

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  475021	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/28/2025
NAME OF PROVIDER OR SUPPLIER  Saint Albans Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 596 Sheldon Road Saint Albans, VT 05478	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29776</b></p> <p>Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable and homelike environment regarding resident room maintenance and repair on all resident units. This is a repeat deficiency for this facility, with violations cited during the previous two recertification surveys, dated 10/04/23 and 10/26/22.</p> <p>Findings include:</p> <p>An interview was conducted with the facility's Administrator [ADM] on 1/15/25 at 10:30 AM.</p> <p>The ADM provided a Quality Assurance/Performance Improvement [QAPI] meeting report regarding 'Physical Plant' concerns last dated 1/6/25.</p> <p>Per review of the QAPI report, an audit of the physical plant was assigned and completed by the Administrator, with a notation that all residents have the potential to be affected. QAPI areas and actions also included Continued Quality Assurance audits implemented to ensure enhanced system compliance and list Administrator to coordinate with MP [Maintenance] to assure projects continue per environmental audit.</p> <p>Review of the facility audit completed by the ADM, dated 1/3/25 included items identified as in need of replacement, in need of repair/replacement, need patching or painting, and/or need sanding/staining in categories that include ceiling tiles, heater cover, baseboards, holes or discolored sections on wall, bathroom wall, main door, and closet door. Areas and/or items in need of repair, replacement, patching, painting, sanding/staining were identified in all 48 resident rooms in the facility.</p> <p>The Maintenance Director provided a printed list of facility-wide environmental issues identified through the Maintenance Department dated 1/15/25. The maintenance list included Open and In Progress work orders. Review of the Maintenance Department's Open and In Progress work orders reveals the work order list does not contain when the issues and concerns were identified, or any maintenance staff assigned to perform the open tasks or repairs.</p> <p>A tour was conducted of random resident rooms with the Maintenance Director on 1/15/25 at 10:15 AM. In resident room [ROOM NUMBER] West, surveyors identified multiple environmental issues including:</p> <ul style="list-style-type: none"> <li>- Multiple bare plaster spots and cracks in the walls, and scrapes distributed about the walls;</li> </ul> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<ul style="list-style-type: none"> <li>- One double electric outlet that is pushed about 1/2 out of the wall creating a gap behind the faceplate. The top of this gap is covered in paper masking tape;</li> <li>- No toilet paper holder in the bathroom;</li> <li>- Bathroom tiles discolored and appeared to be soiled with unknown substances black and brown in color;</li> <li>- Warped countertop with buckling laminate at the shared room sink;</li> <li>- Countertop at sink with bare wood/unpainted gaps where the countertop abuts the wall;</li> <li>- Approximately 1-foot square area of an unpainted patch on the wall above soap dispenser at shared sink;</li> <li>- Bathroom- Approximately 1-foot square area of an unpainted patch next to soap dispenser;</li> <li>- Heater cover running length of outer wall- multiple areas of brown stains and visible rust;</li> <li>- Bedside cabinet at window with peeling laminate on the door;</li> <li>- Multiple vertical scratches exposing bare wallboard behind head of bed located near window;</li> <li>- Resident light above/behind bed at window with no string/ no resident access.</li> </ul> <p>The Maintenance Director confirmed all areas identified by the surveyors in room [ROOM NUMBER] [NAME] as requiring repair or replacement in order to maintain a homelike environment for residents.</p> <p>A review of the facility's Maintenance Department's Open and In Progress work orders did not identify resident room [ROOM NUMBER] [NAME] as needing any areas of repair and was not included anywhere on the list.</p> <p>Further observations in additional random resident rooms with the Maintenance Director revealed multiple areas in need of repair/replacement confirmed by the Director and again confirmed that they were not identified by the facility and did not appear on the Maintenance Department's Open and In Progress work orders list or on the facility's Physical Plant audit conducted by the Administrator on 1/3/25. Of note, an item in need of repair/replacement listed on the facility's Physical Plant audit dated 1/3/25 is identified as was a State concern previously. The previous State Survey of the facility was conducted on 10/4/2023.