…" Review of clinical record revealed Provider "Recertification Note" dated 1/29/25. There is no evidence pharmacy report was reviewed at this time. During a review of R45's clinical record on 8/26/25 at 3:32 p.m., the Director of Nursing (DON) stated the provider should review a pharmacy recommendations withing 24-48 hours. At this time DON reviewed the above and stated at that time, they had a different provider group and agreed they did not review pharmacy requests in a timely manner.	F0756		
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General.	F0757		

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F0757 SS = D	Continued from page 26 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 interview, the facility failed to monitor for side effects of psychotropic medications for 1 of 5 residents reviewed for unnecessary medications (Resident [R] 86). Finding: R86 has diagnoses to include depression. R86's care plan states, "…uses psychotropic medications r/t [related to] Behavior management: for dx [diagnosis] of Depression…will be/remain free of drug related complications…Monitor/document for side effects and effectiveness … Monitor/record/report to MD [Medical Doctor] prn [as needed] side effects…" Review of R86's clinical record revealed the following active physician orders:Order for "Sertraline HCl Oral Tablet 50 MG [milligram] Give 1 tablet by mouth 1 time a day for Depression."Order for "Venlafaxine HCl ER [extended release] Oral Tablet…75MG…Give 1 tablet by mouth one time a day for Depression."Further review of R86's clinical record lacked evidence he/she was monitored for side effects of the above medications.	F0757	Resident # 86's care plan has been updated to include monitoring for side effects of psychotropic medication usage. It is facility policy to monitor for side effects of psychotropic medications. Director of Nursing and/or designee will provide re-education to licensed nurses. Director of Nursing and/or designee will conduct an audit of current residents who are receiving psychotropic medications to ensure monitoring for side effects. Any resident using psychotropic medications identified as not receiving monitoring of side effects, care plan will be updated. Director of Nursing and/or designee will conduct random weekly audits times four (4) weeks and monthly thereafter times two (2) to ensure compliance. Audit results will be reported to the facility's QAPI committee for further review and recommendations.	10/6/2025

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F0757 SS = D	Continued from page 27 On 8/28/25 at 10:13 a.m., during an interview, the Director of Nursing (DON) reviewed R86's entire clinical record and confirmed R86 was not being monitored for side effects of the above medications.	F0757		
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/kitchenettes were maintained in a clean and sanitary manner for fans, air conditioners, a food mixer, air vents, and walls. Additionally, the facility failed to ensure that foods were stored, dated and labeled properly for 2 of 6 kitchen/kitchenettes tours (Cove Unit Kitchenette and Kitchen) Findings: The facility's "Food Receiving and Storage" policy, revised October 2017, noted under Policy Interpretation and Implementation: 7. Dry foods that are stored in bins will be removed	F0812	All items identified were corrected immediately Cove Kitchenette:.The Jelly was discarded. Drinking cups were brought to the unit. Kitchen: -the box fan by the office was cleaned -Box fan by the coffee machine was cleaned -Dish room ceiling air conditioning unit, by the clean dish rack was cleaned. -The two wall mounted air conditioning units, by the 3 bay sink was cleaned. -The wall behind the steamer unit was cleaned -The food mixer was cleaned and painted -Circular fan, by food prep area was cleaned -The 8 bags of corn meal mix were discarded -Unlabeled items in the walk-in freezer were discarded. Food Service Director and/or designee will provide education regarding proper food procurement/storage and sanitation professional standards for food service safety. The Food service Director and/or designee will conduct random weekly audits times four (4) weeks and thereafter random monthly audits times two (2) months to ensure compliance. The results of the audits will be reported to the facility's QAPI committee for further review and recommendation.	10/6/2025

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F0812 SS = E	Continued from page 28 from original packaging, labeled and dated ("used by date"). 8. All food stored in the refrigerator or freezer will be covered, labeled and dated ("used by date"). 1. On 8/25/2025 at 11:30 a.m., a surveyor observed the following findings in the Cove Unit kitchenette: - The far right upper cupboard had a plastic bottle of grape jelly and a jar of strawberry preserves, which had been previously opened and used, with directions to refrigerate after opening. - The kitchenette had no drinking cups and the staff were using paper cups to serve residents beverages. On 8/25/2025 at 11:40 a.m., in an interview with a surveyor, the Cove Unit Manager confirmed that the grape jelly and strawberry preserves should have been refrigerated and that residents were using paper cups. 2. On 8/25/25 from 11:15 a.m. to 11:45 a.m., a surveyor completed a Kitchen Tour with the Food Service Director in which the following findings were observed: -The box floor fan, by the office, was dusty/dirty. -The box floor fan by the coffee machine was dusty/dirty. -The dish room ceiling air vent, by the clean dish rack, was dusty/dirty. -There were two wall mounted air conditioning units, by the three bay sink, that were heavily soiled with dust. -The wall behind the steamer unit was heavily soiled with dried liquid residue. -The food mixer had chipped/missing paint and dried food particles on the mix arm and base. -The circular fan, by a food preparation area, was dusty/dirty. -The dry storage area had eight large bags of cornbread mix that were not dated. -The walk-in freezer had a bag of French toast, two packages of hot dog buns and two packages of Eggos that	F0812		

