

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205031	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2024
NAME OF PROVIDER OR SUPPLIER Orono Commons		STREET ADDRESS, CITY, STATE, ZIP CODE 117 Bennoch Rd Orono, ME 04473	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>17282</p> <p>Based on record reviews and interviews the facility failed to respond to residents request for assistance in a manner that maintained or enhanced their dignity by not answering the call bells in a timely manner for 3 of 9 residents interviewed (Resident #18 [R18], R9, R4). In addition, the facility failed to provide morning bathing care for 1 of 1 sampled resident (R9) and facility failed to promote care for residents in a manner that maintains each resident's dignity and respect when staff failed to serve all residents seated at the same table at the same time for meal observations on 1 of 2 units (Homestead).</p> <p>Findings:</p> <p>1. On 5/19/24, R18's clinical record was reviewed. R18 was diagnosed with Cerebral Vascular Accident (CVA) with hemiplegia and hemiparesis, wheelchair dependent, and the care plan indicated R18 requires extensive assist with toileting.</p> <p>On 5/19/24 at 10:35 a.m., in an interview with the surveyor, R18 stated he/she rang the call bell at around 10:00 a.m. because they had to move their bowels and needed the bedpan right away. R18 stated a half an hour had past and no one has answered his/her call bell. R18 stated their anal area was on fire and it hurt. R18's call bell was observed being answered at 10:50 a.m., fifty minutes after R18 stated he/she turned the call bell on.</p> <p>2. On 5/19/24, R9's clinical record was reviewed. R9 was diagnosed with diabetes, atrial fibrillation, depression, anxiety and R9's Activity of Daily Living Toileting Task indicated R9 requires extensive to total assist with toileting.</p> <p>On 5/19/24 at 10:45 a.m., in an interview with the surveyor, Resident R9 stated that a couple weeks ago, he/she rang his/her call bell and waited for approximately an hour before someone answered it. R9 stated he/she couldn't hold it and was incontinent of bowel. R9 stated there aren't enough staff to answer call bells. R9 stated he/she has had other incontinent accidents waiting for the call bell to be answered. R9 also stated that he/she has not had a morning bath and likes to have a bath before noon and be clean.</p> <p>On 5/19/24 at 1:15 p.m., in an interview with the surveyor, Certified Nurse Assistant #4 (CNA4) stated she has not given R9 a morning bath because she had so much to do and not enough staff to help. She stated she will do the bath after lunch.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/20/24 at 8:00 a.m., in an interview with the surveyor, R9 stated he/she did not get a bath on 5/19/24 until after 3:00 p.m.</p> <p>35904</p> <p>3. On 5/20/24 at 10:00 a.m., in an interview with a surveyor, R4 stated that a couple of weeks ago he/she rang his/her call bell and waited for approximately one to two hours before someone answered it, mostly at night. R4 stated it's pretty rough if you gotta pee, have to hold it, and stated this happens a lot.</p> <p>33242</p> <p>4. On 5/20/24 8:45 a.m., R168 was observed sitting at table with another resident that was being assisted with eating by staff. R168 did not have his/her food. The CNA assisting the other resident stated that she had been assisting that resident while R168 had been there for 5 to 10 minutes. When asked if R168 was waiting for breakfast the whole time, the CNA stated yes; another CNA stated they were looking for R168's tray. At 8:52 a.m., dietary brought R168's tray up from the kitchen and staff apologized that it was late. On 5/20/24 at 8:57 a.m., during an interview with a surveyor, Homestead Unit Manager (HUM) stated that R168 had been at the table the whole time the other resident was being assisted with eating. R168's tray did not come up on either cart so HUM had to call down to the kitchen to get a breakfast tray.</p> <p>5. On 5/20/24 at 12:15 p.m., a surveyor observed multiple residents sitting around the bar area of the Homestead Unit eating lunch. A surveyor observed that 2 residents did not have their lunch trays. During an interview with a surveyor, CNA7 stated that they separate the tickets for the residents by where they usually eat and send them to the kitchen that way but they just don't always come up that way. She stated that R57 and R219 typically eat at the bar. All other residents seated at the bar area have their food except R57, and R219, the cart was not here with their trays. At 12:22, R57 received his/her tray and 12:26 p.m. , R219 received his/her tray.</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>33242</p> <p>Based on observation and interviews, the facility failed to ensure that a resident's preference for a second serving of the main meal choice for lunch was available on 5/21/24, for 1 of 1 residents (Resident #37 [R37]) reviewed for weight loss and received an appetite stimulant.</p> <p>Finding:</p> <p>On 5/21/24 a during lunch meal service on Homestead Unit, a surveyor observed that chop suey and salad was part of the main menu choice for lunch. R37 requested seconds because he/she did not get enough. A surveyor observed Certified Nursing Assistant #6 (C.N.A.6) call down to the kitchen and reported to R37 that there wasn't any left.</p> <p>On 5/21/24 at 1:10 p.m., during an interview with surveyors, the Food Service Director (FSD) stated that they ran out of the main meal choice of chop suey and salad. It is the last day before our delivery tomorrow, so we ran out, usually I would run to the store to buy lettuce but I couldn't because I was working as staff. Sometimes we do not have enough of something at the end of a supply period. We have a lot of double portions, we are not compensated double portions. We only made enough chop suey for everyone (one serving), we were unable to offer seconds. When we run out, we offer them off the alternative menu.</p> <p>On 5/22/24 at 8:05 a.m., C.N.A.6 stated that R37 did not want anything else other than the chop suey and salad so R37 did not get anything else to eat.</p> <p>R37's admission weight on 2/27/24 was 117.2 pounds (lbs). On 5/3/24, R37's most recent documented weight was 102.1 lbs, a 15.1 lbs weight loss in 2 months.</p> <p>On 3/22/24, a nutrition note was documented that stated R37's Body Mass Index (BMI) was 21.4, which is considered low for age. Would continue to work with resident to meet food preferences and encourage intake. May at some point need to consider an appetite stimulant. Registered Dietician (RD) to continue to monitor and evaluate as indicated. On 3/29/24, another nutrition note was documented, spoke with Speech Language Provider (SLP) and Provider, because R37 was refusing to eat. The Provider ordered Mirtazapine for appetite stimulant.