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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205006	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montello Manor	540 College St Lewiston, ME 04240

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 37648 Based on observations and interviews, the facility failed to ensure a residents call bell was within reach for 4 of 15 sampled residents for 2 of 3 days of survey with multiple observations. (Resident #24, #7, #15, #188) Findings: 1. On 2/18/25 at 10:11 a.m., observation of Resident #24 sitting in a wheelchair beside the middle of the bed. The call bell was at the head of the bed hanging down. At this time, Resident #24 attempted to move the wheelchair and was unable to twist his/her body to reach the call bell. 2. On 2/18/25 at 10:54 a.m., observation of Resident #7 sitting up in a broda chair with a hoyer pad underneath him/her and the broda chair positioned at the foot of the bed. The call bell was wrapped up on the side rail at the head of the bed, not within reach. On 2/18/25 at 12:57 p.m., an additional observation of Resident #7, sitting in a broda chair at the foot of the bed, with a tray table in front of resident. The call bell was placed on the bed behind the broda chair, not within reach. 3. On 2/18/25 at 11:05 a.m. and at 12:57 p.m., observations of Resident #15, sitting in a broda chair placed at the end of the bed with pressure-relieving booties on both feet and the foot of the broda chair elevated. The call bell was not visible anywhere around the resident. 4. On 2/18/25 at 10:56 a.m. and at 12:57 p.m., observations of Resident #188 lying in bed with the call bell wrapped around the call box on the wall behind the bed. 5. On 2/18/25 at 2:10 p.m., 2 surveyors observed Residents #7, #15 and #188 with their call bells out of reach. On 2/18/25 at 2:14 p.m., during an interview, both the surveyor and the Licensed Practical Nurse #4 (LPN) observed Residents #7, #15 and #188 with their call bells out of reach. At this time, the LPN found Resident #15's call bell on the floor under the head of the bed and placed the call bells within reach for each resident. On 2/18/25 at 2:33 p.m., the above was discussed with the Administrator. (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. On 2/19/25 at 8:20 a.m., an additional observation of Resident #7 sitting up in the broda chair positioned at the end of the bed with a breakfast tray in front of the resident. The call bell was on the side of the bed lying on the floor. At 8:24 a.m., a certified nurse's aide (CNA) entered the room and made his/her bed then exited the room leaving the call bell on the floor. At 2/19/25 at 8:28 a.m., the breakfast tray was picked up and the call bell remained on the floor. At 8:54 a.m., CNA #2 entered the room, lowered the resident's bed and moved the broda chair to the side of the bed and gave him/her the call bell. At this time, CNA #2 confirmed Resident #7 did not have the call bell. On 2/19/25 at 9:04 a.m., the above was again discussed the above with the Administrator.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37440 Based on observations and interview, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable environment on 2 of 2 wings (North and East) and the Laundry room for 1 of 1 facility tour. Findings: On 2/20/25 from 9:05 a.m. to 10:00 a.m., a surveyor conducted an Environmental Tour with the Maintenance Director in which the following findings were observed: North Wing: - Resident room [ROOM NUMBER] - The wooden board to the right of the bed holding the metal base board heating unit, had chipped/gouged paint exposing untreated wood. The metal base board heating unit had chipped/gouged paint creating an uncleanable surface. - Resident room [ROOM NUMBER] - The wheelchair right arm rest had a ripped/torn/peeling plastic surface and the wheelchair was visibly dirty with food debris and dust. The bathroom floor had three stained and broken floor tiles around the toilet. - Resident room [ROOM NUMBER] - There was a bed pan and wash basin on the floor next to the toilet. - The exit area vestibule on the North Wing had four bags of trash stored on the floor and not secured in a sealed container. East Wing: - Resident room [ROOM NUMBER] - The cove base around the room was visibly soiled and dirty. - The ceiling vent in the hallway outside resident room [ROOM NUMBER] was dirty and dusty. - Resident room [ROOM NUMBER] - There were three cracked/broken floor tiles in the bathroom. - Resident room [ROOM NUMBER] - There was a large crack in the sheetrock wall by the window. Laundry Room: - The cement floor had chipped/missing paint creating an uncleanable surface. - The large folding table had chipped/missing paint and had duct tape on the top edges creating uncleanable surfaces. On 2/20/25 at 10:00 a.m., in an interview, the Environmental Services Director confirmed the findings.