DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205131	A. BUILDING ______ B. WING ______	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD REHAB & LIVING CTR	**221 Fairbanks Rd** **FARMINGTON, ME 04938**

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F 000	INITIAL COMMENTS From 10/15/24 through 10/17/24, on-site visits were conducted at Edgewood Living and Rehabilitation Center for the purpose of the annual Recertification Survey, and investigating complaints #ME00044454 and #ME00047632. It was determined that Edgewood Living and Rehabilitation Center was not in substantial compliance with 42 CFR 483, Sub-part B Requirements for Long Term Care Facilities.	F 000	Edgewood is submitting this Plan of Correction as it is required by regulations. Submission of this Plan of Correction does not necessarily mean that the facility agrees with the findings as written.	
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. §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;	F 584	The lights in the laundry room have been cleaned as were the standing floor fan in the dining room as well as the visitor's bathroom floor. The wooden stand in the laundry room was addressed so it now has a cleanable surface. The toilet seat in the guest bathroom has been replaced. The whirlpool room floor had the missing floor tiles added/replaced and the stained ceiling tile was replaced. Room 3's footboard was addressed to eliminate peeling and the floor fan was cleaned. Room 4's urinal/bedpan was removed as they were no longer in use. Room 6's door jam was repaired. Room 9's wheelchair was cleaned. Room 11's walls were repaired and fan was cleaned. Room12's wheelchair's armrests were replaced. Room 13's walls, baseboard heater and door jamb were repaired. Room 15's baseboard heater and door jamb were repaired. Room 16's door and jamb were repaired. Facility Maintenance and Housekeeping Laundry Director were educated regarding proper sanitation, safety and providing a safe, clean, comfortable, homelike atmosphere. Facility-wide audits by Maintenance Director, Administrator or designee were occur weekly x4 to ensure that the facility is providing a safe, clean, comfortable homelike atmosphere.	11/27/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert Straznitskas | TITLE: Administrator | (X6) DATE: 11-12-24

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 584	Continued From page 1 §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 maintain adequate housekeeping and maintenance services to maintain a sanitary, orderly, and comfortable interior in 9 of 18 resident rooms, a dining room, a whirlpool room, a bathroom and the laundry room for 1 of 1 Environmental Tour. Findings: On 10/17/24 from 8:33 a.m. to 9:00 a.m., an Environmental Tour was conducted with the Administrator and the Maintenance Director in which the following findings were observed: > The laundry room had debris in the two ceiling lights by the dryers. The wooden stand, under the washing machine's chemicals, was untreated creating an uncleanable surface. > The standing floor fan in large dining room was heavily soiled with dust/dirt. > The bathroom by the nurses station had a chipped/worn toilet seat and the floor was heavily	F 584	Results of the audits will be discussed with the Administrator and Maintenance Director as well as in QAPI meetings to ensure compliance.	

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F 584	Continued From page 2 soiled with dirt around the edges and over the entire floor. > The whirlpool room was missing floor tiles along the edge of the wall and had a large brown stain on one ceiling tile. > Resident Room #3 - The bed footboard laminate and edging was peeling off the bed by the window. The standing floor fan was heavily soiled with dust/dirt. > Resident Room #4 - The bathroom had a urinal on the floor and a bed pan stored on the back of the toilet > Resident Room #6 - The room entrance door jamb had broken surface protectors. > Resident Room #9 - Resident #29's wheelchair seat was soiled and stained. > Resident Room #11 - The walls around the entire room and in the bathroom were marred, chipped and gouged creating uncleanable surfaces. The standing floor fan was soiled with dust/dirt. > Resident Room #12 - Resident #26's wheelchair had ripped/torn armrests. > Resident Room #13 - The walls around the entire room were marred, chipped and gouged creating uncleanable surfaces. The baseboard heater had chipped/missing paint creating an uncleanable surface. The room entrance door jamb had broken surface protectors. > Resident Room #15 - The base board heater had marred/chipped paint. The room entrance door jamb had broken surface protectors. > Resident Room #16 - The room entrance door had chipped/gouged wood and paint. The room entrance door jamb had broken surface protectors. On 10/17/24 at 9:00 a.m., in an interview, the Administrator and the Maintenance Director	F 584		

