

11/16/25
J. Formel, MBA
Fac of Bus

F684 - 483.25 Quality of Care

Findings #1-3

- 1) Res #7's clinical record did not contain evidence of being monitored after an unwitnessed fall, nor did it contain a neurological assessment. The time has lapsed for being able to complete follow-up notes, and to complete the neurological assessment.
- 2) Res #17's clinical record did not contain evidence of being monitored after two unwitnessed fall(s), nor did it contain a neurological assessment. The time has lapsed for being able to complete follow-up notes, and to complete the neurological assessment.
- 3) Res #340's clinical record did not contain evidence of being monitored after an unwitnessed fall, nor did it contain a neurological assessment. The time has lapsed for being able to complete follow-up notes, and to complete the neurological assessment.
 - Other residents have the potential to be affected by this alleged deficient practice. There were no other allegations or findings such as this observed.
 - Staff Education has been provided on January 7, 2025, regarding completing the required documentation and monitoring of a resident after an unwitnessed fall.
 - The Director of Nursing Services, and/or designee(s) will conduct audits weekly x 4 weeks, and then monthly x 3 months to ensure clinical records of a resident who sustains an unwitnessed fall contain the required documentation and monitoring. The results of the audits will be reported to the facility's Quality Assurance Committee for 3 months, as indicated.

Date of Completion: January 16, 2025

F689 - 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices

Finding #1

- 1) The 2 missing safety clips for the Hoyer Lift Reliant 600 were replaced promptly by Maintenance and prior to further use of the lift with any resident.
 - Other lifts have the potential to be affected by this finding. There were no other findings of this nature observed.
 - Staff Education was provided on January 7, 2025, regarding identifying when lift equipment is missing parts which could create an accident hazard.
 - The Maintenance Director and/or designee(s) will conduct audits weekly x 4 weeks, and then monthly x 3 months to ensure lift equipment is not missing parts which could create an accident hazard. The results of the audits will be reported to the facility's Quality Assurance Committee for 3 months, as indicated.

Date of Completion: January 16, 2025

1/16/25
J. Zemel
FacOps Mgr.

F761 - 483.45 (g)(h)(1)(2) Label/Store Drugs and Biologicals

Finding #'s 1-2

- 1) The temperature logs from November 27th to November 30th lacked evidence of twice daily temperature readings, and temperatures were out of range for 2 out of the 4 days. Time has lapsed to be able to correct this alleged deficient practice.
- 2) The temperature logs for December 1st through December 29th lacked evidence of twice daily temperature readings for 12 out of 29 days and temperatures were out of range for 12 out of the 29 days. Time has lapsed to be able to correct this alleged deficient practice.
 - Residents have the potential to be affected by these findings.
 - Staff education was provided on January 7, 2025, regarding properly documenting and storing biologics at appropriate temperatures (between 36 to 41 degrees).
 - The Director of Nursing Services, and/or designee(s), will conduct audits weekly x 4 weeks, and then monthly x 3 months to ensure biologics are being properly stored and temperatures are being documented twice daily on temperature logs. The results of the audits will be reported to the facility's Quality Assurance Committee for 3 months, as indicated.

Date of Completion: January 16, 2025

F812 - 483.60(i)(1)(2) Food Procurement, Store/Prepare/Serve-Sanitary

Finding #1

- 1) The small wall mounted fan in the dish room which was heavily soiled with dust was immediately removed during the survey.
 - Residents have the potential to be affected by this finding.
 - No staff education was provided as the fan was removed from the dietary department.
 - The Food Service Director and/or designee(s) will conduct audits weekly x 4 weeks, and then monthly x 3 months to ensure there are no fans placed in the dietary department. The results of the audits will be reported to the facility's Quality Assurance Committee for 3 months, as indicated.

