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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterville Center for Health and Rehab	7 Highwood St Waterville, ME 04901

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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 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** Based on observations and interviews, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable environment on 3 of 4 Units (Harbor, Cove and Memory Care). Findings:1. On 8/25/25 at 12:09 p.m., a surveyor and the Memory Unit Manager observed, in Resident room [ROOM NUMBER]-R, a soiled wedge cushion against the wall across from Resident #86's bed and that both Resident #86's wheelchair armrests were ripped. At this time, in an interview with a surveyor, the Memory Unit Manager confirmed the findings. 2. On 8/25/25 at 12:15 p.m., two surveyors observed food particles and debris in two lower cabinets in the kitchenette on Cove Unit. On 8/25/25 at 12:20 p.m., in an interview with two surveyors present, the Cove Unit Manager confirmed the findings. 3. On 8/27/25 at 3:04 p.m., a surveyor and the Harbor Unit Manager observed the following findings:- Resident room [ROOM NUMBER] - There were two wall fans that were heavily soiled with dust and were both blowing on Resident #10.- Resident room [ROOM NUMBER] - There was a wall fan at the foot of Resident #6's bed that was heavily soiled with dust. At this time, in an interview with a surveyor, the Harbor Unit Manager confirmed the findings. 4. On 8/28/25 from 10:50 a.m. to 11:20 a.m., a surveyor did an Environmental Tour with the Administrator and the Director of Facility Operations in which the following findings were observed/discussed: - Resident room [ROOM NUMBER] - The bathroom floor had six floor tiles that were dirty and stained under the toilet. The room's metal baseboard heater cover was broken apart and hanging down. Resident #81's wheelchair brakes, where they hook to the wheelchair, had white tape on them that was dirty and stained a brownish color. On 8/28/25 at 11:20 a.m., in an interview with a surveyor, the Administrator and the Director of Facility Operations confirmed the findings.

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, interviews, and a review of Safety Data Sheets (SDS), the facility failed to ensure that the resident's environment was free of accident hazards relating to the unsecured storage of a container of germicidal disposable wipes for 1 of 4 days of survey. (8/25/25), In addition the facility failed to provide adequate supervision resulting in a resident elopement for 1 of 1 residents reviewed (Resident #3 [R3]). Findings: 1. The Safety Data Sheet for Sani-Cloth Germicidal Disposable Wipes stated the following: 5. Emergency and First Aid Procedure: Skin Contact: If rash or irritation develops, discontinue use. Eye Contact: Flush with cool water for 15 minutes. Inhalation: Remove to fresh air. Ingestion: Consult Physician. On 8/25/25 at 12:15 p.m., two surveyors observed a 1 pound 13 ounce container of Sani-Cloth Germicidal Disposable Wipes in a lower, unlocked cabinet in the kitchenette on the Cove Unit. This was accessible to residents. On 8/25/25 at 12:20 p.m., in an interview with two surveyors present, the Cove Unit Manager confirmed the finding. 2. R3 resides on the secured Memory Care Unit and has diagnoses to include dementia, anxiety, and disorganized schizophrenia. During observations on 8/25/25 at 3:45 p.m., and 8/27/25 at 8:28 a.m., R3 was observed aimlessly wandering around the secured Memory Care Unit with a helmet on. Review of R3's care plan updated 8/5/25 states Focus: R3 is an elopement risk/wander due to dementia, impaired safety awareness and Resident wanders aimlessly. Goal: .safety will be maintained through the next review date. Intervention: Distract me from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. I identify pattern of wandering: is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. On 8/28/25 at 8:15 a.m., a surveyor pushed the elevator button in the lobby on the first floor. The elevator door opened and the surveyor observed R3 in the elevator, aimlessly walking in circles with no helmet on. At this time surveyor called out for Business Office Manager (BOM) who was at the reception desk to come help get R3 back up to the secured unit. During an interview on 8/28/25 at 9:09 a.m., Certified Nursing Assistant (CNA) stated they were passing breakfast trays this am, and R3 was wandering over by the elevator but he did not notice anyone getting off the elevator and had no idea how R3 got in the elevator. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/28/25 at 9:10 a.m., Licensed Practical Nurse (LPN) stated that R3 did wander a lot and was able to confirm R3 most likely got onto the elevator after another family member came up to the third floor and did not make sure that the elevator doors closed before they walked away. At this time LPN confirmed R3 was most likely stuck in the elevator for approximately 10 minutes before the surveyor noticed him. During an interview on 8/28/25 at 9:11 a.m., a family member stated he/she arrived at the unit around 8:05 a.m., and did notice Resident 3 by the elevators, but did not wait for the elevator doors to close before going to visit with his/her family member. During an interview on 8/28/25 at 8:25 a.m., the Administrator stated she was already aware of the above findings.