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F 584	Continued From page 3 confirmed the findings.	F 584		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:	F 655	Resident #31 has since been discharged from the facility. A review has taken place to ensure that all current residents have an accurate baseline careplan in place. The facility MDS Coordinator was educated regarding appropriate careplanning for residents. All new admissions will be audited weekly x4 to ensure careplan compliance. Results of the audit will be discussed in QAPI meetings to ensure that the facility is effectively and timely developing resident careplans.	11/27/24

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(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure that a baseline care plan was developed and implemented within 48 hours, that included instructions needed to provide minimum healthcare information necessary to properly care for 1 of 1 residents reviewed for new admissions (Resident #31).

Finding:

Resident #31 was admitted to this facility on 7/12/24. The admission history and physical states Resident #31 had a diagnosis of Acute Ischemic Stroke where the Medical Doctor (MD) noted that he/she had mild left upper extremity weakness along with reports of difficulty swallowing, mixed Alzheimer's and Vascular Dementia with "some agitation" requiring the resident to be redirected and newly anticoagulated for Atrial Fibrillation. Resident #31 had medication orders for an anticoagulant, antidepressant, beta blocker, and an opioid. As of 10/17/24 there was no evidence of a baseline care plan that included instructions necessary to provide safe and effective care to Resident #31.

On 10/17/24 at 9:39 a.m., the above information was confirmed with the Director of Nursing.

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F 684	Continued From page 5	F 684		
F 684 SS=E	Quality of Care CFR(s): 483.25	F 684	Nursing staff has been educated on the company's policy: "Complete Post Fall Observation Tool" as well as the "Neurological Assessment Policy".	11/27/24

§ 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 facility policy, record review and interviews, the facility failed to complete post fall neurological assessments along with appropriate fall assessments for 3 of 3 residents reviewed for falls (#17, #3, #333). In addition, the facility failed to follow physician orders for 1 of 2 residents reviewed for positioning (#18).

Findings:

Section V. Procedure of the Fall Management Policy (dated 7/2019), subsection E states to, "Complete Post Fall Observation tool, following a fall" and subsection F states "Documentation must be completed in the nurse's note on each shift X3 following the fall".

The Neurological Assessment Policy (dated 1/2019) states, "Residents with suspected neurological compromise will have a neurological sign monitored and recorded for a minimum of 12 hours". Subsection III Procedures states "A neurological assessment following resident head injury will be completed for all residents sustaining head trauma or suspected head

Provider's plan of correction (continued):

Weekly audits of residents who have experienced a fall x4 weeks to commence to ensure facility compliance in relation to facility fall policies and proper usage of the neurological assessment policy.

Results of the audits will be discussed at the facility's QAPI meeting to ensure compliance.

Resident 18's knee brace was discontinued by the physician on 10/17/24. The resident is currently working with rehabilitation and it will be determined at the conclusion of the resident's rehab if this brace, or any supportive device, will be introduced.

An audit has been completed to ensure that all facility resident's orders for adaptive / supportive devices are in compliance. Also, a weekly facility audit by Director of Nursing or designee x4 weeks will occur relating to compliance with residents' orders for adaptive / supportive devices.

Results of the audits will be discussed in the facility's QAPI meeting to ensure compliance.

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trauma. In EMR: Neuro Checks will be conducted-every 15 minutes x4, every 30 minutes x4, every 1 hr. x4, every 4 hr. x2, and every 8 hr. x1. Frequency of neuro checks after 24 hours is determined by resident's observed signs and symptoms of neurological compromise."

1. Resident #17 was admitted on 8/1/24 with a diagnosis of Dementia with Behavioral Disturbances and has a Brief Interview of Mental Status (BIMS) score of 4, indicating severe cognitive impairment. Nurse documentation states Resident #17 had four unwitnessed falls one on 9/1/24, 9/29/24,10/2/24, and 10/14/24. Further review of Resident #17's medical record lacked evidence of the facility continuing to monitor him/her for further injuries and/or neurological changes after the unwitnessed fall.

