STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205129	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mercy Home	3402 Aroostook Road Eagle Lake, ME 04739

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33242 Based on record reviews and interviews, the facility failed to immediately notify the resident's physician of an accident that could of had the potential for physician intervention for 3 of 4 sampled residents reviewed who had fallen and bumped their head (Resident #24 [R24], R22, R11). Findings: 1. On 7/30/24 at 10:27 a.m., a surveyor observed R24 falling in the day room and hitting his/her head which resulted in a reddened/bruised area to the left side of the forehead. Review of the fall incident report, dated 7/30/24, and clinical record lacked evidence of the physician being immediately notified. Further review of the clinical record indicated two additional falls April with R24 hitting his/her head: On 4/2/24 at 12:02 p.m., it was reported to the supervisor that R24 was found on the floor by staff in the dining room, laying on his/her left side. According to the nurse's note, dated 4/2/24 at 5:54 p.m., R24 stated that he/she his his/her head. The fall report and clinical record lacked evidence of the physician being immediately notified. On 4/18/24 at 8:30 a.m., it was reported to the supervisor that R24 was found on the floor, laying on his/her back. R24 had a small slightly raised bump to the right head above the temple with mild redness. The fall report and clinical record lacked evidence of the physician being immediately notified. 35904 2. During record review, R22's Resident Incident Report dated 4/16/24 at 7:11 p.m. stated under Incident Type:, Fall w [with]/head injury. There is no evidence in R22's resident incident report or clinical record that a physician was notified of the fall with head injury. 49635 (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 7/30/24, clinical record review indicated R11 was [AGE] years old. A nurse note on 4/2/24 at 6:38 p.m. indicated R11 experienced a fall with a head injury resulting in a large raised bruise on [R11's] right forehead. The clinical record lacked evidence of the physician being notified immediately. On 7/30/24 at 11:30 a.m., in an interview with the Registered Nurse (R1), she stated the provider is not usually notified of a fall with head injury. On 7/31/24 10:12 a.m., in an interview with the Family Nurse Practitioner, she stated she would expect to be notified if there was a blow to the head, a change in neuro status, or a suspected fracture or serious injury; immediately, we do have an after-hours nursing staff to be able to reach a provider after hours. On 8/1/24 at 8:01 a.m., review of the incident report for R11's fall with head injury indicated the provider was not notified of the fall with head injury. On 8/1/24 at 9:12 a.m., in an interview with the Director of Nursing, a surveyor confirmed the provider was not notified of R11's fall with head injury.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33242 Based on record review and interview, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours that included the problems, interventions, and initial goals needed to provide minimum healthcare information necessary to properly care for 1 of 1 residents that were reviewed for new admissions (Resident #82 [R82]). Finding: R82 was admitted to the facility on [DATE] after a hip injury that required surgery, The baseline care plan, developed within 48 hours, did not address the admission orders that included services for therapy, the use of oxygen and monitoring of medications that included medications ordered for pain, depression/anxiety, or a blood thinner, On 8/1/24 at 12:46 p.m., during an interview with the Director of Nursing, a surveyor confirmed this finding