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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. Based on observations and interviews, the facility failed to ensure the kitchen/kitchenettes were maintained in a clean and sanitary manner for fans, air conditioners, a food mixer, air vents, and walls. Additionally, the facility failed to ensure that foods were stored, dated and labeled properly for 2 of 6 kitchen/kitchenettes tours (Cove Unit Kitchenette and Kitchen)Findings:The facility's Food Receiving and Storage policy, revised October 2017, noted under Policy Interpretation and Implementation:7. Dry foods that are stored in bins will be removed from original packaging, labeled and dated (used by date).8. All food stored in the refrigerator or freezer will be covered, labeled and dated (used by date). 1. On 8/25/2025 at 11:30 a.m., a surveyor observed the following findings in the Cove Unit kitchenette: - The far right upper cupboard had a plastic bottle of grape jelly and a jar of strawberry preserves, which had been previously opened and used, with directions to refrigerate after opening.- The kitchenette had no drinking cups and the staff were using paper cups to serve residents beverages. On 8/25/2025 at 11:40 a.m., in an interview with a surveyor, the Cove Unit Manager confirmed that the grape jelly and strawberry preserves should have been refrigerated and that residents were using paper cups. 2. On 8/25/25 from 11:15 a.m. to 11:45 a.m., a surveyor completed a Kitchen Tour with the Food Service Director in which the following findings were observed:-The box floor fan, by the office, was dusty/dirty.-The box floor fan by the coffee machine was dusty/dirty.-The dish room ceiling air vent, by the clean dish rack, was dusty/dirty. -There were two wall mounted air conditioning units, by the three bay sink, that were heavily soiled with dust.-The wall behind the steamer unit was heavily soiled with dried liquid residue.-The food mixer had chipped/missing paint and dried food particles on the mix arm and base.-The circular fan, by a food preparation area, was dusty/dirty.-The dry storage area had eight large bags of cornbread mix that were not dated.-The walk-in freezer had a bag of French toast, two packages of hot dog buns and two packages of Eggos that were not dated and labeled.On 8/25/25 at 11:45 a.m., in an interview with a surveyor, the Food Service Director confirmed the findings.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observations and interviews, the facility failed to ensure that garbage and refuse were disposed of in a manner to prevent pest infestation for 3 of 4 survey days. (8/25/25, 8/26/25 and 8/27/25) Findings:1. On 8/25/25 at 1:00 p.m., a surveyor observed loose trash in a wheeled cart without a lid and a dumpster that had the back top lid open exposing trash, outside the kitchen area. 2. On 8/26/25 at 1:30 p.m., a surveyor observed loose trash in a wheeled cart without a lid and a dumpster that had the back top lid open exposing trash, outside the kitchen area.3. On 8/27/25 at 8:05 a.m., a surveyor and the Food Service Director observed loose trash in a wheeled cart without a lid and a dumpster that had the back top lid open exposing trash, outside the kitchen area. At this time, in an interview with a surveyor, the Food Service Director confirmed the findings.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, record reviews, and interviews, the facility failed to ensure that clinical records were complete and contained accurate information for 6 of 33 sampled residents (Resident #5 [R5], R7, R13, R4, R86, and R48). Findings: 1. Review of Resident #5's medical record stated in the current care plan: Range of motion[ROM] (active or passive) with am/pm care daily. ON HOLD WHILE GETTING THERAPY Date Initiated: 09/12/2024 Revision on: 05/27/2025. The medical record lacked evidence that Range of motion (active or passive) was documented twice daily for the following dates in 2025: June: 1, 3, and 4. July: 1, 2, 4-10, 13, 15, 16, 18, 20, and 25. The clinical record lacks documentation that the resident completed or refused ROM exercises. August 1, 2, 7-9, 11, 14, 16-19, 21, 22, and 23-26. The clinical record lacks documentation that the resident completed or refused ROM exercises. Bathing documentation shows missing/inaccurate documentation with no resident baths given and no resident refusal for the following dates in 2025: June: 3, 12, 19, and 26. July: 10, 24 and 31 August: 10, 24 and 31. On 8/27/2025 at 3:54 p.m., in an interview with a surveyor, the Cove Unit Manager and the Administrator confirmed that there was missing/inaccurate documentation on the resident's ROM and Bathing Documentation. 2. Review of Resident #7's medical record indicated R7 receives a bath/shower on Mondays and Thursdays. Bathing documentation shows missing/inaccurate documentation with no resident baths given and no resident refusal for the following dates in 2025: June: 2, 5, 9, 12, 16, 26, and 30. August: 2, 5, 9, 12, 16 and 26. On 8/28/2025 at 2:30 p.m., in an interview with five surveyors present, the Director of Nursing and the Administrator stated that charting/documentation was not completed accurately and it should have been completed accurately in the resident's clinical records. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 8/26/25 at 8:15 a.m., during an observation of R13's room, the Memory Unit Manager (UM1) entered the room with a surveyor and encouraged R13 to drink fluids from his/her breakfast tray and stated that R13 needs frequent encouragement because he/she forgets to drink fluids. UM1 then stated that R13’s blood pressure is low today, and he/she is complaining of feeling dizzy, so the doctor will be seeing him/her today. Review of R13’s care plan states “…at risk for fluid volume deficit .Monitor/document/report to MD [Medical Doctor] PRN [as needed] s/sx [signs/symptoms] of dehydration…” Review of R13’s clinical record revealed a physician progress note, dated 8/27/25, that states, .seen today for an acute visit for hypotension. This morning [he/she] was reported to have blood pressure of 80s/50s. [He/she] felt lightheaded. Staff encouraged oral fluids and [his/her] blood pressures normalized. [He/she] is now asymptomatic…” Further review of R13’s clinical record revealed his/her last documented blood pressure was 119/84 on 8/5/25, and the clinical record lacked evidence of the low blood pressure taken on 8/26/25 for the above symptoms. On 8/27/25 at 8:56 a.m., during an interview, Licensed Practical Nurse #1 (LPN1) stated she took R13's blood pressure yesterday, and it was low, so she encouraged fluids and re-checked the blood pressure, and it improved and that she verbally notified the physician. LPN1 then stated she did not document the initial low blood pressure, the re-check, or that she notified the physician. At this time, a surveyor discussed the above concerns with UM1. At this time, UM1 stated that vital signs are documented in the electronic medical record (EMR) and that R13’s blood pressures and a nursing progress note should have been documented in the EMR. 4. R4 has diagnoses to include dementia with behavior disturbance and bladder incontinence. Review of R4’s clinical record revealed a physician progress note dated 8/12/25 that states, “…Assessment and Plan…Presumed urinary infection. Patient is incontinent. Patient reports feeling ill today but is unable to articulate why. Physical exam revealed suprapubic tenderness without rebound or guarding. Ordered UA [urinalysis] with reflex culture to evaluate for possible UTI [urinary tract infection] . Review of R4’s active physician orders revealed an order dated 8/12/25 for .UA with reflex culture; suprapubic tenderness on exam + reports of feeling fatigued/ill . Further review of R4’s clinical record lacked evidence of urinalysis results or that the urine sample was collected and sent or that the resident refused. On 8/27/25 at 8:52 a.m., during an interview, LPN1 stated R4 was combative with the attempt to collect the urine sample, and she was unable to obtain a sample, so she passed it onto the night nurse, who was also unable to obtain a sample. LPN1 then stated she notified Nurse Practitioner (NP) 1 that the specimen was unable to be obtained. At this time, a surveyor discussed the above finding with UM1, and she stated it is her expectation that the nurse enter a nursing progress note to reflect the refusal(s) and that the provider was notified. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. R86 has diagnoses to include dementia. R86’s care plan states, .has a POA [Power of Attorney]-Care and POA Financial .has a POA that will remain in effect through next review date . Review of R86’s Interdisciplinary Team (IDT) meeting note, dated 7/17/25, indicates R86’s “…[representative]/POA attended via phone…” and states, .Advanced Directives reviewed, no changes at this time . Further review of R86’s clinical record lacked evidence of POA documentation or Advance Directive documentation. On 8/27/25 at 9:10 a.m., the above finding was discussed with the Memory Unit Social Worker (SW). At this time, the SW stated R86's [representative] is not his/her POA, that R86 does not have an Advance Directive, and that the IDT meeting note and care plan are labeled wrong. 6. Review of R48’s clinical record revealed a nursing Change in Condition (CIC) Evaluation, dated 8/1/25, that indicated R48 sustained an unwitnessed fall at 4:15 p.m. The assessment section of the CIC Evaluation indicated the most recent vital signs taken after the change in condition occurred were documented at 4:10 p.m. Review of R48’s Neurologic Screen Form, dated 8/1/25, indicated that neuro checks were not initiated until 6:00 p.m., however, the vital signs documented under the 6:00 p.m. entry on the Neurologic Screen Form are identical to the vital signs documented at 4:10 p.m. on the CIC Evaluation. Review of the Incident Report for the above fall, dated 8/1/25 at 6:00 p.m., lacked evidence of the actual time of R48’s fall. On 8/28/25 between 9:12 a.m.-10:13 a.m., during an interview, the Director of Nursing reviewed R48's entire clinical record and confirmed that it does does not accurately reflect the time of R48’s fall and stated that she cannot determine what time R48 fell or if neurologic checks should have been started at 4:10 p.m. or 6:00 p.m.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record reviews and interviews, the facility failed to ensure that the resident and/or resident representative was provided with written information concerning the right to formulate an advanced directive for 4 of 33 residents reviewed (Residents R43, R74, R73 and R58). Findings: 1. Resident #43 was admitted in July of 2025. A review of the entire electronic record lacked evidence that the facility offered or provided the resident and/or resident representative with written information concerning the right to formulate an advanced directive. 