</p> <p>The following is a list of resident room issues identified during observations conducted on 1/13 thru 1/15/25:</p> <p>East Wing:</p> <p>room [ROOM NUMBER] East:</p> <ul style="list-style-type: none"> <li>- Large crack running down right wall;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<ul style="list-style-type: none"> <li>- Bathroom has loose toilet paper holder.</li> </ul> <p>room [ROOM NUMBER] East:</p> <ul style="list-style-type: none"> <li>- Bathroom has a loose toilet paper holder;</li> <li>- Tiles around the left side of toilet have visible rust stains.</li> </ul> <p>room [ROOM NUMBER] East:</p> <ul style="list-style-type: none"> <li>- 2 inch by 2 inch hole at right end of radiator by window;</li> <li>- Window on the left side of the room has shard of metal and screws coming loose from the window.</li> </ul> <p>room [ROOM NUMBER] East:</p> <ul style="list-style-type: none"> <li>- Loose handrail next to toilet;</li> <li>- Toilet paper holder is loose;</li> <li>- The room number sign outside the door for room [ROOM NUMBER] East is missing numbers.</li> </ul> <p>room [ROOM NUMBER] East:</p> <ul style="list-style-type: none"> <li>- Large scrapes in the drywall behind the head of one of the beds that ran the entire length of the headboard;</li> <li>- Six metal dry wall anchors inserted into the wall with sharp edges and nothing installed into them;</li> <li>- The toilet paper holder in the bathroom was partially ripped out of the wall;</li> <li>- The light in the bathroom was a bare light bulb with no covering.</li> </ul> <p>room [ROOM NUMBER] East:</p> <ul style="list-style-type: none"> <li>- The entry door side of the room there is a 1-inch hole in the wall by the TV;</li> <li>- Approximately 3 feet of baseboard molding missing on wall behind bed near doorway;</li> <li>- Baseboard molding pulling away from wall;</li> <li>- Plaster is hanging and falling off the ceiling;</li> <li>- In the bathroom there were several small holes (less than an inch each) and plaster was peeling off the walls;</li> </ul> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>- Radiator has bent fins</p> <p>Common Areas:</p> <p>Name plates on resident doors had broken letters, excessive tape, or stickers that made it difficult to read the resident's name for rooms W2, W3, W4, W5, W6, W7, W8, W9, W11, W14, W15, W16, W17, W18, W19, W20, W21, W22, W23, W24, W25, W27, CE1, CE2, CE3, CE4, CE5, CE6, CE7, CE8, CE9, E15, E16, E17, E18, E19, E20, E21, E22, E23, E24, E25, E26, E27.</p> <p>Resident room doors, visible from the hallway, had excessive amounts of tape or areas where a significant amount varnish had been striped from the door for rooms: W11, W14, W15, W16, W17, W20, W22, W25, W27, CE1, CE2, CE3, CE4, CE5, CE6, CE7, CE8, CE10, E15, E16, E17, E18, E19, E20, E21, E22, E23, E24, E25, E26, and E27.</p> <p>Dining room:</p> <ul style="list-style-type: none"> <li>- Approximately 10 stained or broken ceiling tiles with multiple areas of bent metal holding the tiles up.</li> <li>- Approximately 2.5 ft crack in the wall by the dining room entrance</li> </ul> <p>Hall to dining room:</p> <ul style="list-style-type: none"> <li>- Approximately 3 inch x 3 inch hole in the plaster by the baseboard of the dining room door</li> <li>- 2 unpainted areas approximately 3 inches by 3 inches near the upper left hand area by the bathroom door across from the dining room</li> <li>- Approximately 2 foot x 3 foot unpainted area by the center nursing station</li> <li>- Approximately 6 inch by 1 inch long hole in plaster along the baseboard of the center nursing station</li> <li>- Significant dipping of ceiling tiles and bent metal holding the tiles in place in the center nursing station</li> </ul> <p>West common areas:</p> <ul style="list-style-type: none"> <li>- 4 roughly spackled, unpainted areas in hallway approximately 4 x 5 inches each, near rooms CW 9 and CW10</li> <li>- Exposed wires above the exit door</li> <li>- Significant dipping of ceiling tiles and bent metal holding the tiles in place in the hallway</li> <li>- Dipping of ceiling tiles and bent metal holding the tiles in place in the nursing station</li> </ul> <p>East common areas:</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<ul style="list-style-type: none"> <li>- Ceiling tiles dipping with bent metal supporting the tiles in the living room area</li> <li>- Radiator fins are bent in the living room area</li> <li>- Multiple discolored ceiling times in the hallway</li> <li>- Area of unpainted plaster approximately 2 inch x 4 inch in the hallway by room CE7</li> </ul> <p>Per interview with the ADM on 1/15/25 at 10:30 AM, the ADM confirmed a facility wide audit dated 1/3/25 identified areas and/or items in need of repair, replacement, patching, painting, sanding/staining were identified in all 48 resident rooms in the facility. The ADM confirmed the Quality Assurance/Performance Improvement [QAPI] meeting on 1/6/25 regarding the facility's 'Physical Plant' did not contain any plan of action or timeline to address the multiple resident room issues identified in the ADM's audit of 1/3/25.