STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205114	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
High View Rehabilitation and Living Center	517 Riverview St Madawaska, ME 04756

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 - Few	Reasonably accommodate the needs and preferences of each resident. 32540 Based on interviews and observations, the facility failed to meet the reasonable needs of residents in the area of bed size for 1 of 35 residents reviewed for accommodation of needs (Resident #13 [R13]) Finding: On 3/31/25 at 2:00 p.m., a surveyor spoke to R13, he/she stated that his/her bed is too short for them and was told by the facility they would get a bed to fit him/her. R13 stated that it has not happened. Observation of the bed shows there is a 3-inch gap from the end of the mattress to the footboard with a rolled-up blanket to fill the gap. R13 is over 6 feet tall and the mattress on the bed is not long enough leaving a gap at the foot of the mattress where his/her feet hang over the edge of the mattress. On 3/31/25 at 2:19 p.m., a surveyor confirmed this finding during an interview with the Maintenance/Housekeeping/Laundry Supervisor and was told the facility has ordered R13 a longer mattress on this date.

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 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** 49635 Based on observations and interviews, the facility failed to maintain the building in good repair for 4 of 4 days of survey (3/31/25, 4/1/25, 4/2/25, and 4/3/25). Findings: On 3/31/25 at 11:22 a.m., a surveyor observed chipped paint around the room [ROOM NUMBER] placard, and the wall next to the nurse station door had a large un-painted area around a camera installation. On 4/1/25 at 8:08 a.m., during an interview with a surveyor and the Administrator, Resident #26's (R26) bathroom was observed. The bathroom had a large trash bag taped to the ceiling directing a steady leak of water into a trash barrel. Paint chips and insulation debris was observed in the standing water of the trash barrel. The Administrator stated it has been like that over the winter and will not be repaired until it is warmer outside. The Maintenance, Housekeeping, and Laundry Supervisor was able to redirect all the water into R26's bathroom (R26 does not use the bathroom). On 4/2/25 at 7:30 a.m., a surveyor observed the ceiling outside room [ROOM NUMBER] to be discolored, and large pieces of peeling paint were observed hanging down and an out of order sign was observed on the bathroom door in room [ROOM NUMBER]. At 7:51 a.m., during an interview with 2 surveyors, the Maintenance, Housekeeping, and Laundry Supervisor stated the resident in room [ROOM NUMBER] does not use the toilet, and the toilet has been out of order for 2 weeks due to a leaking seal. On 4/3/25 at 9:00 a.m., during a facility tour with a surveyor and the Maintenance, Housekeeping, and Laundry Supervisor, the following were observed and confirmed: -the transition strip, connecting the hall to the sitting area created uncleanable surfaces at the wall, and had accumulations of dirt /debris along the strip border; -the wall next to the nurse station door had a large un-painted area around a camera installation; -the wall around the room number placard for room [ROOM NUMBER] had chipped paint; -the ceiling outside of room [ROOM NUMBER] is discolored, and peeling paint observed hanging from the ceiling; -the resident bathroom in room [ROOM NUMBER] is out of order due to a leaking toilet; -the closet door of room [ROOM NUMBER] is displaced from the track, the track support is broken. The closet ceiling in room [ROOM NUMBER] is discolored with peeling paint. Paint chips observed on the resident's clothing below the ceiling damage; and (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-the resident bathroom in room [ROOM NUMBER] is observed with trash bag funnel taped to ceiling draining water into the trash barrel below. Paint chips and insulation debris observed in the standing water of the collection barrel.