STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205180	A. BUILDING _____ B. WING _____	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDWARD GARDENS	**105 MECHANIC ST CAMDEN, ME 04843**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS From 4/22/24 through 4/25/24, on-site visits were conducted at Windward Gardens for the purpose of a Recertification Survey and investigating intakes #ME00046708, #ME00046720, #ME00046740, #ME00046777, #ME00046950, #ME00047019, #ME00047183, and #ME00047185. It was determined that Windward Gardens was not in substantial compliance with 42 CFR 483, Sub-part B Requirements for Long Term Care Facilities.	F 000		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still	F 578		

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

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legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on facility policy, record review, and interviews the facility failed to provide residents/representatives written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive for 14 of 17 residents reviewed for advanced directives (Resident's #5, #14, #19, #21, #22, #26, #27, #34, #44, #49, #52, #54, #58 and #219).

Findings:

Review of facility policy titled " Review of facility policy "Health Care Decision Making" dated 1/8/24 states " .... Centers must: Inform and provide written information to all patients concerning the rights to accept or refuse medical or surgical treatment and, at the patient's option, formulate an advance directive: ...approach a capable patient who does not have an advance directive upon admission , ... so that patient's rights will be honored and their wishes will be

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executed at the appropriate time...Upon admission, determine whether the patient has an advance directive and...If the patient/patient representative has copies with them, make copies, place in medical record, and notify the interprofessional team..."

1. Resident #5 was admitted to the facility on 3/15/22. A review of Resident #5's clinical record lacked evidence that the facility provided resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive.

2. Resident #14 was admitted to the facility on 5/25/23. A review of Resident #14's clinical record lacked evidence that the facility provided resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and or formulate an advance directive.

3. Resident #19 was admitted to the facility on 4/3/24. A review of Resident #19's clinical record lacked evidence that the facility provided resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive.

4. Resident #21 was admitted to the facility on 7/25/23. A review of Resident #21's clinical record lacked evidence that the facility provided resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and or formulate an advance directive.

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5. Resident #22 was admitted to the facility on 8/17/22. A review of Resident #22's clinical record lacked evidence that the facility provided resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and or formulate an advance directive.

6. Resident #26 was admitted to the facility on 9/21/23. A review of Resident #26's clinical record lacked evidence that the facility provided resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and or formulate an advance directive.

7. Resident #27 was admitted to the facility 5/22/23. Review of quarterly Minimum Data Set (MDS) dated 3/15/24 revealed Brief Interview for Mental Status 14 of 15 indicating resident #27 is cognitively intact. During an interview on 4/24/24 at 12:48 p.m. Resident #27 indicated he/she does have an advanced directive and believed that it was provided to facility on admission. Review of Resident #27's clinical record lacked evidence of an advanced directive.

8. Resident #34 was admitted to the facility on 12/11/23. A review of Resident #34's clinical record lacked evidence that the facility provided resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive.

9. Resident #44 was admitted to the facility on 5/4/23. A review of Resident #44's clinical record lacked evidence that the facility provided resident and/or resident's representative written

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information concerning the right to accept or refuse medical or surgical treatment and or formulate an advance directive.

10. Resident #49 was admitted to the facility on 1/25/24. A review of Resident #44's clinical record lacked evidence that the facility provided resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and or formulate an advance directive.

11. Resident #52 was admitted to the facility on 10/25/23. A review of Resident #52's clinical record lacked evidence that the facility provided resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive.

12. Resident #54 was admitted to the facility on 11/14/23. A review of Resident #54's clinical record lacked evidence that the facility provided resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive.

13. Resident #58 was admitted to the facility on 2/10/24. A review of Resident #58's clinical record lacked evidence that the facility provided resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive.

14. Resident #219 was admitted to the facility on 4/11/24. A review of Resident #219's clinical record lacked evidence that the facility provided

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F 578	Continued From page 5 resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. On 4/23/24 a 1:30 p.m., during an interview, the Senior Director of Nursing confirmed the above findings.	F 578		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide	F 582		

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notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure the Skilled Nursing Facility Advance Beneficiary Notices (SNFABN) Form 10055, which included appeal rights and liability of payment, were provided at least 2 days prior to the resident's last covered day, for 2 of 3 residents whose Medicare Part A services were discontinued, and remained in the facility (#274 and #276).

Findings:

1. Resident #274's Medicare Part A coverage for skilled services ended on 11/24/23. The medical

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F 582	Continued From page 7 record lacked evidence that Resident #274 or his/her legal representative was provided a SNFABN when the Medicare A coverage for skilled services was discontinued. The resident remained living in the facility. 2. Resident #276's Medicare Part A coverage for skilled services ended on 3/14/24. The medical record lacked evidence that Resident #276 or his/her legal representative was provided a SNFABN when the Medicare A coverage for skilled services was discontinued. The resident remained living in the facility. On 4/25/24 at 8:28 a.m., during an interview, the Administrator confirmed the SNFABN notices were not provided to Resident #274 and #276.	F 582		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		

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F 584	Continued From page 8 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: 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 interior for the 4 of 4 units (Spring Gardens, North Wind, Penbscoto and Windward Center), the laundry room and hallways for 2 of 2 facility tours (4/22/24 and 4/25/24). Findings: 1. On 4/22/24 at 9:20 a.m., during a tour of Spring Gardens Unit, 2 surveyors, and the Corporate Nurse Educator (CNE) observed the following findings:	F 584		