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F0812 SS = E	Continued from page 29 were not dated and labeled. On 8/25/25 at 11:45 a.m., in an interview with a surveyor, the Food Service Director confirmed the findings.	F0812		
F0814 SS = E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is NOT MET as evidenced by: Based on observations and interviews, the facility failed to ensure that garbage and refuse were disposed of in a manner to prevent pest infestation for 3 of 4 survey days. (8/25/25, 8/26/25 and 8/27/25) Findings: 1. On 8/25/25 at 1:00 p.m., a surveyor observed loose trash in a wheeled cart without a lid and a dumpster that had the back top lid open exposing trash, outside the kitchen area. 2. On 8/26/25 at 1:30 p.m., a surveyor observed loose trash in a wheeled cart without a lid and a dumpster that had the back top lid open exposing trash, outside the kitchen area. 3. On 8/27/25 at 8:05 a.m., a surveyor and the Food Service Director observed loose trash in a wheeled cart without a lid and a dumpster that had the back top lid open exposing trash, outside the kitchen area. At this time, in an interview with a surveyor, the Food Service Director confirmed the findings.	F0814	All identified items were corrected immediately. Dumpster lid was closed. Wheeled cart was replaced with a cart that has a lid Food Service Director and/or designee will provide re-education to kitchen staff regarding appropriate disposal of garbage and Refuse Food Service Director and/or designee will conduct weekly random audits times four (4) weeks and monthly thereafter times two (2) months. Audit results will be reported to the facility's QAPI committee for review and further recommendations.	10/6/2025
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.	F0842	Resident #86's record will be updated to reflect the inaccurate/wrong IDT meeting note dated 7/17/2025. It is facility policy to ensure that clinical records are complete and contain accurate information, including ROM, Bathing, Vital Signs, change in condition evaluations, and notification of provider documentation. Director of Nursing and/or designee will provide re-education to cna's, licensed nurses, and the IDT regarding policy.	10/6/2025

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(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
F0842 SS = E	Continued from page 30 §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 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.	F0842	The Director of Nursing and/or designee will conduct random weekly audits times four (4) weeks and thereafter monthly times two (2) months of ROM and Bathing documentation to ensure accurate completion. The Director of Nursing and or/designee will conduct random weekly audits times four (4) weeks and thereafter monthly times two (2) months of Change of Condition Evaluations and V/S to ensure accurate completion. All Aduit results will be reported to the facility's QAPI committee for further review and recommendations.	10/6/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205120	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2025

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F0842 SS = E	Continued from page 31 §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 observation, record reviews, and interviews, the facility failed to ensure that clinical records were complete and contained accurate information for 6 of 33 sampled residents (Resident #5 [R5], R7, R13, R4, R86, and R48). Findings: 1. Review of Resident #5's medical record stated in the current care plan: Range of motion[ROM] (active or passive) with am/pm care daily. ON HOLD WHILE GETTING THERAPY Date Initiated: 09/12/2024 Revision on: 05/27/2025. The medical record lacked evidence that Range of motion (active or passive) was documented twice daily for the following dates in 2025: June: 1, 3, and 4. July: 1, 2, 4-10, 13, 15, 16, 18, 20, and 25. The clinical record lacks documentation that the resident completed or refused ROM exercises. August 1, 2, 7-9, 11, 14, 16-19, 21, 22, and 23-26. The clinical record lacks documentation that the resident completed or refused ROM exercises. Bathing documentation shows missing/inaccurate documentation with no resident baths given and no	F0842		