</p> <p>On 5/21/24, R37's clinical record was reviewed. R37's care plan included a Nutrition care area that indicated, Resident is at nutritional risk: related to poor intake, which was initiated on 3/4/24 with an intervention to Honor food preferences within meal plan.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32540</p> <p>Based on observations and interview, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain an environment free from offensive odors for 2 of 3 days of survey (5/19/24 through 5/21/24) and to maintain the building in good repair and in a sanitary condition for 1 of 1 environmental tour (5/21/24).</p> <p>Findings:</p> <p>On 5/19/24 at 10:30 a.m., a surveyor observed a strong, foul odor of urine in the corridor outside room [ROOM NUMBER].</p> <p>On 5/19/24 at 10:45 a.m., in room [ROOM NUMBER]-1, in an interview with the surveyor, Resident #9 (R9) stated that almost every day a strong urine odor from the hall seeps into his/her room and is very unpleasant.</p> <p>On 5/19/24, between 10:30 a.m. and 1:15 p.m., a surveyor observed a lingering, strong, foul urine odor in the corridor outside room [ROOM NUMBER].</p> <p>On 5/20/24 at 7:30 a.m., in the corridor outside room [ROOM NUMBER], the strong, foul odor of urine continued and was observed throughout the day until 2:00 p.m. when the observations were stopped.</p> <p>On 05/21/24, between 2:10 p.m. and 2:29 p.m., a surveyor completed an environmental tour with the Director of Nursing, the Administrator, and the Maintenance Supervisor.</p> <p>The following findings were confirmed at the time of observations:</p> <p>At 2:15 p.m. during the tour, in the hallway near Rooms 133, and room [ROOM NUMBER] the strong odor of urine was confirmed with the Director of Nursing, the Administrator, and the Maintenance Supervisor.</p> <p>room [ROOM NUMBER], the floor tile had a torn section that was patched and had unsealed seams creating an uncleanable surface.</p> <p>room [ROOM NUMBER], the threshold has tear in the flooring which is unsealed creating an uncleanable surface.</p> <p>room [ROOM NUMBER], threshold has unsealed flooring creating an uncleanable surface.</p> <p>A wheelchair (K2-lite) being used on the Homestead unit has a torn armrest on the left side.</p> <p>room [ROOM NUMBER], the bathroom was observed to have flooring that was heavily soiled and stained around toilet.</p> <p>room [ROOM NUMBER], the bathroom was observed to be dirty and not homelike.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>room [ROOM NUMBER], the wheelchair in the room was observed to have torn armrests on the left and right side creating an uncleanable surface and the floor was noted to be sticky when you walked on it causing your shoes to stick to the floor, in the bathroom the toilet paper holder was missing a piece and was not attached to the wall, the walls had peeling/chipped paint and the sink top was peeling, all creating uncleanable surfaces.</p> <p>room [ROOM NUMBER], the baseboard heater was observed with chipped paint and the recliner chair was dirty.</p> <p>room [ROOM NUMBER], the bathroom had chipped paint on the walls and the wheelchair in the room had torn armrests on the left and right side creating an uncleanable surface.</p> <p>room [ROOM NUMBER], the bathroom walls had chipped paint and the recliner chair in the room had torn armrests.</p> <p>R38's recliner chair had torn armrest on the right and left side creating an uncleanable surface.</p> <p>R52's recliner chair had a torn back handle creating an uncleanable surface.</p> <p>R11's wheelchair had a torn armrest on the right side creating an uncleanable surface.</p> <p>In the large dining room on the Homestead unit a table had peeled top creating an uncleanable surface.</p>

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<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>33242</p> <p>Based on record reviews and interviews, the facility failed to notify the resident and/or resident representative in writing for the reason of a transfer/discharge from the facility, for 2 of 3 sampled residents reviewed for hospitalization (Resident #37 [R37], and R24). In addition, the facility failed to notify the Ombudsman of transfer/discharges since January 2024.</p> <p>Findings:</p> <p>1. On 5/21/24, R37's clinical record was reviewed and indicated that the resident was transferred to the hospital on 3/8/24 and admitted to the hospital. The clinical record lacked evidence of a written transfer/discharge notice being provided to the resident/resident representative. On 5/21/24 at 10:22 a.m., during an interview with a surveyor, the Market Clinical Advisor stated she was unable to find evidence that a written transfer/discharge notice had been given to the resident and/or representative.</p> <p>2. On 5/22/24, R24's clinical record was reviewed and indicated that the resident was transferred to the hospital on 12/4/23 and was admitted to the hospital. The clinical record lacked evidence of a written transfer/discharge notice being provided to the resident/resident representative. On 5/22/24 at 11:12 a.m., during an interview with a surveyor, the Senior Director of Nursing stated she was unable to find evidence of a written transfer/discharge notice had been given to the resident and/or representative.</p> <p>On 5/22/24 at 10:45 a.m., during an interview with a surveyor, the Director of Nursing stated the last time the Ombudsman received notification of transfer/discharges was in January.</p>		

