STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205134	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph's Rehabilitation and Residence	1133 Washington Ave Portland, ME 04103

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 33639 Based on observations and interviews, the facility failed to ensure that residents who required feeding assistance were aided with feeding in a dignified manner for 2 of 3 dining observations. (#42) Findings: 1. On 8/19/24 between 12:27 p. m. and 12:34 p.m., a surveyor observed the lunch meal service in the C - Unit dining room. A surveyor observed Certified Nursing Assistant #3 (CNA#3) standing over Resident #42 while feeding him/her. In addition, the CNA did not engage in any conversation with the resident while feeding him/her. In an interview, a surveyor confirmed the above findings with CNA #3 on 8/19/24 at 12:34 p.m., and also confirmed the above findings on 8/19/24 at 1:45 p.m. with the Director of Nursing (DON). 44049 2. On 8/20/24 at 8:15 a.m. a surveyor observed CNA#1 in Unit C dining room, standing over a resident while aiding him/her feeding. A surveyor observed CNA #2 in the hallway at the nurse's station, standing over a resident while aiding him/her with feeding. This was confirmed with the Unit Manager at the time.

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 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 44049 Based on observations and interview, the facility failed to post, in a place readily accessible to residents, family members, and legal representatives, the results of the most recent survey of the facility in the survey folder (located in the entrance foyer). Finding: On 8/22/24 at 9:05 a.m. a surveyor went to the main lobby to review the book that contained the Latest Survey Results and the book was empty. The Director of Clinical Services was asked where the results are and she stated that she did not know and did not know how long it had been empty.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 48648 Based on record review, and interviews, the facility failed to inform and provide written information concerning the right to formulate an advance directive for 4 of 16 residents reviewed for advanced directives. (#62, #65, #40, #21) Findings: 1. On 8/20/24 at 9:22 a.m. a surveyor reviewed Resident #62's clinical record and was unable to locate an advance directive. Also, documentation was not found that the resident was informed and provided information they had the right to formulate an advance directive. An Advance Care Planning Tracking form was located in Resident #62's clinical record but the document was unsigned and blank other than Full Code being selected. On 8/20/24 at 9:34 a.m. a surveyor reviewed Resident #65's clinical record and was unable to locate an advance directive. Also, documentation was not found that the resident was informed and provided information they had the right to formulate an advance directive. A form was located in Resident #65's clinical record titled Advance Care Planning Tracking form This form was signed by their representative but in the section Date of Discussion the representative had written was none. The rest of the form was blank other than Do Not Resuscitate (DNR) being selected. On 8/20/24 at 1:55 p.m. a surveyor reviewed Resident #40's clinical record and was unable to locate an advance directive. Also, documentation was not found that the resident was informed and provided information they had the right to formulate an advance directive. On 8/21/24 at 2:45 p.m. a surveyor met and discussed the above findings with the Director of Nursing who was also unable to locate the requested documentation. 44049 2. On 08/19/24 at 1:38 p.m., a surveyor was unable to locate documentation of an Advanced Directive discussion with Resident #21. On 8/20/24 at 12:40 p.m. After an extensive search of the electronic record and the hard copy of the clinical record, the charge nurse of Unit A stated that she could find no documentation that advanced directive documentation was ever given to the resident. She confirmed, You are correct, I do not see it anywhere.

