STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205131	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewood Rehab & Living Ctr	221 Fairbanks Rd Farmington, ME 04938

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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 1 of 1 wing (Long Term Care), a sitting area and the laundry room for 1 of 1 facility tours.Findings:On 8/20/25 from 11:15 a.m. to 11:40 a.m. a surveyor did an environmental tour with the Maintenance Director and the Healthcare Services District Manager, in which the following findings were observed: Laundry Room-There were two stained ceiling tiles behind the left dryer. There was a large area of wall, behind the left dryer, that was heavily soiled with dust. The wall next to the window had chipped/missing paint creating an uncleanable surface. The electric baseboard heating unit had chipped/missing paint and was marred with black marks. - The wall air conditioning unit, in the hallway across from the nurse's station, was heavily soiled with dust and covered with yellowish, brown stains. - The public bathroom by the nurse's station had a dirty floor and dirt build up around the edges. Also, the toilet seat had enamel that was chipped and missing. - There were five cracked/broken floor tiles at the entrance to the long term care wing. - There were two greenish colored chairs in the sitting area that had worn /missing edging around the footrest areas. There was also one lighter greenish colored chair that had chipped/missing finish on the armrests. This created uncleanable surfaces on the chairs. - The whirlpool tub and jets were stained a yellowish, brown color. The water was leaking into the tub continuously. The room walls had chipped/gouged paint exposing sheetrock and created uncleanable surfaces. The bottom corner of the wall to the right of the sink was damaged and missing paint and sheetrock. - Resident room [ROOM NUMBER]- There was a commode bucket and lid on the floor under the sink. - Resident room [ROOM NUMBER]- The inside of the bathroom door had chipped/missing paint creating an uncleanable surface. The linoleum floor was dirty and stained black around the base of the toilet. There were two stained ceiling tiles above the toilet. The room entrance door frame had a ripped/torn frame protector on the bottom left side. On 8/20/25 at 11:40 a.m., in an interview with a surveyor, the Maintenance Director and Healthcare Services District Manager 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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record reviews and interviews, the facility failed to issue a written transfer/discharge notices and bed hold notices residents or known family member or legal representative for facility-initiated transfers/discharges for 2 of 4 sampled residents transferred/discharged to an acute care facility. Resident #1(R1) and #8(R8). Additionally, the facility failed to notify the Ombudsman's office. Findings:On 8/19/25 at 12:24 p.m., in an interview with three surveyors present, the Social Worker stated that she is supposed to notify the Ombudsman of hospital transfers and had she not been doing them. 1. Documentation in R1's clinical record indicated that he/she was transferred to an acute hospital on 6/15/25 and subsequently admitted . The clinical record lacked evidence that the facility issued a written transfer/discharge notice and a bed hold notice to the Power of Attorney/family member/legal representative and that the Ombudsman's office was notified. On 8/19/2025 at 2:44 p.m., in an interview with a surveyor, the Director of Nursing confirmed that the POA/family member legal representative for R1 did not receive transfer discharge notice and bed hold notice in writing for transfer to hospital on 6/15/25. 2. Documentation in R8's clinical record indicated that he/she was transferred to an acute hospital on 4/11/25 and 4/17/25 subsequently admitted for both. The clinical record lacked evidence that the facility issued a written transfer/discharge notice and a bed hold notice to the Power of Attorney/family member/legal representative and that the Ombudsman's office was notified. On 8/19/25 at 3:00 p.m., in an interview with a surveyor, the Director of Nursing confirmed that the POA/family member legal representative for R8 did not receive transfer discharge notices and bed hold notices in writing for transfers to hospital on 4/11/25 and 4/17/25. On 8/18/25, in an interview with three surveyors present, the Social Worker confirmed that no one mails notices of transfer/discharge or bed holds to the resident's representatives.