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F 584	Continued From page 9 > The shower room had a black headband, a white towel and a razor on the sink. > Resident Room 101 - The toilet seat was visibly dirty/soiled and the call bell cord had blue yarn tied to it as an extender. > Resident Room 107 - The toilet was continuously running. > Resident Room 110 - The bathroom toilet was visibly dirty. There were 3 large holes in the wall above the toilet. The bathroom door was marred/gouged on the inside and outside of the door. > Resident room 113 - The room floor was dirty and cluttered. The bathroom sink was dirty/stained. On 4/22/24 at 9:20 a.m., in an interview, the Corporate Nurse Educator (CNE) confirmed the findings. 2. On 4/25/24 from 8:27 a.m. to 9:15 a.m., an environmental tour was conducted with the Senior Maintenance Director, the Administrator and the Housekeeping/Laundry Supervisor in which the following findings were observed: Laundry > The floor had numerous cracked/broken tiles and the walls had chipped/missing paint and missing cove base. North Wind > The wheelchair scale had ripped/missing non-skid surfaces creating an uncleanable surface. > There were multiple large stains on the hallway carpets throughout the unit. > The sitting area, across from the nurse's station, had 2 dried liquid spills on the wall near	F 584		

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the window. The end table near the window had a worn off surface exposing untreated wood which created an uncleanable surface.
> Resident Room 1 - The bathroom toilet bar was broken and laying on the floor.
> Resident Room 3 - The bathroom floor had a quarter size hole in the linoleum. The wooden bathroom door was chipped/gouged.
> Resident Room 4- The floor was dirty and the caulking dirty/stained around the base of the toilet. The bathroom exhaust fan was dusty/dirty. The bathroom light had debris in the lens.
> Resident Room 9- There were 9 small holes in the bathroom floor linoleum by the toilet. There was a plunger and another wooden plunger handle on floor behind the toilet.
> Resident Room 10 - There was a wash basin on floor under the sink. The floor was dirty around the base of the toilet. The bathroom light had debris in the lens.
> Resident Room 16 - The shower stall had non-slip grip tape peeling up.

Penobscot House
> Resident Room 18 - The sink countertop had he edging missing exposing untreated wood and creating an uncleanable surface.
> Resident Room 20 - The shower stall had non-slip grip tape peeling up.
> Resident Room 28 - Resident #271's wheelchair was dirty and had dried food and liquid residue on it.

Windward Center
> Resident Room 201 - The bathroom door was marked/marred.
> Resident Room 202 - The bathroom floor was dirty and had debris/trash on it. The bathroom walls were marked/marred.

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F 584	Continued From page 11 > Resident Room 204 - The bathroom floor was dirty and had debris/trash on it. The bathroom walls were marked/marred. > Resident Room 205 - The bathroom floor was dirty and had debris/trash on it. The bathroom walls were marked/marred. > Resident Room 206: The bathroom floor was dirty and had debris/trash on it. The bathroom walls were marked/marred. > Resident Room 207 - The floor was dirty and had debris/trash on it. The walls were marred and dirty. > Resident Room 208 - The bathroom floor was dirty and had debris/trash on it. The bathroom walls were marked/marred. The toilet tank lid was missing, On 4/25/24 at 9:15 a.m., in an interview, the Senior Maintenance Director, the Administrator and the Housekeeping/Laundry Supervisor confirmed the findings.	F 584		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and	F 623		

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F 623	Continued From page 12 (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in	F 623		

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completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at §

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F 623	Continued From page 14 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to notify the resident, family and/or the resident's representative in writing of the transfers/discharge to an acute care hospital for 2 of 6 residents sampled for hospitalizations (Residents #5 and #49). Findings: 1. Documentation in Resident #5's clinical record indicated that the resident was transferred to the hospital on 11/22/23 and 11/24/23 and subsequently admitted. The clinical record lacked evidence that Resident #5 and/or the resident representative were provided with written transfer/discharge notices upon either transfer. On 4/24/24 at 9:45 a.m., during an interview, the Licensed Social Worker stated he/she could not locate the transfer/discharge for the dates of 11/22/23 and 11/24/23. 2. Documentation in Resident #49's clinical record indicated that the resident was transferred to the hospital on 4/17/24 and subsequently admitted. The clinical record lacked evidence that Resident #49 and/or the resident representative were provided with a written transfer/discharge notice upon transfer. On 4/24/24 at approximately 10:15 a.m., the surveyor confirmed these findings with the Senior Director of Nurses.	F 623		
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)	F 625		

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F 625	Continued From page 15 §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to issue a bed hold notice which included the daily bed hold cost, to a resident, known family member and/or legal representative for 2 of 6 sampled residents who had been transferred to the hospital (Residents #5 and #49). Findings:	F 625		

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F 625	Continued From page 16 1.Resident #5's clinical record revealed the resident was transferred to an acute care hospital on 11/22/23 and 11/24/23 and subsequently admitted. The clinical record lacked evidence that Resident #5 and/or the resident representative were provided with a written bed hold notice for the dates of 11/22/23 and 11/24/23. On 4/24/24 at 9:45 a.m., during an interview, the Licensed Social Worker stated he/she could not locate the bed hold notice for the dates of 11/22/23 and 11/24/23. 2. Resident #49's clinical record revealed the resident was transferred to an acute care hospital on 4/17/24 and subsequently admitted. The clinical record lacked evidence that Resident #49 and/or the resident representative were provided with a written bed hold notice. On 4/24/24 at approximately 10:15 a.m., the surveyor confirmed these findings with the Senior Director of Nurses.	F 625		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation	F 645		

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performed by a person or entity other than the State mental health authority, prior to admission,
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in

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the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and interview, the facility failed to ensure that 2 of 2 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 (Resident #34 and Resident #52).