Date of Completion: January 16, 2025

F867 – 483.75 (c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities

Finding #'s 1-7

- 1) F584: a POC has been written to maintain adequate housekeeping and maintenance services in a sanitary, orderly, and comfortable interior.
- 2) F655: a POC has been written to ensure baseline care plans are developed and implemented within 48 hours, that include instructions necessary to properly care for new admissions.
- 3) F684: a POC has been written to ensure staff are monitoring residents who have an unwitnessed fall in accordance with the Neurological Assessment and Fall policies.
- 4) F761: a POC has been written to ensure biologics are being stored at the correct temperature and temperature logs are being completed twice daily.
- 5) F812: a POC has been written to ensure there are no dusty fans located within the dietary department.
- 6) F883: a POC has been written to ensure the facility offers current residents influenza and pneumococcal vaccines per policy.
- 7) F887: a POC has been written to ensure the facility offers current residents the updated 2024-2025 Covid-19 vaccine.

1/16/2025
Tafonkelari MCA
Fac QPS Mgr.

Edgewood Rehabilitation & Living Center
Revisit Survey of Long Term Care Survey Process
(December 30, 2024)

- Residents have the potential to be affected by this finding.
- Staff education has been provided on January 7, 2025, regarding clinical citations. Staff education has been provided on January 16th, 2025, regarding Maintenance and Housekeeping citations.
- Audits have been assigned to the Maintenance, Food Service Directors as well as to the Director of Nursing, and/or their designees, to conduct audits weekly x 4 weeks, and then monthly x 3 months to ensure the areas cited remain in compliance. The facility is conducting routine Safety/QAPI meetings and will report the results of the audits at these meetings and to the facility's Quality Assurance Committee for 3 months, as indicated.

Date of Completion: January 16, 2025

F883 – 483.80(d)(1)(2) Influenza and Pneumococcal Immunizations

Finding #'s 1-6

- 1) Resident #6's record has been updated to reflect the current status of the Influenza and Covid-19, vaccines; and the resident has received education on the benefits and the potential side effects of, and have been offered and/or administered the PCV 20 vaccine.
 - 2) Resident #18's record has been updated to reflect the resident has received education on the benefits and the potential side effects of, and have been offered and/or administered the PCV 20 vaccine.
 - 3) Resident #19 was discharged from the facility on 12/12/2024, and did not receive the Prevnar 20 vaccine.
 - 4) Resident #337's record has been updated to reflect the resident has received education on the benefits and the potential side effects of, and have been offered and/or administered the Influenza and PCV 20 vaccine(s).
 - 5) Resident #338 was discharged on 12/20/2024 without receiving the Influenza and PCV 20 vaccine(s).
 - 6) Resident #339 was discharged on 12/21/2024 without receiving the Influenza and PCV 20 vaccine(s).
- Other residents have the potential to be affected by this alleged deficient practice.
 - Staff Education has been provided on January 7, 2025, regarding offering the Influenza, Covid-19, and Pneumococcal Vaccines, and to provide education on the benefits and the potential side effects of, and to administer the Influenza, Covid-19, and PCV 20 vaccine(s), as indicated.
 - The Director of Nursing Services, and/or designee(s), will conduct audits weekly x 4 weeks, and then monthly x 3 months to ensure the offering of the Influenza, Covid-19, and Pneumococcal Vaccines and the provision of education on the benefits and the potential side effects of, and administration of the Influenza, Covid-19, and PCV 20 vaccine(s) is being completed, as indicated. The results of the audits will be reported to the facility's Quality Assurance Committee for 3 months, as indicated.

Date of Completion: January 16, 2025

1/16/2025
Judy Penick, MA
Fac Ops Mgr.

