STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205106	A. BUILDING _____ B. WING _____	12/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTSIDE CENTER FOR HEALTH & REHABILITATION, LLC	**516 MT HOPE AVENUE BANGOR, ME 04401**

(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 On 12/18/23, 12/21/23, and 12/22/23, on-site visits were conducted at Eastside Center for Health & Rehabilitation, Llc for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification, complaints #ME00044902, #ME00045108, #ME00044902, and facility reported incidents #ME00042981, #ME00044999, #ME00045088, #ME00045573. It was determined that Eastside Center for Health & Rehabilitation, Llc was not in compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the	F 552		

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

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F 552	Continued From page 1 facility failed to inform a Resident Representative (RR), in advance, of treatment risks and benefits, options, and alternatives related to use of an antipsychotic medication for 1 of 5 sampled residents reviewed for psychoactive medication use (Resident #10 (R10)). Finding: On 12/21/23, R10's record was reviewed and indicated that on 12/14/23, an order for a new medication, Seroquel (anti-psychotic psychoactive medication) was started to be given at bedtime and also as needed (PRN). The medical record lacked evidence that consent was given for treatment with this new medication by the RR and that the RR was informed of the risks and the benefits of treatment with this psychoactive medication or alternative options. On 12/22/23 at 10:36 a.m., during an interview with a surveyor, the Registered Nurse Supervisor #1 (RNS1) was unable to find evidence that the RR was notified. The Registered Nurse #1 (RN1) who entered the order for the Seroquel into the electronic record was present during this interview and was asked if she had notified the RR or completed the psychotropic consent form. The RN1 stated that she could not recall if she had. The surveyor confirmed this finding at this time and the RNS1 said she would notify the RR right away.	F 552		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that:	F 607		

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F 607	Continued From page 2 §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on facility policy review, employee personnel file review, and interview, the facility failed to ensure that references were checked for 1 of 5 sampled employees hired in 2023 (Employee #2, (E2)). Finding: The facility's "Abuse Policy & Procedure", revised 1/2023, indicated the following:	F 607		

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F 607	Continued From page 3 Screening shall include, but is not limited to: -At least one favorable reference from previous or current employers (reference can be either written or verbal) and to document date, time, name, and title of person giving reference. On 12/22/23, a surveyor reviewed E2's personnel file and could not find evidence of reference checks. On 12/22/23 at 8:10 a.m., during an interview with a surveyor, the Administrator stated that when gathering information for E2's file, they discovered that reference checks had not been completed. He stated that the facility was without a Human Resources person at that time and that was their responsibility.	F 607		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §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	F 761		

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F 761	Continued From page 4	F 761		

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 observation, interviews, and record review the facility failed to ensure proper medication and biological storage temperatures for 1 of 2 medication storage room refrigerators (B wing).

Finding:

On 12/22/23 at 11:43 a.m., a surveyor and Registered Nurse #1 (RN1) observed the medication storage room refrigerator on B wing. The refrigerator contained insulin, and controlled liquid medications. A temperature log sheet, located on front of the refrigerator dated for the month of December, 2023 has multiple days when temperatures were documented above 46 degrees Fahrenheit. The temperature log sheet noted, "normal temp Range 36-46 degrees. If temp exceeds normal range, document action taken to correct.". There is no documentation as to what, if anything, was done regarding the temperatures above 46 degrees Fahrenheit.

A review of the temperature log sheet lacked evidence of documentation of action taken to correct temperatures above 46 degrees Fahrenheit in the medication storage room refrigerator on B wing as follows:

12/1/23 nights 47 degrees Fahrenheit
12/5/23 nights 49.3 degrees Fahrenheit
12/6/23 nights 47.5 degrees Fahrenheit

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F 761	Continued From page 5 12/11/23 night 48 degrees Fahrenheit 12/12/23 nights 49.(illegible) degrees Fahrenheit 12/13/23 nights 49.1 degrees Fahrenheit 12/15/23 night 47.9 degrees Fahrenheit 12/16/23 nights 47 degrees Fahrenheit 12/18/23 nights 49 degrees Fahrenheit 12/19/23 nights 47.5 degrees Fahrenheit 12/20/23 nights 47.5 degrees Fahrenheit 12/21/23 nights 48 degrees Fahrenheit The refrigerator temperatures where documented on days and nights, 12 of 23 shifts exceeded normal temperature range of 46 degrees Fahrenheit with no documentation of action taken to correct temperatures above 46 degrees Fahrenheit. On 12/22/23 at 11:43 a.m., in an interview with RN1, a surveyor confirmed there was no documentation for dates the refrigerator temperature was above 46 degrees Fahrenheit.	F 761		
F 801 SS=E	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A	F 801		