</p> <p>An interview was conducted with the Maintenance Director on 1/15/25 at 10:09 AM. The Maintenance Director reported that any staff member can submit a maintenance request through the facility's automated system. The system generates a report for the Maintenance Director who can then assign and track the request from the time the request was generated through the time it was completed. Additionally, the Maintenance Director stated s/he conducts daily rounds throughout the facility to identify maintenance needs and areas in need of repair. The Maintenance Director confirmed that multiple concerns and issues regarding providing residents with a homelike environment were identified during observations conducted on 1/13 through 1/15/25 and required action but were not identified by the Maintenance Department and did not appear on the Open and In Progress work orders list. The Maintenance Director reported if a maintenance concern or issue is not processed through the Work Order system, the Director and Maintenance staff have no process to assign or track the issue or ensure the repair and/or replacement is completed.</p> <p>Facility policy titled PM403 Physical Plant Inspections, last reviewed 1/8/24, reads, An inspection of the physical plant will be performed quarterly, by using the Physical Quarterly Inspection Checklist as a guideline for inspection and to schedule any repairs that are needed. Checklist comparisons may help identify solutions to persistent problems. Attached to the policy is the Physical Plant Quarterly Inspection Checklist, which lists general categories to inspect with specific areas to inspect in each category. For example, Halls and Corridors prompts documenting if baseboard moldings, ceiling tiles, and walls are in acceptable condition, and if not, what action was taken. Patient rooms prompts documenting if ceilings, walls, windows, and closets are in acceptable condition, and if not, what action was taken.</p> <p>A review of maintenance quarterly checklists for the past year (3/29/24, 6/28/24, 9/24/24, and 12/31/24) reveal an inspection of general categories rather than specific details in each category on a different checklist than what the policy included. The above quarterly inspection checklists answered yes to halls and corridors and patient rooms being acceptable. Actions required in these areas were marked as not applicable.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Saint Albans Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  596 Sheldon Road Saint Albans, VT 05478	
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a walk through of the facility on 1/28/25 at 11:30 AM with the Regional Environmental Director, s/he confirmed that the issues identified above should have been identified and a work order should have been put in. On 1/28/25 at 12:25 PM, the Regional Environmental Director explained that the system for quarterly inspection is flawed because it does not go through the detailed checklist of the general areas. S/He explained that the issues identified during the walk through should have been identified on the quarterly inspection and were not.</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29776</b></p> <p>Based on interview and record review, the facility failed to ensure a required Level 1 Preadmission Screening and Resident Review (PASRR) was conducted for 2 residents [Res.#16 &amp; #75] of 23 sampled residents to ensure the residents were evaluated for serious mental illness and were not inappropriately placed in nursing homes for long term care. Findings include:</p> <p>Per the Centers for Medicare and Medicaid:</p> <p>The Preadmission Screening and Resident Review (PASRR) process requires that all applicants to Medicaid-certified nursing facilities be given a preliminary assessment to determine whether they might have serious mental illness and/or intellectual disability. This is called a 'Level I screen.' Those individuals who test positive at Level I are then evaluated in depth, called 'Level II' PASRR. The results of this evaluation result in a determination of need, determination of appropriate setting, and a set of recommendations for services to inform the individual's plan of care.</p> <p>(<a href="https://www.medicare.gov/medicaid/long-term-services-supports/institutional-long-term-care/preadmission-screening-and-resident-review/index.html">https://www.medicare.gov/medicaid/long-term-services-supports/institutional-long-term-care/preadmission-screening-and-resident-review/index.html</a>)</p> <p>1.) Per record review, Res.