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 35904 Based on clinical record review and interviews, the facility failed to ensure physician orders were followed for 1 of 5 residents reviewed for unnecessary medications (Resident #27, [R27]). Finding: On 4/2/25 during a review of R27's clinical record, a telephone order on 3/21/25 at 17:57 (5:57 p.m.) stated, Eliquis (a blood thinner) oral tablet 2.5 m.g (milligram) give 1 tablet by mouth two times a day related to non-ST elevation MI (myocardial infarction [heart attack]) HOLD 3/22/25 06:00 a.m. - 3/24/25 14:00 (2:00 p. m.), Hold Date / Reason: procedure for wart removal on 3/24/25. Review of R27's medication administration record dated March 2025 stated, on 3/23/25 at 20:00 (8:00 p.m.) H (Hold). On 4/3/25 at 10:38 a.m. in an interview with a surveyor, the Director of Nursing (DON) stated that the Registered Nurse (RN) gave Eliquis to R27 on the evening of 3/23/25 when it should have been held, and the RN only noticed the hold order when she went to chart medication given. A review of Resident/Facility Notification Form to the provider on 3/24/25 stated, Resident's (R27's) Eliquis was on hold for 3/24/25 appointment to remove lesion. Med tech did not notice the hold on this med, and it was given. On 4/3/25 at 10:39 a.m., during an interview with a surveyor, the DON confirmed that Eliquis was given to R27 on the evening of 3/23/25 when the medication was supposed to be held. The failure to follow the providers orders to hold Eliquis for R27 prior to a medical procedure resulted in the cancellation and rescheduling of the medical procedure and necessity to hold the Eliquis a second time prior to a medical procedure.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 33242 Based on observations, review of facility's Bed Safety policy, clinical record reviews, and interviews, the facility failed to identify hazards in a resident's environment and implement interventions to prevent avoidable accidents/injuries. This failure resulted in Resident #3 (R3) obtaining a skin tear when hitting his/her right arm on the exposed, uncovered, square tubing on the bed frame that the mattress was not wide enough to cover, and failure to identify exposed areas of a bed frame that created a risk of entrapment for Resident #26 (R26). This created an Immediate Jeopardy (IJ) situation for all 35 residents. Findings: On 3/31/25, the facility census was 35; all 35 resident bed frames have a mattress, and 2 quarter size bed rails attached to the bed frames. On 3/31/25, the facility's Bed Safety policy, undated, was reviewed. The policy indicated the following: -To try to prevent deaths/injuries from the beds and related equipment (including the frame, mattress, side rails, headboard, footboard, and bed accessories), the facility shall promote the following approaches: -Inspection by maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment risks; - Review that gaps within the bed system are within the dimensions established by the Federal and Drug Administration (FDA) (See Bionix Bed System Measurement Device Instructions and www.Bionix.com). -Ensure that bed side rails are properly installed using the manufacturer's instructions and other pertinent safety guidance to ensure proper fit (e.g., avoid bowing, ensure proper distance from the headboard and footboard etc.); and - Identify additional safety measures for residents who have been identified as having a higher than usual risk for injury including entrapment (e.g. altered mental status, restlessness, etc.). -The maintenance department or designee shall provide a copy of inspections to the Administrator and report results to the Quality Assurance (QA) Committee for appropriate action. Copies of the inspection results and QA Committee recommendations shall be maintained by the Administrator and/or Safety Committee. -The staff shall report to the Director of Nursing and Administrator any deaths, serious illnesses and/or injuries resulting from a problem associated with a bed and related equipment including the bed frame, bed side rails, and mattresses. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-The Administrator shall ensure that reports are made to the Food and Drug Administration (FDA) or other appropriate agencies, in accordance with pertinent laws and regulations including the Safe Medical Devices Act. According to the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment document, published by the FDA on March 10, 2006, the FDA is recommending a dimensional limit of less than 120 millimeters (4 3/4 inches) for the area between the inside surface of the (bed) rail and the compressed mattress. 