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F 801	Continued From page 6 qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or	F 801		

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F 801	Continued From page 7 (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on interviews, the facility failed to ensure there was a Food Service Director (FSD) that met the qualifications of a FSD. This has the potential to affect all the residents. Findings: On 12/18/23 at 11:05 a.m., during an interview with the consulting Food Service Director #1 from a sister facility, she stated there is no FSD at this time. On 12/21/23 at 8:15 a.m., during an interview with	F 801		

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F 801	Continued From page 8 the consulting Food Service Director #2 from a sister facility, she stated, this facility does not have a qualified FSD at this time. 12/21/23 11:20 a.m., in an interview with the Dietician, she stated she comes in to assess and make recommendations when a need is identified such as when a resident has a pressure ulcer, swallowing difficulties, or weight loss. On 12/18/23 and on 12/21/23, two surveyors confirmed that the facility had not employed a qualified FSD, and used a consulting dietician, who was not employed by the facility in a full-time position.	F 801		
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	F 812		

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F 812	Continued From page 9	F 812		

by:
Based on observations and interview, the facility failed to ensure dishes were stored in a sanitary manner for 3 of 3 days (12/18/23, 12/21/23, and 12/22/23), failed to ensure food was stored under sanitary conditions for 1 of 3 days (12/18/23), failed to ensure that dented cans were removed from use for 1 of 3 days (12/18/23), failed to remove expired foods from walk-in refrigerator and emergency food supply storage for 1 of 3 days (12/18/23), failed to retrieve a bread delivery from the loading dock allowing it to be stored next to a full garbage bag for 1 of 3 days (12/21/23), failed to ensure dishes were not wet stacked for 1 of 3 days, (12/21/23), and failed to ensure sanitizing chemical was present in sanitation sink for 1 of 1 days (12/21/23).

Findings:

1. On 12/18/23 at 11:00 a.m., during an initial tour of the kitchen, two surveyors observed a stack of serving pans stored face up on back left corner of top shelf, next to oven.

On 12/21/23 at 11:15 a.m., two surveyors observed a stack of serving pans stored face up on back left corner of top shelf, next to oven.

On 12/22/23 at 7:57 a.m., two surveyors observed a stack of serving pans stored face up on back left corner of top shelf, next to oven.

On 12/22/23 at 7:57 a.m., two surveyors confirmed the serving pans were stored upward facing on shelf with consulting Food Service Director #2 (FSD2) and Kitchen Supervisor/Cook for 3 of 3 days.

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2. On 12/18/23 at 11:00 a.m., two surveyors observed one soiled container in the dry storage food area. The container held boxed graham crackers, boxed pasta, and some scattered straws. There was an unidentified pile of light colored crumbs loose within container.

On 12/18/23 at the time of the observation, two surveyors confirmed the above finding with the consulting Food Service Director #1 (FSD1).

3. On 12/18/23 at 11:00 a.m., two surveyors observed two dented cans of Ready to Serve Tomato Soup 7.25 ounce (oz) (One dented on top seal, one dented on bottom seal), one 50oz can of Condensed Tomato Soup dented near bottom seal, and one 48oz can Pulled Chicken with Broth with a dented/crushed-in top seal.

On 12/18/23 at the time of the observation, two surveyors confirmed the above findings with the consulting FSD1.

4. On 12/18/23 at 11:10 a.m., during observation of the walk-in refrigerator, two surveyors observed one case of 4oz cups (48 in total) Dannon Light and Fit yogurt with a best by date of 12/16/23, and one 5 pound (lb) container of Parmesan cheese that was not labeled with an open date or a discard date.

On 12/18/23 at 11:10 a.m., two surveyors confirmed with the FSD1 that the yogurt was past the best by date and the Parmesan cheese was open without an open date. The consulting FSD1 stated the facility's practice is to use the best by date as the expiration date.