F887 – 483.80(d)(3)(i)-(vii) Covid-19 Immunization

Findings #1-8

- 1) Resident #6's record has been updated to reflect the current status of the Covid-19 vaccine.
 - 2) Resident #7's record was updated to reflect he/she was provided education on the benefits and potential side effects of, and was offered or had administered the 2024-2025 Covid-19 vaccine.
 - 3) Resident #18's record was updated to reflect he/she was provided education on the benefits and potential side effects of, and was offered or had administered the 2024-2025 Covid-19 vaccine.
 - 4) Resident #19 was discharged on 12/12/2024 without receiving the 2024-2025 Covid-19 vaccine.
 - 5) Resident #21's record was updated to reflect he/she was provided education on the benefits and potential side effects of, and was offered or had administered the 2024-2025 Covid-19 vaccine.
 - 6) Resident #337's record was updated to reflect he/she was provided education on the benefits and potential side effects of, and was offered or had administered the 2024-2025 Covid-19 vaccine.
 - 7) Resident #338 was discharged on 12/20/2024 without receiving the 2024-2025 Covid-19 vaccine.
 - 8) Resident #339 was discharged on 12/21/2024 without receiving the 2024-2025 Covid-19 vaccine.
- Other residents have the potential to be affected by this alleged deficient practice.
 - Staff Education has been provided on January 7, 2025, regarding providing education on the benefits and the potential side effects of, and to administer the Covid-19 vaccine, as indicated.
 - The Director of Nursing Services, and/or designee(s), will conduct audits weekly x 4 weeks, and then monthly x 3 months to ensure the provision of education on the benefits and the potential side effects of, and administration of the Covid-19 vaccine is being completed, as indicated. The results of the audits will be reported to the facility's Quality Assurance Committee for 3 months, as indicated.

Date of Completion: January 16, 2025

1/16/2025
J. Peneloni, MA
FacOps Mgr.

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/30/2024
NAME OF PROVIDER OR SUPPLIER EDGEWOOD REHAB & LIVING CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 221 Fairbanks Rd FARMINGTON, ME 04938		
(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	{F 000}			
{F 584} SS=E	On 12/30/24, an unannounced on-site visit was conducted at Edgewood Rehabilitation and Living Center to follow up on the deficiencies cited at the annual Long Term Care Survey Process for Federal Recertification for 10/17/24. It was determined that Edgewood Rehabilitation and Living Center was not in compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. 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}	<i>See attached</i> <i>POC</i> <i>11/16/25</i>		

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

J. J. Danielaw, BARNMCA FacOps Mgr. *11/16/2025*

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 for 6 of 19 resident rooms for 1 of 1 environmental tour. Findings: On 12/30/24 from 11:15 a.m. to 11:30 a.m. an environmental tour was conducted with the Maintenance Director in which the following findings were observed: 1. Room #2- The walls around the entire room and in the bathroom were marred, chipped, and gouged creating uncleanable surfaces. 2. Room #2- Resident #24's Broda Chair had ripped/torn positioning pad for his/her right shoulder. 3. Room #3- The standing floor fan was heavily soiled with dust/dirt. 4. Room #4- The bathroom had a bed pan stored on the floor by the toilet. The room entrance door			{F 584}	<i>See attached Poc</i>		<i>1/16/25</i>

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{F 584}	Continued From page 2 jamb had broken surface protectors. 5. Room #11- The walls around the entire room and bathroom were marred and chipped paint on the wall behind the privacy curtain. 6. Room #15- The room entrance door jamb had broken surface protectors. 7. Room #19- The room entrance door jamb had broken surface protectors. On 12/30/24 at 11:30 a.m., in an interview with the Maintenance Director the above information was confirmed.	{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	{F 655}	<i>See attached PoC</i>		<i>1/16/25</i>

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{F 655}	Continued From page 3 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: (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 interviews 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 2 of 5 residents reviewed for new admissions. (Resident #338 and #340) 1. Resident #338 was admitted to the facility on 12/10/24 with the diagnosis of Malignant Neoplasm of the bladder, Post-Traumatic Stress Disorder, Diabetes, Chronic Obstructive Pulmonary Disease, and Chronic systolic heart failure. His/her baseline care plan was not completed until 12/19/24. 2. Resident #340 was admitted to the facility on 12/11/24 with the admitting diagnosis of Post			{F 655}	<i>See attached POC</i>		<i>1/16/25</i>

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{F 655}	Continued From page 4 Polio Syndrome, Anxiety, Adult Failure to Thrive, and Pneumonia. His/her baseline care plan was not completed until 12/19/24.	{F 655}			
{F 684} SS=E	On 12/30/24 at 1:06 p.m., during an interview with the Material Data Set Coordinator the above information was confirmed. 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 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 (Resident #7, #17, #340). 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	{F 684}	<i>See attached doc</i>		<i>1/14/25</i>