1. On 3/31/25 at 10:58 a.m., a surveyor observed a skin tear on R3's right arm. R3 stated that he/she fell on Saturday (3/29) and hit their arm on the bed frame as R3 pointed to an area of the bed frame; the surveyor observed that R3's mattress did not cover the bed frame, exposing a mechanical hinge, a screw, and sharp metal edges where plastic caps were missing. Review of R3's clinical record indicated that R3 self-reported to nursing that he/she had fallen in his/her room and hit the bed frame. On 3/31/25 at 11:44 a.m., a surveyor and the Director of Nursing (DON) observed R3's skin tear and the area of the bedframe that R3 hit their arm on. R3 stated to the DON that the bed frame was harder than his/her arm. The DON stated to R3 that someone would be in to clean up the injury and started treatment for R3's skin tear. On 3/31/25 at 1:10 p.m., the Maintenance/Housekeeping/Laundry Supervisor stated that the Administrator brought down a tool (Bionix Bed System Measurement Device) from the third floor, but he doesn't know how to use it or what the proper measurements are supposed to be (between mattress and bed side rail). The surveyor shared photos of R3 and R29's bed frames and mattresses with the Maintenance/Housekeeping/Laundry Supervisor at this time and confirmed the mattresses did not fit the bed frames. On 3/31/25 at 1:18 p.m., during an interview with the DON, a surveyor confirmed that R3's mattress does not fit the bed frame which allowed R3's arm to strike the square tubing on the bed frame that was not covered. On 3/31/25 at 2:19 p.m., two surveyors observed Maintenance/Housekeeping/Laundry Supervisor in the process of changing R3's bedframe. He stated it was one of the last beds in the facility this way and that the mattress was a 36 inch mattress on a 39 inch bed frame. On 4/2/25, R3's clinical record was reviewed; on 4/1/25 at 4:57 p.m., it was documented that R3's right forearm skin tear dressing was changed. There was serous drainage and during the wound dressing change, R3 reported pain 3/10. At 7:20 p.m., the skin tear measurements were documented as follows: the top measures 1.2 centimeters (cm) length (L) x 0.8 cm width (W), the middle skin tear measured 1.5 cm L x 0.7 cm W, and the bottom skin tear measured 0.5 cm L x 0.5 cm W and was superficial. The length of all 3 areas together measured 4 cm L x 0.8 cm W. 49635 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. On 3/31/25 at 11:32 a.m., 2 surveyors observed R26 lying in bed leaning toward his/her left side. The mattress did not appear to be compatible with the bed frame as several inches of bed frame was observed exposed on both sides of the mattress creating multiple areas for possible entrapment of body parts (See F909 for details). The bed rail at the height of the resident's head measured 10 inches from the mattress, this had the potential to cause death as a result of entrapment of body parts (See F700 for details). On 4/1/25 at 8:30 a.m., during an interview with 2 surveyors and the Maintenance/Housekeeping/Laundry Supervisor, R26's bed frame was observed to be wider than the mattress by a couple inches (improved compared to observation on 3/31/25). The Maintenance/Housekeeping/Laundry Supervisor stated he had narrowed the width of the bed frame this morning, and staff independently adjust bed equipment, and he doesn't know why. On 4/1/25 at 9:05 a.m., during an interview with a surveyor, the Administrator stated night staff have made changes such as switching out a resident's bed mattress without letting administrative staff know of the changes. At this time the surveyor confirmed that staff did not identify the risk for accidents / injuries associated with exposed bed frames around resident mattresses. The immediate jeopardy that began on 3/31/25 when the facility failed to identify hazards in a resident environment and implement interventions to prevent injury including the risk of death by entrapment of body parts. The Administrator was notified of the immediate jeopardy at 12:25 p.m. on 4/1/25. Please See F-000 Initial Comments related to the IJ removal plan.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 33242 Based on observations, manufacturer's instructions, facility policy review, and interview, the facility failed to provide oxygen therapy in a sanitary manner for 2 of 4 days of survey (2/10/25 and 2/11/25) for Resident #19 (R19). Finding: The manufacturer's instructions for Invacare Perfecto2 indicated that there is one cabinet filter located on the back of the cabinet; environmental conditions that may require more frequent inspection and cleaning of the filter include, but are not limited to: high dust, air pollutants, etc and to remove the filter and clean as needed. The facility's policy, Departmental (Respiratory Therapy)-Prevention of Infection, revised 3/2025, directed staff to wash filters from oxygen concentrators every seven days with soap and water. 