On 12/18/23 at 11:20 a.m., during observation of

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F 812	Continued From page 11	F 812		

Emergency Food Storage, two surveyors observed one Case (6 total cans in the box) of 6lb Yellow Cling Diced Peaches in Pear juice dated to be used by 3/1/23, two 64oz Jars of West Creek Grape Jelly with best by date of 9/17/23, and one box (6 total cans) of 4lbs 2.5oz cans Chunk Light Skip Jack Tuna in Water dated to be used by 11/24/23.

On 12/18/23 at 11:20 a.m., two surveyors confirmed with the consulting FSD1 the above findings. The consulting FSD1 stated the facility's practice is to use the best by date as the expiration date.

5. On 12/21/23 at 11:35 a.m., during an observation of the kitchen, two surveyors observed a stack of pallets containing bread for resident use in contact with a trash bag on the loading dock outside the kitchen door.

On 12/21/23 at 11:43 a.m., two surveyors confirmed the above finding with the Administrator and consulting FSD2. The Administrator stated the bread had been delivered that morning.

6. On 12/21/23 at 1:25 p.m., two surveyors observed two stacks of multiple plate warmer tops wet stacked on top shelf in clean dish area.

On 12/21/23 at 1:25 p.m., two surveyors confirmed this finding with consulting FSD2.

7. On 12/21/23 at 1:29 p.m., two surveyors observed the sanitation sink full of clear liquid. A pallet of dishes was observed to be drip drying to the right of the sink. When a surveyor asked how the dishes were sanitized, the consulting FSD2

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F 812	Continued From page 12 utilized a chemical test strip to test the chemical level in the sanitation sink; the test strip did not register presence of the sanitizing agent. On 12/21/23 at 1:29 p.m., two surveyors confirmed with the consulting FSD2 that the sanitization chemical was not present, and she stated the dishes would need to be re-processed.	F 812		
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to properly dispose of garbage on 2 of 3 days of survey (12/18/23 and 12/21/23). Findings: On 12/18/23 at 11:15 a.m., two surveyors observed a full black trash bag left sitting on the walkway outside the kitchen door. On 12/21/23 at 11:35 a.m., two surveyors observed, through a kitchen door window, a full trash bag on loading dock with crushed boxes. On 12/21/23 at 11:43 a.m., in an interview with the Administrator and Food Services Director #2, two surveyors confirmed the above findings.	F 814		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.	F 842		

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EASTSIDE CENTER FOR HEALTH & REHABILITATION, LLC	516 MT HOPE AVENUE BANGOR, ME 04401

(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
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(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.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or

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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 the clinical records contained accurate documentation for 1 of 5 residents reviewed for unnecessary medications. (Resident #28 [R28])

Findings:

On 12/22/23, during a review of R28's electronic medication administration record (EMAR), it was noted that Morphine Sulfate (a narcotic pain medication) was entered on 11/29/23 in a concentration of 20 milligrams (mg)/5 milliliters (ml). The EMAR stated, "Give 0.25 ml by mouth at bedtime for comfort until 12/29/2023 to equal 5

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mg AND Give 0.25 ml by mouth every 1 hours as needed for severe pain until 12/29/2023 to equal 5 mg".

On 12/22/23 during a review of R28's clinical record, the provider's written order signed on 11/29/23 states "Change Morphine Sulfate to 20 mg/ml, 5 mg SL (sublingual (applied under the tongue)) QHS (at bedtime), and 5mg SL Q1[hour] (Once per hour) PRN (as needed) for severe pain or dyspnea (shortness of breath)". Prescription duration of "28 days [without] refills".

The order entered in the EMAR on 11/29/23 states to give 0.25 ml equals 1 mg morphine, not 5 mg as ordered by the provider. The same order entered in the EMAR on 11/29/23 states to give by mouth, not sublingual as ordered by the provider. The same order entered in the EMAR on 11/29/23 states with a stop date of 12/29/23 equals 31 days, not 28 days as ordered by the provider.

On 12/21/23 at 4:00 p.m., during an interview with Registered Nurse #2 (RN2), she looked at the EMAR and stated, "R28's order is for 20 mg/5 ml of Morphine, I would give 0.25 ml for a 5 mg dose. "When asked if that is equal to 5 mg she states "yes." Then looking closer she stated, "it looks funny". After looking in the paper chart, she noted the order is written for concentration of 20 mg/ml.

On 12/21/23 at 4:06 p.m., in an interview with RN2, two surveyors confirmed the above findings.