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33242 Based on record review and interview, the facility failed to develop a care plan in the area of falls after 2 comprehensive assessments for 1 of 3 sampled residents (Resident #24 [R24]). Finding: On 7/30/24, R24's clinical record was reviewed. The admission Minimum Data Set 3.0 (MDS), dated [DATE] and significant change MDS, dated [DATE], under section V0200A11 indicated that R24 would be care planned for falls. The surveyor reviewed R24's care plan and was unable to find a care plan for R24 in this area. On 8/1/24 at 10:26 a.m., during an interview with a surveyor, the Director of Nursing reviewed R24's care plan and also could not find a care plan that addressed problem, interventions, and goals for R24 in the area of falls.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 49635 Based on interviews and record review, the facility failed to provide individual activities to promote the psychosocial well-being of a resident as directed by the care plan for 1 of 1 residents reviewed for activities (Resident #7 [R7]). Findings: On 7/29/24 at 10:00 a.m., in an interview with a surveyor, R7 stated not participating in activities due to difficulty with communication. R7 stated there is nothing applicable available. On 8/1/24, clinical record review indicated R7's Care Plan identified the problem of social isolation. The goal to resolve this problem indicated R7 will participate in a [1 on 1] activity with staff at least 3 times each week through next review date 8/15/ 24. Interventions to meet this goal included staff will attempt to engage [R7] in 1 on 1 activities at least 3 times each week, and staff will attempt to engage [R7] in a game of [R7's] choice. Review of the Activities Roster documentation indicated, on 7/16/24, R7 participated in resident council independently. On 7/22/24 and 7/25/24, R7 participated in a religious activity independently. The clinical record lacks evidence that 1 on 1 activities were offered, received or refused three times per week for the month of July. On 8/01/24 at 12:35 p.m., in an interview with the Activities Coordinator, she stated R7's activities can be de-escalating behaviors or just talking, but she does not have structured activities for R7. The surveyor confirmed at this time the clinical record lacks evidence to indicate R7 was offered, received or refused 1 on 1 activities as directed by the care plan 3 times per week.

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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. 33242 Based on facility policy reviews, record reviews, and interviews, the facility failed to complete fall assessments per policy for 2 of 2 residents reviewed (R24 and R11), and failed to ensure a medication was held per physican order for 1 of 1 resident (R30). Findings: The facility's policy, Accident Investigation, last reviewed 2/24, states: Employees witnessing an accident situation will: -render immediate assistance and not move the victim until he/she has been assessed for possible injuries. The facility's policy, Fall Prevention, last reviewed 2/24, states: when a fall occurs, the Nurse shall assess and document/report the following each shift for 3 days: -vital signs -pain -musculoskeletal function, observing for changes in normal range of motion (ROM), weight bearing, etc -change in cognition or level of consciousness - neurological status -injury such as bruise, laceration, hematoma, fracture etc. -precipitating factors, details on how fall occurred The facility uses Lippincott Manual of Nursing Practice 11th edition, as their standards of practice for determining neurological status as the facility does not a neurological assessment policy and procedure or flowsheet. On page 943, for Injuries to the head, spine, and face (Head Injuries) under subsequent assessments should include: level of consciousness (LOC) which includes change in mental status and Glasgow Coma Scale. (The Glasgow Coma Scale assigns a number for each category of: eye opening (1 to 4), best verbal response (1 to 5), and best motor response (1 to 6). The guidance states, on page 354 indicates that the best score is 15, worst score =3; 7 or less generally indicates coma and that changes from baseline are most important). 1. On 7/31/24, R24's clinical record was reviewed and included the following documentation: On 4/2/24 at 12:02 p.m, a Resident Incident Report was completed that indicated that R24 had fallen and stated that he/she hit their head. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/24 at 5:54 p.m.