1. On 4/01/25 at 10:21 a.m., a surveyor observed R19 wearing oxygen via nasal cannula and that the oxygen concentrator filter on the back of the machine was very dusty. 2. On 4/2/25 at 8:15 a.m., a surveyor observed that the oxygen concentrator filter on the back of the machine was very dusty. At 8:21 a.m., during an observation and interview with the Director of Nursing, a surveyor confirmed this finding.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 32540 Based on record review and interview, the facility failed to identify a resident's current diagnosis of Post-Traumatic Stress Disorder (PTSD) to determine what trigger(s) might cause re-traumatization for 1 of 1 sampled resident reviewed with a current diagnosis of PTSD (Resident #5 [R5]). Finding: On 4/2/25 during a clinical record review for R5, it was noted that R5 had a diagnosis of PTSD listed as an active diagnosis. Review of R5's care plan updated on 2/19/25 lacked evidence that a trauma informed care plan was established to include triggers for this resident's PTSD diagnoses. Review of R5's quarterly Minimum Data Set (MDS) 3.0, Section I, Active Diagnoses, Psychiatric/Mood Disorder, I6100 was coded to indicate R5 had an active diagnosis for Post Traumatic Stress Syndrome (PTSD). On 4/2/25 at approximately 1:30 p.m., during an interview with the Director of Nursing the surveyor confirmed that R5 did not have a trauma informed care plan.

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 49635 Based on observation, interview, and record review, the facility failed to ensure a resident's bed dimensions were appropriate for a resident resulting in a 10 inch gap between the mattress and the bed rail. This failure created the potential for bodily injury including death by entrapment of body parts, for 1 of 35 residents [Resident #26 (R26]. In addition to the resident in immediate jeopardy, the facility's failure to regularly inspect and monitor bed rails resulted in the potential for harm for 35 out of 35 residents with bed rails. Finding: According to the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment document, published by the FDA on March 10, 2006, the FDA is recommending a dimensional limit of less than 120 millimeters (4 3/4 inches) for the area between the inside surface of the (bed) rail and the compressed mattress. According to the clinical record, R26 is diagnosed with HEMIPLEGIA AND HEMIPARESIS (paralysis or severe loss of motor function on one side of the body) affecting the resident's left side, and osteoporosis (condition where bones become weak and brittle increasing the risk of fractures). The care plan indicates The resident has limited physical mobility [related to (r/t)] Stroke, and The resident is at risk for falls r/t Hemiparesis, Confusion Unaware of safety needs. Care plan interventions indicate that R26 is on fall precautions, requires fall mats on the floor beside the bed, R26 will use the bed rails for independent bed mobility, and R26 is dependent on 2 staff for turning and repositioning in bed. On 3/31/25 at 11:32 a.m., 2 surveyors observed R26 lying in bed leaning toward his/her left side. The mattress was observed to be smaller than the bed frame. The resident's left bed rail measured 10 inches from the mattress at resident's head level. The mattress was off set, creating a wedge shaped gap with the opening wider toward the top of the mattress. On 3/31/25 at 1:10 p.m., during an interview with a surveyor, the Maintenance/Housekeeping/Laundry Supervisor stated the facility has a tool to measure the bed rail gaps, but he does not know how to use it, or what the proper measurements are supposed to be (between mattress and bed side rail). At this time, the surveyor confirmed the mattresses did not fit the bed frame creating the potential for entrapment of body parts. The immediate jeopardy that began on 3/31/25 when the facility failed to ensure a resident's bed dimensions were appropriate for a resident resulting in a 10 inch gap between the mattress and the bed rail creating the potential for entrapment of body parts including the risk of death. The Administrator was notified of the immediate jeopardy at 12:25 p.m. on 4/1/25. Please See F-000 Initial Comments related to the IJ removal plan.