On 10/16/24 at 10:53 a.m., during an interview, the Director of Nursing (DON) stated all unwitnessed falls with a resident with a low BIMS score should have a neurological check's done per the facilities neurological assessment policy.

On 10/16/24 at 1:13 p.m., during an interview, the Quality Improvement Specialist (QIS) stated that the post fall observation tool is what triggers nurses to do the neurological assessments, and the nurses should document in a nurses note daily for three days following a fall. At this time, the QIS confirmed Resident #17's record lacked evidence of a post fall observation tool being completed and daily nursing notes for each shift for 3 days following all 4 of the falls.

2. Resident #3 was admitted on 8/27/24 with a diagnosis to include Dementia, Cerebral Infarction, Neurocognitive Disorder with Lewy

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Bodies, Vertigo and had a BIMS score of 11, indicating moderate cognitive impairment. Nurse documentation indicated Resident #3 had an unwitnessed fall on 5/27/24. The clinical record lacked evidence that documentation was completed in the nurse's note on each shift x3 following the fall.

On 10/17/24 at 10:25 a.m., the DON confirmed that there were no nursing notes about the incident initially and for the next three shifts as facility policy states.

3. Resident #18 was admitted on 6/1/24 with a diagnosis to include Dementia, difficulty walking, Kidney Disease, Delirium and had a BIMS score of 7, indicating severe cognitive impairment. Current signed physician orders, dated 9/24/24, noted the following: "6/18/2024 Active (Current)Treatment, Knee brace - left knee -on when out of bed"

On 10/15/24 at 9:30 a.m., a surveyor observed Resident #18 in his/her wheelchair eating breakfast in the dining room and he/she was not wearing a knee brace on his/her left knee.

On 10/16/24 at 8:50 a.m., a surveyor and the QIS interviewed Certified Nurse's Assistant, (CNA #1) who stated that she has taken care of the resident for a long time and the resident has never had a knee brace and doesn't wear one.

On 10/16/24 at 9:00 a.m., a surveyor and the QIS observed and interviewed Resident #18, who stated that he/she was supposed to get a left knee brace a long time ago but never got one so he/she does not wear one.

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F 684	Continued From page 8 On 10/16/24 at 9:10 a.m., a surveyor and the QIS reviewed the resident clinical record and the physician's order for a left knee brace at all times when resident out of bed. At this time, the QIS confirmed that the facility was not following the physician's order for a left knee brace for the resident to be worn while he/she is out of bed. 4. Resident #333 was admitted to the facility on 11/21/22 with diagnosis of Dementia, walking difficulty, muscle weakness, osteoporosis and had a BIMS score of 6, indicating severe cognitive impairment. The medical record states on 7/25/23 Resident #333 was found on the bedroom floor after an unassisted attempt at ambulation which resulted in bruising. Further review of the medical record lacked evidence of the facility continuing to monitor him/her for further injuries and/or neurological changes after the unwitnessed fall. On 10/16/24 at 2:15 p.m., during an interview, the Director of Nursing confirmed the above.	F 684		
F 689 SS=D	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 observation, interviews, and Material	F 689	Nursing and Housekeeping staff were educated regarding the importance of keeping appropriate doors locked as doors that are left open can endanger residents who might enter - exposing them to chemicals and other dangers. Audits by Maintenance Director or designee of facility doors which secure chemicals and other hazards will be audited weekly x4 to ensure that doors will remain locked except when in active use. Results of the audits will be discussed in the facility's QAPI meeting to ensure compliance relating to appropriate facility door security.	11/27/24

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Safety Data Sheet (MSDS) review, the facility failed to ensure doors were locked where potentially dangerous chemicals were stored for 1 of 3 days of survey.

Findings:

On 10/15/24 at 9:48 a.m., a surveyor observed the Soiled Utility room, located on the Long-Term Care unit unlocked. Inside the Soiled Utility room, were four cabinets with four unlocked padlocks that contained the following: 1 bottle of Eco lab Rapid Multi Surface Disinfectant cleaner, 1 can of 3M Glass cleaner, 1 container of Simplex scour power and instant chlorine bleach, 1 can of WD-40, 1 bottle of True Clean Emerald Optically Enhanced floor cleaner and 1 bottle of Apollos Power Clean Industrial Grade cleaner & detergent.