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, facility policy the facility failed to update and include interventions on the resident's current comprehensive care plan for the areas of oxygen for 2 of 2 residents (Resident's [R]11 & R34), and in the area of activities for 1 of 4 care plans reviewed for activities (R15).Findings: 1. On 8/18/25 at 9:50 a.m. and 8/19/25 at 9:40 a.m., an oxygen concentrator was observed next to Resident (R) 11's bed. Review of R11's clinical record revealed a Quarterly Minimum Data Set Assessment, dated 6/5/25, Section J indicated shortness of breath with exertion, lying flat. Section O indicated R11 uses oxygen therapy, and an Interdisciplinary Team (IDT) note, dated 6/12/25 states, . is wearing [his/her] oxygen most of the time now .happy to have assistance to reapply it. Care plan updated as needed . Review of R11's comprehensive care plan lacked evidence that goals and interventions were implemented for R11's oxygen use. On 8/19/25 at 11:09 a.m. the above finding was discussed with the Director of Nursing (DNS). 2. On 8/18/25 at 9:28 a.m., an oxygen concentrator was observed next to R34's bed and a nebulizer machine was observed on his/her nightstand. On 8/19/25 at 9:35 a.m., R34 was observed lying in bed, wearing oxygen at 2 liters per minute via a nasal cannula. Review of R34's clinical record revealed that R34 was transferred to the facility from an out-of-state facility with diagnoses to include Chronic Obstructive Pulmonary Disease (COPD). Review of R34's transfer records revealed an order for O2 [oxygen] @2L/MIN [at 2 liters per minute] VIA NASAL CANNULA. Review of R34's active physician orders revealed the following: -order for Change Nebulizer Kit One Time Weekly . -order for Budesonide 0.25mg/mL suspension for nebulization .Two Times Daily . Review of R34's comprehensive care plan lacked evidence that goals and interventions were implemented for R34's oxygen and nebulizer use. On 8/19/25 at 11:09 a.m., during an interview, the DNS stated R34 has used oxygen at bedtime and when lying in bed during the day since he/she was admitted to the facility. At this time, the DNS reviewed R34's care plan and confirmed it did not include R34's oxygen and nebulizer use. 3.Review of facility policy Comprehensive Person-Centered Care Planning dated 1/19 states The facility must develop and implement a comprehensive person-centered care plan for each resident, which includes measurable objectives and timeframes to meet a residents medical, nursing, mental/psychosocial needs identified in the comprehensive assessment/evaluation . R15 was admitted in 2024 and has diagnoses to include dementia, hearing loss, and major depressive (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disorder Review of R15 Activity assessment dated [DATE] states its important for [him/her] to have books, newspaper and magazines to read, be around animals/pets, keep up with the news, be around groups of people, and do favorite activities, Review of R15's care plan updated 8/15/25 lacked evidence that goals and interventions were put into place in the area of activities. During a review of R15's care plan on 8/20/25 at 9:57 a.m. the [NAME] President of Clinical Operations confirmed R15's care plan does not include goals and interventions for activities.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record reviews, activity calendar review, and Resident Council meeting minutes, the facility failed to provide residents with a continuous resident centered activities program for 3 of 3 residents reviewed for activity participation. (Resident's #[R]6, R15 & R35).Findings:1.Review of R6's care plan updated 7/29/25 states Activity: [R6] needs assistance to develop an activity program that meets [R6's] abilities and interests GOAL: [R6] will participate in activities/social events of their choosing over the next 90 days. Interventions Encourage socialization with peers .Review of R6's Activities log dated May 2025 through August 20, 2025 (3 months 20 days) reveled R6 attended 2 (two) group activities and received 6 (six) 1:1 visits. There is no evidence that R6 was offered/refused to attend the remaining offered activities.2. Review of R15 Activity assessment dated [DATE] states it's important for him/her to have books, newspaper and magazines to read, be around animals/pets, keep up with the news, be around groups of people, do