Finding:

1. Resident #34 was admitted to the facility on 12/11/23 with diagnosis of Bipolar Disorder. Resident #34's clinical record contained a PASRR Level I determination letter dated 12/11/23 that stated further PASRR evaluation was not required due to Resident #34 met the criteria for a short-term convalescence admission. Resident #34 was not discharged after a short stay and was assessed to be Nursing Facility level of care

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F 645	Continued From page 19 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 Resident #34's stay changed from short-term to long-term. 2. Resident #52 was admitted to the facility on 10/25/23 with diagnosis of Bipolar Disorder and Borderline Personality Disorder. Resident #52's clinical record contained a PASRR Level I determination letter dated 10/23/23 that stated further PASRR evaluation was not required due to Resident #52 met the criteria for a short-term convalescence admission. Resident #52 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 Resident #52's stay changed from short-term to long-term. On 4/25/24 at 12:25 p.m., in an interview, the Market Clinical Advisor confirmed that the PASRR Level I was not forwarded again to the State Mental Health Authority to determine if PASRR Level II evaluation and determination was needed for Resident #34 and Resident #52 after their stay changed from short-term to long-term.	F 645		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		

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F 656	Continued From page 20 implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F 656		

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F 656	Continued From page 21 §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to update/implement goals and interventions in the area of antipsychotic medication use for 1 of 6 residents reviewed for medications (Resident #10) Finding: Resident #10 was admitted to facility on 11/17/22 and has diagnoses to include dementia, and major depressive disorder. Review of Resident #10's active orders effective April 2024 revealed order with start date of 2/29/24 for antipsychotic "Risperdal oral tablet (Risperidone). Give 0.125 mg by mouth two times a day for mood stabilizer, agitation." On 4/23/24 at 2:51 p.m., during review of Resident #10's entire clinical record, the Senior Director of Nursing confirmed Resident #10's care plan lacked goals/interventions and monitoring of side effects for antipsychotic use.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 657		

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F 657	Continued From page 22 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review, the facility failed to revise the care plan to reflect a resident's current status for 1 of 3 residents reviewed for falls (#49). Findings: 1. On 4/23/24 at 8:01 a.m., during an interview, Resident #49 stated, "I lost my balance and fell hit my head... I was getting up to take my walker to go to the dining room." The Surveyor asked if staff was with him/her when the fall occurred, resident stated, "Yes, it happened so quick." At this time, the surveyor observed a rolling walker across the room.	F 657		

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F 657	Continued From page 23 Resident #49's care plan initiated on 2/22/24 states, Resident/Patient requires assistance/is dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to: Recent illness, hospitalization, etc. resulting in fatigue, activity intolerance, confusion, etc. with intervention of: Provide resident/patient with extensive assist of 1 for ambulation using a wheelchair. Review of Therapy notes stated on 3/7/24 Resident #49 goals were met for "Patient will safety ambulate on level surfaces 25 feet using two-wheeled walker with Contact Guard Assist (GCA). Review of the Interdisciplinary meeting that was held on 3/13/24 indicated Resident #49 was now "using 2 wheeled walker ...walking short distances 25'- 40' with CGA" On 4/24/24 at 11:22 a.m., during an interview with the Senior Director of nursing, a surveyor discussed the above concerns that the care plan was not revised to reflect the current status of the residents need for ambulating after the Interdisciplinary meeting.	F 657		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the	F 679		

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physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.
This REQUIREMENT is not met as evidenced by:
Based on care plan review, observations, interviews, and facility policy, the facility failed to provide residents with a continuous resident centered activities program. This failure has the potential to affect all residents that would normally participate in activities.

Findings:

Review of facility policy "Recreation Services Policies and Procedures" dated 8/7/23 states "Centers/Communities must provide, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of an and support the physical, mental, and psychosocial wellbeing of each patient, encouraging both independence and integration in the community. ...Programs will be scheduled seven days a week. Weekend activities include secular and non-secular opportunities."

1. Resident #10 was admitted to the facility on 11/17/22 and relies on staff for Activities of Daily Living.

Review of Resident # 10's quarterly Minimum Data Set (MDS) dated 11/10/23 revealed a Brief Interview for Mental Status (BIMS) 15 of 15 indicating he/she is cognitively intact. Further review of MDS revealed Section-F: Preferences for Customary Routine and Activities" indicated he/she felt it was very important to do group activities, keep up with news, attend favorite activities and listen to music he/she likes.

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Review of Resident #10's care plan initiated 11/17/22 revealed ...While in the facility, [Resident #10] states that it is important ... has the opportunity to engage in daily routines that are meaningful relative to [his/her] preferences ..."

On 4/22/24 at 10:27 a.m., Resident #10 indicated that he/she really likes to go to BINGO, but never knows when it is. Observation of Resident #10's room lacked evidence of an Activity Calendar.

Review of facility provided Activity Calendar April 2024 revealed BINGO was held on 4/1/24, 4/5/24, 4/6/24, 4/8/24, 4/10/24, 4/13/24, 4/15/24, 4/17/24, and 4/22/24. Review of Resident #10's Activity Participation log dated April 2024 lacked evidence that he/she was invited or declined to join activities.

Further review of April 2024 activity calendar revealed the following scheduled activities:
-4/22/24: Activity Cart; 10:30am- Coffee Social; 2pm: Bingo in AR (activity room); 4pm Room to Room, 5:15pm Crossword game. Observations of activity room between 10:30am and 2:45 p.m. lacked evidence that any activities were being held.
-4/23/24: Activity Cart; 10am Coffee and Music Social; 2pm arts & Crafts (bring your own craft) 4pm Mail Delivery and Socializing. Observation of activity room between 10:00 a.m., and 3:00 p.m., lacked evidence that any activities were held.

On 4/23/24 at 3:08 p.m., Activities Director (AD) confirmed that there were no activities provided 4/22/24 and 4/23/24 stating "I've been out for 10 days and I'm not feeling well and had been out for

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10 DAYS, so I'm taking the opportunity to play catch up and do assessments".