(day shift) fall documentation included neuro checks normal but did not include a score per Glasgow Coma Scale. On 4/2/24 at 9:13 p.m. (evening shift) fall documentation included neuros negative at this time but did not include a score per Glasgow Coma Scale. On 4/3/24 at 6:58 p.m. (day shift) fall documentation lacked evidence of a neurological assessment being completed. On 4/3/24 at 9:30 p.m. (evening shift) fall documentation included neuros negative but did not include a score per Glasgow Coma Scale. On 4/4/24 at 11:00 a.m. (day shift) fall documentation included neuro checks within normal limits (WNL) at this time but did not include a score per Glasgow Coma Scale. On 4/4/24 at 9:08 p.m. (evening shift) fall documentation included neuros negative but did not include a score per Glasgow Coma Scale. On 4/5/24 at 11:08 a.m. (day shift) fall documentation included neuro checks WNL but did not include a score per Glasgow Coma Scale. On 4/5/24 at 10:06 p.m. (evening shift) fall documentation included neuros WNL but did not include a score per Glasgow Coma Scale. On 4/18/24 T 8:00 a.m., R24 was found laying on his/her back with a small slightly raised bump to the right head above the temle with mild redness. On 4/18/24 at 2:34 p.m. (day shift) fall documentation included neuro checks WNL but did not include a score per Glasgow Coma Scale. On 4/4/24 at 9:08 p.m. (evening shift) fall documentation included neuros negative but did not include a score per Glasgow Coma Scale. On 4/18/24 at 9:19 p.m. (evening shift) fall documentation included neuros negative but did not include a score per Glasgow Coma Scale. On 4/19/24 at 11:02 a.m. and 1:16 p.m. (day shift) fall documentation included neuro checks WNL but did not include a score per Glasgow Coma Scale and did not include ROM . On 4/19/24 at 8:27 p.m. (evening shift) fall documentation included neuros negative but did not include a score per Glasgow Coma Scale and pain was not addressed. On 4/20/24 at 3:50 p.m. (day shift) fall documentation included neuro checks WNL but did not include a score per Glasgow Coma Scale. On 4/20/24 at 8:56 p.m. (evening shift) fall documentation included neuros negative but did not include a score per Glasgow Coma Scale and pain was not addressed. On 4/21/24 at 1:52 p.m. (day shift) fall documentation did not include neuro checks assessment. On 4/21/24 at 9:02 p.m. (evening shift) fall documentation included neuros negative but did not include a score per Glasgow Coma Scale and pain was not addressed. On 7/30/24 at 10:27 a.m., a surveyor observed R24 fall to the floor, hitting his/her head. The resident was hoyered up into wheelchair then transferred across the room and parked during discussion between staff. The surveyor did not observe a licensed staff member assess R24 prior to being transferred into the wheelchair. The equipment to take vitals was not obtained and brought over until the resident had already been transferred up into the wheelchair and transported across the room. The equipment was brought to the room ahead of the resident. There was no assessment until the resident was in his/her room. On 7/30/24 at 11:25 a.m., during an interview with a surveyor, LPN2 stated that Registered Nurse #1 (RN1) was in charge. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the incident report and nurses documentation completed by RN1, dated 7/30/24 at 1:26 p.m., indicated that the resident fell forward out of a seat, striking his/her head on the floor on the left side and had a reddened area to the left side of his/her forehead. Resident was assisted to a wheel chair via hoyer and 2 assist. Resident taken to his/her room to be assessed for injuries. This documentation indicated that neuro checks performed, all negative but did not include a score per Glasgow Coma Scale. On 7/31/24 at 12:33 a.m. (evening shift) fall documentation included neuros WNL but did not include a score per Glasgow Coma Scale and pain was not addressed. This fall assessment did not mention ROM status. On 7/31/24 at 1:55 p.m. (day shift) fall documentation did not include a neurological assessment. On 7/31/24 at 10:35 p.m. (evening shift) fall documentation included neuros WNL but did not include a score per Glasgow Coma Scale and pain was not addressed. This fall assessment did not mention ROM status. 