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 48648 Based on record reviews and interview, the facility failed to ensure the Notice of Medicare Provider Non-Coverage (CMS-10123-NOMNC) form was provided for 2 of 3 sampled residents whose Medicare Part A Skilled services were discontinued. In addition, the facility failed to ensure the Skilled Nursing Facility Advance Beneficiary Notice (CMS-10055-SNF ABN), which included appeal rights and liability of payment was provided for 2 of 2 sampled residents who remained in the facility after Medicare Part A benefits ended. Findings: On 8/20/2024 a surveyor reviewed a random sample of 3 residents who had been discharged from Medicare Part A and found: 1. A resident's last covered day was 3/3/24 and they remained in the facility. This resident should have received a CMS-10123-NOMNC form and a CMS-10055-SNF ABN form. They received neither. 2. A resident's last day of coverage was 2/28/24 and were discharged to home on 2/29/24. They should have received a CMS-10123-NOMNC form. They did not. 3. A resident's last day of coverage was 3/29/24 and they remained in the facility. They should have received a CMS-10123-NOMNC form and CMS-10055-SNF ABN form. They did not receive a CMS-10055-SNF ABN form. On 8/20/2024 at 9:30 a.m. a surveyor discussed the missing forms with the Director of Nursing.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33639 Based on a review of the Nursing Facility Reportable Incident Form submitted to the Division of Licensing and Certification on 6/11/24, written statements by staff, facility policy, clinical record review, and interviews, the facility failed to protect residents from physical abuse for 1 of 34 sampled residents. (#91) Finding: The facility's Abuse, Neglect, Misappropriation of Resident Property and Exploitation, Effective 10/2022 . each resident will be free from abuse. Abuse can include verbal, mental, sexual or physical abuse. Corporal punishment or involuntary seclusion. The resident will also be free from physical or chemical restraints imposed for purposes of discipline or convenience. And that are not required to treat the residents' medical symptoms. Additionally, residents will be protected from abuse, neglect and harm while they are residing at the facility. No abuse or harm of any type will be tolerated, and residents and staff will be monitored for protection. On 6/11/24, the Division of Licensing and Certification received from the facility a Reportable Incident Form which indicated an allegation of abuse of a resident (Resident #91) by Certified Nursing Assistant #4. (CNA #4) While CNA #4 was providing 1:1 care to Resident #91. CNA #5 observed Resident #91 grabbing CNA #4's arm and CNA #4 slapping the resident's arm/hand and stating: How do you like it? A Clinical record review indicates that Resident #91 was admitted to the facility on [DATE] for long term care. Resident #91 has a diagnosis of Down Syndrome, Conduct Disorder, Alzheimer's disease and dementia with behavioral disturbance. On 8/21/24 at 3:17 p.m. a surveyor conducted a telephone interview with CNA #4. CNA #4 stated Resident #91 was being very combative, and he/she had a lot of feces on his/her hands because he/she kept digging all day long. I took him/her in the room, I cleaned him/her up, brought him/her back outside, and he/she tried to reach out to give me a hug. I took his/her hand and placed his/her hands by his/her side, and I attempted to fix his/her pants zipper at one point, and he/she kicked me, and he/she punched me. The other caregivers saw and rushed over to help. On 8/21/24 at 3:24 p.m., a surveyor conducted a telephone interview with CNA #5. CNA #5 stated she observed Resident #91 grab CNA #4's arm. She then observed CNA #4 hit Resident #91 and say, How does it feel? A statement written by CNA #5 states Resident #91 became agitated from being followed by his 1:1 (CNA #4). When Resident #91 tried to walk away from CNA #4. CNA #4 grabbed Resident #91 to redirect him/her. Resident #91 grabbed and squeezed CNA #4's arm. CNA #4 pushed Resident #91's arm away and slapped Resident #91's arm hard and said How do you like it? (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A statement written by CNA #6 states Resident #91 was agitated walking around the common area. CNA #6 states she heard the 1:1 (CNA #4) yell loudly at Resident #91. She then observed Resident #91 grab the 1:1's (CNA #4) arm and the 1:1 (CNA #4) removed Resident #91's hand off her arm and reached up and smacked Resident #91 in the right arm and said, How do you like it? loudly. A care plan dated 4/25/23 indicates when resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. If resisting care, stop care, ensure he/she is safe and retry care in 5-10 minutes. Attempt care 3 times, if he/she continues to refuse care, alert charge nurse for further. Observe and Document observed behavior and attempted interventions. Provide 1:1 supervision as needed. On 8/20/24 at 3:05 p.m. a surveyor discussed this finding in an interview with the Director of Nursing (DON). The DON stated that CNA #4 was immediately sent home, and the facility terminated her contract with the agency.