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F0842 SS = E	Continued from page 32 resident refusal for the following dates in 2025: June: 3, 12, 19, and 26. July: 10, 24 and 31 August: 10, 24 and 31. On 8/27/2025 at 3:54 p.m., in an interview with a surveyor, the Cove Unit Manager and the Administrator confirmed that there was missing/inaccurate documentation on the resident's ROM and Bathing Documentation. 2. Review of Resident #7's medical record indicated R7 receives a bath/shower on Mondays and Thursdays. Bathing documentation shows missing/inaccurate documentation with no resident baths given and no resident refusal for the following dates in 2025: June: 2, 5, 9, 12, 16, 26, and 30. August: 2, 5, 9, 12, 16 and 26. On 8/28/2025 at 2:30 p.m., in an interview with five surveyors present, the Director of Nursing and the Administrator stated that charting/documentation was not completed accurately and it should have been completed accurately in the resident's clinical records. 3. On 8/26/25 at 8:15 a.m., during an observation of R13's room, the Memory Unit Manager (UM1) entered the room with a surveyor and encouraged R13 to drink fluids from his/her breakfast tray and stated that R13 needs frequent encouragement because he/she forgets to drink fluids. UM1 then stated that R13's blood pressure is low today, and he/she is complaining of feeling dizzy, so the doctor will be seeing him/her today. Review of R13's care plan states "…at risk for fluid volume deficit...Monitor/document/report to MD [Medical Doctor] PRN [as needed] s/sx [signs/symptoms] of dehydration…" Review of R13's clinical record revealed a physician progress note, dated 8/27/25, that states, "...seen today for an acute visit for hypotension. This morning [he/she] was reported to have blood pressure of 80s/50s. [He/she] felt lightheaded. Staff encouraged oral fluids and [his/her] blood pressures normalized.	F0842		

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F0842 SS = E	Continued from page 33 [He/she] is now asymptomatic..." Further review of R13's clinical record revealed his/her last documented blood pressure was 119/84 on 8/5/25, and the clinical record lacked evidence of the low blood pressure taken on 8/26/25 for the above symptoms. On 8/27/25 at 8:56 a.m., during an interview, Licensed Practical Nurse #1 (LPN1) stated she took R13's blood pressure yesterday, and it was low, so she encouraged fluids and re-checked the blood pressure, and it improved and that she verbally notified the physician. LPN1 then stated she did not document the initial low blood pressure, the re-check, or that she notified the physician. At this time, a surveyor discussed the above concerns with UM1. At this time, UM1 stated that vital signs are documented in the electronic medical record (EMR) and that R13's blood pressures and a nursing progress note should have been documented in the EMR. 4. R4 has diagnoses to include dementia with behavior disturbance and bladder incontinence. Review of R4's clinical record revealed a physician progress note dated 8/12/25 that states, "...Assessment and Plan...Presumed urinary infection. Patient is incontinent. Patient reports feeling ill today but is unable to articulate why. Physical exam revealed suprapubic tenderness without rebound or guarding. Ordered UA [urinalysis] with reflex culture to evaluate for possible UTI [urinary tract infection]..." Review of R4's active physician orders revealed an order dated 8/12/25 for "...UA with reflex culture; suprapubic tenderness on exam + reports of feeling fatigued/ill..." Further review of R4's clinical record lacked evidence of urinalysis results or that the urine sample was collected and sent or that the resident refused. On 8/27/25 at 8:52 a.m., during an interview, LPN1 stated R4 was combative with the attempt to collect the urine sample, and she was unable to obtain a sample, so she passed it onto the night nurse, who was also unable to obtain a sample. LPN1 then stated she notified Nurse Practitioner (NP) 1 that the specimen was unable to be obtained. At this time, a surveyor discussed the above finding with UM1, and she stated it is her expectation that the nurse enter a nursing progress note to reflect	F0842		

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F0842 SS = E	Continued from page 34 the refusal(s) and that the provider was notified. 5. R86 has diagnoses to include dementia. R86's care plan states, "...has a POA [Power of Attorney]-Care and POA Financial...has a POA that will remain in effect through next review date..." Review of R86's Interdisciplinary Team (IDT) meeting note, dated 7/17/25, indicates R86's "…[representative]/POA attended via phone…" and states, "...Advanced Directives reviewed, no changes at this time..." Further review of R86's clinical record lacked evidence of POA documentation or Advance Directive documentation. On 8/27/25 at 9:10 a.m., the above finding was discussed with the Memory Unit Social Worker (SW). At this time, the SW stated R86's [representative] is not his/her POA, that R86 does not have an Advance Directive, and that the IDT meeting note and care plan are labeled wrong. 6. Review of R48's clinical record revealed a nursing Change in Condition (CIC) Evaluation, dated 8/1/25, that indicated R48 sustained an unwitnessed fall at 4:15 p.m. The assessment section of the CIC Evaluation indicated the most recent vital signs taken after the change in condition occurred were documented at 4:10 p.m. Review of R48's Neurologic Screen Form, dated 8/1/25, indicated that neuro checks were not initiated until 6:00 p.m., however, the vital signs documented under the 6:00 p.m. entry on the Neurologic Screen Form are identical to the vital signs documented at 4:10 p.m. on the CIC Evaluation. Review of the Incident Report for the above fall, dated 8/1/25 at 6:00 p.m., lacked evidence of the actual time of R48's fall. On 8/28/25 between 9:12 a.m.-10:13 a.m., during an interview, the Director of Nursing reviewed R48's entire clinical record and confirmed that it does does not accurately reflect the time of R48's fall and stated that she cannot determine what time R48 fell or if neurologic checks should have been started at 4:10 p.m. or 6:00 p.m.	F0842		
F0880 SS = D	Infection Prevention & Control	F0880		