Further review of Activity Calendar dated April 2024 revealed the following scheduled activities:
- 4/24/24 Activity Cart 10am- Coffee and Music Social; 2pm BINGO; 4pm Room to room.
Observation of activity room on 4/22/24 at 10:09 a.m., the activity room door was closed, upon entrance, 4 residents were observed sitting at the table with coffee, and the room was quiet. AD was sitting at desk in the corner.
-4/25/24 at 10:00 a.m., Review of April 2024 Activity calendar revealed "Activity Cart, 10am-Coffee and Music Social" At 10:10 a.m., a surveyor observed activity room to be empty, Activity Assistant (AA) indicated that they just made coffee, and residents will trickle in as they want, and they will go around and encourage people to come in. -When asked why the activity hasn't started yet as it says it begins at 10 a.m., AA indicated they don't normally start to go around until after the activity is supposed to start. On 4/25/24 at 10:25 a.m., observation of activity room revealed 3 residents sitting at table drinking coffee and listening to oldies on the television. AA did not respond when asked if the residents in the other 3 units were asked if they wanted to attend. (Review of resident census dated 4/25/24 revealed there were 66 residents un the facility).

On 4/23/24 at 3:12 p.m., during an interview with 2 surveyors, the Senior Director of Nursing indicated that the expectation is to have Activities offered daily and documented.

On 4/24/24 at 10:10 a.m., The Director of Nursing indicated that it was her expectation that the residents should already be in the activity room

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F 679	Continued From page 27 when the activity starts. On 4/25/24 at 10:28 a.m., the Senior Activity Director indicated that it was his expectation that the activity calendar was followed, residents should be invited and, in the room, when it starts.	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to follow physician orders for 2 of 11 sampled residents (Resident #219 and Resident #269). Findings: 1. On 4/24/24, Resident #219's clinical record was reviewed. Resident #219 had a medication order, dated 4/11/24, for Lorazepam Oral Tablet 0.5 MG (milligrams) Give 0.5 mg by mouth two times a day for anxiety. A review of Resident #219's Medication Administration Record indicated that Resident #219 did not receive Lorazepam on 4/20/24 and 4/21/24. On 4/24/24 at 12:05 p.m., in an interview, the Senior Director of Nursing confirmed that	F 684		

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F 684	Continued From page 28 Resident #219 did not receive his/her Lorazepam on 4/20/24 and 4/21/24 as ordered. 2. Resident #269 was admitted to the facility on 3/7/24 with diagnosis of Benign non-nodular prostatic hyperplasia with lower urinary tract symptoms. A provider's note dated 3/8/24 stated, "review of symptoms: genitourinary - frequency. Assessment/plan: urinary frequency- will check UA" (urinalysis- urine sample). A Providers order dated 3/8/24 instructs nursing to, "UA C&S (culture and sensitivity) one time only for 4 days, laboratory". Review of the Treatment Administration Record indicated on 3/8/24 a UA was obtained and signed off at 1405. Further review of the medical records lacked evidence of the UA C&S laboratory results. On 4/24/24 at 2:42 p.m., during an interview, the Senior Director of Nursing confirmed there are no records of the completed UA C&S in the resident's medical record or available through the laboratory they utilize.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to	F 686		

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F 686	Continued From page 29	F 686		

promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on record review, observation, and interviews, the facility failed to ensure that treatment plans were followed, and resident records were accurate for 1 of 1 resident reviewed for pressure and venous ulcers (Resident #60).

Finding:

Resident #60 was admitted on 3/5/24 with a Pressure ulcer to his/her right hip, and venous ulcers to bilateral lower extremities (shin). Review of the medical record contained the following Provider orders:
- Order dated 4/17/24 for "Venous - Right shin: Cleanse with wound cleanser, apply xeroform to wound base and cover with foam dressing. Every day shift for Wound care."
- Order dated 4/17/24 for "Venous - Left shin: Cleanse with wound cleanser, apply xeroform to wound base and cover with foam dressing. Every day shift for Wound care."
- Order dated 4/16/24 for "Pressure Injury - Right hip: Cleanse with wound cleanser, apply maxorb AG to wound base and cover with foam border. Every day shift for Wound care AND as needed."
- Order dated 3/6/24 for "Wound(s): Monitor site(s) (L) shin, hip, (R) calf Daily for status of surrounding tissue and wound pain. Monitor for status of dressing(s), if applicable Additional Documentation in NN if needed every day shift."

On 4/22/24 at 2:06 p.m., a surveyor observed Registered Nurse #1 (RN #1) perform a dressing change to Resident #60's right hip pressure ulcer

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F 686	Continued From page 30 and both right and left shin venous ulcers. Upon removal of the old dressings, both surveyor and RN#1 observed all 3 wound dressings dated with the date of 4/20/24 and initialed. At this time, the RN#1 confirmed the dressings were not changed on 4/21/24 stating, the dressings are supposed to be changed daily and upon changing the dressing the nurse will put the date and his/her initials for when it was completed. Further review, the treatment administration record indicated, by initials and a check mark, that the nurse had completed and signed off that all three dressing were completed on 4/21/24. In addition, the care plan for pressure ulcer, initiated on 3/11/24 states, "Provide wound care per treatment order." On 4/24/24 at 11:22 a.m., during an interview with the Senior Director of Nursing, the surveyor discussed the failure to follow the physician's orders, the current treatment plan and to ensure accurate resident records.	F 686		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and a review of Safety Data Sheets (SDS), the facility failed to ensure that the resident's environment was free	F 689		