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 33639 Based on record reviews and interviews, the facility failed to issue a written transfer/discharge notice to a resident or their legal representative for a facility-initiated transfer/discharge for 5 of 5 sampled residents transferred/discharged to an acute care facility. (#75, #40, #65, #78 and #88) Findings: 1. Documentation in Resident #75's clinical record indicated that he/she was transferred to an acute hospital on 7/14/24 and subsequently admitted . The clinical record lacked evidence that the facility issued a written transfer/discharge notice to the resident and/or legal representative. On 8/21/24 at 3:30 p.m., in an interview with the surveyor, the Director of Nursing (DON) and confirmed that she was unable to locate evidence that a transfer/discharge form for Resident #75 was completed and provided to the resident or resident representative at the time of transfer to the hospital. 2. Documentation in Resident #40's clinical record indicated that he/she was transferred to an acute hospital on 10/31/23 and subsequently admitted . The clinical record lacked evidence that the facility issued a written transfer/discharge notice to the resident and/or legal representative. 3. Documentation in Resident #65's clinical record indicated that he/she was transferred to an acute hospital on 11/2/23 and subsequently admitted . The clinical record lacked evidence that the facility issued a written transfer/discharge notice to the resident and/or legal representative. 4. Documentation in Resident #78's clincial record indicated that he/she was transferred to an acute hospital on 4/11/24 and subsequently admitted . The clinical record lacked evidence that the facility issued a written transfer/discharge notice to the resident and/or legal representative. 5. Documentation in Resident #88's clinical record indicated that he/she was transferred to an acute hospital on 4/11/24 and subsequently admitted . The clinical record lacked evidence that the facility issued a written transfer/discharge notice to the resident and/or legal representative. On 8/22/24 at 9:40 a.m. a surveyor interviewed RN #4 and learned a written transfer/discharge notice for the resident and/or representative is not used in this facility but he/she remembers using it at other facilities. On 8/22/24 at 2:50 p.m. a surveyor discussed the above findings with the DON and confirmed the facility does not provide a transfer/discharge form to residents and/or representatives and they were unaware this was necessary. 48648

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 33639 Based on record reviews and interviews, the facility failed to issue a written bed hold notice to a resident, a family member or legal representative for 5 of 5 sampled residents who had been transferred to an acute care facility (#75, #40, #65, #78 and #88). Findings: 1. Documentation in Resident #75's clinical record indicated that he/she transferred to an acute care hospital on 7/14/24 and subsequently admitted . The clinical record lacked evidence that the facility issued a written bed hold notice to the resident, a family member, or legal representative upon transfer. On 8/21/24 at 3:30 p.m., in an interview with the Director of Nursing (DON) confirmed that she was unable to locate evidence that the facility issued a written bed hold notice to the resident, a family member, or a legal representative upon transfer for Resident #75. 2. Documentation in Resident #40's clinical record indicated that he/she transferred to an acute care hospital on 10/31/23 and subsequently admitted . The clinical record lacked evidence that the facility issued a written bed hold notice to the resident, a family member, or legal representative upon transfer. 3. Documentation in Resident #65's clinical record indicated that he/she transferred to an acute care hospital on 11/2/23 and subsequently admitted . The clinical record lacked evidence that the facility issued a written bed hold notice to the resident, a family member, or legal representative upon transfer. 4. Documentation in Resident #78's clinical record indicated that he/she transferred to an acute care hospital on 4/11/24 and subsequently admitted . The clinical record lacked evidence that the facility issued a written bed hold notice to the resident, a family member, or legal representative upon transfer. 5. Documentation in Resident #88's clinical record indicated that he/she transferred to an acute care hospital on 4/11/24 and subsequently admitted . The clinical record lacked evidence that the facility issued a written bed hold notice to the resident, a family member, or legal representative upon transfer. On 8/21/24 at 1:27 p.m.a surveyor discussed the findings with the DON and confirmed that she was unable to locate evidence that the facility had issued completed bed hold notices for Resident #40, Resident #65, Resident #78 and Resident #88. 48648