#16 was admitted to the facility on [DATE] with diagnoses that included schizophrenia and cognitive communication deficit. Prior to their admission to the facility, Res.#16 was receiving care through a counseling and support service for continued care of long-standing history of schizophrenia.</p> <p>Res.#16 underwent an initial PASRR screening on 10/21/24. The resident received a Short -Stay exemption which states the individual may be admitted to the nursing facility without further screening if the physician certifies that the individual is likely to require less than 30 days in the nursing facility to qualify for this exemption. The PASRR continues, If it is later decided the individual will exceed 30 days, another Level 1 form screening for serious mental illness and Intellectual/developmental disability and/or related condition must be completed by the admitting nursing home.</p> <p>Further record review, conducted during the survey on 1/14/25, revealed Res.#16 is currently a resident at the facility, with their length of stay 84 days and counting. There was no documentation that a Level 1 PASRR review was conducted, despite the resident remaining at the facility past the 30-day exemption period.</p> <p>An interview was conducted with the facility's Social Service Director [SSD] on 1/15/25 at 12:33 PM. The SSD confirmed that a Level 1 PASRR was required after Res.#16's stayed in facility longer than initial 30 day stay but the PASRR assessment was not done. The SSD confirmed Res.#16 has a diagnosis of schizophrenia and is on antipsychotic medications and was receiving counseling services prior to admission. The SSD stated that the facility was figuring out the process and contacting a patient manager to see if the resident can continue to get services. The SSD confirmed that had the Level 1 PASRR screen been conducted as required, services might have already been identified and in place to assist the resident.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2.) Per record review, Res.#75 was admitted to the facility on [DATE]. Physician Notes dated 11/21/24, prior to their admission to this facility, record the resident was seen for chief complaint of acute adjustment disorder with features of anxiety and depressed mood where the physician and Res.#75 discussed care options including pharmacotherapy and counseling.</p> <p>Res.#75 underwent an initial PASRR screening on 11/25/24. The resident received a Short -Stay exemption which states the individual may be admitted to the nursing facility without further screening if the physician certifies that the individual is likely to require less than 30 days in the nursing facility to qualify for this exemption.</p> <p>Further record review, conducted during the survey on 1/14/25, revealed Res.#75 is currently a resident at the facility, with their length of stay 49 days and counting. There was no documentation that a Level 1 PASRR review was conducted, despite the resident remaining at the facility past the 30-day exemption period. Per interview with the SSD on 1/15/24, the SSD confirmed the Level 1 PASRR was not completed as required after Res.#75's stay extended beyond 30 days. The SSD confirmed that had the Level 1 PASRR screen been conducted as required, services might have already been identified and in place to assist the resident.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>50431</p> <p>Based observation, interview, and record review, the facility failed to ensure that a resident who is unable to carry out activities of daily living (ADLs) without assistance receives the proper level of assistance for 2 of 3 sampled residents (Resident #36 and Resident #4) related to nail care. Findings include:</p> <p>1. Per observation on 1/14/25 at 8:42 AM, Resident #36 had long toenails. Per interview with Resident #36 on 1/15/25 at 9:09 AM. Resident #36 stated s/he wants his/her nails cut.</p> <p>Per record review on 1/14/25, Resident #36 has medical diagnoses of Diabetes Mellitus Type II, COPD [Chronic Obstructive Pulmonary Disease], and CHF [Congestive Heart Failure]. Per record review of Resident #36's care plan states, [Resident #36] requires assistance for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, location, and toileting.</p> <p>Per the facility's NSG217 Foot Care policy [last revised 8/7/23] states, Patients who have complicating disease processes requiring foot care including, but not limited to, infections/fungus, ingrown toenails, diabetes mellitus, neurological disorders, renal failure, and peripheral vascular disease must be referred to qualified professionals such as podiatrists or other qualified providers.