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F 689	Continued From page 31 of accident hazards relating to base board hot water heating units for 2 of 2 observations and failed to ensure that that chemicals were properly secured for 1 of 4 days of survey. (4/22/24) Findings: 1. On 4/22/24 at 11:45 a.m., a surveyor observed the following on the Penobscot House Unit: > Resident Room 15- The base board heating unit cover was partially off exposing sharp metal edges and hot pipes. > Resident Room 19 - The base board heating unit was missing approximately an 18 inch section of pipe covering which exposed hot piping. > Resident Room 20 - The base board heating unit was missing approximately an 18 inch section of pipe covering which exposed hot piping. On 4/22/24 at 11:55 a.m., in an interview, the Administrator confirmed the findings. 2. On 4/22/24 at 12:40 p.m., a surveyor observed the following in Resident Room 9. > There was a 7.7 ounce container of Disinfectant wipes in the room. > There was a 12.2 ounce container of Downey Fabric Softener in the room. > There was a 50 ounce container of Woolite Laundry Detergent in the room. > Resident Room 9 - The base board heating unit cover was partially off exposing sharp metal edges and hot pipes. The Safety Data Sheet for Disinfecting Wipes(Fresh Scent) noted the following: 4. First Aid Measures	F 689		

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Inhalation: Not a normal route of exposure. If symptoms develop move victim to fresh air.
Skin contact: Rinse skin with water/shower. Get medical attention if irritation develops and persists.
Eye contact: Hold eye open and rinse slowly and gently with water for 15 to 20 minutes. Remove contact lenses, if present, after the first 5 minutes, and then continue rinsing eye. Call Poison Control Center or doctor for treatment advice.
Ingestion: not a normal route of exposure. Called poison Control Center or doctor for treatment advice.

The Safety Data Sheet for Downy Liquid Fabric Softener noted the following:
4. First Aid Measures
Skin and eye, oral ingestion. Mild eye and skin irritant.
Prolonged skin contact or installation into the eye may result in transient, superficial effects similar to those produced by a mild toilet soap.
Oral injection may result in gastro intestinal irritation with nausea, vomiting, or diarrhea.
Eye contact: flush eyes with water.
Oral ingestion: dilute with fluids and treat symptomatically.
Skin contact: rinse exposed skin. Remove contaminated clothing and launder before reuse.

The Safety Data Sheet for Woolite Damage Defense Laundry Detergent noted the following:
4. First Aid Measures
Eye contact: immediately flush eyes with plenty of water, occasionally lifting the upper and lower eyelids. Check for and remove any contact lenses. Continue to rinse for at least 10 minutes. Get medical attention.

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F 689	Continued From page 33 Inhalation: remove victim to fresh air and keep at rest in a position comfortable for breathing period if not breathing, if breathing is irregular or if respiratory arrest occurs, provide artificial respiration or oxygen by trained professional. It may be dangerous to the person providing aid to give mouth to mouth resuscitation. Get medical attention if adverse health effects persist or are severe. If unconscious, place in recovery position and get medical attention immediately. Maintain an open airway. Loosen tight clothing such as a collar, tie, belt or waistband. In case of inhalation of decomposition products in a fire, symptoms may be delayed. The exposed person may need to be kept under medical surveillance for 48 hours. Skin contact: wash with plenty of soap and water. Remove contaminated clothing and shoes. Wash contaminated clothing thoroughly with water before removing it, or wear gloves. Continue to rinse for at least 10 minutes. Get medical attention. In the event of any complaints or symptoms, avoid further exposure. Wash clothing before reuse. Clean shoes thoroughly before reuse. Ingestion: wash out mouth with water. Remove dentures if any period remove victim to fresh air and keep at rest in a position comfortable for breathing period if material has been swallowed and the exposed person is conscious, gives small quantities of water to drink. Stop if the exposed person feels sick as vomiting may be dangerous period do not induce vomiting unless directed to do so by medical personnel. If vomiting occurs, the head should be kept low so that the vomit does not enter the lungs. Get medical attention if adverse health effects persist or are severe. Never give anything by mouth to an unconscious person. If unconscious, place in recovery position	F 689		

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F 689	Continued From page 34 and get medical attention immediately. Maintain an open airway. Loosen tight clothing such as collar, tie, belt or waistband. On 4/22/24 at 12:50 p.m., in an interview, the Administrator confirmed the above findings.	F 689		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to oxygen and nebulizer mask/tubing for 2 of 2 residents reviewed for respiratory care (Residents #19 and #49) for 2 of 2 observations (4/22/24 and 4/23/24). Findings: 1. On 4/22/24 at 12:15 p.m., and on 4/23/24 at 8:50 a.m., a surveyor observed the unlabeled oxygen tubing for Resident #19. A review of the Resident #19's clinical record revealed that there was no order to change the tubing and no documentation showing that the tubing had been changed weekly.	F 695		

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F 695	Continued From page 35 On 4/24/24 at 2:15 p.m., in an interview, the Senior Director of Nursing confirmed that Resident #19's oxygen tubing had not been changed weekly and that Resident #19's clinical record lacked evidence showing that the tubing had been changed weekly. 2. On 4/22/24 at approx. 10:03 a.m., and on 4/23/24 at 8:00 a.m., observations of Resident #49's nebulizer mask stored on the nightstand labeled with a dated of 4/1/24. In a brief interview Resident #49 stated, he/she uses the nebulizer twice daily. Review of Resident #49's medical record lacked evidence of an order or documentation of the nebulizer mask and tubing changed weekly. On 4/24/24 at 8:42 a.m., the above was discussed with the Senior Director of Nursing who stated, the nebulizer masks should be rinsed and air dried after use then placed in plastic bag for storage and all oxygen related tubing should be changed every Sunday.	F 695		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on performance evaluation review and interview, the facility failed to complete annual	F 730		