2. Resident #74 was admitted in July of 2025. A review of the entire electronic record lacked evidence that the facility offered or provided the resident and/or resident representative with written information concerning the right to formulate an advanced directive. On 8/26/25 at 1:35 p.m., in an interview with 5 surveyors present, the Social Services Director confirmed that the residents did not have and/or did not decline an Advance Directives. 3. On 8/26/25 the clinical record for R73 was reviewed. The clinical record lacked evidence that the facility offered or provided the resident and/or resident representative with written information concerning the right to formulate an advanced directive. 4. On 8/26/25 the clinical record for R58 was reviewed. The clinical record lacked evidence that the facility offered or provided the resident and/or resident representative with written information concerning the right to formulate an advanced directive. On 8/26/25 at 2:03 p.m., during an interview with the Social Services Director, the surveyor confirmed the facility failed to offer or provide the residents and/or resident representatives with written information concerning the right to formulate an advanced directive.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interviews, the facility failed to ensure that a resident's physician was notified of the discontinuance of a medical device that uses negative pressure to promote wound healing (Wound Vacuum-Assisted Closure [Wound VAC]) for 1 of 1 resident reviewed for notification of change. (Resident #111 [R111]). Finding: On 8/27/25, during a clinical record review for R111, Documentation indicates he/she was admitted with an order for a wound vac. Review of a Health Status Note, dated 7/9/25 at midnight, shows documentation that at 11:30 p.m. on 7/8/25, R111's wound vac canister was full and needed to be changed. The nurse was unable to replace the canister and discontinued the wound vac. She then applied a wet to dry dressing, covered it with an abdominal pad, and secured it with Kerlix. Upon further review of R111's clinical record there is no evidence that his/her physician was made aware of the discontinuation of the wound vac and did not provide an order for the wet to dry dressing that was applied. A Provider's progress note, dated 7/9/25, indicated the wound vac was still applied when it was documented as being removed at 11:30 p.m. on 7/8/25. This shows the Provider was not aware of the discontinuation of the wound vac treatment. On 8/28/25, during an interview with a surveyor, R111's primary Provider stated that she was not made aware of the wound vac being removed until she saw R111 on 7/11/25. Her progress note dated 7/11/25 documents the wound vac was reapplied the evening prior on 7/10/25. On 8/28/25 at 12:00 p.m. during an interview with the Director of Nursing and the Unit Manager for Cove and Harbor units, the surveyor confirmed that the facility did not have the needed wound vac supplies to continue with a wound vac treatment for R111, the Provider was not made aware of the discontinuance of the wound vac, and a nurse started a treatment for the wet to dry dressing without a physician order.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on interviews and record review, the facility failed to develop and/or implement an effective discharge planning process by failing to send referrals to appropriate entities timely, to involve the interdisciplinary team in discharge planning process, and to update the comprehensive care plan with goals and preferences regarding discharge, with referrals to appropriate entities made for this purpose and /or responses to information received from referrals to appropriate entities, for 1 of 4 residents reviewed for Discharge (Resident #88 [R88]).Findings: On 8/25/25 at 2:24 p.m., during an interview with a surveyor, R88 stated he/she has wanted to transfer to another facility for the past 3 years but has not had the help he/she needs to achieve this goal. On 8/27/25, R88's clinical record was reviewed and revealed the following:-Review of the R88's Care Plan indicated the focus discharge: [R88 will] remain in the facility through the next review date, revised on 12/01/2022. The intervention for this focus stated, Discuss with [R88] appropriate options through the next review date, revised on 06/16/23. The clinical record lacks evidence that R88's comprehensive care plan was updated to address R88's goals and preferences regarding discharge, documentation of referrals to appropriate entities made for this purpose and /or response to information received from referrals to appropriate entities.- On 9/13/24, A Social Service Note stated that R88 was anxious to hear if he/she was approved to transfer to another facility. The clinical record lacks evidence that R88's comprehensive care plan was updated in response to information received from the referral.-On 9/24/24, R88's Interdisciplinary Care Meeting indicated that R88's Care Plan was reviewed and updated. The summary note states [R88] has an incentive to move to a new placement. The clinical record lacked evidence that the Interdisciplinary Team was involved in the process of developing the discharge plan, or that R88's comprehensive care plan was updated to include R88's goals and preferences regarding discharge, referrals to appropriate entities made for this purpose and /or updated in response to information received from referrals to appropriate entities.