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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 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37648 Based on record reviews and interview, the facility failed to ensure that 1 of 5 residents reviewed with a specialized mental health diagnosis, whose stay went beyond the expected 30 days, had been referred to the appropriate state-designated authority for Pre-Admission Screening & Resident Review Level II (PASRR) evaluation and determination (Residents #55). Finding: Resident #55 was admitted to the facility on [DATE] with diagnosis of bipolar disorder. Resident #55's clinical record contained a PASRR Level I determination letter dated 10/18/21 that stated further PASRR evaluation was not required due to Resident #55 met the criteria for a short-term convalescence admission. Resident #55 was not discharged after a short stay and was assessed to be Nursing Facility level of care and continued to reside in the facility. The clinical record lacked evidence to indicate that the PASRR Level I was forwarded again to the State Mental Health Authority to determine if a PASRR Level II evaluation and determination was needed after the Residents stay changed from short-term to long-term. On 8/21/24 at 12:38 p.m., in an interview, the Director of Clinical Services confirmed the findings.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 37648 Based on interviews and record review the facility failed to review and revise the care plan by an interdisciplinary team (IDT), that included but is not limited to, the attending physician, a registered nurse and Certified Nurses Aid (CNA) with responsibility for the resident, a member of nutrition services and to the extent possible, include the participation of the resident and/or resident's representative, after each Minimum Data Set (MDS) assessment for 16 of 29 residents whose care plans were reviewed (#9, #13, #18, #30, #31, #40, #54, #55, #62, #65, #67, #71, #75 #78, #88, #93 and #95). Findings: 1. Review of Resident #9's medical record, the surveyor noted IDT meetings held on 7/13/23, and 4/11/24 where the only IDT members in attendance were a registered nurse and nutrition services. The IDT held on 7/13/23 and 10/11/23 only had nutrition services in attendance. 2. Review of Resident #13's medical record, the surveyor noted an IDT meetings held on 1/4/2024, with only Dietary & Nursing in attendance. No documentation of resident or family invitation or attendance. Review of Resident #13's medical record, the surveyor noted an IDT on 3/27/2024, with only Dietary & Nursing in attendance. A note stated resident has no complaints or concerns. goes to dialysis x3 wk scheduled for cataract surgery 4/22/24. dialysis is concerned with residents eating consumption (high K+/Ca+ foods & fluid intake) resident has been educated numerous times. No documentation of resident or family invitation or attendance. Review of Resident #13's medical record, the surveyor noted an IDT on 7/2/2024 with only Dietary in attendance. A note stated, Renal, large portions protein tid with meals, regular consistency (level 4) thin liquids, 1500cc fluid restriction. Allergic to raw carrots, celery and peaches. No documentation of resident or family invitation or attendance 3. Review of Resident #18's medical record, the surveyor noted IDT meetings held on 11/3/23, 2/3/24, and 5/3/24 where the only IDT members in attendance were a registered nurse and nutrition services. The IDT held on 8/3/24 only had a registered nurse in attendance. 4. Review of Resident #30's medical record, the surveyor noted IDT meetings held on 11/23/23 and 2/14/24 where the only IDT members in attendance were a registered nurse and nutrition services. The IDT held on 5/15/24 only had a registered nurse and activities in attendance. The IDT held on 8/14/24 only had a registered nurse in attendance. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 8/19/24 at 1:53 p.m., during an interview, Resident #31 was asked if he/she was invited or participated in their plan of care meetings with the IDT team, he/she stated, not sure if he/she was invited. Review of Resident #31's medical record, the surveyor noted IDT meetings held on 10/30/23 and 1/29/24 where the only IDT members in attendance were a registered nurse and nutrition services. An MDS Quarterly assessment was completed on 5/20/24. The medical record lacked evidence that a care plan meeting had been held by the IDT after the 5/20/24 assessment. All past 3 IDT meetings lacked documentation of resident #31 being invited or attending his/her IDT. 6. Review of Resident #40's medical record, the surveyor noted IDT meetings held 3/6/24 and 2/27/24 where only dietary attended. An IDT meeting held 11/21/23 where only nursing and dietary attended. 7. Review of Resident #54's medical record, the surveyor noted IDT meetings held on 1/26/24 and 7/23/24 where the only IDT members in attendance were a registered nurse and nutrition services. The IDT held on 7/27/23, 10/26/23 and 4/25/24, only had nutrition services in attendance. 