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F0880 SS = D	Continued from page 35 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 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.	F0880	Resident # 66 drainage bag and catheter tubing was fixed immediately. It is facility policy to maintain an Infection Prevention and Control Program designed to provide a sanitary environment to help prevent the development and transmission of disease infection related to the storage of a urinary catheter. Director of Nursing and/or designee will provide re-education to CNA's and licensed nurses. The Director of Nursing and/or designee will conduct randomly weekly audits times four (4) weeks and thereafter monthly times two (2) months of residents utilizing urinary catheters to ensure proper storage and maintenance of infection control practices. Audit results will be reported to the facility's QAPI committee for review and further recommendations. It is facility policy to notify all residents and resident's family and/or responsible party of a COVID 19 outbreak. The facility utilities a text messaging system (cliniconex) as well as posting of signage on facility entrance and verbal notification in building to notify residents, resident's family members and/or responsible parties of a COVID.-19 outbreak. Administrator and/or designee will provide re-education to facility department heads	10/6/2025

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F0880 SS = D	Continued from page 36 (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 reviews, the facility failed to maintain an Infection Control Program designed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to the storage of a urinary catheter drainage bag for 1 of 3 residents reviewed for indwelling urinary catheters (Resident #66 [R66]). Additionally, the facility failed to ensure proper notification was given to resident representatives during 1 of 1 Covid-19 outbreak in the facility. Findings: 1. R66 has diagnoses to include obstructive uropathy (a blockage in urine flow), indwelling suprapubic urinary catheter, and chronic urinary tract infection. Review of R66's care plan states, "...has Suprapubic Catheter for OBSTRUCTIVE AND REFLUX UROPATHY and I get chronic urinary tract infections..." On 8/25/25 at 12:38 p.m., R66 was observed foot-propelling in his/her wheelchair from the Memory Unit dining room to the day room area, and his/her urinary catheter drainage bag was hanging under the wheelchair, with the catheter tubing and drainage bag	F0880		

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F0880 SS = D	Continued from page 37 dragging on the floor. On 8/26/25 at 7:55 a.m., R66 was observed seated in his/her wheelchair in the Memory Unit dining room, and his/her urinary catheter drainage bag was hanging below his/her wheelchair, touching the floor. On 8/27/25 at 9:00 a.m., a surveyor discussed the above observations with the Memory Unit Manager (UM1) and at this time, a surveyor and UM1 observed R66 in the day room area with his/her urinary catheter drainage bag hanging on the bottom of his/her wheelchair and the drainage bag and catheter tubing touching the floor. The UM1 then stated there is a spot on the wheelchair to hang the bag so it does not touch the floor and adjusted R66's drainage bag. 2. Based on record review, and interview the facility failed to notify residents and families of a Coronavirus (COVID 19) outbreak. This has the potential to affect all residents residing in the facility. Review of the provided facility "COVID Line List" revealed the following: Between 1/6/25 and 2/10/25, 18 residents tested positive for COVID 19 on the Cove unit, 4 residents tested positive on Memory Lane, 2 housekeepers, one activities staff member and 1 Minimum Data Set (MDS) Coordinator (whose office is on the skilled unit). During an interview with Director of Nursing (DON) and Infection Preventionist (IP) on 8/27/25 at 9:00 a.m., the DON stated that the Cove unit was shut down during the COVID outbreak, they tried to keep the same staff in that area (unit), and everyone was on 10 days of precautions. The DON further stated that as staff and residents tested positive, all staff were notified via the facility messaging system through scheduling, and only the residents and families residing on the Cove unit were notified of the outbreak. When asked if the residents and families for the other units were notified of the COVID outbreak, the DON replied that a notice of outbreak was posted on the main entrance to notify visitors of the COVID outbreak, but every resident and every family member in the facility was not notified because it was contained to the Cove unit. The facility failed to provide evidence that the residents and families of the skilled unit and Memory Lane were notified of the COVID outbreak.	F0880		