favorite activities, Review of R15's Activity Participation log from May 20, 2025, through August 20, 2025, states R15 had 2 (two) 1:1 visits. There was no evidence that R15 was offered /refused any other activities during this time.3 Review of R35's Activity assessment dated [DATE] states ifs important for [him/her] to listen to music, be around animals such as pets, do things with groups of people, and to do [his/her] favorite activities.Review of R35's care plan updated 4/10/25 states Activity: [R35] needs assistance to develop an activity program that meets [R35's] abilities and interests GOAL: [R35] will participate in activities/social events of their choosing over the next 90 days Interventions: [R35] prefers independent activities. [R35] prefers to attend group activities passively; Encourage socialization with peers; Encourage visits from family, friends, and clergy, etc .Review of R35's Activities Log from May 2025 through August 20,2025 states R35 attended 1 (one) group activity during this time. There was no evidence that R15 was offered /refused any other activities during this time. Review of Resident council meeting minutes dated January and February 2025 states the residents would like more activities.Review of monthly Activity Calendars revealed the following:-May 2025 Activity Calendar lacks day activities on Wednesday 5/7/25, Friday 5/2/25, 5/9/25, 5/16/25, and 5/30/25. Lacks weekend activities on 5/3/25, 5/4/25, 5/11/25, 5/17/25, 5/18/25, 5/24/25, 5/25/25 and 5/31/25.-June 2025 Activity Cal lacks weekend activities on 6/1/25, 6/7/25, 6/8/25, 6/14/25, 6/15/25, 6/21/25, 6/22/25, 6/28/25 and 6/29/25.-July 2025 lacks weekend activities on 7/5/25, 7/6/25, 7/13/25, 7/19/25, 7/20/25, 7/26/25, and 7/27/25.-August 2025 lacks evidence of weekend activities on 8/2/25, 8/3/25, 8/10/25, 8/16/25, 8/17/25, 8/23/25, 8/24/25, 8/30/25 and 8/31/25.During an interview on 8/20/25 at 10:25 a.m.,. R8 states there are no evening or weekend activities, but there should be.During an interview on 8/20/25 at 10:30 a.m., R16 states there are no evening and weekend activities.During an interview on 8/18/25 at 11:25 a.m., the Activity Director (AD) was asked why there were no evening or weekend activities. The AD stated because she only works 40 hours a week.During an interview on 8/20/25 at 11:07 a.m., the above was discussed with the Administrator.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, record review, interview, and facility policy, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to respiratory care and failed to obtain a physician order for oxygen for 2 of 2 residents reviewed for respiratory care (Resident [R] 11, 34).Findings:Review of facility policy, Oxygen Use & Storage Policy, revised 7/2025 states, Respiratory Care .A sanitary environment must be maintained to prevent the transmission of disease and infection. Nasal Cannula's will be discarded and changed every 2 weeks. The respiratory set up bag will be labeled with residents name and the date the equipment was changed or the date changed can be directly labeled on the cannula with a piece of tape. When the nasal cannula is not in use, on both concentrator and portable tanks, the cannula will be stored in a plastic bag to avoid the risk of it becoming contaminated (i.e. touching the floor, etc.) .Nebulizer parts should be rinsed after each use, allowed to air dry then placed in respiratory set up bag once dried. Respiratory set-ups for nebulizers will be changed every 2 weeks .Staff changing the tubing should document on the Treatment Administration Record (TAR) when the tubing has been changed following this policy.1.On 8/18/25 at 9:50 a.m. and 8/19/25 at 9:40 a.m., a surveyor observed R11's unbagged, undated oxygen tubing draped over the top of on his/her oxygen concentrator, with the nasal cannula prongs in direct contact with the front surface of the concentrator and R11's undated nebulizer tubing draped over the nightstand and extending to the floor, with the exposed nebulizer tubing in direct contact with the floor by the head of the bed.Review of R11's clinical record revealed a Quarterly Minimum Data Set Assessment, dated 6/5/25, Section O indicated R11 uses oxygen therapy, and an Interdisciplinary Team (IDT) note, dated 6/12/25 states, . is wearing [his/her] oxygen most of the time now .Review of R11's clinical record lacked a physician order for the oxygen, and review of the August 2025 Treatment Administration Record (TAR) lacked evidence of oxygen tubing changes