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 37440 Based on observation, interviews and record review, the facility failed to ensure a person-centered comprehensive care plan was developed in the area of Chronic Obstructive Pulmonary Disease (COPD) and failed to implement the care plan in the area of ADL (Activities of Living) and oxygen maintenance for 4 of 15 residents care plans reviewed (#8, #7, #10 and #24) Findings: 1. Review of Resident #8's current physician orders noted Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) mg(milligram)/3ml(milliliter)-1 application Inhale orally four times a day for COPD- start date- 1/15/25 1100, morning(am) 06, noon, evening(pm) 15, night(hs)18. Resident #8's current care plan was reviewed and it lacked evidence that the care plan was updated to include goals and interventions for the care area of COPD/Nebulizer use. On 2/20/25 at 2:00 p.m., in an interview, the Administrator confirmed that Resident #8's care plan was not updated to include goals and interventions for the care area of COPD/Nebulizer use. 37648 2. On 2/18/25 at 10:54 a.m., and on 2/18/25 at 12:57 p.m., Resident #7 was observed sitting up in a broda with the call bell out of his/her reach. On 2/19/25 at 8:20 a.m., an additional observation of Resident #7 sitting up in the broda chair positioned at the end of the bed with a breakfast tray in front of the resident. The call bell was on the side of the bed lying on the floor. He/she was eating breakfast independently, no staff supervision and using a metal spoon, scooping up egg yolk. At 8:24 a.m., a certified nurse's aide (CNA) entered the room and made his/her bed then exited the room leaving the call bell on the floor. At 2/19/25 at 8:28 a.m., the breakfast tray was picked up. At 8:54 a.m., CNA #2 entered the room, lowered the resident's bed and moved the broda chair to the side of the bed and gave him/her the call bell. At this time, during a brief interview, CNA #2 confirmed Resident #7 did not have the call bell available. The surveyor asked what eating assistance is required for Resident #7, she stated you have to sit with [him/her], [he/she's] supervision. At this time, the surveyor discussed the lack of supervision while he/she ate breakfast using a metal spoon. Review of Resident #7's care plan for ADL (Activities of Living) self-care performance deficit r/t dementia revised on 12/8/23 has an intervention of Eating: [Resident] requires total assist by 1 staff to eat; Should use small plastic spoon and give small bites to promote increased intake. The care plan for swallowing problem r/t dementia, coughing or choking during meals or swallowing med, difficulty with thin liquids revised on 12/4/23 has an intervention of Resident to eat only with supervision. The care plan for communication problem r/t Alzheimer's dementia revised on 6/26/24 has an intervention of Ensure/provide a safe environment: call light in reach. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/19/25 at 9:04 a.m., the above failure to have the call bell available, the lack of supervision while eating and the use of a metal spoon was discussed with the Administrator. 3. On 2/18/25 at 10:33 a.m., and at 2:10 p.m., Resident #10 was observed using a nasal cannula for his/her oxygen administration with the tubing dated 1/28/25. Review of Resident #10's care plan for Altered cardiovascular status r/t CHF (congestive heart failure) Hypertension, AFIB (atrial fibrillation), Aortic stenosis, revised on 10/25/23 has an intervention of change O2 (oxygen) tubing weekly and PRN (as needed) 4. On 2/18/25 at 10:11 a.m., Resident #24 was observed sitting in a wheelchair bedside the middle of the bed. The call bell is at the head of the bed hanging down. At this time, resident #24 attempted to move the wheelchair and was unable to twist his/her body to reach the call bell. Review of Resident #24's care plan for ADL self-care performance deficit r/t Alzheimer's dementia, impaired balance/unsteady gait, arthritis, revised on 5/2/23 has an intervention of Encourage [Resident] to use the call bell for assistance and the care plan for high-moderate risk for falls relating to confusion, gait/balance problems, psychoactive drug use and unaware of safety needs, has an intervention of be sure the residents call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. On 2/18/25 at 2:33 p.m., the above was discussed with the Administrator.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 51331 Based on observations, interviews and record review, the facility failed to follow physician orders in the area of urinary care, activities of daily living, and respiratory care for 3 of 15 residents sampled (Resident #12, #7, and #10). 1. Review of Resident #12's clinical record contained a physician order dated 1/8/25 instructing nursing to flush resident's foley catheter with 60 cc (cubic centimeter) of normal saline every day for obstructive uropathy. The clinical record lacked evidence of this was being completed. On 2/19/25 at 9:59 a.m., during an interview, the Administrator confirmed the above physician order was not completed daily by staff. 37648 2. Review of Resident #7's provider order, dated 9/14/24 instructs nursing to provide, Minced and Moist diet, minced texture, Nectar consistency, Fed by Staff, use plastic spoon. On 2/19/25 at 8:20 a.m., observation of Resident #7 eating breakfast independently, no staff supervision and using a metal spoon, scooping up egg yolk. At 8:24 a.m., a certified nurse's aide (CNA) entered the room and made his/her bed then exited the room. At 2/19/25 at 8:28 a.m., the breakfast tray was picked up. At 8:54 a.m., during a brief interview, the surveyor asked what eating assistance is required for Resident #7, she stated you have to sit with [him/her], [he/she's] supervision. At this time, the surveyor discussed the lack of supervision while Resident #7 ate breakfast using a metal spoon. 3. Review of the Resident #10's provider order, dated 12/2/24 instructs nursing to, change and date O2 and C-pap tubing Clean concentrator filter every night shift every Mon. On 2/18/25 at 10:33 a.m., and at 2:10 p.m., observations of Resident #10 using a nasal cannula for his/her oxygen (O2) administration with the tubing dated 1/28/25. On 2/19/25 at 2:20 p.m., the above was discussed with the Administrator.