The Material Safety Data Sheets, each dated 1/1/2007, were reviewed and indicated the following:

1. Eco Rapid Multi Surface Disinfectant cleaner

Section 4 First Aid Measures
Eyes: Rinse immediately with plenty of water, also under the eyelids, for at least 15 minutes. Continue rinsing. Get medical attention immediately.
Skin contact: Wash off immediately with plenty of water for at least 15 minutes. Wash clothing before reuse. Thoroughly clean shoes before reuse. Get medical attention immediately.
Ingestion: Rinse mouth with water. Do not induce vomiting. Get medical attention immediately.

Section 7 - Handling and Storage

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F 689	Continued From page 10 Conditions for safe storage: Keep out of reach of children. Store in suitable labeled containers. 2. 3M Glass cleaner Concentrate Section 4 First Aid Measures Eyes: Immediately flush with large amounts of water. Get medical attention. Skin contact: Immediately wash with soap and water, if signs/symptoms develop, get medical attention. Ingestion: Rinse mouth. If you feel unwell, get medical attention. Precautions for safe handling: Keep out of reach of children. 3. Simplex scour power and instant chlorine bleach Section 4 First Aid Measures Eyes: Flush eyes with plenty of water for at least 15 minutes. Continue rinsing. Get immediate medical advice/attention. Skin: Flush skin with plenty of water. If skin irritation occurs get medical advice/attention Ingestion: not induce vomiting. Rinse mouth with water. If victim is conscious and alert, give 2 to 4 capfuls of water. Get medical attention immediately. Section 2. Hazards Identification Keep out of reach of children. 4. WD-40 Multi-Use Product Aerosol Section 4 First Aid Measures Eyes: Flush thoroughly with water. Get medical attention if irritation persists. Skin: Wash with soap and water. If irritation	F 689		

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develops and persists, get medical attention.
Ingestion: Aspiration Hazard. Do not induce vomiting. Call physician.

Section 7 Handling and Storage
Keep out of reach of children.

5. True clean Emerald Optically Enhanced floor cleaner

Section 4 First Aid Measures
Eyes: Rinse immediately with water for 15 minutes. Consult physician if symptoms occur.
Skin: Rinse with soap and water. Consult physician if symptoms occur.
Ingestion: Do not induce vomiting. Get medical attention.

Section 7 Handling and Storage
Wash thoroughly after handling. Avoid repeated contact with skin. Keep out of reach of children.

6. Apollo Power clean Industrial Grade cleaner & detergent

Section 4 First Aid Measures
Eyes: Flush eyes thoroughly with plenty of water for 15 minutes.
Skin: Sensitive-skinned persons should wash off with soap and water.
Ingestion: Do not induce vomiting. Give lots of water and call a physician if necessary.

On 10/15/24 at 9:49 a.m. during an interview with Certified Nursing Assistant #1 (CNA) and CNA #2, the surveyor confirmed this finding. CNA #1 and CNA #2 stated that the key to the Soiled Utility room is kept above the door and the door should be locked. The cabinets inside the Soiled

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F 689	Continued From page 12 Utility room are supposed to have the padlocks locked. On 10/15/24 at 9:59 a.m. a surveyor discussed the above finding with the Administrator.	F 689		
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 732	A new, compliant staffing form is now being utilized for daily staffing. This new form breaks down the staffing hours by position as required (RN, LPN, and unlicensed staff responsible for direct care). Nursing Administration was educated regarding appropriate nurse staffing posting as well as the new form that the facility will be using from this point forward. Director or Nursing or designee will audit the daily staffing posting for regulatory compliance weekly x4 weeks. Results of the audit will be discussed in the facility's QAPI meeting to ensure compliance.	11/27/24