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F 730	Continued From page 36 performance evaluations at least every 12 months for 5 of 5 sampled employees (Certified Nursing Assistant [CNA]). Findings: 1. CNA #1 was hired on 2/4/2019. The last annual performance evaluation was completed in 2021. The facility was unable to provide evidence of a completed annual performance evaluations for 2022 and 2023. 2. CNA #2 was hired on 2/4/2020. The last annual performance evaluation was completed in 2021. The facility was unable to provide evidence of a completed annual performance evaluations for 2022 and 2023. 3. CNA #3 was hired on 4/5/2021. The facility was unable to provide evidence of a completed annual performance evaluations for 2022 and 2023. 4. CNA #4 was hired on 10/12/2021. The facility was unable to provide evidence of a completed annual performance evaluations for 2022 and 2023. 5. CNA #5 was hired on 7/2/2018. The last annual performance evaluation was completed in 2021. The facility was unable to provide evidence of a completed annual performance evaluations for 2022 and 2023. On 4/25/24 at 9:30 a.m., in an interview, the Market Clinical Advisor confirmed there was no facility documentation of annual performance evaluations for the CNAs since 2021.	F 730		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records	F 755		

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F 755	Continued From page 37 CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews the facility failed to ensure that two people who are authorized to administer medications signed the Narcotic Bound Book	F 755		

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Shift Count page indicating that they counted all the controlled substances at the change of shift for multiple shifts between 4/11/24 through 4/22/24 on 1 of 3 units observed. (North Wind)

Findings:

Genesis HealthCare policy titled "Controlled Drugs: Management of" states, "A complete count of all Schedule II-IV controlled substances is required at the change of shifts per state regulation or at any time in which narcotic keys are surrendered from one licensed nursing staff to another. The count must be performed by two licensed nurses and/or authorized nursing personnel, per state regulations."

Review of bound medication book labeled WWG, NW, Book 2 revealed that oncoming nurse failed to sign the shift count page on 4/11/24 at 7:00 a.m., 4/17/24 at 7:00 a.m. and 4/18/24 at 7:00 a.m. The outgoing nurse failed to sign 4/18/24 at 1900 and on 4/21/24 evening shift.

On 4/24/24 at 10:41 a.m., during an interview, the Licensed Practical Nurse (LPN) unit manager for North Wind unit demonstrated the process of shift change with the narcotic bound book. The LPN explained that count is to occur every shift. Oncoming shift will check the medication cards and outgoing shift will use the narcotic book index to confirm count. After the count is confirmed both staff would sign the shift count in the back of the book. At this time, the LPN stated that signatures are not currently audited but should be and acknowledged there were holes on signature page.

On 4/24/24 at 11:31 a.m., during an interview, the

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F 755	Continued From page 39 Director of Nursing(DON) and Senior Director of Nursing with DON confirmed the above.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs	F 758		

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are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on record review, interview, and facility policy, the facility failed to show evidence of documentation to justify the use of psychotropic medications for 1 of 5 residents reviewed for unnecessary medications (#10).

Findings:

Review of facility policy "Psychotropic Medication Use" dated 11/28/16 states " ... All medications used to treat behaviors must have a clinical indication and be uses in the lowest dose to achieve the desired therapeutic effect. All medications used to treat behaviors should be monitored for: Efficacy, risks, benefits and harm or adverse consequences. Antipsychotic medications used to treat Behavioral or Psychosocial Symptoms of Dementia must be clinically indicated, be supported by adequate rational for uses, and may not be used for behavior with an unidentified causes .....Facility should ensure that Physician/Prescriber has conducted a comprehensive assessment for the resident and has documented in the clinical

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F 758	Continued From page 41 record that the psychopharmacological medication is necessary .....Facility staff should monitor the resident's behavior pursuant to facility policy using a behavioral monitoring chart or behavioral assessment record for residents receiving psychotropic medication for organic mental syndrome with agitated or psychotic behaviors .....Facility staff should inform the resident and/or resident representative of the initiation, reason for use, and the risks associated with he use of psychotropic medications, per facility policy or applicable state regulations." Resident #10 was admitted to facility on 11/17/22 and has diagnoses to include dementia, depression, and major depressive disorder. Review of Resident #10's clinical record revealed active medication orders dated 4/2024 revealed the following: -Order with start date of 2/29/24 for antipsychotic medication, "Risperdal oral tablet (Risperidone). Give 0.125 mg by mouth two times a day for mood stabilizer, agitation." -Order with start date of 11/3/23 for antidepressant "Zoloft oral tablet 50 MG (Sertraline HCl). Give 1 tablet by mouth in the morning for major depression ..." On 4/23/23 at 2:50 p.m., during a review with Senior Director of Nursing (Corporate) Resident #10's entire clinical record lacked evidence of psychotropic assessment for use, signed consents, or side effect/behavior monitoring for above medications.	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		

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F 761	Continued From page 42 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews, facility policy, and Centers for Disease Control (CDC) guidance, the facility failed to ensure proper vaccine storage temperatures for 2 of 2 medication storage room refrigerators (Spring Harbor and Penobscot House). Findings: Review of facility policy titled "Medication Storage Guidance ...influenza vaccine" dated 2023 states,	F 761		