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32540 Based on observations, interviews and record review, the facility failed to ensure the kitchen was maintained in a clean manner on 4 of 4 days of survey ([DATE], [DATE], [DATE], and [DATE]), the facility failed to label thawed nutritional shakes with a thaw date on 1 of 4 days of survey. ([DATE]), the facility failed to discard expired foods on 1 of 4 days of survey ([DATE]), the facility failed to label, and date opened foods for 1 of 4 days of survey ([DATE]). In addition, the facility failed to consistently monitor and document food temperatures for proper cooked temperatures and proper serving temperatures for 94 of 99 meals reviewed. (Food Temperature Log sheets for March and 2 days in April) Findings: On [DATE] at 10:50 a.m., during the initial tour of the kitchen a surveyor observed the following areas that were not clean: Under the dish storage rack there was a seam in the linoleum flooring that was raised and had dirt buildup. Under the stove there was a seam in the linoleum flooring that was raised and had dirt buildup. The wall behind the stove was observed to have food splatter and around the pipes on the back wall was a build up of dirt and grime. The wall behind the meat slicers was observed to have food splatter. The warewasher room (dishwasher room) on the clean side, the flooring was raised and had dirt build up, the tiles on the dirty side were soiled and had dirt build up in the grout lines. In the reach in cooler there were ,d+[DATE] fluid ounce thawed cartons of Mighty Shakes with directions to store frozen, thaw at or below 40 degrees Fahrenheit and use thawed produce within 14 days. There was a , d+[DATE] gallon of fat free milk with an expiration date of [DATE] that was available for use. In the walk-in refrigerator there were 5 containers of Yoplait plain yogurt 2 pounds each with a best by date of [DATE]. There were 3 containers of Ricotta Cheese 48 ounce each with a best by date of [DATE]. On the second shelf there was a steamtable pan that contained thawed meat wrapped in plastic with a label identifying the meat as Roast Beef with a use by label of [DATE]. (Food Service Supervisor (FSS) opened the plastic wrap, and the inner label identified the meat as a Pot Roast.) In the dry food storage area, there was an unopened bag with a label of 4 Season with a use by date of [DATE] (per interview with the FSS this would be the date it should have been discarded). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There were 12 bags of unlabeled/unidentified crumbs with no expiration date, there were 11 assorted bags of cereal that were not labeled or had expiration dates. On a serving cart, on the second shelf, was a bin containing 8 unlabeled bags of cereals with no expiration dates, and 3 opened bags with no labels or expiration dates. On [DATE] at 11:30 a.m. during an interview with the FSS the surveyor confirmed the above findings. On [DATE] at 11:00 a.m. during a meal prep and meal service observation the surveyor observed the FSS taking the cooked temperatures of the lunch meal. The surveyor asked the FSS for the facilities food temperature logs for previous meals. Upon reviewing the facilities food temperature logs for the month of March, the facility failed to consistently record cooked temperatures and serving temperatures for 94 out of 99 meals. The surveyor confirmed this finding during an interview with the FSS at 2:40 p.m.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49635 Based on observations, interviews, and record reviews, the facility's Quality Assurance Committee failed to ensure the plan of correction for identified deficiencies from the annual survey dated [DATE] was effective. Findings: At the annual recertification survey of [DATE] through [DATE], the following deficiencies were cited: F812, F880 and F883. During the annual recertification survey of [DATE] through [DATE], it was determined that F812, F880 and F883 would be cited again for the same issues: F812 was cited again for failure to ensure the kitchen was maintained in a clean and sanitary manner and failure to discard expired foods; F880 was cited again for failure to implement a water management program to monitor for and prevent the growth and spread of Legionella and other water-borne pathogens; and F883 was cited again for failure to offer the updated Pneumococcal vaccination to 3 of 5 residents. On [DATE] at 8:25 a.m., during an interview with a surveyor and the Administrator, repeat deficiencies were reviewed. The Administrator stated the plan of correction from the previous survey indicated monitoring for 3 months, monitoring was not continued beyond that time. At this time the surveyor confirmed the above finding.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205114	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