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F 732	Continued From page 13 §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post nurse staffing information on a daily basis including: the total number and the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift for 2 of 3 survey days. Finding: On 10/15/24 and 10/16/24, a surveyor observed the nurse staffing information, posted in the main entrance, the posting lacked the total number of hours and the actual hours worked for the Registered Nurse, Licensed Practical Nurse and unlicensed nursing staff responsible for direct resident care. On 10/16/24 at 9:26 a.m., the above was confirmed with the Director of Nursing.	F 732		
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.	F 761	Nursing staff was educated regarding facility policy "Omnicare Storage and Expiration of Medications, Biologicals, Syringes and Needles" especially pertaining to the section describing the appropriate temperature range for refrigeration as well as the need to record temperatures twice a day. Director of Nursing or designee will audit the medication storage refrigerator weekly x4 to ensure proper temperature compliance as well as proper temperature recording.	11/27/24

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F 761	Continued From page 14 §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 facility policy, record review and interviews, the facility failed to adequately ensure medications and biologics were monitored and stored at appropriate temperatures in 1 of 1 refrigerator observed and 3 of 3 months of medication refrigerator logs reviewed. Findings: Facility policy and procedure for "Omnicare Storage and Expiration of Medications, Biologicals, Syringes and Needles", revised 8/1/24 states, "Facility should ensure that medications and biologicals are stored at their appropriate temperatures according to the United States Pharmacopeia (USP) guidelines for temperature ranges and manufacturer guidance ... refrigeration: 36° to 46°F." On 10/15/24 at 12:15 p.m., observation of the	F 761	Results of the audit will be discussed in the facility's QAPI to ensure compliance.	

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F 761	Continued From page 15 medication storage room with Registered Nurse (RN) contained a refrigerator containing insulin, 8 boxes of influenza vaccinations, and Tuberculin Purified Protein. At this time, the RN states that refrigerator temperatures are checked twice daily. The facilities "Medication Refrigerator" log indicates temperatures are to be monitored twice daily. Review of the temperature logs from 8/2024 through 10/2024 lacked evidence of temperatures being monitored twice daily, or maintained at the appropriate temperature ranges for the following dates: - August 2024 lacked evidence of temperature readings for 16 out of 31 days and temperatures were out of range for 11 out of 31 days. - September 2024 lacked evidence of temperature readings for 17 out of 30 days and temperatures were out of range for 11 out of 30 days - October 2024 lacked evidence of temperature readings for 5 out of 15 days and temperatures were out of range for 2 out of 15 days reviewed. On 10/16/24 the above was confirmed with the Director of Nursing.	F 761		
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	F 812	the standing floor fan was cleaned and removed from the food prep area. The food mixer was addressed to eliminate any missing/chipped paint. The dish room ceiling vents were cleaned as was the wall mounted fan. All kitchen ceiling vents have been cleaned. The kitchen office's lens was replaced and bulb protectors were installed. All stained ceiling tiles in the kitchen were replaced. The cracked/broken celing light lens in the middle of the kitchen was replaced.	11/27/24

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F 812	Continued From page 16 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, and review of the facility's "Dish Machine Temperature and Sanitizer Log Form", the "Refrigerator/Freezer Food Storage and Temperature policies and procedures, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for fans, a food mixer, ceiling vents, ceiling lights, ceiling tiles and a door thresh hold; failed to ensure foods were sealed in the walk-in freezer; failed to monitor the temperatures of the walk-in freezer and the walk-in refrigerator; failed to monitor the dishwasher wash and rinse cycle temperatures as well as the chemical sanitizer levels for the sanitizing sink and the sanitizing buckets for 1 of 1 kitchen tour and for 1 of 1 survey days (10/15/24). This has the potential to affect all residents. Findings: The facilities "Dish Machine Temperature and Sanitizer Log Form" noted: Policy: Dishwashing staff will monitor and record dish machine temperatures to assure proper sanitizing of dishes. Procedure: 1. Staff will monitor dish machine temperatures throughout	F 812	The open bag of french fries was discarded. The walk-in cooler door threshold is being addressed to eliminate the "give" when weight is applied. Also, the threshold rust and functionality is in the process of being repaired. Kitchen environmental rounds by Maintenance Director or designee to occur weekly x4 to ensure proper sanitation and functionality of all appliances and areas of the kitchen. Results of the audits will discussed in the facility's QAPI meeting to ensure compliance. Facility Kitchen staff were educated regarding proper temperature compliance and recording as it pertains to kitchen refrigerators, freezers, sink/bucket sanitizer and high temperature ware wash. Weekly audits x4 will occur by Administrator or designee to ensure compliant temperatures and temperature recording as it pertains to kitchen refrigerators, freezers, sink/bucket sanitizing and high temperature ware wash. Results of the audits will be discussed in the facility's QAPI meeting to ensure compliance.	