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37440 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 storage of chemicals being properly secured for 4 of 4 observations for 2 of 3 days of survey (2/18/25 and 2/20/25). Findings: 1. On 2/18/25 at 10:28 a.m., a surveyor observed an unsecured 40 oz bottle of Ajax laundry detergent on the back of the toilet in Resident room [ROOM NUMBER]'s bathroom, which is shared with occupied resident room [ROOM NUMBER]. 2. On 2/18/25 at 11:08 a.m., 2 surveyors observed an unsecured 40 oz bottle of Ajax laundry detergent on the back of the toilet in Resident room [ROOM NUMBER]'s bathroom, which is shared with resident room [ROOM NUMBER] and occupied. 3. Resident #4, who occupies room [ROOM NUMBER], stated in an interview that he/she accesses the bathroom for use. On 2/18/25 at 12:36 p.m., , in an observation and interview, the Environmental Services Director confirmed there was an unsecured 40 oz bottle of Ajax laundry detergent on the back of the toilet in Resident room [ROOM NUMBER]'s bathroom. The Safety Data Sheet for Ajax Classic Heavy Duty Liquid Laundry Detergent noted the following: 4. First Aid Measures Eye contact: flush affected areas with water for at least 15 minutes. Seek medical assistance if required. Skin contact: Rinse with water. If skin irritation occurs in use, seek medical assistance. Inhalation: Give the subject access to fresh air. If symptoms do not resolve quickly, seek medical assistance. Ingestion: may be harmful if swallowed and large quantities. On 2/18/25 at 12:44 p.m., in an interview, a surveyor discussed the findings with the Administrator. 4. On 2/20/25 at 9:33 a.m., a surveyor and the Environmental Services Director observed 5 pieces of metal approximately 2 feet long, which appeared to be brackets laying on the floor in the North wing staff exit vestibule. At this time this was confirmed by the Environmental Services Director that the metal brackets were on the floor, creating an accident hazard, and that residents had access to this area.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 37440 Based on observations, interviews and record review, the facility failed to maintain a respiratory program to help prevent the development and transmission of disease and infection related to respiratory equipment care for 4 of 4 residents reviewed for respiratory care (Resident #19, #7, #10, and #187) for 3 of 3 days of survey. (2/18/25, 2/19/25 and 2/20/25) Findings: 1. On 2/18/25 at 11:02 a.m., a surveyor observed an unbagged oxygen tubing and a nasal canula hanging on an oxygen tank that was secured to the back of Resident #19's wheelchair which was stored in the hallway outside of the resident's room. The oxygen tubing was not dated. 2. On 2/18/25 at 2:20 p.m., 2 surveyors observed an unbagged oxygen tubing and a nasal canula hanging on an oxygen tank that was secured to the back of Resident #19's wheelchair which was stored in the hallway outside of the resident's room. The oxygen tubing was not dated. 37648 3. On 2/19/25 at 8:20 a.m., Observation of Resident #7's nebulizer machine with an unlabeled mask and tubing stored on the dresser next to the television. Review of the Resident #7's Medication Administration Record states, a nebulizer treatment was last administered on 2/13/25. The Medical record lacked evidence of orders for, or the changing of the nebulizer mask and tubing weekly. 4. On 2/18/25 at 10:33 a.m., and 2:10 p.m., observations of Resident #10's oxygen nasal cannula tubing labeled with the date of 1/28/25. On 2/19/25 at 8:24 a.m., and 12:21 p.m., observations of a nasal cannula tubing draped over personal belongings on the bedside dresser, not hooked to the oxygen concentrator. Review of Resident #10's medication administration record for January 2025 has documentation of the O2 nasal canula tubing being changed on 1/27. February 2025 record has documentation of the O2 nasal cannula tubing being changed on 2/3, 2/10 and 2/17. 5. On 2/18/25 at 9:47 a.m., and on 2/19/25 at 12:35 p.m., Resident #187's oxygen nasal cannula tubing was wrapped up and stored under the oxygen concentrator handle On 2/19/25 at 2:20 p.m., the above findings were discussed and observed by the administrator and the surveyor. 6. On 2/20/25 at 7:49 a.m., an additional observation of Resident #187's nasal cannula tubing wrapped up and stored under the oxygen concentrator handle. At 8:02 a.m., Resident #7's nebulizer mask and tubing, undated and still stored on the dresser and available for use. On 2/20/25 at 9:00 a.m., during an interview with the Administrator, the surveyor again the confirmed the oxygen and nebulizer mask/tubing were still being stored improperly and available for use. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facilities Policy: Respiratory Therapy last revised on 2/2022 states, The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. Infection control considerations related to oxygen administration states, Change the oxygen cannula and tubing every seven (7) days, or as needed and Keep the oxygen cannula and tubing used PRN in a plastic bag when not in use. Infection control considerations related to medication nebulizers continuous aerosol states, Store the circuit in plastic bag, marked with date and resident's name, between uses and Discard the administration set up every seven (7) days.