High View Rehabilitation and Living Center	517 Riverview St Madawaska, ME 04756

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 33242 Based on facility policy review and interviews, the facility failed to notify the Centers for Disease Control and Prevention (CDC) of an outbreak of Norovirus in the facility. In addition, based on review of the facility's Legionella Water Management Program and interview, the facility failed to fully develop and implement a water management program to monitor for and prevent the growth and spread of Legionella and other water-borne pathogens. Findings: The facility's policy, Reporting Communicable Diseases, revised 3/20/25, indicated that the Infection Preventionist is responsible for notifying the local, district, or state health department of confirmed cases of state-specific reportable diseases. The Maine CDC Notifiable diseases and Conditions List, dated 2/17/21, indicated that any cluster/outbreak of illness with potential public health significance needs to be reported. 1. On 3/31/25 at 10:15 a.m., the Administrator stated that the facility is experiencing what was thought to be an outbreak of Norovirus. On 3/31/25 at 3:59 p.m., during an interview with a surveyor, the Director of Nursing (DON) stated the CDC had not been notified of the outbreak. She also stated that they have not tested residents for Norovirus but five (5) residents have symptoms of nausea, vomiting, and diarrhea. On 4/1/25, the DON provided a statement that she had contacted the CDC and that she was advised that they are not required to test symptomatic individuals for Norovirus and to continue precautions per guidance. A line list of affected residents will be sent to the CDC when the outbreak is completed and that an outbreak of unknown etiology is reportable (to the CDC). On 4/2/25 at 2:10 p.m., during an interview with a surveyor, the Nurse Manager-Infection Preventionist stated she was away part of last week and that the DON filled her in on the communication with the CDC. 2. On 4/3/25, a review of the facility's Legionella Water Management Program was completed by the surveyor with the Administrator and Maintenance/Housekeeping/Laundry Supervisor. The program lacked evidence of testing protocols and acceptable ranges for control measures, documentation of the results of testing, and what corrective actions would be taken if control limits are not maintained. The program also lacked evidence of validating the effectiveness of the program by testing the water for Legionella/water pathogens.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 33242 Based on facility policy review, record reviews, Centers for Disease Control and Prevention (CDC) recommendations, and interview, the facility failed to offer the updated Pneumococcal vaccination to 3 of 5 residents (Resident #3 [R3], R22, and R29). Findings: The facility's policy, Pneumococcal Vaccine, revised 3/2025, indicated prior to or upon admission, residents will be assessed for eligibility to receive the Pneumococcal vaccine series and when indicated, are offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has completed the current recommended vaccine series. Assessments of Pneumococcal vaccination status are conducted within five (5) working days of the resident's admission if not conducted prior to admission. Administration of the Pneumococcal vaccines are made in accordance with current CDC recommendations at the time of the vaccination. On 4/3/25 at 9:10 a.m., during an interview with a surveyor, the Nurse Manager-Infection Preventionist stated she was unable to find information to indicate that R3, R22, and R29 were offered the most recent Pneumococcal vaccination, and that the facility does use the PneumoRecs VaxAdvisor: Vaccine Provider App | CDC tool to determine Pneumococcal vaccination recommendations. The following were confirmed at this time: 1. The documentation in R3's clinical record indicated that R3 received the Pneumococcal Conjugate Vaccine (PCV) 13 in 2019. The CDC recommendation was to give one dose of PCV20 or PCV21 at least 1 year after PCV13. 2. The documentation in R22's clinical record indicated that R22 received the PCV13 in 2015 and the Pneumococcal Polysaccharide Vaccine (PPV) 23 in 2011. The CDC recommendation was based on shared clinical decision-making, decide whether to administer one dose of PCV20 or PCV21 at least 5 years after the last pneumococcal vaccine dose. 3. The documentation in R29's clinical record indicated that R29 received the PCV13 in 2016 and the PPV23 in 2007. The CDC recommendation was based on shared clinical decision-making, decide whether to administer one dose of PCV20 or PCV21 at least 5 years after the last pneumococcal vaccine dose