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F 812	Continued From page 17	F 812		

the dishwashing process. 2. Staff will record dish machine temperatures for the wash and rinse cycles after each meal.

The facilities "Refrigerator/Freezer Food Storage" policy and procedure noted: 13. Refrigerated food storage: b. Thermometers should be checked at least two times each day. d. Refrigerator/freezers on nursing units should be supplied with thermometers and monitored for appropriate temperatures. f. All foods should be covered, labeled and dated. 14. Frozen foods: c. All foods should be covered, labeled and dated....

The facilities "Refrigerator/Freezer Temperature policies and procedures noted: 9. Refrigerator/freezer temperatures a period take the internal temperatures of each unit and document.

1. On 10/15/24 from 8:50 a.m. to 9:40 a.m., during an initial kitchen tour, a surveyor observed the following findings:
> The standing floor fan was heavily soiled with dust and dirty.
> The food mixer had chipped/missing paint on the mix arm and the base.
> The dish room had two ceiling vents and a small wall mounted fan that were dirty and heavily soiled with dust.
> There were 3 ceiling vents in the kitchen and 1 ceiling vent in the kitchen office heavily soiled with dust and dirty.
> The kitchen office had a ceiling light missing the lens and didn't have bulb protectors on them.
> There were 2 ceiling tiles with brown stains on them over the hood system.
> There was 1 ceiling tile with a brown stain on it over the reach-in freezer by the kitchen

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bathroom.
> The ceiling vent by the ice machine was heavily soiled with dust.
> There was a cracked/broken ceiling light lens in the middle of the kitchen.
> The reach-in freezer, by the ice machine, had a bag of french fries that had been ripped open to the air.
> The walk-in cooler door thresh hold was rusty, broken and spongy when stepped on.

On 10/15/24 at 9:40 a.m., in an interview, the Administrator confirmed the findings.

2. On 10/16/24 at 2:40 p.m., the Kitchen Refrigerator/Freezer temperatures, Sink/Bucket Sanitizer, and Daily High-temp Ware Wash Logs were requested by a surveyor for July, August, September and October 2024 and reviewed with the Food Service Director. The following findings were observed:

Missing monitoring and documentation of Refrigerator/Freezer Temperatures:
Snack Refrigerator/Freezer- 2024

>July:
Snack Freezer - 23-25

>August:
Refrigerator - 1-21(am and pm), 24(pm)
Freezer - 1-21(am and pm)

>September:
Big Freezer - 24 and 25(am); 26-28(pm)
Vegetable Freezer - 24 and 25(am); 30(pm)
Bread Freezer - 24 and 25(am); 30(pm)
Walk-in Refrigerator - 24 and 25(am); 30(pm)
Walk-in Refrigerator IFT - 24 and 25(am); 30(pm)

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Missing monitoring and documentation of Sink/Bucket Sanitizer-2024
>July:
5:00 a.m. - 28
9:00 a.m. - 28
1:00 p.m. - 2, 14, 20, 21 and 28
5:00 p.m. - 1-3, 9, 12, 18, 19, 28 and 31

>August:
5:00 a.m. - 11, 13-15, 23, 28 and 31
9:00 a.m. - 4, 9-11, 15, 16, 23, 28 and 31
1:00 p.m. - 2, 3, 5, 9, 10, 22, 26, 29 and 31
5:00 p.m. - 2, 5, 10, 22, 29-31

>September: 1-30

>October:
9:00 a.m. - 6 and 9
5:00 p.m. - 1

Missing monitoring and documentation of Daily High-Temperature Ware Wash Checklist - 2024
>July:
Breakfast wash/rinse - 20-22 and 28
Lunch wash/rinse - 20 and 28
Supper wash/rinse - 1-3, 10-12, 18, 19, 28 and 31