8. Review of Resident #55's medical record, the surveyor noted IDT meetings held on 9/7/23 and 12/7/23 where the only IDT member in attendance was nutrition services. The IDT held on 3/6/24 only had a registered nurse, activities and nutritional services in attendance and the IDT held on 6/5/24 only had a registered nurse and nutritional services in attendance. 9. Review of Resident #62's medical record, the surveyor noted IDT meetings held 10/4/23, 1/30/24, 4/26/24 and 7/29/24 where only nursing and dietary attended. 10. Review of Resident #65's medical record, the surveyor noted IDT meetings held 2/10/23, 8/10/23, 11/9/23, 3/15/24 where only nursing and dietary attended. An IDT meeting held 5/12/23 where nursing, dietary, wife and resident attended. A meeting held 6/13/24 where only activities attended. 11. Review of Resident #67's medical record, the surveyor noted IDT meetings held on 3/21/24 and 6/11/24 where the only IDT members in attendance were a registered nurse and nutrition services. 12. On 8/19/24 at 10:14 a.m., during an interview, Resident #71 was asked if he/she was invited or participated in their plan of care meetings with the IDT team, he/she stated, No, nobody said anything about it. Review of Resident #71's medical record, the surveyor noted IDT meetings held on 11/6/23 and 2/2/24 where the only IDT members in attendance was a registered nurse and nutrition services. The IDT held on 5/10/24 only had nutrition services in attendance and the IDT on 8/7/24 only had a registered nurse in attendance. All past 4 IDT meetings lacked documentation of resident #71 being invited or attending his/her IDT. 13. Review of Resident #75's medical record, the surveyor noted IDT meetings held on 6/29/23 where the only IDT members in attendance were a registered nurse and nutrition services. The IDT held on 6/29/23 and 9/14/23 only had nutrition services in attendance. 14. Review of Resident #78's medical record, the surveyor noted IDT meetings held 9/21/23 where only dietary attended. IDT meetings held 6/22/23, 12/21/23, 3/26/24 where only nursing and dietary attended. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	15. Review of Resident #88's medical record, the surveyor noted IDT meetings held 5/1/24 and 8/1/24 where only dietary attended. IDT meetings held 8/4/23, 11/3/23 and 2/1/24 where only nursing and dietary attended. 16. Review of Resident #93's medical record, the surveyor noted IDT meetings held on 4/17/24 and 7/24/24 where the only IDT member in attendance was a registered nurse and nutrition services. 17. On 8/19/24 at 10:32 a.m., during an interview, resident #95 was asked if he/she was invited or participated in their plan of care meetings with the IDT team, he/she stated, I don't think I've had one for quite a while. Review of Resident #95's medical record, the surveyor noted IDT meetings held on 9/22/23 and 12/22/23 where the only IDT member in attendance was a registered nurse and nutrition services. The IDT held on 3/22/24 only had nutrition services in attendance and the IDT on 6/21/24 only had activities and nutritional services in attendance. All past 4 IDT meetings lacked documentation of Resident #95 being invited or attending his/her IDT. 33639 44049 48648

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 37648 Based on interview and record review, the facility failed to develop a discharge summary which included a recapitulation of the resident's stay for 1 of 1 residents reviewed for discharge (Resident #105). Findings: Resident #105 was admitted to facility on 2/1/24 for skilled services. On 6/12/24 Resident #105 was discharged to the community. The clinical record lacked evidence a recapitulation of the resident's stay was completed at discharge. On 8/22/24 at 9:41 a.m., during an interview, the Director of Clinical Services indicated that she reviewed Resident #105's clinical record and was unable to find evidence that a recapitulation of stay was completed for this resident.

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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. 33639 Based on record review and interview, the facility failed to ensure that physician's orders were followed for 1 of 33 sampled residents (#9). Finding: Resident #9's Physician Order Summary sheet dated 4/9/24 indicated the resident was to be weighed weekly on Tuesday and Thursday for Congestive Heart Failure. There was no evidence in the resident's clinical record to indicate the resident was weighed on 4/18/24, 5/23/24, 6/6/24, 6/11/24, 7/11/24, 7/18/24 and 7/25/24. On 8/21/24 at 3:30 p.m., the surveyor confirmed this finding in an interview with the Director of Nursing (DON).