49635 2. On 7/31/24, R11's clinical record was reviewed and included the following documentation: On 4/2/24 at 6:38 p.m. (day shift), a nurse note indicated R11 had a fall with head injury which resulted in a raised bruised area to right forehead. Fall documentation indicated, neuro checks are within normal limits (WNL), but did not include a baseline score per Glasgow Coma Scale. On 4/2/24 at 9:30 p.m. (evening shift), fall documentation included neuros negative, but did not include a score per Glasgow Coma Scale. On 4/3/24 at 7:46 p.m. (day shift), fall documentation indicated, neuro checks WNL at this time, but did not include a score per Glasgow Coma Scale. On 4/3/24 at 9:36 p.m. (evening shift), fall documentation indicated, neuros negative, but did not include a score per Glasgow Coma Scale. On 4/4/24 at 1:36 p.m., documentation did not include a score per Glasgow Coma Scale. On 4/424 at 9:13 p. m., fall documentation indicated, neuros negative, but did not include a score per Glasgow Coma Scale. On 4/5/24 at 11:13 a.m., fall documentation indicated, neuro checks WNL, but did not include a score per Glasgow Coma Scale. On 4/5/24 at 10:31 p.m., fall documentation indicated neuros WNL, but did not include a score per Glasgow Coma Scale. On 7/31/24 at 1:15 p.m., during an interview with the Administrator, surveyors confirmed that there was missing fall assessment documentation per policy and that R24 was moved before a nurse assessed him/her for injuries. 35904 3. On 7/31/24, R30's clinical record was reviewed and included a physician order, dated 6/25/24, for Amlodipine Besylate (a medication to treat high blood pressure) 5 mg (milligrams) tab - Give 1 tablet by mouth (PO) daily. Hold if BP (blood pressure) less than or equal to 140/80. Diagnosis Essential (primary) hypertension (high blood pressure). R30's Medication Record, Administration Record for June 2024, and July 2024 indicated the following medication was administered when the BP was less than or equal to 140/80: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/28/24 R30's BP was 108/62 and he/she received Amlodipine Besylate 5 mg tab PO. The BP was less than 140/80. On 6/29/24 R30'3 BP was 119/64 and he/she received Amlodipine Besylate 5 mg tab PO. The BP was below 140/80. On 6/30/24 R30's BP was 130/66 and he/she received Amlodipine Besylate 5 mg tab PO. The BP was below 140/80. On 7/2/24, R30's BP was 138/54 and he/she received Amlodipine Besylate 5 mg tab PO. The BP was below 140/80. On 7/9/24, R30's BP was 124/49 and he/she received Amlodipine Besylate 5 mg tab PO. The BP was below 140/80. On 7/12/24 R30's BP was 138/60 and he/she received Amlodipine Besylate 5 mg tab PO. The BP was below 140/80. On 7/14/24 R30's BP was 105/61 and he/she received Amlodipine Besylate 5 mg tab PO. The BP was below 140/80. On 7/16/24 R30's BP was 137/64 and he/she received Amlodipine Besylate 5 mg tab PO. The BP was below 140/80. On 7/17/24 R30's BP was 135/75 and he/she received Amlodipine Besylate 5 mg tab PO. The BP was below 140/80. On 7/27/24 R30's BP was 126/69 and he/she received Amlodipine Besylate 5 mg tab PO. The BP was below 140/80. On 7/30/24 R30's BP was 133/66 and he/she received Amlodipine Besylate 5 mg tab PO. The BP was below 140/80. On 7/31/24 at approximately 11:30 a.m. in an interview with the Nurse Supervisor, a surveyor confirmed that R30 received Amlodipine Besylate on the above dates when the medication was supposed to be held per physician order.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 33242 Based on record review and interviews, the facility failed to provide adequate supervision for 1 of 1 residents (Resident #24 [R24]) that was already observed to be exit seeking during that shift and then did that elope from the building on the same shift on 7/30/24. Finding: On 7/31/24, during record review for R24, a surveyor observed a nursing note dated 7/30/24 at 6:14 p.m., that indicated after eating dinner, resident wandered for 10 minutes around the dayroom before seeking the exit to the patio. Staff was there attempting redirection but it proved ineffective. Resident pushed through the door to the patio and was outside for less than 30 seconds before the writer (Licensed Practical Nurse #2 (LPN2) had gotten to the resident. At approximately 6:20 p.m., the alarm had gone off on the end