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F 761	Continued From page 43 "Store in the refrigerator at 36 degrees to 46 degrees Fahrenheit". Review of CDC guidance "Vaccine Storage and Handling Toolkit" dated 1/23 states "...Refrigerators should maintain temperatures between 2° C and 8° C (36° F and 46° F) ...Every vaccine storage unit must have a Temperature Monitoring Device (TMD). An accurate temperature history that reflects actual vaccine recommended temperature range." 1.On 4/23/24 at 7:15 a.m., two surveyors and Director of Nursing (DON) observed Spring Garden medication room refrigerator containing 3 vials of influenza vaccine available for use. Further observation of the medication room lacked evidence of monitoring refrigerator temperatures. At this time, the DON indicated that refrigerator temperatures should be monitored on a daily basis. 2. On 4/23/24 at 12:40 p.m., during observation of Penobscot House medication room with the Registered Nurse (RN#1), a surveyor noted the "Temperature Log for Medication/Vaccine Refrigerators - Fahrenheit" dated April 2024 which stated, "Record temps twice each day" lacked evidence that refrigerator temperatures were taken from 4/1/24 through 4/15/24 (15 days). RN#1 indicated that she had been at the facility for eight months and was not aware they needed to be documented. On 4/23/24 at 3:13 p.m., the Senior Director of Nursing was unable to provide refrigerator temperature logs from 1/1/24 through 4/15/24, confirming the facility did not start monitoring temperature for vaccine storage until 4/16/24.	F 761		

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F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews and the facility's policies, the facility failed to ensure products in the walk-in refrigerator and freezer were labeled and/or dated and failed to remove expired foods available for use for 1 of 1 kitchen tours. Further, the facility failed to ensure that the freezers were monitored, and temperatures documented accurately and that the dish machine was maintaining proper temperature ranges for proper washing/cleaning. This has the potential to affect all residents. Findings: Facilities Cold food policy and procedure revised 4/2018 states, "All Time/Temperature Control for	F 812		

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F 812	Continued From page 45 Safety (TSC) foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the FDA Food Code." 4. "An accurate thermometer will be kept in each refrigerator and freezer a written record of daily temperatures will be recorded." 5. "All foods will be wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination." Facilities "Machine Warewashing and Sanitizing" policy effective 5/2023 states: "To ensure all dishware is cleaned and sanitized after use' and "For high temperature machine, the wash cycle temperatures ranges between 150-165 degrees Fahrenheit for a sanitary rack, single temperature machine". 1. On 4/22/24 at 9:20 a.m., during a kitchen tour with the Dietary manager, the following was observed, Walk-in refrigerator contained: One opened bottle of Horseradish 32 oz with expiration date of 10/19/22 One opened container of Lobster base with expiration date of 4/5/2024 One opened container of Gochujang Red pepper paste with expiration date of 8/22/23 One bottle of Kiwi Lime Flavored Dessert Sauce with expiration date of 2/23/24. Walk-in Freezer contained: 2 bags of patties not labeled or dated 1 bag of pizza dough crust not labeled or dated On 4/22/24 at approx. 9:30 a.m., the Dietary Manger confirmed the above and removed the expired foods and unlabeled/dated products.	F 812		

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2. Review of the facilities Temperature logs from November 2023 to the current April 2024 revealed the freezer temperatures for November 2023, February 2024, March 2024 (except for 4 days in March) and April 2024 are all documented temperatures of "0" degrees twice daily.

On 4/25/24 at 10:14 a.m., during an interview, the Dietary Manager stated the freezer was out of order from Nov 2023 through April 2024 and recently was fixed approx. 2 weeks ago. In the meantime, the facility had an outside refrigerator/freezer they were utilizing. The surveyor asked how all the freezer temperatures for 4 months are documented as "0" degrees. The Dietary Manager confirmed that the freezer temperatures fluctuates and it's very unlikely the temperatures would all be at 0 degrees, confirming accurate temperatures were not documented properly.

3. On 4/25/24 at approx. 10:20 a.m., both the surveyor and the Dietary Manager observed the dish machine wash and rinse cycles x2 which failed to reach the wash cycle temperatures ranges between 150-165 degrees.
- wash temperature - 140 degrees, rinse temperature 188 degrees
- wash temperature - 140 degrees, rinse temperature 192 degrees
At this time, the Dietary Manager notified maintenance.

Review of the facilities Dish Machine Temperature logs from January 2024 through the current April 2024 revealed the dish wash temperature was 155 degrees and the rinse temperatures were 180 degrees for breakfast, lunch and dinner daily. At this time, the dietary

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F 812	Continued From page 47 Manager could not explain why all the temperatures for the wash and rinse cycle were exactly the same, several times a day and for 4 months in a row. On 4/25/24 at 10:21 a.m., during an interview with the Market Clinical Advisor, the above concerns for both the freezer temperatures and dish wash/rinse temperatures all being the same temperature multiple times daily were discussed. On 4/25/24 at 10:34 a.m., the Senior Maintenance Director met with the surveyor and observed dish washer temperatures once again. He stated the screen in the dishwasher was out and being rinsed when the previous temperatures were being observed, so the water would go right down the drain during the wash, not holding proper temperature. Additional observations of wash temperatures: Wash temperature - 154 degrees, Rinse temperature - 194 degrees Wash temperature - 148 degrees, Rinse temperature - 194 degrees Wash temperature - 148 degrees, Rinse temperature - 196 degrees Wash temperature - 150 degrees, Rinse temperature - 196 degrees Once again at 10:44 a.m., additional wash cycle temperature was observed to reach 150 degrees On 4/25/24 at 10:47 a.m., a surveyor confirmed the above with the Administrator and the Market Clinical Advisor	F 812		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information.	F 842		

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F 842	Continued From page 48 (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F 842		

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F 842	Continued From page 49 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure that clinical records were complete and contained accurate information for 2 of 3 residents reviewed for medication administration (Resident #10 and #219). Findings: 1. Resident #10 was admitted to facility on 11/17/22 and has diagnoses to include dementia, and major depressive disorder. Review of Resident #10's active orders effective April 2024 revealed:	F 842		

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-Order with start date of 2/29/24 for antipsychotic "Risperdal oral tablet (Risperidone). Give 0.125 mg by mouth two times a day for mood stabilizer, agitation." Review of Resident #10's entire clinical record lacked evidence of behavior monitoring for side effects.
- Order with start date of 11/3/23 for antidepressant "Zoloft Oral Tablet 50 MG (Sertraline HCl). Give 1 tablet by mouth in the morning for major depression ..." Review of Resident #10s clinical record lacked evidence of behavior monitoring for side effects.