>August:
Breakfast wash/rinse - 10, 11, 15, 16, 25, 28, 30 and 31
Lunch wash/rinse - 16, 25, 28, 30 and 31
Supper wash/rinse - 2, 4, 5, 14, 24-26, 30 and 31

>September: 1-30
October:
Breakfast wash/rinse - 5 and 6

On 10/16/24 at 2:40 p.m., in an interview, the

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F 812	Continued From page 20 Food Service Director confirmed the findings.	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 observations and interviews, the facility failed to maintain garbage storage areas in a sanitary condition to prevent the harborage and feeding of pests for 1 of 2 dumpsters for 3 of 3 days and 2 of 2 dumpsters for 1 of 3 days of survey. (10/15/24, 10/16/24 and 10/17/24) Findings: 1. On 10/15/24 at 9:30 a.m., a surveyor observed the large trash dumpster had left side slide door missing/open and the top left front door open both exposing trash, a small dumpster which had the front right top open on it and plastic and paper trash on the ground around the dumpsters. Additionally, trash was observed stored in an open top cart outside the laundry room exit. On 10/15/24 at 9:40 a.m., in an interview, the Administrator confirmed the findings. 2. On 10/16/24 at 7:35 a.m., a surveyor observed the left side door missing and the right side door of the large trash dumpster to be fully open, exposing trash. The surveyor also observed plastic and paper trash on the ground around the dumpster. On 10/16/24 at 8:30 a.m., in an interview, the Administrator confirmed the findings. 3. On 10/17/24 at 7:35 a.m., a surveyor observed	F 814	Facility Nursing, Houskeeping and Dietary staff were educated regarding proper disposal of trash, usage of the facility dumpster (especially pertaining to keeping lids and doors closed), and the need to keep the grounds free of debris. Staff were also educated regarding the need to not store trash outside uncovered. Administrator or designee will conduct audits weekly x4 to ensure proper disposal of garbage, proper usage of the dumpster, dumpster area sanitation, as well as not storing trash outside uncovered. Results of the audit will be discussed in the facility's QAPI meeting to ensure compliance.	11/27/24

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F 814	Continued From page 21 the left side door missing of the large trash dumpster to be fully open, exposing trash. The surveyor also observed plastic and paper trash on the ground around the dumpster. Additionally, trash was observed stored in an open top cart outside the laundry room exit. On 10/17/24 at 8:00 a.m., in an interview, the Administrator confirmed the findings.	F 814		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.	F 883	The facility's Infection Preventionist educated by the Director of Nursing regarding the facility's " Immunization Policy" especially as it pertains to offering the influenza and pneumococcal vaccine per policy. Current residents who have been identified to have not had the influenza and/or the pneumococcal vaccine(s) offered to them previously will be offered each vaccine. Each newly admitted resident will be offered the influenza and pneumococcal vaccine per policy. Resident records will be audited weekly x4 by the facility's Infection Preventionist or designee to ensure that all residents have been offered the pneumococcal and influenza per policy. Residents of the audits will be discussed in the facility's QAPI meeting to ensure compliance.	11/27/24

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F 883	Continued From page 22 §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on immunization record review, review of the facility's immunization policy and interview, the facility failed to implement their pneumococcal immunization policy for 3 of 5 residents whose immunization records were reviewed (#18, #19, #28) Findings: The facility's "Immunization Policy" indicated in Procedure I: Before offering the Influenza or Pneumococcal vaccine, each resident, and/or	F 883		

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resident's legal representative will receive education produced by the Maine and/or Federal Centers for Disease Control regarding the benefits and potential side effects of the vaccines for the current year. The resident's clinical record will include the following documentation: Signature of the person receiving the educational material, designating receipt and understanding of the material. Verbal consent may also be obtained if communication is done via a telephone conversation. Proof the resident either received the Influenza and/or the Pneumococcal vaccine, the vaccine(s) was contraindicated for medical reasons, or the resident refused the vaccine(s). Each resident will be offered a Pneumococcal Vaccine, upon admission unless the immunization is medically contraindicated, or the resident has already been immunized. Vaccines will be given in accordance with the Maine Center for Disease Control. For Immunocompromised adults aged 65 years or older. A single dose of PCV 20 may be administered or administered 1 dose of PCV 15, if not previously administered, followed by 1 dose of 23 valent pneumococcal polysaccharide vaccine (PPSV23) at a minimum interval of 8 weeks between both doses. The vaccine administration will be documented on the vaccine record in the medication administration record.