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F 0726

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 33639

Based on record review, interviews, and the facilities Medication Administration Policy, the facility failed to ensure that licensed staff are provided with training and are assessed for competency which includes transcription of physician orders in the facilities electronic clinical documentation program Point Click Care (PCC) the facility utilizes for 2 of 7 residents reviewed for medications. (Resident #1 & Resident #34)

Findings:

1. A Nursing Progress note dated 9/12/24 indicating Resident #1 was seen by the provider regarding increased delusions and complaints of visual hallucinations. The progress notes further indicated the resident had received Bupropion 300 milligrams (mg) and Bupropion 450 mg daily for 4 days. Physicians' orders were obtained to immediately discontinue the Bupropion ER 450 mg, hold the Bupropion ER 300 mg for 4 days and hold the antidepressant medication Duloxetine for 4 days. Continue to monitor resident and send to the emergency room for evaluation or deterioration of condition.

A review of the September 2024 Medication Administration Record (MAR) for Resident #1 indicates that he/she received Bupropion ER 300 mg at 6:00 a.m. on 9/9/24, 9/10/24, 9/11/24 & 9/12/24 and Bupropion ER 450 mg at 6:00 a.m. on 9/9/24, 9/10/24, 9/11/24, 9/12/24.

2. Resident #34's MAR indicates that a physician's order dated 10/8/24 instructs staff to administer Reglan 5 mg Give one tablet 4 times a day for 14 days. The MAR indicates that the resident received the medication Reglan 5 mg 4 times daily from 10/8/24 - 10/27/24. Resident #34 received 6 additional days of Reglan 5 mg 4 times daily. (24 doses)

A Medication Incident Report dated 10/28/24 for Resident #34 indicates that on 10/7/24 Reglan was ordered for 14 days and did not have a stop date entered in the electronic clinical documentation program, Point Click Care (PCC).

On 2/20/25 at 10:10 a.m., during an interview with the Director of Nursing (DON), she stated the physicians order for Bupropion ER 450 mg was entered into the electronic clinical charting software, PCC incorrectly. The physicians order for Bupropion ER 450 mg should have been put on hold until the facility received the medication from the pharmacy. The surveyor asked if new staff and agency staff are required to complete training on the Point Click Care system. The DON stated that It varies. Some nurses do not want any training. Most of them have used PCC because it's so widely used. If we see something [NAME], we will do reeducation. Resident #34's physicians order for Reglan 5 mg one tablet four times a day for 14 days did not have a stop date entered in the PCC system. The stop date should have been entered 10/21/24.

A review Licensed Nurse Orientation Checklist states All items require the initials of the staff person teaching the skill:

Point Click Care Electronic System:

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Order entry for medications & treatments - Using MARS & TARs - Medication Error Report I. Medication: - Medication pass - time frames and standards - New medication orders - entry into PCC & communication with the pharmacy II. Documentation - Physician orders, transcription into PCC, noting & 2nd noting - Written & Telephone - Medication Error Report The facility policy, Administering Medications revised 2/2022, Policy Interpretation and Implementation, 3. Medications must be administered in accordance with the orders, including any required time frame. 7. The individual administering the medication must check the label three (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. On 2/20/25 at 12:08 p.m., a surveyor confirmed that licensed staff are not provided training on the facilities electronic clinical documentation program (PCC) the facility utilizes with the Administrator.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 51331 Based on the review of annual evaluations and interviews, the facility failed to complete an annual performance evaluation for Certified Nursing Assistants (CNA) at least every 12 months, for 5 of 5 CNA's reviewed with employment greater than 1 year. (CNA#1, CNA#2, CNA#3, CNA#4, and CNA#5) Finding: 1. CNA #1 was hired on 11/26/2018. The employee record lacked evidence of an annual performance evaluation being completed for 2024. 2. CNA #2 was hired on 7/31/2023. The employee record lacked evidence of an annual performance evaluation being completed for 2024. 3. CNA #3 was hired on 9/5/1991. The employee record lacked evidence of an annual performance evaluation being completed for 2024. 4. CNA #4 was hired on 7/31/2023. The employee record lacked evidence of an annual performance evaluation being completed for 2024. 5. CNA #5 was hired on 2/6/2017. The employee record lacked evidence of an annual performance evaluation being completed for 2024. On 2/20/25 at 11:47 a.m., during an interview with the Facility Administrator and 2 surveyors present, the above information was confirmed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205006	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER: Montello Manor		STREET ADDRESS, CITY, STATE, ZIP CODE: 540 College St Lewiston, ME 04240	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33639 Based on reviews of facility report sent to the Division of Licensing and Certification, record reviews, and interviews, the facility failed to ensure that 2 of 5 sampled residents reviewed for medications was free of significant medication errors. (Resident #1 & Resident #34) Findings: 1. On 9/18/24 a facility report was submitted to the Division of Licensing and Certification. A review of the facility report and the five day follow-up report stated the following: Adult Protective Services (APS) received an anonymous report of an overdose. A medication error was discovered on 9/12/24 involving incorrect dosing of the antidepressant Wellbutrin (Bupropion). Provider on-site and evaluate Resident #1. Orders obtained to hold Wellbutrin (Bupropion) and Duloxetine for four days. Monitor for seizures or worsening of condition and send to the emergency room if any decline in status or seizure activity. Resident #1 was removed from the facility by Emergency Medical Services (EMS) shortly after. A Nursing Progress note dated 9/12/24 indicating Resident #1 was seen by the provider regarding increased delusions and complaints of visual hallucinations. The progress notes further indicated the resident had received Bupropion 300 milligrams (mg) and Bupropion 450 mg daily for 4 days. Physicians' orders were obtained to immediately discontinue the Bupropion ER 450 mg, hold the Bupropion ER 300 mg for 4 days and hold the antidepressant medication Duloxetine for 4 days. Continue to monitor resident and send to the emergency room for evaluation or deterioration of condition. A review of emergency room Documentation indicates that Resident #1 was evaluated for complaints of feeling dry, intermittent visual hallucinations and staff and resident are worried that he/she may be receiving too much Bupropion. Resident #1 had complaints of feeling nauseous for 1 week with occasional vomiting and having trouble with oral intake. Resident #1 was admitted to the hospital on 9/15/24 and discharged from the hospital on 9/16/24 with a diagnosis of Lactic acidemia with elevated anion gap, resolved and a UTI. A review of the September 2024 Medication Administration Record (MAR) for Resident #1 indicates that he/she received Bupropion ER 300 mg at 6:00 a.m. on 9/9/24, 9/10/24, 9/11/24 & 9/12/24 and Bupropion ER 450 mg at 6:00 a.m. on 9/9/24, 9/10/24, 9/11/24, 9/12/24. 2. Resident #34's MAR indicates that a physician's order for Reglan 5 mg, give one tablet 4 times a day for 14 days. The MAR indicates that the resident received the medication Reglan 5 mg 4 times daily from 10/8/24 - 10/27/24. Resident #34 received 6 additional days of Reglan 5 mg 4 times daily. (24 doses) A Medication Incident Report dated 10/28/24 for Resident #34 indicates that on 10/7/24 Reglan was ordered for 14 days and did not have a stop date entered in the electronic clinical charting software, Point Click Care (PCC). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/20/25 at 10:10 a.m., during an interview with the Director of Nursing (DON), she stated the physicians order for Bupropion ER 450 mg was entered into the electronic clinical charting software, PCC incorrectly. The physicians order for Bupropion ER 450 mg should have been put on hold until the facility received the medication from the pharmacy. Staff did not review the medication order completely that would have instructed them to discontinue the Bupropion ER 300 mg when the Bupropion ER 450 mg was received from the pharmacy. The surveyor asked if new staff and agency staff are required to complete training on the Point Click Care software. The DON stated that It varies. Some nurses do not want any training. A lot of them have used PCC because it's so widely used. The staff orientation consists of where things are located, the residents and we will get them into the Pyxis system. If we see something [NAME], we will do reeducation. Resident #34's physicians order for Reglan 5 mg one tablet four times a day for 14 days did not have a stop date entered in the PCC system. The stop date should have been 10/21/24. On 2/20/25 at 12:08 p.m., a surveyor confirmed the significant medication errors for Resident #1 and Resident #34 with the Administrator.

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F 0806

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 37648

Based on interviews and record reviews, the facility failed to provide food that accommodates the resident preferences and failed to provide a second-choice meal/alternative that is similar in nutritive value as the first-choice meal for 1 of 1 resident reviewed for food choices (Residents #10), this has the potential to affect all residents who have a Minced and moist diet and Puree diet.

Findings:

1. On 2/18/25 at 10:42 a.m., during an interview, Resident #10 stated, there is not enough staff to do mechanical soft for just me. I get minced moist. Speech therapist tested me and gave me a list of what I could and could not eat and they still said no.