</p> <p>An interview was conducted with the Unit Manager on 1/15/25 at 9:51 AM. The Unit Manager discussed that the staff cannot cut Resident #36's nails due to his/her diagnosis of Diabetes and confirmed s/he would need to see a podiatrist. The Unit Manager provided documentation of the last podiatry progress note for Resident #36. The last podiatry note was on 5/22/23. Per record review of the resident's last podiatry note states, f/u [follow-up] [in] 3 months, further foot evaluation and treatment. The Unit Manager confirmed Resident #36 does not currently have a podiatry appointment and had not been seen for podiatry care since 5/22/23.</p> <p>51586</p> <p>2) Per observation on 1/13/25 at 10:00 AM, Resident #4 had very long fingernails with a black dirt like substance embedded under each fingernail on both hands. An interview was conducted with Resident #4 on 1/13/25 at 10:10 AM. Resident #4 stated that they would like their fingernails trimmed and has asked staff to do this for them. Resident #4 stated that they are just waiting for staff to come do it. On 1/15/25 at 1:00 PM, Resident #4 stated that staff had still not trimmed his/her fingernails.</p> <p>Per record review, Resident #4's care plan states that resident requires extensive assistance of 2 for hygiene care. Record review from 12/15/24 to 1/15/25 including progress notes, LNA [Licensed Nursing Assistant] tasks, medication administration, and treatment administration record show that Resident #4 did not receive hygiene care related to finger nail trimming within the last 30 days. Resident #4's care plan states resident is at risk for injury or complications related to anticoagulation [blood thinner] therapy.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Per interview with the Unit Manager on 1/15/25 at 1:20 PM, the Unit Manager stated that Resident #4's fingernails must be trimmed by a licensed nurse due to the resident being on an anticoagulant medication. The Unit Manager also stated I do not have any good answer for why this (the trimming of Resident #4's finger nails) has not been done.</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46135</p> <p>Based on interviews and record review, the facility failed to develop an individualized care plan that addresses the assessed emotional and psychosocial needs of the resident and failed to provide services that address the assessed needs of the resident for 1 of 23 residents (Resident #5). Findings include:</p> <p>Per record review, Resident #5 was admitted to the facility on [DATE]. Per a 12/19/2024 PHQ-2 to 9 Evaluation (mood evaluation), a mood interview was conducted with Resident #5, who reported that over the past two weeks, s/he had little interest or pleasure in doing things several days, felt down, depressed, or hopeless for several days, was tired or had little energy half or more of the days, and had trouble concentrating on things half or more of the days.</p> <p>Per interview on 1/13/25 at 1:34 PM, Resident #5 stated that s/he is sad and has crying spells. S/He reported not to have any mental health services and would utilize them if they were offered.</p> <p>A Nursing Progress Note dated 1/15/24 reveals that Resident #5 stated 'I'd be better off dead,' when Social Services came to reevaluate Resident #5's mood.</p> <p>Per record review, Resident #5's care plan does not address his/her reported mood and does not have any interventions to support the resident with depression such as daily check ins or mental health support.</p> <p>Per interview on 1/15/25 at 9:50 AM, the Director of Social Services explained that if a resident's mood assessment tool identified symptoms of depression, s/he would inform the Nurse Practitioner, create a care plan for mood that included interventions such as daily check ins, and put in a referral for a psychiatric consult.</p> <p>Per interview on 1/15/25 at 3:06 PM, the Director of Nursing confirmed that Resident #5 didn't have a care plan and psychiatric services offered after the mood assessment on 12/19/24 and should have.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>46135</p> <p>Based on observation, interview, and record review, the facility failed to ensure that freezer food temperatures were maintained at a safe level for 3 of 4 freezers, including the walk-in freezer for the main kitchen that serves food for all residents in the facility. This is a repeat deficiency. Findings include:</p> <p>Per observation on 1/13/25 at 9:54 AM, the walk-in freezer door was unable to shut completely after inspection by the survey team. Review of temperature logs for November and December 2024 reveals that 30 of the 30 days in November the walk-in freezer had recorded temperatures between 5 and 19 degrees Fahrenheit, all days above zero degrees and out of range; and 31 of the 31 days in December the walk-in freezer had recorded temperatures between 3 and 18 degrees Fahrenheit, all days above zero and out of range.