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<p>F 0625</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>33242</p> <p>Based on record review and interview, the facility failed to notify the resident and/or the resident's representative in writing of a bed hold notice after a transfer/admission to an acute care hospital for 3 of 4 sampled residents reviewed that were sent to the hospital (Resident #37 [R37], R24, and R71).</p> <p>Findings:</p> <p>1. On 5/21/24, R37's clinical record was reviewed and indicated that the resident was transferred to the hospital on 3/8/24 and admitted to the hospital. The clinical record lacked evidence of a written bed hold notice being provided to the resident/resident representative. On 5/21/24 at 10:22 a.m., during an interview with a surveyor, the Market Clinical Advisor stated she was unable to find evidence that a written bed hold notice had been given to the resident and/or representative.</p> <p>2. On 5/22/24, R24's clinical record was reviewed and indicated that the resident was transferred to the hospital on 12/4/23 and was admitted to the hospital. The clinical record lacked evidence of a written bed hold notice being provided to the resident/resident representative. On 5/22/24 at 11:12 a.m., during an interview with a surveyor, the Senior Director of Nursing stated she was unable to find evidence that a written bed hold notice had been given to the resident and/or representative.</p> <p>49635</p> <p>3. On 5/22/24, review of R71's clinical record indicated the resident was transported to the hospital on 6/8/24 and admitted to the hospital. The bed hold notice in the record does not indicate that it was provided to R71's representative. On 5/22/24 at 12:27 p.m., in an interview with the Director of Nursing and the Senior Director of Nursing, the Director of Nursing stated she was unable to find evidence that the bed hold notice was provided to the resident representative. At this time a surveyor confirmed this finding.</p>		

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<p>F 0655</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33242</p> <p>Based on record reviews and interview, the facility failed to provide the resident and/or their representative with a summary of the baseline care plan for 4 of 5 residents reviewed for baseline care plans (Resident #37 [R37], R168, R63, and R270).</p> <p>Findings:</p> <p>1. On 5/19/24, R37's clinical record was reviewed which indicated R37 was admitted to the facility on [DATE]. There was no evidence in R37's clinical record that a copy of the baseline care plan summary was provided to the resident or his/her representative.</p> <p>2. On 5/21/24, R168's clinical record was reviewed which indicated R168 was admitted to the facility on [DATE]. There was no evidence in R168's clinical record that a copy of the baseline care plan summary was provided to the resident or his/her representative.</p> <p>On 5/21/24 between 10:25 a.m. and 10:31 a.m., during interviews with a surveyor, the Riverview Unit Manager she stated that during the care plan meetings, she currently does not and did not provide a copy of the baseline care plan to the resident or resident representative.</p> <p>49635</p> <p>3. On 5/20/24 record review indicated R63 was admitted on [DATE] with Hemiparesis (weakness or the inability to move one side of the body) following cerebral infarction affecting the right dominant side. The baseline care plan was completed on 4/16/24. The care plan identifies the resident is incontinent with potential for improved control or management of urinary elimination and includes the intervention assist the resident to the toilet at scheduled times i.e. (that is) upon rising, before meals, at HS (bedtime) and as needed.</p> <p>On 5/20/24 at 7:53 a.m., in an interview with a surveyor, R63 stated it can be hard to get help to the bathroom, by the time someone is able to come help, sometimes it is too late. R63 stated staff only assist R63 to the bathroom when the resident initiates the request.</p> <p>On 5/21/24 at 10:37 a.m., in an interview with a surveyor, the Director of Nursing stated it looks like the care plan was completed on 4/16/24. At this time the surveyor confirmed the care plan was not completed within 48 hours of admission.</p> <p>On 5/21/24 at 2:04 p.m., in an interview with a surveyor, Certified Nursing Assistant #8 (CNA8) stated the toileting schedule is not on R63's Kardex. CNA8 stated he was unaware of that being part of R63's care plan and believes the care plan should be updated as R63 is able to ring the call bell to use the bathroom. CNA8 stated he had not assisted R63 to the bathroom since approximately 10:00 a.m. At this time the surveyor confirmed with CNA8 that the toileting schedule on R63's care plan was not followed.</p> <p>(continued on next page)</p>

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F 0655 Level of Harm - Potential for minimal harm Residents Affected - Some	4. On 5/20/24 record review indicated R270 was admitted on [DATE] with Pneumonitis due to inhalation of food and vomit, autistic disorder, and reduced mobility. The baseline care plan was completed on 5/19/24 (4 days after admission). On 05/21/24 at 9:24 a.m., in an interview with the Director of Nursing, a surveyor confirmed that the base line care plan was not completed within 48 hours.		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>17282</p> <p>Based on record review and interview, the facility failed to develop a care plan for the area Post Traumatic Stress Syndrome (PTSD) for 1 of 1 sampled resident with a diagnosis of PTSD (Resident #18 [R18]).</p> <p>Finding:</p> <p>On 5/21/24, a review of R18's care plan, under the care problem of 'Resident/patient exhibits or is at risk for distressed/fluctuating mood symptoms related to: depression, anxiety, PTSD.' There was no documented evidence of a care plan developed to address the issues of PTSD.</p> <p>On 5/22/24 at 9:55 a.m., in an interview with the surveyor, the Director of Nursing (DON) stated she did not find a care plan for PTSD other than it being mentioned as one of the problems under fluctuating mood symptoms in the care plan. The DON stated the Licensed Social Worker (LSW) told the DON an assessment of R18's PTSD was not done. The DON confirmed there was no care plan for PTSD.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>33242</p> <p>Based on record reviews and interviews, the facility failed to complete neurological assessments as directed, failed to follow physician orders for obtaining vital signs, referrals, medication administration, and failed to order urgent/stat diagnostic testing timely for 6 of 10 sampled residents (Resident #37 [R37], R24, R68, R168, R26, and R71).</p> <p>Findings:</p> <p>The facility's policy, Neurological Evaluation, revised 2/1/23, directed staff to completed a neurological evaluation when a resident sustains an injury to the head, or face, and/or has an unwitnessed fall. Evaluations will be performed every 15 minutes for 2 hours, then every 30 minutes for 2 hours, then every 60 minutes for 4 hours, and then every 8 hours until at least 72 hours as elapsed.</p> <p>1. On 5/20/24, R37's clinical record was reviewed and included documentation that on 3/28/24 R37 was observed sitting on floor in-between the bed and nightstand and had a small bruise noted to forehead. On 5/20/24 at 10:18 a.m., during an interview with the Homestead Unit Manager, a surveyor confirmed that the Neurological Evaluation Flowsheet was not completed as directed for a resident who had a fall and hit their head.