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{F 684}	Continued From page 5 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 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. Review of Resident #7's medical record revealed that on 11/14/24 he/she had a Brief Interview of Mental Status (BIMS) of 8 of 15, indicating he/she has moderate cognitive impairment. Review of Resident #7's record indicates he/she sustained an unwitnessed fall on 12/19/24. 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. 2. Review of Resident #17's quarterly Minimum Data Set (MDS) dated 12/19/24 revealed Resident had a BIMS of 8 of 15, indicating he/she has moderate cognitive impairment. Review of Resident #17's record shows he/she sustained 2 unwitnessed falls on 12/5/24. 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 falls. 3. Review of Resident #340's medical record	{F 684}	<i>See attached for</i> <i>11/16/25</i>		

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{F 684}	Continued From page 6 shows he/she sustained an unwitnessed fall on 12/24/24 resulting in a hematoma to his/her left forehead and left cheek. Further review of his/her medical record lacked evidence of the facility continuing to monitor him/her for further injuries and/or neurological changes after the unwitnessed fall.	{F 684}	<i>See attached for</i>		<i>1/16/25</i>
{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 observations and interviews, the facility failed to ensure the resident environment remained as free of accident hazards, related to a patient lift on 1 of 1 units. Findings: On 12/30/24 at 9:04 a.m., a surveyor observed the Hoyer Lift Reliant 600 in the Long-Term Care hallway, available for use, with 2 missing safety springs. At 9:06 a.m., the Director of Nursing (DON) was notified of the missing springs. At 9:11 a.m., 2 surveyors again observed the	{F 689}			

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{F 689}	Continued From page 7 hoyer lift in the Long-Term Care hallway available for use, missing the 2 safety springs. At 9:16 a.m., 2 surveyors observed CNA #2 with Resident #18 in his/her wheelchair and the hoyer pad underneath him/her. The hoyer pad was attached to the hoyer arms. At this time CNA #3 entered the room to assist with a hoyer transfer. During a brief interview with both surveyors, CNA #2 and CNA #3 discussed only having one hoyer available for use as the other one is currently not working, as the facility is waiting on batteries and were unaware of the safety concerns with the missing springs. On 12/30/24 at 9:20 a.m., 2 surveyors spoke with the DON, alerting her to staff currently using the hoyer that has 2 missing safety springs. The DON stated, Maintenance is obtaining the safety clips now and immediately responded intervened with the CNA's. On 12/30/24 at 9:25 a.m., during an interview, the DON confirmed the 2 missing safety clips were now in place.	{F 689}	<i>See attached PoC</i>	<i>1/16/25</i>	
{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	{F 761}			

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{F 761}	Continued From page 8 §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 2 of 2 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 12/30/24 at 2:00 p.m., observation of the Unit A medication storage room refrigerator which contained 33 Novavax Vaccinations (COVID-19)	{F 761}	<i>See attached doc</i> <i>1/16/25</i>		

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{F 761}	Continued From page 9 and 6 Fluzone Vaccinations. On 12/30/24 a surveyor reviewed the facilities "Daily Temperature Recording Chart" for the medication refrigerator for the months of November and December. 1. November 27th through November 30th lacked evidence of twice daily temperature readings for 4 out of the 4 days and temperatures were out of range for 2 out of the 4 days. 2. December 1st through December 29th lacked evidence of twice daily temperature readings for 12 out of 29 days and temperatures were out of range for 12 out of the 29 days. On 12/30/24 at 12:15 p.m., during an interview, the above was confirmed with the Director of Nursing.	{F 761}	<i>All attached pcc</i>		<i>1/16/25</i>
{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.	{F 812}			

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{F 812}	Continued From page 10 §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 observation and interview, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for 1 of 1 kitchen tour and for 1 of 1 survey days (12/30/24). This has the potential to affect all residents. Finding: On 12/30/24 from 8:30 a.m. to 8:48 a.m., during an initial kitchen tour, a surveyor observed the dish room with a small wall mounted fan that was dirty and heavily soiled with dust. On 12/30/24 at 9:05 a.m., during an interview with the Administrator and the Cook, the above finding was confirmed.	{F 812}			
F 867	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such	F 867	See attached pOC		1/16/25

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F 867	Continued From page 11 information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems	F 867	<i>All attached Poc</i>		<i>1/16/25</i>