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F 0909 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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. 49635 Based on observation, interview, and record review, the facility failed to identify the existing risk for entrapment of body parts through bed inspections, this failure created the potential for severe bodily injury including death by entrapment of body parts, for 3 of 35 residents [Resident #26 (R26), (R3) and (R13)]. In addition to the resident in immediate jeopardy, the facility's failure to implement an effective inspection of all resident bed equipment (bed frames, mattresses, and bed rails) to ensure that bed mattresses fit the bed frames to prevent entrapment of body parts, this has the potential to effect 35 out of 35 residents with bed rails. Findings: On 3/31/25, the facility's Bed Safety policy, undated, was reviewed. The policy indicated, to prevent deaths/injuries, maintenance staff would inspect all beds and related equipment to identify risks and problems including potential entrapment of body parts using the Bionix Bed System Measurement Device (Please see F689). 1. According to the clinical record, R26 is diagnosed with HEMIPLEGIA AND HEMIPARESIS (paralysis or severe loss of motor function on one side of the body) affecting the resident's left side, and osteoporosis (condition where bones become weak and brittle increasing the risk of fractures). The care plan indicates The resident has limited physical mobility [related to (r/t)] Stroke, and The resident is at risk for falls r/t Hemiparesis, Confusion Unaware of safety needs. Care plan interventions indicate that R26 is on fall precautions, requires fall mats on the floor beside the bed, R26 will use the bed rails for independent bed mobility, and R26 is dependent on 2 staff for turning and repositioning in bed. On 3/31/25 at 11:32 a.m., 2 surveyors observed R26 lying in bed leaning toward his/her left side. The mattress did not appear to be compatible with the bed frame. The bed frame had exposed square holes measuring 4 inches by 5 inches along the lower end of the bed frame on both sides of the mattress creating the risk for entrapment of body parts. On R26's left side at his/her waist level, the bed frame had rectangular openings creating risk for entrapment of body parts. The bed rail at the height of the resident's head measured 10 inches from the mattress, creating the risk of entrapment of body parts (See F700 details). 2. On 3/31/25 at 11:22 a.m., 2 surveyors observed a skin tear on R3's right upper forearm. R3's mattress observed to be smaller than the bed frame, exposing a mechanical hinge, a screw, and sharp metal edges where plastic caps are missing. At 2:19 p.m., the Maintenance/Housekeeping/Laundry Supervisor stated the mattress does not fit the frame, the mattress is 36 inches, and the frame is 39 inches (See F689 for details). 3. On 3/31/25 at 2:00 p.m., a surveyor observed R13's mattress length was not compatible with the length of the bed frame creating a 3 inch gap between the end of the mattress and the foot board (See F558 for details). (continued on next page)

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F 0909 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 3/31/25 at 1:10 p.m., during an interview with a surveyor, the Maintenance/Housekeeping/Laundry Supervisor stated the facility has a tool to measure the bed rail gaps, but he does not know how to use it, or what the proper measurements are supposed to be (between mattress and bed side rail). He stated bed inspections were recently completed but he was not sure what the inspection included. On 4/1/25 at 7:15 a.m., during an interview with a surveyor, the Administrator stated the recent bed inspections only evaluated the electrical mechanics of resident beds. At this time a surveyor confirmed that bed inspections did not evaluate bed mattress and bed frame compatibility or identify areas of possible entrapment. The immediate jeopardy that began on 3/31/25 when the facility failed to implement an effective inspection of all resident bed equipment or identify the existing risk for entrapment of body parts. The Administrator was notified of the immediate jeopardy at 12:25 p.m. on 4/1/25. Please See F-000 Initial Comments related to the IJ removal plan.