</p> <p>2. On 5/22/24, R24's clinical record was reviewed and included documentation that on 5/1/24, R24 had a fall and was found by staff on floor in the bathroom. R24 reported that he/she hit his/her head on the toilet. A surveyor reviewed the Neurological Evaluation Flowsheet and found that neuro checks were not completed as directed. On 5/22/24 at 11:00 a.m., during an interview with the Director of Nursing-Center Nurse Executive (DON), a surveyor confirmed this finding.</p> <p>3. On 5/20/24, R24's clinical record was reviewed and contained a physician order, dated 3/29/24, to administer Atenolol, a blood pressure medication, daily and to hold if systolic blood pressure is less than 110 or the heart rate is less than 60. On 5/21/24 at 8:50 a.m., a surveyor reviewed the clinical record with the Homestead Unit Manager (HUM) and was unable to find evidence that the vitals were taken daily, prior to the administration of the medication. The HUM stated the way the order was entered into the electronic system lacked evidence of a place to record the vitals prior to the administration of the medication. The surveyor confirmed this finding during this review.</p> <p>4. On 5/20/24, R24's clinical record was reviewed and contained a hand written order by the Medical Provider, dated 4/4/24, to complete orthostatic vital signs in the morning and to notify the provider if positive. This order was entered by staff into the electronic orders with the directions to take Blood Pressure while lying and take Blood Pressure while standing (which was not the way the Medical Provider wrote it). On 5/20/24 at 10:39 a.m., a surveyor and the HUM reviewed R24's documentation and the HUM stated that the orthostatic vital signs were not completed correctly. The HUM stated that vital signs should have been completed while R24 was lying and while sitting as R24 is unable to stand. The surveyor confirmed that the orthostatics were not completed correctly during this review.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5. On 5/21/24, R68's clinical record was reviewed and included a physician order, dated 10/31/23, for both an urgent wound clinic referral for progressive wounds with poor healing, and an order for an urgent vascular consult. The surveyor was only able to find a vascular clinic referral and visit which addressed the vascular wound concerns and not a wound clinic referral or visit for the non-vascular wounds (multiple pressure, moisture related and abrasions). On 5/22/24 at 8:31 a.m., during an interview with a surveyor, the DON stated she was unable to find where a wound consult was obtained other than the vascular consult.</p> <p>6. On 5/21/24, R168's clinical record was reviewed and included a physician order, dated 5/7/24, for Acetaminophen (analgesic pain reliever) Tablet 325 milligrams (mg), give 2 tablets every 4 hours as needed (PRN) for mild pain and if more than 3 doses in 48 hours to notify the provider. Do not exceed 3 grams (3000 mg) a day. On 5/9/24, a physician order was received that directed staff to administer 500 mg, give 2 tablets of Acetaminophen twice a day, at 9:00 a.m. and 5:00 p.m.</p> <p>A review of the clinical record indicated that on 5/10/24, R168 received the following Acetaminophen doses:</p> <p>1 dose of 325 mg x 2 tabs PRN at 2:13 a.m. = 650 mg</p> <p>1 dose of 500 mg x 2 tabs scheduled at 9:00 a.m. = 1000 mg</p> <p>1 dose of 325 mg x 2 tabs PRN at 2:45 p.m. = 650 mg</p> <p>1 dose of 500 mg x 2 tabs scheduled at 5:00 p.m. = 1000 mg</p> <p>On 5/21/24 at 11:03 a.m., during an interview with the DON, a surveyor confirmed that R168 received greater than 3000 mg of Acetaminophen in a 24 hour period.</p> <p>35904</p> <p>7. On 5/22/24, R26's clinical record was reviewed and contained information that on 4/9/24 R26 was standing at the table and then fell to the ground and landed on his/her right side. R26 complained of discomfort in his/her right arm and right leg. On 4/11/24 at 11:21 a.m. R26's electronic record contained an order by the Medical Provider to have an urgent/stat diagnostic CAT Scan of the right hip. The order summary stated, recent fall, x-rays of right hip in ED (emergency department) were negative for fracture but significant pain with hip flexion. Concern for occult hip fracture. The diagnostic CAT Scan was not ordered by the facility until 4/15/24, 4 days after the urgent/stat order. On 5/22/24 at 2:17 p.m., during an interview with the DON, a surveyor confirmed that the facility failed to follow the Medical Provider's order timely for an urgent/stat order for diagnostic CAT Scan right hip. The DON stated the facility staff did not see the order until 4/15/24, 4 days after the order was written by the provider.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>8. On 5/22/24, R26's clinical record was reviewed and included a physician order, dated 4/11/24, to give 5 units Novolog (insulin) SQ (subcutaneous) if glucose (blood sugar [BS]) greater than 300, before meals and at bedtime for DM (Diabetes Mellitus). On 4/13/24 at 7:00 a.m. BS was 288, Novolog 5 units SQ was given, at 11:00 a.m. BS was 245, Novolog 5 units SQ was given, and at 4:00 p.m. BS was 213, Novolog 5 units SQ was given. Novolog 5 units was given on 4/13/24 at 7:00 a.m., 11:00 a.m., and 4:00 p.m. when not needed. On 5/22/24 at 2:50 p.m., during an interview with the Minimum Data Set Coordinator, and the Senior Director of Nursing, a surveyor confirmed that R26 received three doses of insulin when not needed/ordered.</p> <p>49635</p> <p>9. On 5/22/24, review of R71's clinical record indicated an unwitnessed fall on 6/6/23. R71 was observed on the floor between the beds laying on R71's left side. The resident was unable to tell the staff what happened. Nurse notes indicated neurological evaluation were recommended by the provider and initiated.</p> <p>On 5/22/24 at 12:27 p.m., in an interview with the DON and the Senior Director of Nursing, a surveyor confirmed that the Neurological Evaluation Flowsheet was not completed as directed for R71, who had an unwitnessed fall.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>35904</p> <p>Based on record reviews, observation, and interviews, the facility failed to ensure that weekly pressure ulcer assessment documentation, used to monitor the healing progress of the wounds, were completed, failed to follow physician orders in obtaining a wound clinic referral, and failed to follow a care plan for 3 of 4 residents reviewed with pressure ulcers (Resident #15 [R15], R68, and R31).