On 2/19/25 at 8:24 a.m., in an additional interview, Resident #10 stated, Speech ok'd a list of foods that are good but they are not giving them to me because it's too much trouble for the kitchen. All those foods, I can only choose 2 items. I used to have graham crackers .They serve French toast here but I'm not able to have it. He/she then stated, he/she is not able to choose his/her foods and there are no alternatives for his/her meals, stating I do ask for hot cocoa, I often have gone without a meal and It's unjust, but I don't want to be a burden to the kitchen. I'm working on dealing with the injustice of the situation. At this time, he/she confirmed he/she has not been offered a waiver discussing the potential risks involved with eating the foods of his/her choice.

Review of Resident #10's Quarterly Minimum Data Set with the Assessment Reference Date of 11/27/24 revealed he/she had a Brief Interview for Mental Status of 14 out of 15 indicating [he/she] is cognitively intact. Further review of the medical record stated he/she is responsible for decision making for him/herself.

Review of the current care plan for Activities of Daily Living self-performance deficit included an intervention of Eating: [Resident#10] is able to feed [him/herself] after set-up, 1:1 staff supervision for exception foods.

Review of the Speech Therapy recommendations given by the Master's degree in Speech-Language Pathology and the Certificate of Clinical Competence in Speech-Language Pathology (MS CCC-SLP) upon discontinued speech services dated 8/29/24 states: Response to treatment: patient has made functional gains with [his/her] swallowing and maintained safety on several mechanical soft foods, however the facility is only allowing 2 exceptions to [his/her] minced and moist diet, stating more is too complicated . Impact to daily life: Patient would be most appropriate on a mechanical soft diet which is not offered by [his/her] living facility. Consequently there are several food items [he/she] is judged to be safe on that [he/she] is denied. Short term goal not met with the explanation of: Patient would be most appropriate on mechanical soft textures, but the facility does not offer that consistency as a meat choice and is only allowed 2 of the foods [he/she] has been cleared for, stating more is too complicated.