On 4/23/24 at 2:50 p.m., review of Resident 10's entire clinical record with the Senior Director of Nursing confirming the above findings.

2. On 4/24/24 during a record review for Resident #219, it was noted that he/she had an order for "Lorazepam Oral Tablet 0.5 MG (milligram) (Lorazepam) Give 0.5 mg by mouth two times a day for anxiety Pharmacy Start date 4/11/2024 16:00.(4:00 p.m.)"

On 4/21/24 at 20:04 (8:04 p.m.), a nursing note was written that noted "Not enough ativan to get [resident] through weekend until providers arrive on Monday. [Resident] has BID dosing".

On 4/22/24 at 00:28(12:28 a.m.), a nursing note was written that noted "Note Text: Lorazepam Oral Tablet 0.5 MG Give 0.5 mg by mouth two times a day for anxiety not available when scheduled-delivered on midnight run resident sleeping"

On 4/24/24, review of the North Wind Medication Control Book #2 noted on page #23 that on 4/19/24 at 1645(4:45 p.m.), the last tablet was

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F 842	Continued From page 51 administered to the resident making the count zero. A new page, #27, was started for the resident and noted that on 4/21/24 at 2230(10:30 p.m.), 6 tablets were received and signed in from pharmacy. Medication was not given to the resident until 4/22/24 at 8:30 a.m.. Review of the resident's Medication Administration Record (MAR) showed documentation of Resident #219 receiving the medication, signed off by a nurse on the morning of 4/20/24 and not again until 4/22/24. On 4/24/24 at 12:05 p.m., in an interview, the Senior Director of Nursing stated that the facility has an emergency kit for medications and the nurse could have called the pharmacy to get override code and get the medication for the resident. She further stated that it would be documented in the back of the North Wind Medication Control Book #2 that the emergency kit was used. The pharmacy would have documentation of the facility call and authorization to access the emergency kit. Upon review, she could not find documentation showing the emergency kit was accessed. She also called the pharmacy and found they were never called for access to the emergency kit. At this time, after reviewing Resident #219's clinical record with the surveyor, the Senior Director of Nursing confirmed that the MAR documentation was not accurate and that Resident #219 did not receive the medication on 4/20/24 and 4/21/24.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		

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F 880	Continued From page 52 designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the	F 880		

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F 880	Continued From page 53 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to maintain an Infection Control Program designed to help prevent cross contamination and/or development of infection by maintaining a safe and sanitary environment related to personal toileting items, wash basins, medical supplies and linen for 2 of 4 days of survey on 3 of 4 units (Windward Gardens Penobscot and Spring Gardens). Findings: 1. On 4/22/24 and 4/23/24, a surveyor observed on Windward Gardens unit a bedpan and a wash basin located in a shared bathroom on the floor	F 880		

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F 880	Continued From page 54 under the sink in Room 208. On 4/23/24 at approximately 9:45 a.m., in an interview with a surveyor, the Administrator confirmed the above observations did not support good infection control practice. 2. On 4/22/24 at 10:54 a.m. to 11:06 a.m., observation of Penobscot to have the following: - Room 18 had bariatric bed pan stored on the floor next to the toilet and a wash basin on shower floor. - Room 19 had a bed pan stored upside down on the toilet seat. - Room 21 had a bed pan stored on the shower room floor On 4/23/24 at 8:12 a.m., observation of Penobscot Room 16 with a bariatric bed pan stored on the floor with another bed pan stored inside of it. On 4/23/24 at 9:33 a.m., during an interview, the above was discussed with the Senior Director of Nursing 3. On 4/22/24 and 4/23/24 the following was observed on Spring Gardens by two surveyors: - Room 107-108 shared bathroom contained a soiled hospital gown and a used glove on the floor. - Room 101-102 shared bathroom contained an empty sealed specimen cup in a biohazard bag and an unlabeled urinal hanging on grab bar next to sink. - Room 115 contained a bariatric commode stored over the toilet which contained urine and a bed pan was stored on floor with the emergency call bell string resting on the inside of the bed	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205180	A. BUILDING _____ B. WING _____	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 55 pan. On 4/23/24 at 9:20 a.m., the above findings were confirmed during a tour of Spring Gardens with 2 surveyors and the Corporate Nurse Educator (CNE).	F 880		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to implement and maintain an effective training program which includes, at a minimum, training on abuse, resident rights and dementia management by failing to ensure that 4 of 5 Certified Nursing Assistant's (CNAs) employed, completed the required annual training (CNA #1,	F 947		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 947	Continued From page 56 CNA #2, CNA #4 and CNA #5). Findings: On 4/25/24, during a review of employee personnel records, the following was noted: 1. CNA #1 was hired on 2/4/2019. CNA #1's employee personnel record lacked evidence of mandatory resident rights education and dementia training within the last twelve months. 2. CNA #2 was hired on 2/4/2020. CNA #2's employee personnel record lacked evidence of mandatory abuse education, resident rights education and dementia training within the last twelve months. 3. CNA #4 was hired on 10/12/2021. CNA #4's employee personnel record lacked evidence of mandatory resident rights education within the last twelve months. 4. CNA #5 was hired on 7/2/2018. CNA #5's employee personnel record lacked evidence of mandatory abuse education, resident rights education and dementia training within the last twelve months. On 4/25/24 a 9:30 a.m., in an interview, the Market Clinical Advisor confirmed that CNA #1, CNA #2, CNA #4 and CNA #5 did not receive all required mandatory education and training within the last twelve months.	F 947		