</p> <p>Findings:</p> <p>1. On 5/22/24, R15 clinical record was reviewed. Pressure wound documentation for wound #7, left gluteus; #8 right gluteus; and #9 left gluteus, were reviewed with the Riverview Unit Manager. The Wound Evaluation documentation in the clinical record lacked evidence of weekly assessments/evaluations for the week of 3/31/24-4/6/24 and 4/28/24-5/4/24.</p> <p>On 5/22/24 at 10:01 a.m., in an interview with the Riverview Unit Manager, a surveyor confirmed weekly pressure ulcer wound evaluation assessment/measurements for R15 were not done for the week of 3/31/24-4/6/24, and 4/28/24-5/4/24.</p> <p>33242</p> <p>2. On 5/21/24, R68's clinical record was reviewed and included a physician order, dated 10/31/23, for an urgent wound clinic referral for progressive wounds with poor healing. As of 10/31/23, the facility was treating multiple pressure wounds that included an unstageable on the coccyx, unstageable on the left lower back, a stage 2 in the genital region, and a deep tissue injury on the left heel. On 5/22/24 at 8:31 a.m., during an interview with a surveyor, the Director of Nursing (DON) stated she was unable to find where a wound clinic consult was obtained for R68's multiple pressure injuries.</p> <p>3. On 5/22/24, R31's clinical record was reviewed which indicated that R31 had a current stage II pressure injury to the left buttock that was first observed on 4/24/24. The surveyor was unable to find weekly (assessment) documentation for the week of 5/5/24 - 5/11/24. On 12:06 p.m. during an interview with the Senior Director of Nursing (SDN), a surveyor confirmed this finding. The SDN stated that it is the facility's practice to complete weekly assessments (which include measurements to monitor healing).</p> <p>In addition, R31's current careplan indicated that R31 should have had a redistribution cushion to his/her chair. On 5/22/24 at 12:28 p.m., during an observation of R31 seated in his/her chair and interview with the Homestead Unit Manager (HUM), a surveyor confirmed that R31 did not have a redistribution cushion in his/her chair. At 12:39 p.m., the HUM stated that R31 used to have a cushion but that the resident kept sliding and they sent the cushion for adjustment and no one knows where it went. The surveyor confirmed this finding.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33242</p> <p>Based on observations, record review, and interviews, the facility failed to follow its own policy for oxygen use and humidification, failed to ensure physician orders were followed for oxygen administration, failed to ensure that oxygen tubing was changed weekly, and failed to ensure that respiratory equipment was maintained in a clean manner for 4 of 4 days of survey (5/19/24-5/22/24) for Resident #168 (R168).</p> <p>Findings:</p> <p>The facility's policy and procedure for Oxygen:Nasal Cannula, revised 8/7/23, indicated the following:</p> <ul style="list-style-type: none"> - Verify order, -Determine if humidification is needed by using the table - 2 liters of oxygen per minute does not indicate the use for humidification, -Nasal cannula labeled with date of initial set-up, - If humidifier is used, label with date, - Replace disposable set-up every seven days, date and store in a treatment bag when not in use. <p>R168 was admitted to the facility on [DATE]. The physician orders contained an order, dated 5/7/24, to administer oxygen at 2 liters per minute. The clinical record lacked evidence of orders/treatments to use humidification, clean the concentrator, or change the tubings.</p> <ol style="list-style-type: none"> 1. On 5/19/24 at 12:14 p.m., a surveyor observed R168 sitting in a wheelchair and using portable oxygen. The oxygen tank regulator was set on 3 liters of oxygen per minute. 2. On 5/19/24 at 12:35 p.m., two surveyors observed the filter on R168's concentrator dusty and the oxygen tubing extension connector touching the floor. The surveyors also noted that there was a humidifier bottle attached to the concentrator that was not dated nor was the oxygen tubing extension dated. 3. On 5/19/24 at 2:34 p.m., during an interview with a surveyor, Licensed Practical Nurse #1 (LPN1) stated that she brought R168 back to his/her room and hooked up the nasal cannula tubing from the portable oxygen tank to the extension tubing that has hooked to the concentrator. LPN1 stated that she did not notice that the extension tubing connector had been on the floor and she did not use an alcohol wipe prior to connecting the extension to the tubing. LPN1 was not sure if housekeeping had been in the room prior to bringing R168 back to his/her room (surveyor noticed the room had been cleaned between observations). The surveyor confirmed with LPN1 that the tubing had been observed laying on the floor and had not been cleaned or changed prior to connecting to the nasal cannula. <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. On 5/20/24 at 8:46 a.m., a surveyor observed R168 sitting in a wheelchair and using portable oxygen. The oxygen tank regulator was set on 3 liters of oxygen per minute.</p> <p>5. On 5/20/24 at 10:49 a.m., a surveyor and the Homestead Unit Manager observed R168's portable oxygen regulator was set on 3 liters of oxygen per minute and not the physician ordered 2 liters per minute. The surveyor also confirmed that the concentrator filter was dusty and humidifier bottle that was connected to the concentrator, was not dated.</p> <p>6. On 5/21/24 at 11:25 a.m., during an interview with the Market Clinical Advisor, a surveyor confirmed there was no evidence of R168's oxygen tubing being changed weekly and that there was no order for the use of the humidifier bottle that was not dated. The facility's policy and procedure that was provided to the surveyor did not indicate the use of humidification based on R168's physician order for 2 liters per minute of oxygen.</p> <p>7. On 5/22/24 at 2:32 p.m., a surveyor observed the undated humidifier bottle still attached to R168's oxygen concentrator. The clinical record still lacked evidence of an order to use humidified oxygen.</p>

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>17282</p> <p>Based on record review and interview, the facility failed to identify a resident's current diagnosis of Post-Traumatic Stress Disorder (PTSD)/trauma to determine what trigger(s) might cause re-traumatization for 1 of 1 sampled resident reviewed with a current diagnosis of PTSD (Resident #18 [R18]).</p> <p>Finding:</p> <p>On 5/21/24, a review of R18's clinical record, in the Minimum Data Set (MDS) 3.0, Section I, Active Diagnoses, Psychiatric/Mood Disorder, I6100 was coded to indicate R18 had an active diagnosis for Post Traumatic Stress Syndrome (PTSD). The surveyor was unable to find information in the clinical record that indicated what R18's PTSD was caused by or what events might cause re-traumatization.</p> <p>On 5/22/24 at 9:55 a.m., in an interview with the surveyor, the Director of Nursing (DON) stated she did not find a care plan (goal and trauma interventions) for PTSD other than it being mentioned as one of the problems under fluctuating mood symptoms in the care plan. The DON confirmed the Licensed Social Worker (LSW) did not assess Resident #18's PTSD.</p>