of the East Wing. On 7/31/24 at 2:13 p.m., during an interview with a surveyor, Certified Nursing Assistant #1 (CNA1) stated last evening he was providing care behind closed doors and when he came out of the room, he heard an alarm going off. It took some time to figure out which alarm was going off. He located R24 outside the door on the East wing. A copy of the facility's investigation, dated 7/31/24, stated that, CNA (CNA1) did not see a resident outside when assessing alarm, came inside to search room to room and inform charge nurse. CNA1 recognized that R24 was missing. Charge Nurse (LPN2) and CNA (CNA1) went to alternate exits, finding resident for (from) a time from between 3-5 minutes, the time discrepancy is due to being out (of) camera site for several minutes. On 7/31/24 at 1:15 p.m., during an interview with the Administrator, a surveyor confirmed that R24 was not provided with adequate supervision since he/she was already exit seeking and then did elope from the building.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33242 Based on facility policy review, observation, and interview, the facility failed to ensure that tube feedings were administered according to policy for 1 of 1 residents tube feeding administration observed (Resident #28 [R28]). Finding: The facility's policy, Tube Feeding Administration, directed staff for bolus feedings to: -flush G-tube (gastrostomy tube is a tube inserted through the belly that brings nutrition directly to the stomach) by administering water through feeding port to ensure tube patency. - Clamp the tubing -Remove the plunger from the syringe and attach the syringe to the tubing, -Hold up the tube and syringe with one hand. -Unclamp the tubing. -Slowly pour formula into the syringe with you [NAME] hand. -Allow formula to flow by gravity into the tube. -It should take about 15 minutes to deliver 8 ounces of formula -Flush the feeding tube with the amount of water recommended -Clamp the tubing and disconnect the syringe. On 8/1/24 at 8:15 p.m., a surveyor observed Licensed Practical Nurse #1 (LPN1) change R28's dressing around the feeding tube. The physician orders directed staff to cleanse with soap and water, rinse, and pat dry and cover with gauze dressing twice a day. The surveyor observed LPN1 apply bacitracin around the feeding tube area before applying the clean gauze dressing. According to the physician orders, R28 receives 237 milliliters (1 can), 6 times a day and does not use a machine for administration. LPN1 cleaned the feeding port with alcohol and checked for residual prior to the administration of the Jevity. The surveyor then observed LPN prepare and administer R28's bolus Jevity feeding via G-tube. LPN #1 poured the Jevity into a cup and drew up the Jevity via syringe utilizing the syringe plunger. She then placed the syringe into the feeding port and slowly pushed with the plunger in the syringe to administer the bolus feeding. LPN1 repeated this 3 more times except she added medication to be mixed in with the Jevity and slowly pushed the plunger in the syringe for these administrations also. She then flushed the tube by drawing up water into the syringe and slowly pushing this into the feeding port and repeated a second time. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/1/24 at 9:10 a.m., during an interview with the Director of Nursing (DON), a surveyor explained the observation. The DON stated that the bacitracin should not be applied around the feeding tube area unless it was ordered, medications should not be mixed in with the Jevity, and that R28's tube feeding should not be slowly pushed by syringe. The surveyor confirmed these findings during this interview.