Review of Speech Therapy dietary recommendations dated 8/29/24 and signed into order by provider on 9/5/24 states, Pt now only needs supervision when consuming diet exceptions.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident notes states the following: A dietary note on 8/16/24 at 10:19 a.m. states, This writer met with [Resident] to explain that [him/her] diet had indeed been upgraded to ground meat with no raw vegetables, rice or nuts. A dietary note on 8/16/24 at 2:31 p.m. states, [Resident's] diet has been downgraded to Minced and Moist. In a conversation with [resident] it was explained by this writer and the DON (Director of Nursing) that [he/she] could choose two items off the diet that had been deemed safe to continue to be offered. [Resident] commented that the raisins [he/she] provides on [his/her] own so they should not count. [Resident] was advised that even though [he/she] purchased them, they were not on [his/her] diet and therefore if [he/she] ate them without choosing them as one of her 2 foods [he/she] wishes to have. It was explained to [him/her] that blended diets was not a good practice so [he/she] would continue to receive speech with the goal of upgraded [him/her] to the next diet, and allowing one food and a time would not be done moving forward. A dietary note on 8/26/24 states, when this write was auditing the resident refrigerator in the nourishment kitchen there was a piece of cake with [Resident #10's] name on it dated 8/22/24. This writer took the piece of cake and will inquire tomorrow when [family] visits if [family] [NAME] that to [him/her]. A dietary note on 9/11/24 during the Interdisciplinary Team Meeting, Resident #10 stated that [he/she] is allowed to have cornflakes and many other things per speech. [Resident] was remined that ST (Speech) is no longer involved in [his/her] care at this time and when discharged [he/she] was put on a minced and moist diet with only those exceptions noted, with supervision. A dietary note on 12/11/24 during the Interdisciplinary Team Meeting, Resident #10 stated, Well if I can manage all these things I should just be able to have regular food. It was then explained to [Resident] that [he/she] was not safe to have regular food, and that was not going to occur . [Resident asked to speak with the MD (Doctor) in regards to upgrading [his/her] diet. [He/she] was informed that the MD would be made aware of [his/her] wish, but [his/her] likelihood of ever having a regular diet were rare. A dietary note on 12/27/24 states a discussion with Resident #10's family, It was explained to [family] the reason behind the diet, and the entire purpose of the diet was to keep [him/her] safe as this was the most appropriate diet for [him/her] as recommended by speech therapy. It was explained to [family] about additional diet textures offered by larger facilities and should [he/she] want to explore that option we would help facilitate that move. [Family] stated he believes [Resident #10] is ordering takeout and having it delivered. I explained that [he/she] should not be doing that, and I would notify the DON (Director of Nursing) so she can educate her staff that any food ordered from outside should be in compliance with [his/her] minced and moist diet, or should not be allowed, due to safety concerns. Review of a MediTelecare note dated 1/30/25 states, [Resident #10 .being seen today for an initial evaluation for psychotropic medication management .[he/she] is a good historian .Reports depression only when [he/she] cannot eat [his/her] favorite foods .Reports at times [he/she] does not enjoy [his/her] food. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the admission contract signed on 9/1/23 under section Dining/Meals/Guest Meals/Diet/Food from outside states, Special diets will be prepared if ordered by a physician. Any resident that chooses a diet different from what the physician has ordered, may have a regular diet order if he/she signs a waiver. The facilities Resident Diet Policy effective 1/1/2017 states: Should a patient fail to follow the therapeutic diet on a regular basis, the noncompliance will be documented, and the dietary director will advocate for the diet to be changed to regular. On 2/19/25 at 8:44 a.m., during an interview with 2 surveyors, the Director of food and dietary confirmed there are no residents with a current food waiver stating, they try not to because of their previous immediate Jeopardy (IJ), they don't want to end up in IJ again and the Physician and Nutritionist push everyone to be on a regular diet. 2. Review of the posted Minced and Moist and Puree menus for the 4-week meal rotation lacks an alternative option for all meals; Breakfast Lunch and Dinner. In addition, both the Minced and Moist and Puree Breakfast menus have oatmeal and eggs served every day of the week. On 2/19/25 at 11:12 a.m., during an interview with 4 surveyors, the DON stated the doctor had very clear conversation with the resident on the risks involved with eating foods outside of his/her diet. Surveyor asked about staff supervision while the resident is consuming these restricted foods, the DON stated, I don't have the staff to go in every hour and sit with [him/her] while [he/she] eats a cracker and doesn't dunk it in the milk. [He/she] would not follow Speech recommendations. At this time, the Surveyor discussed the admission contract which states a waiver would be given to residents who choose a different diet, reviewed speech recommendations for the resident to have foods outside of the diet with supervision, the MediTelecare note which states the resident experiences depression for not eating his/her favorite foods and the lack of alternative choices in meals for residents who have a minced and moist and puree diet. At this time, the DON confirmed resident #10 is his/her own decision maker and had not been offered a waiver for the diet of choice.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 37648 Based on record reviews and interviews, the facility failed to ensure that the clinical records were complete and contained accurate documentation for 1 of 4 residents review for respiratory care. (Resident #10) Findings: On 2/18/25 at 10:33 a.m., and at 2:10 p.m., observations of Resident #10 using a nasal cannula for his/her oxygen (O2) administration with the tubing dated 1/28/25. Review of Resident #10's provider order dated 12/2/24 instructs nursing to, change and date O2 and C-pap tubing Clean concentrator filter every night shift every Mon. Review of the medication administration record for January 2025 has documentation of the O2 nasal canula tubing being changed on 1/27. February 2025 record has documentation of the O2 nasal cannula tubing being changed on 2/3, 2/10 and 2/17. On 2/19/25 at 2:20 p.m., the above was discussed with the Administrator.