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.</p> <p>35904</p> <p>Based on record reviews and interviews, the facility failed to ensure the physician reviewed the resident's total program of care, which included signing orders for medications and treatments listed on the Physician Orders (block orders) in a timely manner for 1 of 8 sampled residents (Residents #15 [R15]).</p> <p>Finding:</p> <p>Documentation in R15's clinical record stated that the Physician signed the Physician Orders (block orders) on 2/12/24. These orders were in effect for 60 days. The next Physician Orders (block orders), including a 10-day grace period, needed review and the Physician's signature by 4/22/24. The medical record lacked evidence that Physician reviewed and signed orders on or around 4/22/24. Documentation in R15's clinical record stated that the Physician signed the Physician Orders (block orders) on 5/21/24, 29 days late, including the 10-day grace period.</p> <p>On 5/22/24 at 1:13 p.m. in an interview with the Senior Director of Nursing, a surveyor confirmed the above finding.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>17282</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure sufficient direct care staff were scheduled and on duty to meet the needs of all 73 residents that reside on the Homestead and Riverview units. This has the potential to affect all residents that need assistance with Activities of Daily Living (ADL).</p> <p>Findings:</p> <p>1. On 5/19/24, R18's clinical record was reviewed. R18 was diagnosed with a Cerebral Vascular Accident (CVA) with hemiplegia and hemiparesis, wheelchair dependent, and the care plan indicated R18 requires extensive assist with toileting.</p> <p>On 5/19/24 at 10:35 a.m., in an interview with the surveyor, R18 stated he/she rang the call bell at around 10:00 a.m. because they had to move their bowels and needed the bedpan right away. R18 stated a half an hour had past and no one has answered his/her call bell. R18 stated their anal area was on fire and it hurt. R18's call bell was observed being answered at 10:50 a.m., fifty minutes after R18 stated he/she turned the call bell on.</p> <p>2. On 5/19/24, R9's clinical record was reviewed. R9 was diagnosed with diabetes, atrial fibrillation, depression, anxiety and R9's Activity of Daily Living Toileting Task indicated R9 requires extensive to total assist with toileting.</p> <p>On 5/19/24 at 10:45 a.m., in an interview with the surveyor, R9 stated that a couple weeks ago, she rang her call bell and waited for approximately an hour before someone answered it. R9 stated he/she couldn't hold it and was incontinent of bowel. R9 stated there aren't enough staff to answer call bells. R9 stated he/she has had other incontinent accidents waiting for the call bell to be answered. R9 also stated that he/she has not had a morning bath and likes to be clean and have a bath before noon.</p> <p>On 5/19/24 at 1:15 p.m., in an interview with the surveyor, Certified Nurse Assistant #4 (CNA4) stated she has not given R9 a morning bath because she had so much to do and not enough staff to help. She stated she will do the bath after lunch.</p> <p>On 5/20/24 at 8:00 a.m., in an interview with the surveyor, R9 stated he/she did not get a morning bath on 5/19/24 until after 3:00 p.m.</p> <p>3. On 5/21/24 at 9:15 a.m., in an interview with CNA4, she stated that there are days when she just barely gets her work done. CNA5 stated sometimes she skips her break to get things done. She stated on this past Friday, May seventeenth, there were two CNA's for forty residents. She stated bath were barely done and R9 did not get a bath the way she usually likes to have it done.</p> <p>33242</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. On 5/20/24 at 9:10 a.m., a surveyor observed CNA6 assisting R27 with breakfast. CNA7 needed to get a straw for R27's beverage and noticed R37's call light on. She went into R37's room who wanted his/her eggs warmed up. CNA6 proceeded to warm R37's eggs up and then another resident wanted their eggs warmed up too, so CNA6 did that too. CNA6 then returned back to R27 and apologized for being gone for so long and placed the straw in the beverage. During an interview with a surveyor, CNA6 stated that there was no one else available to do it and she needed to assist the others at the same time and not make them wait.</p> <p>32540</p> <p>5. On 5/21/24 at 10:44 a.m. during a resident council meeting R4 stated there are not enough staff. He/she knows this because they are supposed to be up before breakfast and he/she is not getting up before 10:00 a.m., this happens at least 1-2 times a week and it's because they don't have enough staff. R4 does have a care plan intervention that documents that it is important for him/her to engage in daily routines that are meaningful to him/her. One of the listed interventions it that he/she likes to get up in the morning between 7:00 a.m. and 9:00 a.m.</p> <p>6. On 5/21/24 at 10:46 during a resident council meeting R5 stated that there is not enough staff. They don't go without, but they must wait almost 1.5 hours to use the bathroom and that is not ok. It has become a regular thing to be shorthanded almost daily.</p> <p>35904</p> <p>7. On 5/20/24 at 10:00 a.m., in an interview with a surveyor, R4 stated that a couple of weeks ago he/she rang his/her call bell and waited for approximately one to two hours before someone answered it, and it happens mostly at night. R4 stated it's pretty rough if you gotta pee, have to hold it, and stated this happens a lot.</p>		

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<p>F 0730</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>17282</p> <p>Based on review of annual evaluations and interview, the facility failed to complete an annual performance evaluation for nurse aides at least every 12 months for 2 of 4 sampled Certified Nurse Assistants (CNA) employed greater than a year (CNA1, and CNA2).</p> <p>Findings:</p> <p>On 5/22/24 surveyors reviewed the employee files:</p> <p>1. CNA1 was hired on 2/1/20. There was no evidence that an annual performance evaluation was completed by 2/1/24. On 5/22/24 at 2:00 p.m., in an interview with the surveyor, the Director of Nursing (DON) stated she was unable to find any annual performance evaluations completed after 2022. She confirmed that CNA1 had not had an annual performance evaluation.</p> <p>2. CNA2 was hired on 8/14/17. There was no evidence that an annual performance evaluation was completed by 8/14/23. On 5/22/24 at 2:00 p.m., in an interview with the surveyor, the DON stated she was unable to find any annual performance evaluations completed after 2022. She confirmed that CNA2 had not had an annual performance evaluation.</p>