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F 867	Continued From page 12 impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this	F 867	<i>See attached pOC</i>		<i>1/16/25</i>

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F 867	Continued From page 13 section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews, the facility's Quality Assurance Committee failed to ensure that the Plan of Correction (POC) for identified deficiencies from the annual Long Term Care Recertification Survey, dated 10/17/24, was effective. Several issues were again identified during the revisit survey, on 12/30/24. Findings: During the revisit survey on 12/30/24, it was determined the Federal citations: F584, F655, F684, F761, F812, F883 and F887 would be recited for the same following issues: F584 The POC indicated the facility educated the Maintenance and Housekeeping Director and audits to be completed. The facility failed to maintain adequate housekeeping and maintenance	F 867	<i>See attached POC</i>		<i>1/16/25</i>

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F 867	Continued From page 14 services to maintain a sanitary, orderly, and comfortable interior. F655 The POC indicated the facility educated the MDS Coordinator regarding appropriate care planning time frames. The facility failed to ensure that baseline care plans were developed and implemented within 48 hours, that included instructions needed to provide minimum healthcare information necessary to properly care for new admissions. F684 The POC indicated that nursing staff was educated on the Neurological Assessment Policy and Fall Policy. The facility failed to monitor residents after a fall. F761 The POC indicated that nursing staff was educated on the Pharmacy policies/procedures regarding Medication Storage and appropriate temperatures and the need to record temperatures. The facility failed to adequately ensure medications and biologics were monitored and stored at appropriate temperatures. F812- The POC indicated that the kitchen staff were educated and to complete audits. The facility failed to ensure the kitchen was maintained in a clean and sanitary manner. F883 The facility failed to identify current resident who were not offered the vaccine. F887 The POC indicated the Infection Preventionist was educated and current residents were offered the vaccine and educated. The facility to educate, offer and/or administer the updated 2024-2025 COVID -19 vaccines to residents. On 12/30/24 at 3:45 p.m., the above concerns were discussed with the Administrator and Director of Nursing.	F 867	<i>See attached POC</i>		<i>1/16/25</i>
{F 883} SS=E	Influenza and Pneumococcal Immunizations	{F 883}			

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{F 883}	Continued From page 15 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. §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	{F 883}	<i>See attached poc</i>	<i>1/16/25</i>	

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{F 883}	Continued From page 16 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 the facility's immunization policy, record review and interview, the facility failed to implement their influenza and pneumococcal immunization policy for 6 of 9 residents whose immunization records were reviewed (#6, #18, #19, #337, #338, #339). Findings: The facility's "Immunization Policy" indicated in Procedure I: Before offering the Influenza or Pneumococcal vaccine, each resident, and/or 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	{F 883}	<i>See attached POC</i>		<i>1/14/25</i>

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{F 883}	Continued From page 17 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. The facilities "Immunization Consent Form" adopted 7/2024 states, "I have been offered and given the appropriate Vaccine Information Sheet (VIS)" This form allows the resident and/or representative to give or not give consent for the influenza vaccine, Prevnar 20 vaccine (PCV20) and the COVID-19 vaccine. 1. Resident #6's clinical record contained an immunization consent form, signed on 9/25/24, indicating he/she had given permission for the Influenza and COVID vaccines. The medical record lacked evidence that he/she was provided education on the benefits and potential side effects, offered and/or administered the PCV 20 vaccine. 2. Resident #18 was admitted to the facility on	{F 883}	<i>See attached POC</i> <i>1/16/25</i>		

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{F 883}	Continued From page 18 6/19/24. Review of the clinical records lacked evidence that he/she was provided education on the benefits and potential side effects, offered and/or administered the PCV 20 vaccine. 3. Resident #19's clinical record contained an immunization consent form, signed on 10/10/24, indicating he/she had given permission for the following vaccines: Influenza, Prevnar 20 and COVID (Coronavirus). Further review states he/she received the Influenza vaccine on 10/21/24 but did not receive the Prevnar 20 vaccine as of his/her discharge of 12/12/24. 4. Resident #337 was admitted to the facility on 12/17/24. Review of the clinical record lacks evidence that he/she was provided education on the benefits and potential side effects, offered and/or administered the influenza and PCV 20 vaccine as of 12/30/24. 5. Resident #338 was admitted on 12/10/24. Review of the clinical record lacks evidence of a vaccine history or that he/she was provided education on the benefits and potential side effects, offered and/or administered the influenza and PCV 20 vaccine as of his/her discharge on 12/20/24. 6. Resident #339 was admitted on 12/10/24. Review of the clinical record lacks evidence of a vaccine history or that he/she was provided education on the benefits and potential side effects, offered and/or administered the influenza and PCV 20 vaccine as of his/her discharge on 12/21/24. On 12/30/24 at 2:15 p.m., during an interview, the Infection Preventionist (IP) confirmed the above,	{F 883}	<i>See attached for</i> <i>11/16/25</i>		