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 37440 Based on record review and interview, the facility's Quality Assurance Committee failed to ensure that the Plan of Correction for identified deficiencies from the Annual Long Term Care Survey Process for Federal Recertification dated 12/12/23, were effective. The Federal citations F584, F623, F625, F689, and F806 were cited again during the annual Long Term Care Recertification Survey dated 2/20/25. Findings: During the Annual Long Term Care Survey Process for Federal Recertification dated 2/20/25, it was determined that F584, F623, F625, F689, and F806 would be recited for the same reasons: F584 for failure to adequately provide housekeeping and maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable environment; F623 failure to issue a written transfer/discharge notice to a Resident or their legal representative for a facility-initiated transfer/discharge; F625 failure to issue a written bed hold notice to include cost of care to the Resident and/or resident representative; F689 failure to ensure that the resident's environment was free of accident hazards relating to the storage of chemicals being properly secured; and F806 failure to provide food that accommodates the resident preferences and failed to provide a second-choice meal/alternative that is similar in nutritive value as the first-choice meal. On 2/20/25 at 12:28 p.m., during an interview, the above findings were discussed with the Administrator.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 37440 Based on review of the Quality Assessment and Assurance (QAA) attendance sheets and interview, the facility failed to ensure that an Infection Preventionist and the Director of Nursing attended 1 of 4 quarterly QAA meetings. Findings: A review of the quarterly QAA meeting attendance sheets indicated that the Director of Nursing did not attend the February 20, 2024 quarterly QAA meeting and an Infection Preventionist did not attend the June 4, 2024 quarterly QAA meeting. On 2/20/25 at 12:28 p.m., in an interview, the above was confirmed with the Administrator.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33639 Based on observation, record review, and interview, the facility failed to disinfect reusable resident equipment during medication administration for 2 of 4 residents observed during medication administration. In addition, the facility failed to implement infection prevention measures for 1 of 3 days of survey (2/20/25). Findings: 1. On 2/19/25 at 8:44 a.m., Certified Nursing Assistant (CNA)- Med Tech was observed taking a blood pressure (BP) with a BP cuff for Resident #10 with a reading of 97/60. The CNA-M removed the BP cuff and did not sanitize afterwards. On 2/19/25 at 9:13 a.m., Certified Nursing Assistant - Med Tech was observed taking a blood pressure with a BP cuff for Resident #31 with a reading of 109/79. The CNA-M removed the BP cuff and did not sanitize afterwards. During an interview on 2/19/25 at 9:22 a.m., the CNA-M indicated equipment should be cleaned in between residents with a sanitizing wipe but she forgot today. The facility policy Cleaning and Disinfecting Resident Care Items and Equipment revised 2/2022 Policy Interpretation and Implementation - 4. Reusable resident care equipment will be decontaminated and/or sterilized between residents. On 2/19/25 at 11:35 a.m., a surveyor discussed the above finding in an interview with the Administrator. 37440 2. On 2/20/25 at 9:40 a.m., during an environmental tour, a surveyor asked to go into Resident room [ROOM NUMBER] on the North wing and was told by the Maintenance Director that Resident #1 had Norovirus and that room is under contact precaution. The surveyor and the Maintenance Director observed no contact precaution sign stating that there was contact precaution or what staff needs to wear when going into that room. He said the room will not be cleaned until he is told by Nursing administration that the room is no longer on contact precaution. On 2/20/25 at 9:43, the Administrator observed resident room [ROOM NUMBER] with a surveyor and the Maintenance Director, stated the resident had been sent to the hospital and confirmed that there should be a contact precaution sign on the door. On 2/20/25 at 10:06 a.m., in an interview, the Infection Preventionist(IP0 confirmed that if a resident on Transmission Based Precaution(TBP) was sent to the hospital then the room stays shut with precaution signs on the door and remains on precautions. The IP went on to state that it is still a precaution room and there are germs in side of it and the 48 hours hasn't passed where that resident would be off precaution.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. 37440 Based on interviews, the facility failed to conduct regular inspection of all bed frames and mattresses as part of a regular maintenance program to ensure that the mattresses and bed frames are compatible and identify areas of possible entrapment for 1 of 37 beds.(Resident #11's) Finding: On 2/18/25 at 10:28 a.m., a surveyor observed Resident #11's bed and found the mattress was approximately 12 inches to short for the bed and left a large gap between the mattress and the footboard of the bed creating an area of possible entrapment. On 2/18/25 at 11:08 a.m., 2 surveyors observed Resident #11's bed and found the mattress was approximately 12 inches to short for the bed and left a large gap between the mattress and the footboard of the bed creating an area of possible entrapment. On 2/18/25 at 12:36 p.m., in an interview, the Maintenance Director confirmed the mattress was approximately 12 inches to short for the bed and left a large gap between the mattress and the footboard of the bed creating an area of possible entrapment. On 2/18/25 at 12:44 p.m., in an interview, a surveyor discussed the finding with the Administrator.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 51331 Based on Certified Nursing Assistant (CNA) employee education record review and interview, the facility failed to monitor and ensure that the CNA attended the required 12 hours of annual in-service education training for 5 of 5 randomly selected CNAs employed greater than 1 year. Furthermore the facility failed to ensure that the CNA attended the mandatory yearly dementia trainings for 3 of 5 CNA's employed greater than 1 year. (CNA#1, CNA#2, CNA#3, CNA#4, and CNA#5). On 2/20/25 a surveyor reviewed the following employee files: 1. CNA #1 was hired on 11/26/2018. Review of CNA #1 Employee In-service/attendance Records lacked evidence of dementia training along with the required 12 hours for continuing education for the year of 2024. 2. CNA #2 was hired on 7/31/2023. Review of CNA #2 Employee In-service/attendance Records lacked evidence of dementia training along with the required 12 hours for continuing education for the year of 2024. 3. CNA #3 was hired on 9/5/1991. Review of CNA #3 Employee In-service/attendance Records lacked evidence of the required 12 hours for continuing education for the year of 2024. 4. CNA #4 was hired on 7/31/2023. Review of CNA #4 Employee In-service/attendance Records lacked evidence of dementia training along with the required 12 hours for continuing education for the year of 2024. 5. CNA #5 was hired on 2/6/2017. Review of CNA #5 Employee In-service/attendance Records lacked evidence of the required 12 hours for continuing education for the year of 2024. On 2/20/25 at 11:47 a.m., During an interview with the Facility Administrator and 2 surveyors present, the above information was confirmed.