or changes of the respiratory set-up for the nebulizer.2. On 8/18/25 at 9:28 a.m., a surveyor observed R34's undated, unbagged oxygen tubing draped over his/her oxygen concentrator, with the nasal cannula prongs in direct contact with the front surface of the concentrator. On 8/19/25 at 9:35 a.m., during a follow-up observation, R34 was observed lying in bed, wearing oxygen at 2 liters per minute via a nasal cannula.Review of R34's clinical record revealed that R34 was transferred to the facility from an out-of-state facility with diagnoses to include Chronic Obstructive Pulmonary Disease (COPD). Review of R34's transfer records revealed an order for O2 [oxygen] @2L/MIN [at 2 liters per minute] VIA NASAL CANNULA.Review of R34's physician orders revealed an order for Pulse Oximetry Triate [titrate] O2 to maintain O2 Saturation.maintain 90% but lacked a physician order for the oxygen delivery method and flow rate, and review of R34's August 2025 TAR lacked evidence of oxygen tubing changes.On 8/19/25 at 11:09 a.m., the above findings were discussed with the Director of Nursing (DNS), and the DNS stated the nasal cannulas should be stored in a bag when not in use. At this time, the DNS reviewed R11's and R34's clinical records and confirmed the records lack physician orders for the oxygen and that the TARs lack evidence of tubing changes.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review, observations, and interviews, the facility failed to ensure that two people who are authorized to administer medications signed the Shift Count page indicating that they counted all controlled substances at the change of shift for multiple shifts for 1 of 3 Controlled Substance Books reviewed (Certified Nursing Assistant-Medication Tech [CNA-M] medication cart book).Findings:On 8/19/25 at 9:00 a.m., during a medication storage observation, the Controlled Substances Book and Shift Counts for the CNA-M med cart were reviewed, which indicated the facility counts at the change of each shift, approximately 2 times per day, and revealed the following:The person authorized to administer medications coming on duty failed to sign the Shift Count page of the Controlled Substances Book that indicated the controlled substances count was done on the following dates: 4/9/25 at 10:00 p.m., 4/22/25 at 6:00 a.m., 4/24/25 at 10:00 a.m., 5/1/25 at 6:00 a.m., 5/11/25 at 6:00 a.m., 5/15/25 at 7:00 p.m., 5/17/25 at 6:00 p.m., 6/4/25 at 7:00 p.m., 6/10/25 at 6:00 a.m., 6/11/25 at 7:00 p.m., 6/22/25 at 7:00 p.m., 7/17/25 at 7:00 p.m., 7/25/25 at 7:00 p.m., 7/29/25 at 6:00 a.m., and 8/14/25 at 7:00 p.m.The person authorized to administer medications going off duty failed to sign the Shift Count page of the Controlled Substances Book that indicated the controlled substances count was done on the following dates: 4/1/25 at 6:30 a.m., 4/13/25 at 6:00 a.m., 4/13/25 at 6:30 a.m., 4/22/25 at 6:30 a.m., 4/24/25 at 6:30 a.m., 4/24/25 at 10:30 a.m., 4/27/25 at 6:30 a.m., 5/1/25 at 6:30 a.m., 5/2/25 at 6:15 a.m., 5/9/25 at 6:30 a.m., 5/11/25 at 6:30 a.m., 5/15/25 at 6:30 a.m., 5/16/25 at 6:00 a.m., 5/16/25 at 6:00 p.m., 5/18/25 at 6:00 a.m., 6/5/25 at 6:00 a.m., 6/10/25 at 6:30 a.m., 6/12/25 at 6:00 a.m., 6/20/25 at 6:00 a.m., 6/23/25 at 6:00 a.m., 7/16/25 at 7:00 p.m., 7/26/25 at 6:00 a.m., 7/29/25 at 6:30 a.m., 8/6/25 at 7:00 p.m., and 8/15/25 at 6:30 p.m.The person authorized to administer medications coming on duty and the person authorized to administer medications going off duty both failed to sign the Shift Count page of the Controlled Substances Book that indicated the controlled substances count was done on the following dates: 4/3/25 at 6:00 a.m., 4/10/25 at 6:00 a.m., and 8/15/25 at 6:00 a.m.A review of the facility's Inventory Control of Controlled Substances policy, revised 8/1/24 states, Facility should ensure the incoming and outgoing nurses count all Schedule II controlled substances and other medications with a risk of abuse or diversion at the change of each shift . and document the results on a ?Controlled Substance Count Verification/Shift Count Sheet'.On 8/19/25 at 9:07 a.m., during an interview, CNA-M1 stated she came in after night shift left, so she did the count with Registered Nurse (RN)1 this morning at the start of her shift but forgot to date and sign the shift count page.On 8/19/25 at 8:49 a.m., the above findings were discussed with the Director of Nursing (DNS), who stated she just audited the count book on Sunday and is aware of the missing signatures.