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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. 37648 Based on observations, record reviews, facility policy, and interviews, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to respiratory care for 4 of 4 residents reviewed for respiratory care (#30, #60, #93 and #70) Findings: Facility policy and procedure Oxygen Use and Storage effective 3/2023 states under Respiratory Care, A sanitary environment must be maintained to prevent the transmission of disease and infection. Nasal cannula should be discarded and changed weekly. A label indicating the date and the initials of the staff changing the cannula/tubing should be applied to the nasal cannula. Nebulizer parts should be wrenched after each use and discarded every week. A label indicating the date in the initials of the staff changing the parts/tubing should be applied to the tubing . Staff changing the tubing should document on the treatment administration record (TAR) when the tubing has been changed following the policy. 1. On 8/19/24 at 9:22 a.m., on 8/20/24 at 2:45 p.m., and on 8/21/24 at 10:02 a.m., observations of Resident #30's oxygen (O2) nasal cannula tubing unlabeled/undated, an oxygen tubing connected to the CPAP (continuous positive airway pressure) machine with the open end hanging of the bedside table and resting on the floor and a nebulizer pipe stored on the bedside table amongst personal belongings unlabeled/undated. Review of the clinical record lacked documentation of both the O2 and nebulizer tubing change weekly. 2. On 8/19/24 at 9:46 a.m., and on 8/21/24 at 10:04 a.m., observations of Resident #60's nebulizer tubing unlabeled/undated with the mouthpiece hanging down the backside of the bedside dresser and wall. Review of the clinical record lacked documentation of the nebulizer tubing change weekly. 3. On 8/19/24 at 10:30 a.m., and on 8/20/24 at 2:47 p.m., observations of Resident #93's nebulizer tubing unlabeled/undated with the mask stored on the bedside table amongst personal belongings and another nebulizer pipe hanging off the top between the dresser and wall. 08/19/24 at 1:59 p.m., During observation and discussion with Resident #70, a surveyor observed that his Oxygen was running at 2L and that there was no date on the tubing. He stated, I don't wear it that much. Review of the clinical record lacked documentation of the oxygen tubing change weekly. This was verified with the LPN passing meds and with the charge nurse at that time. On 8/21/24 at 10:08 a.m., during an interview, the Licensed Practical Nurse stated, O2 tubing and nebulizers are changed weekly, should be signed off on the TAR and the tubing should be initialed. On 8/21/24 at 10:35 a.m., both the surveyor and the Director of Clinical Services observed the above O2/nebulizer tubing and storage. The Director of Clinical Services stated the tubing is usually stored coiled up and stored on top of the machines and should be changed weekly and documented on the Treatment Administration Record (TAR). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	44049

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37648 Based on record review and interview, the facility failed to identify a resident's past history of Post-Traumatic Stress Disorder (PTSD)/trauma to determine what trigger(s) might cause re-traumatization and failed to revise the care plan to include trauma informed care for 1 of 5 sampled residents reviewed for trauma. (#60) Finding: Facility policy and procedure, Trauma Informed Care, revised 11/2023 states, upon admission to the facility, social services, or designee, will assess each resident using screening question on admit for a history of trauma and or post traumatic stress disorder to ensure identified residents receive appropriate treatment and services. Any additional information may be obtained from the medical record or resident representative. Identified traumatic events and triggers will be reviewed by the interdisciplinary care team, who will work with the resident/resident representative to develop methodologies and approaches to mitigate/eliminate the triggers . Trauma specific interventions will be placed on the residence care plan, and this will be reviewed quarterly, and updated as necessary. On 8/19/24 during an interview, Resident #60 stated, the facility is aware that he/she has PTSD, and he/she is not to have male caregivers. Resident #60's clinical record was reviewed and indicated the resident was admitted to the facility on [DATE]. The history and physical completed on 5/9/22 states under Past Medical History, Diagnosis: History of sexual abuse in childhood. The Psychosocial Assessment & History completed on 5/9/22 and on 6/6/23 - Section 6 indicates, he/she had Physical/Sexual/Emotional Abuse History. The screening for trauma informed care completed on 6/5/23 and on 5/9/24 indicate yes for facing a traumatic event or experience in the past. The clinical record lacked information that indicated what Resident #60's PTSD triggers are or what events might cause re-traumatization. On 8/20/24 at 8:59 a.m., during an interview, the Director of Clinical Services stated she could not find a care plan (goal and trauma interventions) for the above history of trauma other than, resident does not want male direct care givers (CNAs) being mentioned as an intervention under Personalized care. At this time, the Director of Clinical Services confirmed the above.