-On 12/23/24, R88's Interdisciplinary Care Meeting indicated that R88's Care Plan was reviewed and updated. The clinical record lacked evidence that the Interdisciplinary Team was involved in the process of developing the discharge plan, or that R88's comprehensive care plan was updated to include R88's goals and preferences regarding discharge, referrals to appropriate entities made for this purpose and /or updated in response to information received from referrals to appropriate entities.-On 3/13/25, a social service note indicates a Social Worker sent R88's Case Manager (not employed by the facility) a list of referrals to facilities already explored and indicated the Case Manager would help make referrals. The clinical record lacked evidence that the Interdisciplinary Team was involved in the process of developing the discharge plan, or that R88's comprehensive care plan was updated to include R88's goals and preferences regarding discharge, referrals to appropriate entities made for this purpose, collaboration with R88's Case Manager, and/or responses to information received from referrals to appropriate entities.-On 3/26/25, R88's Interdisciplinary Care Meeting indicated that R88's Care Plan was reviewed and updated. The summary indicated Referrals are continuing to be completed for other facility options. The clinical record lacked evidence that R88's comprehensive care plan was updated to include R88's goals and preferences regarding discharge, referrals to appropriate entities made for this purpose and /or updated in response to information received from referrals to appropriate entities.-On 6/24/25, R88's Interdisciplinary Care Meeting indicated that R88's Care Plan was reviewed and updated. The summary indicated Referrals are continuing to be completed for other facility options. The clinical record lacked evidence that R88's comprehensive care plan was updated to include R88's goals and preferences regarding discharge, referrals to appropriate entities made for this purpose and /or updated in response to information received from referrals to appropriate entities. On 8/27/25, the facility's policy Discharge of Resident: Home [or] Other Facility dated 6/12/14 was reviewed. The policy does not address the discharge planning (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	process. On 8/27/25 at 12:40 p.m., during an interview with a surveyor, the Director of Nursing (DON) stated there is not a specific policy for discharge planning regarding a resident's requesting to transfer to another facility. The DON confirmed that it is the expectation that the facility will make referrals to appropriate entities when requested by residents. The DON stated that this was made clear to the Director of Social Services. She stated the Director of Social Services has made referrals to appropriate entities since that discussion (2/24/25). On 8/27/25 at 4:30 p.m., during an interview with the DON and the Administrator, a surveyor confirmed the above findings. The Administrator stated there is a policy within the Care Plan policy to include transfers to other facilities. On 8/28/25, the facility's policy Care Plans, Comprehensive Person-Centered, Revised December 2024, was reviewed and stated 8. The comprehensive, person-centered care plan will: . f. include the resident's stated preference and potential for future discharge, including his or her desire to return to the community and any referrals made to local agencies or other entities to support such a desire; . 14. The interdisciplinary team must review and update the care plan: . b. when the desired outcome is not met; . 16. Discharge Planning: a. The facility will develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them post discharge. The clinical record lacks evidence that the comprehensive care plan was updated to include R88's goals and preferences regarding discharge, referrals to appropriate entities made for this purpose and /or updated in response to information received from referrals to appropriate entities. On 8/28/25, the facility's Discharge Planning Protocol, (undated), was reviewed and stated 4. If a resident is requesting to. be transferred to another facility, initiate referral to. facility of choice. The clinical record lacks evidence that referrals to appropriate entities were made for R88 to transfer to another facility between September 2024 and 2/24/25. On 8/28/25 at 12:15 p.m., during an interview with the Administrator and the Social Services Director, the Social Services Director confirmed that the facility failed to make referrals to appropriate entities after R88's request to transfer, between September 2024 and 2/24/25. At this time the surveyor confirmed the above finding.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on record review and interview, the facility failed to ensure a resident with a specialized mental health diagnosis had been referred to the appropriate state-designated authority for Pre-admission Screening & Resident Review (PASRR) evaluation and determination for 1 of 1 resident reviewed for PASRR evaluation (Resident #81).Finding:On 8/26/25, clinical record review indicated Resident #81 was admitted to the facility in October of 2024 from a hospital, with a specialized mental health diagnosis. The clinical record lacked evidence that that the resident had been screened for a PASRR Level I determination and that it was submitted to the State-designated authority prior to admission. On 8/28/25 at 12:23 p.m., in an interview with five surveyors present, the Social Services Director and the Administrator confirmed that Resident #81's clinical record lacked evidence that that the resident had been screened for a PASRR Level I determination and that it was submitted to the State-designated authority when the resident was admitted in October of 2024.