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 35904 Based on observations and interviews, the facility failed to ensure expired medications were removed from the supply available for use in 1 of 1 medication supply cabinet (charge nurse room), and 1 of 1 medication cart. Findings: On 7/29/24 between 10:31 a.m. and 10:47 a.m., during a medication cart review, and a medication supply cabinet review with the Certified Nursing Aid-Medications (CNA-M), a surveyor observed the following: In the medication cart: -One bottle of Calcium 600 mg (milligrams) + D 5 mcg (micrograms) available for use with an expiration date of 6/24. In the medication supply cabinet located in the charge nurse room: -Three bottles of Calcium 600 mg + D 5 mcg available for use with expiration dates of 6/24. -One bottle of Melatonin 1 mg available for use with an expiration date of 4/24. -Four bottles of Vitamin B-12 100 mcg available for use, three bottles with an expiration date of 4/24, and one bottle with an expiration date of 10/23. On 7/29/24 at 10:47 a.m., a surveyor confirmed the above findings with the CNA-M at the time of observations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205129	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mercy Home	3402 Aroostook Road Eagle Lake, ME 04739

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49635 Based on observations and interviews, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety by not monitoring food temperatures to prevent food borne illness prior to serving residents for 1 of 4 days of survey (7/31/24), not restraining hair with a hair net for 1 of 4 days of survey (7/31/24), not storing dishes in a sanitary manner for 2 of 4 days of survey (7/30/24 and 7/31/24), and not maintaining a clean kitchen floor for 4 of 4 days of survey (7/29/24, 7/30/24, 7/31/24, and 8/1/24). Findings: On 7/29/24 at 9:20 a.m., a surveyor observed with the Dietary Manager (DM), in the dry food storage room, the floor was soiled with dark grey black streaks. Freezer #4 was heavily soiled with food debris on the walls and floor. In the dishwashing area, a large square patch of cement was observed to be uncleanable. These findings were confirmed with DM at the time of the observation. On 7/30/24 at 2:45 p.m., a surveyor observed with the DM, wet stacking of serving pans on the shelf next to the steam table. Half of the serving pans were stored upward facing allowing them to accumulate debris from the environment. Debris was noted on the shelving around the pans. The kitchen floor in the dishwashing area remained uncleanable. The surveyor confirmed these findings with the DM at the time of the observations. On 7/31/24 at 11:20 a.m., a surveyor observed the floor in the dishwashing area was unclean and under repair, and a kitchen aid was observed with a long ponytail not contained by a hair net. This was observed and confirmed with the DM at the time of the finding. 08/01/24 12:00 PM Observation of kitchen, flooring in dishwashing area remains soiled from repairs to uncleanable floor. This was observed and confirmed with DM at the time of the finding.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 33242 Based on record review and interview, the facility failed to maintain complete documentation of a medical record related to medication parameters for 1of 1 resident (R82) and range of motion for 1 of 1 resident (R7). 1. On 7/31/24, R82's clinical record was reviewed and included physician orders for Metoprolol Tartrate (blood pressure medication) twice a day with parameters to hold this medication if pulse was less than or equal to 55. The clinical record lacked evidence of the pulse being checked prior to each medication administration. R82's clinical record also included an order for Tramadol (opioid pain medication) to give 1 tablet every 4 hours as needed (PRN) for pain not relieved with acetaminophen. The acetaminophen order was for 500 milligrams, take 2 tablets every 12 hours PRN. On 7/25/24 at 4:32 p.m., R82 received Tramadol but acetaminophen was not administered on 7/25. The clinical record lacked evidence of Acetaminophen being administered prior to the use of the Tramadol. 2. On 7/30/24 at 9:27 a.m., in an interview with a surveyor, R7 stated the facility does not do anything for the reduced ROM in R7's left elbow and shoulder. On 8/01/24 at 11:37 a.m., record review indicated R7 has a restorative program which states, staff to complete ROM exercises daily as tolerated to reduce the risk of contractures. The clinical record lacks evidence that R7 was offered, participated, or refused ROM exercises on 7/1/24, 7/3/24, 7/4/24, 7/6/24, 7/7/24, 7/8/24, 7/26/24, 7/27/24 and 7/28/24 (9 out of 31 days in July). On 8/01/24 at 1:16 p.m., in an interview with the Director of Nursing, a surveyor confirmed the above finding.