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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, interviews and the facility's Dish Machine Temperature and Sanitizer Log Form, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for ceiling air vents, walls, ceiling tiles, ceiling grids, a food mixer, a food disposal, a wash rack, floors and the dry storage room; and failed to properly label and date foods in the walk-in refrigerator, the reach-in freezers, and the activity room kitchenette area. Additionally, the facility failed to ensure that a kitchen staff members wore hair and facial hair protection. Further, the facility failed to monitor/document dish machine temperatures.Findings:1. On 8/18/25 from 9:05 a.m. to 9:40 a.m., a surveyor completed a kitchen tour with the Food Service Director in which the following findings were observed: -A male worker in the kitchen was not wearing hair and facial hair protection.- The kitchen office had a ceiling vent, the surrounding walls and surrounding ceiling tiles that were heavily soiled with dirt/dust.- The metal ceiling grid, above the ice machine and the kitchen office, was dirty and rusty. - The food mixer had chipped/missing paint on the mix arm and the base. Additionally, there was dried food and dried liquid residue on the base. - There were four ceiling tiles in the kitchen with brown stains on them.- There was a large bin of a white powder that was not labeled and dated. -The wall behind the two-bay pot sink was dirty and had chipped/missing paint creating an uncleanable surface.- The food disposal had dried food particles and dried liquid residue on it.- There was a wash rack, on the floor under the dishwasher, that had dried food particles and dried liquid residue on it. - The were two dish room ceiling air vents that were heavily soiled with dirt/dust. - There were three ceiling air vents and surrounding tiles in the kitchen area that were dirty/dusty.- The entire kitchen floor had food debris and trash on it and under the equipment. - The walk-in refrigerator had food debris and trash on the floor and under the shelving. - Reach-in Freezer #1, by the ice machine, had a package of pie shells that was not labeled and dated. - Reach-in Freezer #2, by the mixer, had a large box of hamburgers that was not sealed and open to the air and had a package of manicotti that was not dated. - The dry storage room had a small bag of chips that was not sealed and open to the air. The were four small bags and two large bags of soft taco wraps that were not labeled and dated. There was food, trash and debris on the floor under the shelving.- The reach-in bread freezer had three loaves of bread that were not dated and labeled and had large amounts of ice crystals inside each one. - The activity room snack area had a previously opened loaf of bread, sitting on the microwave, that was not labeled and dated. The facilities Refrigerator/Freezer Food Storage policy and procedure noted: 13. Refrigerated food storage: b. Thermometers should be checked at least two times each day. d. Refrigerator/freezers on nursing units should be supplied with thermometers and monitored for appropriate temperatures. f. All foods should be covered, labeled and dated. 14. Frozen foods: c. All foods should be covered, labeled and dated On 8/18/25 at 9:40 a.m., in an interview with a surveyor, the Food Service Director confirmed the findings. 2. On 8/19/25 at 10:30 a.m., a surveyor reviewed the documentation from the kitchen and found missing monitoring/documentation for the dish machine for May, June and July of 2025. May:Lunch- 23rd and 31st.Supper- 31st. June:Lunch- 5th, 20th and 27th.Supper- 6th, 7th, 14th and 27th. July:Supper- 22nd.The facilities Dish Machine Temperature and Sanitizer Log Form noted: Policy: Dishwashing staff will monitor and record dish machine temperatures to assure proper sanitizing of dishes. Procedure: 1. Staff will monitor dish machine temperatures throughout the dishwashing process. 2. Staff will record dish machine temperatures for the wash and rinse cycles after each meal.On 8/19/25 at 10:37 AM, in an interview with a surveyor, the Administrator confirmed the missing dishwasher temperatures. 3. On 8/20/25 at 10:20 a.m., a surveyor observed a male cook with no facial hair protection for his moustache. On 8/20/25 at 10:26 a.m., in an interview with a surveyor, the Administrator confirmed the finding.