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interview, the facility failed to develop a care plan in the area of anticoagulant (blood thinner) use for 1 of 5 residents reviewed for unnecessary medications (Resident #48 [R48]). In addition, the facility failed to update a care plan for 1 of 1 residents reviewed for Coronavirus 19 (COVID 19) (Resident #45 [R45]).Findings: 1. R48 has diagnoses to include chronic embolism (blockage in a blood vessel) and thrombosis (blood clot formation) of right popliteal vein (a deep vein located behind the knee joint). Review of R48's active physician orders revealed an order for Eliquis Oral Tablet 5MG [milligram] Give 5mg by mouth two times a day for R/O [rule out] Clot. Review of R48's comprehensive care plan lacked evidence that goals and interventions were developed or implemented for the use of an anticoagulant (Eliquis). On 8/27/25 at 3:00 p.m., during an interview, the Memory Unit Manager reviewed R48's care plan and confirmed it did not include the use of an anticoagulant. 2. Review of facility Covid line listing revealed R45 tested positive for COVID 19 on 2/13/25. Review of R45's care plan updated 7/21/25 states COVID: [R45] has a Respiratory Infection with a congested cough. (Covid19) Date Initiated: 02/13/2025 . During an interview with the Director of Nursing (DON) and the Infection Preventionist on 8/27/25 at 9:00 a.m., the DON confirmed R45 tested positive for COVID 19 on 2/13/25 and would have been quarantined for up to 10 days. At this time DON confirmed no residents in the facility are COVID 19 positive. During an interview on 8/27/25 at 9:03 a.m., the above was confirmed with DON.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interviews and record reviews, the facility failed to review and revise the care plans by an interdisciplinary team (IDT), that included, to the extent possible, participation of the resident and/or his/her representative after each Minimum Data Set (MDS) assessment for 5 of 33 residents reviewed for care planning (Resident #125 [R125], R2, R45, R57, and R1).Findings: 1. Review of R125's clinical record revealed an MDS admission Assessment was completed on 11/8/24. Further review of R125’s clinical record indicated an Interdisciplinary Team (IDT) meeting was held 11/25/24 and lacked evidence that an IDT meeting was held within 7 days following the assessment. On 8/28/25 at 12:22 p.m. during an interview, the above finding was discussed with the Social Services Director. 2. Review of R2’s clinical record revealed the quarterly MDS was completed on 5/29/25. Further review of R2’s clinical record indicated, the Interdisciplinary Team meeting (IDT) was held on 6/15/25 (19 days after MDS completion). 3. Review of R45’s clinical record revealed the quarterly MDS was completed on 6/3/25. Further review of R45’s clinical record revealed the IDT was held on 5/29/25 (6 days prior to completed MDS). Review of R45’s quarterly MDS completed on 2/18/25. Review of R45’s clinical record revealed the IDT was held 2/27/25 (9 days after completed MDS). 4. Review of R57’s clinical record revealed quarterly MDS completed on 12/16/24. Further review of R57’s clinical record revealed the IDT was held on 1/8/25 (24 days after completed MDS). Review of R57’s clinical record revealed significant change MDS completed on 12/16/24. Further review of R57’s clinical record revealed the IDT was held on 1/8/25 (23 days after completion of MDS). Review of R57’s clinical record revealed quarterly MDS completed on 5/9/25. Further review of R57’s clinical record revealed the IDT was held on 5/8/25 (1 day before the completed MDS). During an interview on 8/26/25 at 4:04 p.m., in presence of 5 surveyors Minimum Data Set (MDS) Coordinator stated she uses the Assessment Reference Date (ARD) date to schedule IDT meetings. During an interview with Director of Nursing and Administrator on 8/28/25 at 12:45 p.m., the Director of Nursing stated that the IDT meetings are held within 7 days after the completion of the MDS. 5. On 8/28/25, R1’s clinical record was reviewed. R1’s diagnosis list includes, atrial fibrillation ([afib] an irregular and often very rapid heart rhythm), Chronic Pain and a history of genital herpes and Methicillin-Resistant Staphylococcus Aureus ([MRSA] bacteria that does not get better with the type of antibiotics that usually cure staph infections). R1’s Order Summary states, “Foley [Catheter] wash site with soap and water daily as needed”. The Care Plan states, “[R1] has acute/chronic pain [related to (r/t)]”, the Care Plan does not identify what (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the acute/chronic pain is related to or the location of the chronic pain. R1’s Care Plan does not address the monitoring and management of afib, or R1’s history of genital herpes and MRSA. On 8/28/25 at 2:36 p.m., during an interview with a surveyor, the Director of Nursing (DON) and the Administrator, R1's clinical record was reviewed. The DON stated the last episode of genital herpes resolved in April of 2025 but is unsure why that was removed from the care plan. She also stated R1 had afib in June of 2025. At this time the surveyor confirmed R1's care plan was not updated to address the monitoring and / or management R1’s diagnoses including afib, Chronic Pain or R1’s history of genital herpes and MRSA.