1. Resident #18's clinical record indicated that the resident was admitted to the facility on 6/19/24. Resident #18's immunization records lacked evidence the resident's PCV 20 was current or offered and administered as directed by the facility's Immunization - Influenza, Pneumococcal Policy.

2. Resident #19's clinical record indicated that the

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(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 883	Continued From page 24 resident was admitted to the facility on 3/27/24. Resident #19's immunization record lacked evidence that the PCV 20 vaccine was current or offered and administered as directed by the facility's Immunization - Influenza, Pneumococcal Policy. 3. Resident #28's clinical record indicated that the resident was admitted to the facility on 6/4/24. Resident #28's immunization record lacked evidence that the PCV 20 vaccine was current or offered and administered as directed by the facility's Immunization - Influenza, Pneumococcal Policy. On 10/17/24 between 11:24 a.m. and 11:45 a.m., a surveyor confirmed the above findings in an interview with the Infection Preventionist and the Director of Nursing.	F 883		
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and	F 887	The facility's Infection Preventionist was educated by the Director of Nursing regarding the facility's "Covid 19 Immunization Policy" especially as it pertains to educating and offering residents the Covid 19 vaccinations. Current residents who have been identified to have not had the Covid 19 vaccine offered to them previously will be educated regarding Covid 19 and offered the vaccine. Each newly admitted resident will be educated regarding Covid 19 as well as offered the Covid 19 vaccine per policy. Resident records will be audited weekly x4 by the facility's Infection Preventionist or designee to ensure that all residents have been educated and offered the Covid 19 vaccine per policy. Residents of the audits will be discussed in the facility's QAPI meeting to ensure compliance.	11/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205131	A. BUILDING ______ B. WING ______	10/17/2024

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F 887	Continued From page 25 risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN).	F 887		

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F 887	Continued From page 26	F 887		

This REQUIREMENT is not met as evidenced by:
Based on clinical record reviews, facility policy review and interview, the facility failed to offer updated (COVID-19) vaccine doses for 5 of 5 residents reviewed. (#7, #15, #18, #19 & #28)

Findings:

The facility's policy, "Policy for Suspected or Confirmed Coronavirus (COVID-19) revised 5/7/24 indicated under Vaccines: The facility will be required to educate residents and employees on vaccines and offer updated vaccines to all residents.

On 10/17/24, between 11:20 a.m. and 11:45 a.m., during an interview with the Director of Nursing and the Infection Preventionist, the following resident's vaccination records were reviewed and confirmed that the updated 2023-2024 COVID-19 vaccinations were not offered:

1. Resident #7 was admitted to the facility on 2/26/24. Resident #7 was diagnosed with COVID-19 on 9/5/24. Resident # 7's last documented COVID-19 vaccination was 12/21/23. The clinical record lacked evidence of offering the updated COVID-19 vaccination.

2. Resident #15 was admitted to the facility on 5/11/22. Resident 15's last documented COVID-19 vaccination was 12/20/22. The clinical record lacked evidence of offering the additional dose of the updated COVID-19 vaccination.

3. Resident #18 was admitted to the facility on 6/19/24. Resident #18 was diagnosed with

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F 887	Continued From page 27 COVID-19 on 9/9/24. Resident #18's last documented COVID-19 vaccination was 10/20/22. The clinical record lacked evidence of offering the updated COVID-19 vaccination. 4. Resident #19 was admitted to the facility on 3/27/24. Resident #19's last documented COVID-19 vaccination was 7/8/22. The clinical record lacked evidence of offering the updated COVID-19 vaccination. 5. Resident #28 was admitted to the facility on 6/4/24. Resident #28 was diagnosed with COVID-19 on 9/9/24. Resident #28's last documented COVID-19 vaccination was 9/20/23. The clinical record lacked evidence of offering the updated COVID-19 vaccination.	F 887		