</p> <p>Per review of temperature freezer logs for the unit freezer units, 2 of the 3 unit freezers had temperatures out of range. Review of [NAME] Unit's temperature logs for November and December 2024 reveals that 29 of the 30 days in November the freezer had recorded temperatures between 3 and 36 degrees Fahrenheit, most days above zero and out of range; and 27 of the 31 days in December the freezer had recorded temperatures between 1 and 31 degrees Fahrenheit, most days above zero and out of range. Review of the Center Unit temperature logs for November and December 2024 reveals that 25 of the 30 days in November the freezer had recorded temperatures between 1 and 20 degrees Fahrenheit, most days above zero degrees and out of range; and 26 of the 31 days in December the freezer had recorded temperatures between 1 and 19 degrees Fahrenheit, most days above zero and out of range.</p> <p>Facility policy titled FNS402 Refrigeration/Freezer Temperature Standards, effective 5/1/23, reads, If temperatures fall outside of acceptable range, the Maintenance Department is notified immediately, If repair is delayed, consideration must be made regarding the relocation of perishable items. Acceptable ranges are: . Freezers: -10 to 0 degrees Fahrenheit.</p> <p>Per interview on 1/15/25 at 12:10 AM, the Administrator explained that the kitchen staff do not have access to put in a maintenance work order through their online system, TELS. S/He confirmed that there had not been a work order for the broken walk-in freezer.</p> <p>Per interview on 1/15/25 at 1:12 PM, the Kitchen Manager confirmed that the freezer temperatures on the above temperature logs for all 3 freezers were not in range if the temperature was above 0 degrees Fahrenheit.</p> <p>Per interview on 1/15/25 at 4:40 PM, the Administrator explained that the walk-in freezer had been broken for a while but it has been much worse recently. S/He stated that s/he had made a request for funding to replace the freezer in November 2024.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>51586</p> <p>Based on observation and interview, the facility failed to implement facility-wide systems for the prevention and control of infections and communicable diseases of residents, staff, and visitors. Findings include:</p> <p>1.) On 1/15/25 at 1:27 PM an inspection of the facility laundry room was conducted. Present for the inspection were the Infection Preventionist [IP] and a Laundry Staff. This surveyor observed three areas in the ceiling where water was dripping from leaking pipes directly into the clean laundry area. When questioned, the facility IP stated that these are drainpipes from the shower room which is located directly above the laundry room. The IP confirmed that the shower room was in current use and that the water draining from the shower room above could contain feces, blood, urine, and other infectious materials. Facility laundry staff present for this inspection also stated that the leaks had not been reported to the maintenance department as of the time of this interview.</p> <p>46135</p> <p>2.) Per observation on 1/13/25 at 4:41 PM, a Kitchen Staff was observed getting ready for dinner service. This staff member was observed removing soiled gloves and putting on new gloves without performing hand hygiene in between. This happened 4 more times over the next 12 minutes.</p> <p>Per interview on 1/13/25 at 4:53 PM, the IP confirmed that infection prevention training is given to kitchen staff, which includes proper handwashing and gloving techniques. The I.P. confirmed staff should wash their hands prior to donning gloves and again after removing gloves.</p> <p>29776</p> <p>3.) Per observation on 1/13/25 at 11:17 AM, Res. #65 was observed sitting in h/her wheelchair in the [NAME] Wing hallway. The resident's Foley catheter tubing was observed touching the floor underneath the wheelchair. Additional observations on 1/14/25 again revealed Res.#65 in their wheelchair with the Foley catheter tubing touching the floor while the resident ate breakfast in the [NAME] Wing dining area. Staff were assisting the resident with h/her meal, and did not adjust the catheter tubing.</p> <p>An interview was conducted with the facility's Infection Preventionist [I.P.] on 1/15/25 at 11:00 AM. The I.P. confirmed that Foley catheter tubing touching the floor was a preventable infection risk and was not the facility's practice. The I.P. confirmed a resident with a Foley catheter would be under Enhanced Barrier Precautions and Foley catheter care by staff would require staff to wear PPE.</p>		