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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. Based on facility policy review, record review, and interview the facility failed to document and adequately assess and monitor a resident after an unwitnessed fall for 1 of 5 residents reviewed for unnecessary medications (Resident #48 [R48]).Finding: Review of the policy, Fall Prevention and Response Policy, revised 7/14/25, states, .Immediate Response.Head-to-toe nursing assessment.vitals.anticoagulant use, anticoagulant last dose.Neurological Monitoring Protocol.Unwitnessed fall OR suspected head impact OR ON anticoagulant.Frequency & duration of neuro check.Q [every] 15 min [minutes] x 1h [hour], Q 30 min x 1 h, Q1 h x 4h, Q4 h x 24 h, Q8 h until 72 h total.Record completion of each neuro check in flowsheet. Resident #48 has diagnoses to include long term use of anticoagulant (blood thinner) and falls. Review of R48's clinical record revealed he/she sustained an unwitnessed fall on 6/3/25. Review of R48's Change in Condition Evaluation, dated 6/3/25 and SBAR [Situation, Background, Assessment, Response] nursing progress note, dated 6/3/25, lacked evidence that vital signs were taken at the time of R48's fall and lacked evidence that the provider was made aware that R48 was on an anticoagulant. Additionally, review of R48's Neurologic Screen Form, dated 6/4/25, lacked evidence that neurological checks were initiated on the date and time of the fall. On 8/28/25 at 9:12 a.m., the above finding was discussed with the Director of Nursing (DON). At this time, the DON stated the facility has a Performance Improvement Plan (PIP) in place for falls. Surveyor review of the PIP Summary indicated that the PIP addressed fall prevention and reduction in falls and lacked evidence that documentation, assessing, and monitoring were included in the PIP.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record reviews and interviews, the facility failed to respond to the consultant pharmacist's recommendations in a timely manner for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #45 [R45]).Findings:Review of facility policy Medication Regiment Review (MRR) dated 6/5/24 states .Facility should encourage physician/prescriber or other responsible parties receiving the MMR and the director of nursing to act upon the recommendations contained in the MRR for those that require physician/prescriber intervention, facility should encourage physician/prescriber to either accept and act upon the recommendations contained within the MRR or reject all or some of the recommendations contained in the MRR and provide an explanation as to why the recommendation was rejected, as outlined in the State Operations Manual Appendix PP. The attending physician should document in the residents health record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. Facility should alert the Medical Director where MRRs are not addressed by the attending physician in a timely manner . The attending physician should address the consultant pharmacist's recommendation no later than their next scheduled visit to the facility to assess the resident, per facility policy and state or federal regulations .R45 was originally admitted in 2023 and has diagnoses to include dementia, anxiety, and a major depressive disorder.Review of Pharmacy Consultant Report dated 5/22/25 states .please attempt a gradual dose reduction (GDR) to Sertraline 12.5 mg [milligram] daily. Review of provider response dated 7/20/25 (182 days after Pharmacy review) states Not clinically appropriate at this time due to increase anxiety/agitation. The provider failed to respond to pharmacy recommendation in a timely manner.Review of facility policy Psychotropic Medication Use dated 3/1/25 states The physician shall respond appropriately by changing or stopping problematic doses or medications, or clearly documenting (based on assessing the situation) why the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences .Review of pharmacy consultant report dated 1/19/25 states, .recently began receiving Haloperidol 2 mg twice daily for dementia with behavioral disturbance. This first generation antipsychotic has an unfavorable risk profile. [He/She] has experienced more than one fall since initiation of haloperidol. A resident to resident interaction is attributed as the precipitating factor per facility progress note. Please consider a gradual dose reduction of Haloperidol to 2 mg once daily, with the end goal of discontinuation. Perhaps non-pharmacological interventions could be used to minimize or eliminate precipitating factors? Review of provider response dated 4/30/25 (108 days after Pharmacy review) states D/c Haldol, I have removed it from the med list. Review of R45's Orders revealed Haldol was discontinued on 4/30/25. Review of R45's care plan updated 5/17/25 states [R45] uses psychotropic medications [related to (r/t)] management of her aggressive behavior and agitation.Consult with pharmacy, MD to consider dosage reduction when clinically appropriate.Review of clinical record revealed Provider Recertification Note dated 1/29/25. There is no evidence pharmacy report was reviewed at this time.During a review of R45's clinical record on 8/26/25 at 3:32 p.m., the Director of Nursing (DON) stated the provider should review a pharmacy recommendations withing 24-48 hours. At this time DON reviewed the above and stated at that time, they had a different provider group and agreed they did not review pharmacy requests in a timely manner.