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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 2 of 3 survey days. (8/18/25 and 8/19/25). Findings:1. 0n 8/18/25 at 9:03 a.m., a surveyor observed a mattress on the ground, under the trash dumpster. On 8/18/25 at 9:41 a.m., in an interview with a surveyor, the Maintenance Director confirmed that there was a mattress, on the ground, under the dumpster which was trash and told the surveyor that the mattress had been under the dumpster for a about a month. 2. On 8/19/25 at 8:00 a.m., a surveyor observed a mattress on the ground under the trash dumpster. On 8/19/25 at 8:24 a.m., in an interview with a surveyor, the Maintenance Director confirmed that the mattress was still on the ground under the trash dumpster.

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	205131	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewood Rehab & Living Ctr	221 Fairbanks Rd Farmington, ME 04938

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) - Version 3.0 Assessments were accurately coded in the areas of Health Conditions and Special Treatments for 1 of 13 sampled residents (Resident [R] 34).Findings:On 8/19/25 at 9:35 a.m., R34 was observed lying in bed, wearing oxygen at 2 liters per minute via a nasal cannula.A review of R34's clinical record revealed that he/she was admitted to the facility from an out-of-state facility with diagnoses to include Chronic Obstructive Pulmonary Disease (COPD). Review of R34's transfer records revealed an order for O2 [oxygen] @2L/MIN [at 2 liters per minute] VIA NASAL CANNULA.Review of R34's admission MDS Assessment, dated 9/11/24, and most recent Quarterly MDS Assessment, dated 5/22/25, Section J-Health Conditions indicated none of the above for shortness of breath, and Section O - Special Treatments, Procedures, Programs, indicated none of the above for oxygen use.On 8/19/25 at 11:09 a.m., during an interview, the Director of Nursing (DNS) stated R34 has been using oxygen at bedtime and when lying in bed during the day since his/her admission to the facility. At this time, a surveyor discussed the above finding with the DNS.

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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 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 instructions needed to provide minimum healthcare information necessary to care for 1 of 13 residents reviewed for baseline care plans (Resident #11).Findings:Review of Resident (R) 11's clinical record indicated he/she was admitted to the facility in December 2024 with diagnoses to include B-cell lymphoma and anxiety and was receiving hospice services upon admission. Further record review lacked evidence that a baseline care plan, including goals and interventions, was developed and implemented until 8 days after R11's admission. On 8/20/25 at 10:22 a.m. during an interview, the Director of Nursing reviewed Resident #11's baseline care plan and confirmed it was not developed and implemented until 8 days after admission.

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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 record review and interviews, the facility failed to review and revise the care plan 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 1 of 13 residents reviewed for care planning (Resident 11).Findings: Review of Resident #11's clinical record revealed an MDS Quarterly Assessment was completed on 3/13/25. Further review of Resident #11's clinical record lacked evidence that an interdisciplinary team (IDT) meeting was held within 7 days following the assessment.On 8/20/2025 at 10:22 a.m. during an interview, the Director of Nursing reviewed Resident #11's clinical record and confirmed there was no IDT meeting held following the 3/13/25 MDS assessment.