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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. 37648 Based on facility policy, observations, record review and interviews the facility failed to ensure controlled drug records are in order and an account of all controlled drugs is maintained to enable reconciliation and failed to ensure that two people who are authorized to administer medications signed the controlled substance cycle count once daily for 1 of 1 Omnicell (automated medication dispensing cabinet) reviewed. Findings Facility policy and procedure for Omnicell Inventory & Cycle Count, dated 7/2018 states, Controlled medications will counted at least once daily by two licenses nurses. This specific count will be signed off as complete using the accountability log sheet. On 8/21/24 at 8:14 a.m., observation of the Unit A medication storage room with the Registered Nurse Manager (RN #3) to have an Omnicell machine which contained emergency box medications including controlled drugs. At this time, the RN #3 stated the controlled medications in the Omnicell should be counted daily. The Daily Omnicell Controlled Substance Cycle Count log indicated controlled substances are counted once daily by outgoing and incoming nurse. A review of the logs from 1/2024 through 8/21/24 showed the following missing controlled substance count daily: 1/2024 missing count for 9 of 31 days 2/2024 missing count for 11 of 28 days 3/2024 missing count for 14 of 31 days 4/2024 missing count for 12 of 30 days 5/2024 missing count for 17 of 31 days 6/2024 missing count for 22 of 30 days 7/2024 missing count for 20 of 31 days 8/2024 missing count for 14 of 20 days reviewed On 8/21/24 at 8:50 a.m., the above was discussed with the Director of Clinical Services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 37648 Based on facility policy, observation, interview and record review the facility failed to ensure biologicals were stored at appropriate temperatures in 2 of 2 refrigerators observed (Unit A, #1 and #2 refrigerators). Findings: Facility policy and procedure for Omnicare Storage and Expiration of Medications, Biologicals, Syringes and Needles, revised 8/24 states, Facility should ensure that medications and biologicals are stored at their appropriate temperatures . refrigeration: 36 to 46 F. 1. On 8/21/24 at 8:14 a.m., observation of the Unit A medication storage room with the Registered Nurse Manager (RN #3) which contained 2 refrigerators #1 (containing insulin, Ozempic and Tuberculin Purified Protein) and #2 (containing insulins). At this time, the RN #3 stated the refrigerators temperatures should be monitored once or twice daily, she could not remember. The Medication Fridge Temperatures Log for refrigerators #1 and #2 indicated temperatures are to be monitored twice daily. Review of the temperature logs from 1/2024 through 8/21/24 showed temperatures were only being monitored once daily, with the following daily temperatures missing: 1/2024 missing temp for 6 of 31 days 2/2024 missing temp for 7 of 28 days 3/2024 missing temp for 6 of 31 days 4/2024 missing temp for 4 of 30 days 5/2024 missing temp for 3 of 31 days 6/2024 missing temp for 2 of 30 days 7/2024 missing temp for 6 of 31 days 8/2024 missing temp for 7 of 20 days reviewed On 8/21/24 at 8:50 a.m., the above was discussed with the Director of Clinical Services. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 8/21/24 at 10:24 a.m., both surveyor and Director of Clinical Services observed the vaccine refrigerator in the Infection Control office which contained 22 boxes of influenza vaccine and 3 boxes and 7 syringes of pneumococcal vaccines. Review of the Temperature Logs which were attached to the front of the refrigerator stated July 2024 temperatures were monitored only once daily for 14 out of 31 days and August 2024 temperatures were monitored only once daily for 12 out of 21 days reviewed. At this time, the Director of Clinical Services confirmed the lack of temperature monitoring.

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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. 44049 Based on observations and interviews, the facility failed to serve and store food in a sanitary manner during 1 of 2 observations. Findings: 1. On 8/19/24 at 9:10a.m. during the initial observation of the kitchen, this surveyor found undated and unlabeled pie and other deserts in the reach-in refrigerator. 2. Also, on a cart that the 'person in charge' stated was the breakfast cart observed three different packages of cheese with no dates, and a package of French toast with no date. These were confirmed with the 'person in charge' at the time. 3. On 8/21/24 at 11:30a.m. Observation of Unit A Kitchenet - Observed that the freezer contained a moderate to heavy amount of dirt and the refrigerator contained a light to moderate amount of dirt and it was extremely full. All items observed did have resident names and dates. Observation of Unit B Kitchenet - observed a small to moderate amount of dirt and the temperature log on the outside of the fridge was lacking documentation of temperature checks for 13 of 31 days in July of 24 and for 3 of 21 days in August of 2024. The were confirmed with the person in charge of the Dietary Department at 12:45p.m. 4. On 8/21/24 at 3:45p.m. in an interview with the Food Service Consultant, she reviewed the Dish Machine Temp log with this surveyor that showed when the dish machine needed repair and would no longer record the temp of the wash and rinse, the company told them to add bleach and they were doing it, but never recorded the parts per million (ppm) that they added. The log lacks documentation from 6/7/24 - 7/9/24, this was confirmed with her at that time.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 48648 Based on interviews and reviews of the attendance from the facility Quality Assurance meetings, the facility failed to ensure the Quality assessment and assurance (Qaa) committee consisted of the required members. Findings: A review of the signed attendance list for Qaa meetings held on 6/11/24 and 7/2/24 showed that the administrator, owner, board member or other individual in a leadership role did not attend either meeting. On 8/22/24 at 9:15 a.m. a surveyor discussed the above finding with the Director of Nursing (DON) and learned the Qaa committee meets weekly but the Administrator (or owner, board member or other individual in a leadership role) does not ever attend the Qaa meetings.