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on record review and interview, the facility failed to monitor for side effects of psychotropic medications for 1 of 5 residents reviewed for unnecessary medications (Resident [R] 86).Finding:R86 has diagnoses to include depression.R86's care plan states, .uses psychotropic medications r/t [related to] Behavior management: for dx [diagnosis] of Depression.will be/remain free of drug related complications.Monitor/document for side effects and effectiveness . Monitor/record/report to MD [Medical Doctor] prn [as needed] side effects.Review of R86's clinical record revealed the following active physician orders:Order for Sertraline HCl Oral Tablet 50 MG [milligram] Give 1 tablet by mouth 1 time a day for Depression.Order for Venlafaxine HCl ER [extended release] Oral Tablet.75MG.Give 1 tablet by mouth one time a day for Depression.Further review of R86's clinical record lacked evidence he/she was monitored for side effects of the above medications.On 8/28/25 at 10:13 a.m., during an interview, the Director of Nursing (DON) reviewed R86's entire clinical record and confirmed R86 was not being monitored for side effects of the above medications.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, interviews and record reviews, the facility failed to maintain an Infection Control Program designed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to the storage of a urinary catheter drainage bag for 1 of 3 residents reviewed for indwelling urinary catheters (Resident #66 [R66]). Additionally, the facility failed to ensure proper notification was given to resident representatives during 1 of 1 Covid-19 outbreak in the facility.Findings: 1. R66 has diagnoses to include obstructive uropathy (a blockage in urine flow), indwelling suprapubic urinary catheter, and chronic urinary tract infection. Review of R66's care plan states, .has Suprapubic Catheter for OBSTRUCTIVE AND REFLUX UROPATHY and I get chronic urinary tract infections . On 8/25/25 at 12:38 p.m., R66 was observed foot-propelling in his/her wheelchair from the Memory Unit dining room to the day room area, and his/her urinary catheter drainage bag was hanging under the wheelchair, with the catheter tubing and drainage bag dragging on the floor. On 8/26/25 at 7:55 a.m., R66 was observed seated in his/her wheelchair in the Memory Unit dining room, and his/her urinary catheter drainage bag was hanging below his/her wheelchair, touching the floor. On 8/27/25 at 9:00 a.m., a surveyor discussed the above observations with the Memory Unit Manager (UM1) and at this time, a surveyor and UM1 observed R66 in the day room area with his/her urinary catheter drainage bag hanging on the bottom of his/her wheelchair and the drainage bag and catheter tubing touching the floor. The UM1 then stated there is a spot on the wheelchair to hang the bag so it does not touch the floor and adjusted R66's drainage bag. 2. Based on record review, and interview the facility failed to notify residents and families of a Coronavirus (COVID 19) outbreak. This has the potential to affect all residents residing in the facility. Review of the provided facility COVID Line List revealed the following: Between 1/6/25 and 2/10/25, 18 residents tested positive for COVID 19 on the Cove unit, 4 residents tested positive on Memory Lane, 2 housekeepers, one activities staff member and 1 Minimum Data Set (MDS) Coordinator (whose office is on the skilled unit). During an interview with Director of Nursing (DON) and Infection Preventionist (IP) on 8/27/25 at 9:00 a.m., the DON stated that the Cove unit was shut down during the COVID outbreak, they tried to keep the same staff in that area (unit), and everyone was on 10 days of precautions. The DON further stated that as staff and residents tested positive, all staff were notified via the facility messaging system through scheduling, and only the residents and families residing on the Cove unit were notified of the outbreak. When asked if the residents and families for the other units were notified of the COVID outbreak, the DON replied that a notice of outbreak was posted on the main entrance to notify visitors of the COVID outbreak, but every resident and every family member in the facility was not notified because it was contained to the Cove unit. The facility failed to provide evidence that the residents and families of the skilled unit and Memory Lane were notified of the COVID outbreak.