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>33242</p> <p>Based on observations and interview, the facility failed to post the nurse staffing information in a prominent place, readily accessible and visible to all residents, for 3 of 4 days of survey (5/19/24, 5/20/24, 5/21/24).</p> <p>Finding:</p> <p>On 5/19/24 through 5/21/24, surveyors observed that the nurse staffing information was not posted in a prominent place readily accessible and visible to residents. Surveyors observed the staff posting placed on a table in a room between the entrance door to the facility and an exit door out of the this room to the outdoors. This entrance door to this area was noted to be locked at times and staff had to use a code to allow visitors in or out of the building; a resident would have to be able to exit the entrance door in order to observe the posting that was placed on a table.</p> <p>On 5/21/24 at 3:00 p.m., during an interview with the Director of Nursing, a surveyor confirmed that the staff posting was not accessible to residents for reviewing.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>32540</p> <p>Based on observations and interviews, the facility failed to ensure opened insulin was labeled with an open date in 1 of 2 treatment carts (Homestead unit) and failed to remove expired medications from the supply available for use in 2 of 2 medication storage rooms (Homestead and Riverview units)</p> <p>Findings:</p> <p>On 5/19/24 at 11:16 a.m., a surveyor and a Licensed Practical Nurse (LPN1) observed a Basaglar KwikPen (Lantus) for Resident #35 that was in the treatment cart that did not have an open or discard date (Lantus is good for 28 days once opened and at room temperature).</p> <p>On 5/19/24 at 11:26 a.m. a surveyor and LPN1 observed the medication storage room on the Homestead Unit and found the following expired medications available for use:</p> <p>2 bottles of Stool Softener 100 milligram with expiration date of 4/2024.</p> <p>On 5/19/24 at 11:32 a surveyor and LPN2 observed the medication storage room on the Riverview Unit and found the following expired medications:</p> <p>2 bottles of Aspirin 325 milligram with an expiration date of 4/2024</p> <p>These findings were confirmed by the surveyor at the time of the observations.</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.</p> <p>49635</p> <p>Based on observations and interviews the facility failed to provide adequate dietary staff to ensure the dietary needs of residents were met timely for 3 of 4 days of survey (5/19/24, 5/20/24, and 5/21/24).</p> <p>Findings:</p> <p>Review of the posted meal times for Homestead dining room indicated breakfast is served at 8:00 a.m., lunch is served at 12:00 p.m., and dinner is served at 5:00 p.m.</p> <p>On 5/19/24 at 12:30 p.m., observation of lunch services in the Homestead dining room revealed residents in the dining room were served lunch one-half hour late. Meal trays were delivered to resident rooms up to 1:45 p.m., one and three quarter hours late.</p> <p>On 5/20/24 at 8:32 a.m., a surveyor observed breakfast trays arrived to the Homestead dining room one-half hour late.</p> <p>On 5/20/24 at 8:35 a.m., in an interview with surveyor, a resident stated, they are always late during the week, they are usually early on weekends.</p> <p>On 5/20/24 at 12:30 p.m., a surveyor observed lunch trays arriving to the Homestead dining room one-half hour late.</p> <p>On 5/21/24 at 8:32 a.m., a surveyor observed the breakfast trays arriving to the Homestead dining room one half hour late.</p> <p>On 5/21/24 at 12:35 p.m., a surveyor observed residents and nursing staff requesting more salad as not all residents received a salad. The Account Manager informed them it was all gone.</p> <p>On 5/21/24 at 12:55 p.m., in an interview with a surveyor, the Account Manager stated we are down 2 people today, the open part-time position, and a chef called out. She stated nursing staff have complained about meals not being on time as it makes it hard to plan morning care for residents; it can depend on who is working, we have one staff member who tends to slow things down. The Account Manager also stated they ran out of salad because she was unable go to the store for more ingredients; she was working as kitchen staff to replace the Chef that called out. At this time the surveyor confirmed there were not enough staff to ensure the dietary needs of residents were met timely.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>49635</p> <p>Based on interviews and observations, the facility failed to serve hot foods hot and cold food cold on 1 of 4 days of survey (5/21/24).</p> <p>Findings:</p> <p>On 5/19/24 at 11:36 a.m., during a resident interview they stated concerns regarding the temperature of meals.</p> <p>On 5/19/24 at 12:30 p.m., observation of lunch service revealed residents in the Homestead dining room were served one-half hour late. Meal trays were delivered to resident rooms up to 1:45 p.m., one and three quarter hours late.</p> <p>On 5/20/24 at 8:29 a.m., during a resident interview they stated meals are always late during the week, hot foods are not always hot.</p> <p>On 05/20/24 11:56 a.m., during a resident interview they stated the food is not always warm.</p> <p>On 5/21/24 at 12:55 p.m., two surveyors received test trays with American Chop Suey and Pineapple Crisp (cold dessert) with whipped topping. The temperature of the chop suey was 116.9 degrees Fahrenheit, and 116.8 degrees Fahrenheit. The temperature of the Pineapple Crisp for both trays was 66.8 degrees Fahrenheit. The hot and cold foods on the test trays were found not to be palatable at those temperatures by both surveyors. These findings were observed and confirmed with the Account Manager at the time of the findings.