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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 record review, interview, and facility policy, the facility failed to document and adequately monitor a resident after an unwitnessed fall and failed to notify a physician after a fall for 1 of 3 residents reviewed for falls (Resident [R] 34).Findings:Review of policy, Falls Management Policy, revised 2/2025, states, .A fall incident report will be completed after a resident has had a fall, whether it is witnessed or not.A neurological assessment tool will be initiated for falls where there is a known ?head bump . Neurological Assessment Policy, revised 1/2019, states, Neurological assessment following head injury will be completed for all residents sustaining head trauma or suspected head trauma In EMR [Electronic Medical Record]: Neuro Checks will be conducted - every 15min x 4, every 30min x 4, every 1 hr. x 4, every 4 hr. x 2, and every 8 hr. x 1.The physician will be notified of any significant changes. This will be documented in the narrative notes.1. Review of R34's clinical record revealed he/she sustained an unwitnessed fall on 6/22/25 at 2:10 a.m., 8/2/25, 8/17/25 at 4:15 a.m., and 8/17/25 at 11:00 p.m.Review of R34's Neurological Check Flow Sheets for the above falls revealed the following:Neurological Check Flow Sheet dated 6/22/25 lacked evidence of an initial neurological assessment at the time of the fall and lacked evidence that the one-hour assessments for 6:10 a.m., 7:10 a.m., and 8:10 a.m. were completed. Additionally, the assessment documented at 9:30 a.m. was incomplete, and the flow sheet indicated the 8-hour assessment due at 1:30 a.m. was not performed until 5:30 a.m. on 6/23/25. Neurological Check Flow Sheet dated 8/2/25 lacked evidence of continued neurological assessments after the 1-hour assessment completed at 4:30 a.m.Neurological Check Flow Sheet initiated 8/17/25 at 4:15 a.m. lacked evidence of continued neurological assessments after the 30-minute assessment completed at 5:30 a.m.Neurological Check Flow Sheet initiated 8/17/25 at 11:00p.m. lacked evidence of a neurological assessment for the 8-hour neurological check.2. R34's clinical record review indicated he/she sustained a witnessed fall on 8/10/25.Review of Resident Incident Report Form, dated 8/10/25, indicated the medical provider was notified of R34's witnessed fall at 2:00 p.m. via communication log.Review of the communication log, dated 8/10/25, states, Resident experienced controlled fall to floor from standing position.Staff reporting R [right] side weakness-not noted @ [at] time of fall. The communication log lacked evidence that the provider was made aware of the concern until 8/14/25, 4 days after the fall.3. Review of R34's nursing progress note, dated 8/17/25 states, Resident was sent to the hospital at 1030 [10:30 a.m.]. Resident fell at 0415 this am [4:15 a.m.] and had a big bump on the right side of [his/her] head, was c/o [complaining of] headache. [He/She] was unable to follow some commands. Grandson was called and notified of the fall. He said he would like [him/her] evaluated. The progress note lacked evidence that the medical provider was notified of the fall or head injury.Review of Resident Incident Report, dated 8/17/25 at 5:37 a.m. and signed by the Director of Nursing (DNS) at 1:09 p.m., also lacked evidence that the medical provider was notified.On 8/20/25 at 10:11 a.m., during an interview, Registered Nurse (RN)1 stated when a resident falls, the nurse assesses the resident, decides if they need to be sent to the emergency room, and notifies the provider via phone call. On 8/20/25 at 10:15 a.m., a surveyor discussed the neurological assessment concerns and provider notification concerns with the DNS. At this time, the DNS stated that after a resident falls, the nurse must call the provider to notify them of the fall, in addition to completing the communication log in the paper chart.

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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. Based on record reviews and interviews, the facility failed to ensure that clinical records were complete and contained accurate information for 1 of 3 sampled residents reviewed for nutrition (Resident [R]6).Findings:Review of R6's care plan updated 5/8/25 states Nutrition: Alteration in nutrition/hydration secondary to obesity, diabetes, liver failure, need for adaptive equipment. Goal: [R6] will make food choices within parameters of prescribed therapeutic diet. Will maintain or demonstrate weight loss of 1-2#per week over the next 90 days.Intervention: Monitor eating pattern and record intake. Review of R6's LTC Meal intake dated August 2025 lacks evidence of intake/refusal during breakfast on 8/9/25, lunch on 8/6/25, 8/9/25, 8/11/25, and diner on 8/1/25, 8/8/25, and 8/15/25.During an interview on 8/19/25 at 11:02 a.m. Certified Nursing Assistant (CNA)3 states they are supposed to document meal intakes 3 times a day and if a meal is refused, they should offer an alternative, if that is refused, to document it and notify the charge nurse.During a review of R6's intakes on 8/19/25 at 12:05 p.m. the Clinical Coordinator confirmed above findings.

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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 review, 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 2 of 3 days of the survey.Findings:R4 has diagnoses to include obstructive uropathy and indwelling urinary catheter.On 8/18/25 at 12:04 p.m. and 8/19/25 at 9:38 a.m., during an observation of R4's room, R4's urinary catheter drainage bag, with urine in the tubing and bottom of the drainage bag, was hanging under the sink.On 8/19/25 at 3:05 p.m., a surveyor and the Director of Nursing (DNS) observed R4's drainage bag hanging under his/her sink. At this time, a surveyor discussed the above findings with the DNS.