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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. 33242 Based on observation and interview, the facility failed to maintain an Infection Control Program designed to help prevent cross contamination and/or development of infection by maintaining a safe and sanitary environment related to Enhanced Barrier Precautions (EBP's) and changing of gloves and washing/sanitizing hands while providing care to 1 of 1 residents with a feeding tube (Resident #28 [R28]). Finding: The facility's policy, Enhanced Barrier Precautions, revised 2/2024, indicated that Enhanced Barrier Precautions will be implemented for: - Residents with indwelling medical devices which includes a feed tube. - All barriers will be used as indicated in Universal Precautions plus: gown and gloves should be applied before entering resident room and will be used for all persons performing high contact care activities. - High contact care activities include: device care or use. On 8/1/24 at 8:15 a.m., a surveyor observed Licensed Practical Nurse #1 (LPN1) provide care to R28. A surveyor observed a sign attached to the door frame identifying that a resident in this room needs staff to utilize EBP. The surveyor observed LPN1 gather supplies and went to R28's bedside. LPN1 was only wearing gloves for personal protective equipment (PPE) and was not wearing a gown. LPN1 started with the dressing change around R28's feeding tube. LPN1 removed the old dry gauze that had some drainage on it, cleansed the area around the feeding tube and applied a clean dressing wearing the same soiled gloves. LPN1 then opened the feeding tube port, applied alcohol to the port end, and then checked for residual, still wearing the same soiled gloves. At this time, LPN1 then changed her gloves but did not utilize hand sanitizer or wash her hands in-between glove changes. LPN1 then completed R28's feeding via bolus followed by water. She then removed her gloves, opened the treatment cart to obtain an alcohol wipe, and applied new gloves but did not utilize hand sanitizer or wash her hands in-between gloves changes. She wiped the feeding tube port and closed it, then cleaned up the area (supplies/paper) and then adjusted R28's sheets, pulling them up to cover up the resident wearing the same gloves. At the end of the procedure, out in the hallway, the surveyor asked LPN1 about the EPB for R28, noting the EPB sign on the door frame to the room. She stated she had never worn a gown before for R28 when providing care to the feeding tube. The surveyor confirmed during this interview that LPN1 had not followed EPB and did not change gloves at the appropriate time and when gloves were changed, did not utilize hand sanitizer or wash her hands before applying new gloves.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49635 Based on record review, interview, and facility policy review, the facility failed to ensure residents were offered influenza and pneumococcal vaccinations in accordance with the Centers for Disease and Prevention Control (CDC) recommendations for 4 of 5 residents reviewed for immunizations (Resident #13 [R13], R23, R28 and R26). Findings: On 7/31/24 at 12:00 p.m., record review indicated: 1. R13 was admitted on [DATE]. The CDC recommendation was to review, offer and/or receive one dose of Prevnar 20. On 8/4/23, R13 signed consent for the Prevnar 20 vaccine. The record lacked evidence that R13 had received, been offered, or refused the Prevnar 20 vaccination. 2. R23 was admitted on [DATE]. The CDC recommendation was to review, offer and/or receive one dose of Prevnar 20. The record lacked evidence that R23 had received, been offered, or refused the Prevnar 20 vaccination. 3. R26 was admitted on [DATE]. The CDC recommendation was to review, offer and/or receive one dose of Prevnar 20. The record lacked evidence that R26 had received, been offered, or refused the Prevnar 20 vaccination. 4. R28 was admitted on [DATE]. The CDC recommendation was to review, offer and/or receive one dose of the Influenza Vaccine. On 12/21/23, R28's resident representative signed consent to receive the Influenza Vaccination. The record also indicated the resident representative gave verbal consent to receive the Influenza Vaccination. The record lacks evidence that R28 was offered, received or refused the Influenza Vaccination. On 7/31/24 at 1:00 p.m., review of the Resident Immunizations and Vaccines Policy, revised 2/2024, indicated, The physician will order immunizations following the CDC immunization schedule. On 7/31/24 at 1:14 p.m., during an interview with the Administrator, a surveyor reviewed the CDC recommendations for R13. The surveyor confirmed with the Administrator at that time that the CDC recommendation was to offer the Prevnar 20 to R13. On 7/31/24 at 2:21 p.m., in an interview with the Nursing Supervisor, a surveyor confirmed the above vaccines were offered according to CDC recommendations.