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49635</p> <p>Based on observations, and interviews, the facility failed to monitor food temperatures to prevent food borne illness prior to serving residents for 1 of 4 days of survey (5/19/24), failed to store, prepare, and serve food in accordance with professional standards for food service safety by not storing food in a sanitary manner for 2 of 4 days of survey (5/19/24, and 5/20/24) and failed to ensure that plumbing fixtures were properly installed to prevent backflow as required by the Maine State Plumbing Code on 4 of 4 days of survey (5/19/24, 5/20/24, 5/21/24, and 5/22/24). This has the potential to effect all residents in the facility.</p> <p>Findings:</p> <p>On 5/19/24 at 10:10 a.m., during the initial tour of the kitchen, a surveyor observed on the shelf and available for use in the dry storage:</p> <p>1 package- Lays Classic chips, opened and undated.</p> <p>1 package- white powder, open, unlabeled, and undated. The package was resting on the shelf with biscuit mix and pancake mix. Staff were unable to determined what was in the package.</p> <p>1 package - 4 pounds (lbs) Jello Cheesecake Filling mix, open and undated.</p> <p>3 condiment containers - contained a dark liquid substance later identified as syrup, unlabeled and undated.</p> <p>1 container- 5 lbs peanut butter, observed laying on its side, peanut butter residue on the outside of the container, lid not sealed.</p> <p>The floor in the dry storage was sticky with dark residue in the doorway. The Manager in Training stated, I think we just switched out the juice boxes. Next to the doorway was a juice pump system. The nozzle for a juice container was laying on the floor with a thick sticky substance covering the nozzle and tubing. A dark residual substance was visible inside the tubing in dependent locations. The tubing leading off the nozzle was attached to the same pump as 3 other juice containers.</p> <p>Observation of the walk-in refrigerator revealed on the shelf and available for use:</p> <p>1 package - 5lbs Casa [NAME] Grated Parmesan Cheese, facility sticker label on the package reads opened on 5/9 and labeled discard by 5/16.</p> <p>1 container- 16 ounces (oz) liquid egg whites, undated and open to the environment.</p> <p>Observation of the walk-in freezer revealed on the shelf and available for use:</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1- unlabeled and unidentified previously cooked meat wrapped in plastic wrap. The date 4/7 was written on the plastic wrap. Staff were unable to determine if 4/7 was the date it was cooked, the date it was placed in the freezer, or the date it should be discarded.</p> <p>1- package later determined to be hash browns, open and undated.</p> <p>1- package Italian Sausages open and undated.</p> <p>Observation of the stand-up freezer revealed:</p> <p>1 metal container- staff identified as ice cream, unlabeled and undated.</p> <p>1 package- Rich's pre-sheated pizza dough, undated and open to the environment.</p> <p>The above findings were confirmed with the Account Manager at the time of the observations.</p> <p>On 5/19/24 at 11:00 a.m., a surveyor observed improper air gaps on the drain line of a sink used for food preparation and the ice machine. This direct connection of wastewater and potable water was in violation of the 10-114 State of Maine Rules Chapter 226, definition Section A, which defines an Air-Gap Separation - A physical separation between the free-flowing discharge end of a potable water supply pipeline and an open or non-pressure receiving vessel. An air-gap separation shall be at least twice the diameter of the supply pipe measured vertically above the overflow rim of the vessel - in no case less than one inch (2.54 cm).</p> <p>The above was observed and confirmed with the Account Manager at the time of the finding.</p> <p>On 5/19/24 at 11:15 a.m., observation of Disaster Food Storage revealed on the shelf and available for use:</p> <p>12- 46 fluid (fl) oz bottles, Thick and Easy Clear Hydrolyte Honey Consistency, Use by Date 12/19/20</p> <p>2- 46 fl oz bottles, Thick and Easy Clear Hydrolyte Honey Consistency, Use by Date 9/2/23</p> <p>6- 46 fl oz bottles, Thick and Easy Clear Hydrolyte Honey Consistency, Use by Date 10/28/23</p> <p>2- 46 fl oz bottles, Thick and Easy Clear Hydrolyte Honey Consistency, Use by Date 7/19/23</p> <p>9- 15oz can, Thick-it Beef Stew Puree, Expiration date 3/16/23</p> <p>The above was observed and confirmed with the Account Manager at the time of the finding.</p> <p>On 05/19/24 at 12:10 p.m., a surveyor observed the [NAME] plating meals. The [NAME] stated he forgot to check food temperatures prior to serving. Observation of the temperature binder with the Account Manager revealed the last recorded food temperatures were taken on 5/2/24, seventeen days ago.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/19/24 at 12:50 p.m., in an interview with a surveyor, the [NAME] stated, I have not done them every day. I have done them most of the days, but I won't lie and say I've done it every day. At this time the surveyor confirmed that food temperatures were not taken consistently to prevent food borne illness prior to serving resident.</p> <p>On 5/20/24 at 7:15 a.m., a surveyor observed improper air gaps on the drain line of a sink used for food preparation and the ice machine, this was confirmed on observation with the Account Manager.</p> <p>On 05/20/24 at 7:20 a.m., A surveyor observed:</p> <p>1 package- sub rolls, open and undated</p> <p>1 package- of hamburger buns, open and undated</p> <p>1 package- unidentified white powder in the dry storage on shelf available for use open, unlabeled, and undated.</p> <p>On 5/20/24 at 7:25 a.m., in an interview with a surveyor, the Account Manager stated they should be dating the packages. At this time the surveyor confirmed the above findings.</p> <p>On 5/21/24 at 8:18 a.m., a surveyor observed improper air gaps on the drain line of a sink used for food preparation and the ice machine, this finding was confirmed with the Account Manager.</p> <p>On 5/22/24 at 9:00 a.m., a surveyor observed improper air gaps on the drain line of a sink used for food preparation and the ice machine, this finding was confirmed with the Account Manager.</p>

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>17282</p> <p>Based on employee file reviews and interview, the facility failed to implement and maintain an effective training program which includes, at a minimum, training on abuse for 1 of 4 Certified Nursing Assistants (CNA) reviewed (CNA3).</p> <p>Finding:</p> <p>On 5/22/24, the following employee record was reviewed:</p> <p>CNA3 was hired on 1/29/24. There was no documented abuse training completed by CNA3 in the employee file.</p> <p>On 5/22/24 at 3:09 p.m., in an interview with the surveyor, the Director of Nursing confirmed that she was unable to locate documentation indicating CNA3 completed her abuse training.</p>		