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{F 883}	Continued From page 19 lack of offering and/or administration of the influenza and/or PCV 20 vaccine. At this time, both the surveyor and the IP reviewed the resident "Immunization Consent Form" which states, "I have been offered and given the appropriate Vaccine Information Sheet (VIS)". The Surveyor asked if the VIS sheets with the benefits and side effects are given to the resident and/or representative when she has them sign the immunization consent form. The IP stated she does not provide the VIS sheets. The surveyor asked how the resident and/or representative are educated on the benefits and side effects of the vaccine. The IP stated she does not educate the resident and/or representative.	{F 883}	<i>see attached poc</i>	<i>1/16/25</i>	
{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 risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident,	{F 887}			

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{F 887}	Continued From page 20 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). This REQUIREMENT is not met as evidenced by: Based on facility policy review, record review, observations and interview, the facility failed to offer the updated 2024-2025 COVID-19 vaccine	{F 887}	<i>see attached doc</i>		<i>1/16/25</i>

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

PRINTED: 01/06/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/30/2024
NAME OF PROVIDER OR SUPPLIER EDGEWOOD REHAB & LIVING CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 221 Fairbanks Rd FARMINGTON, ME 04938		
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{F 887}	Continued From page 21 doses for 5 of 5 residents reviewed. (#6, # 7, #18, #19, #21, #337, #338 and #339). 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. The facilities "Immunization Consent Form" for the influenza vaccine, Prevnar 20 vaccine (PCV20) and the COVID-19 vaccine, adopted 7/2024 states, "I have been offered and given the appropriate Vaccine Information Sheet (VIS)". 1. Resident #6's clinical record contained an immunization consent form, signed on 11/8/23 indicating he/she had refused the COVID-19 vaccine. Upon further review, his/her medical record contained an updated immunization consent form, signed on 9/25/24 indicating he/she had given permission for the COVID-19 vaccine. As of 12/30/24, he/she has not received the 2024-2025 COVID-19 vaccine. 2. Resident #7's last documented COVID-19 vaccination was on 12/21/23. As of 12/30/24, the clinical record lacks evidence that he/she was provided education on the benefits and potential side effects, offered and/or administered the 2024-2025 COVID-19 vaccine. 3. Resident #18's clinical record contained an immunization consent form, signed on 9/26/24, indicating he/she had given permission to receive the COVID-19 vaccine. As of 12/30/24, the	{F 887}	<i>See attached POC</i>		<i>1/16/25</i>

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{F 887}	Continued From page 22 clinical record lacks evidence that he/she was provided education on the benefits and potential side effects, offered and/or administered the 2024-2025 COVID-19 vaccine. 4. Resident #19's clinical record contained an immunization consent form, signed on 10/10/24, indicating he/she had given permission for the COVID-19 vaccine. The medical record lacked evidence that he/she was given the 2024-2025 COVID-19 vaccine as of his/her discharge on 12/12/24. 5. Resident #21's clinical record contained a signed immunization consent form indicating he/she had given permission for the influenza vaccine and the COVID-19 vaccine however, lacked a date. Further review states he/she received the Influenza vaccine on 10/17/24. As of 12/30/24, he/she has not received the 2024-2025 COVID-19 vaccine. 6. Resident #337 was admitted to the facility on 12/17/24. As of 12/30/24, the clinical record lacks evidence that he/she was provided education on the benefits and potential side effects, offered and/or administered the 2024-2025 COVID-19 vaccine. 7. Resident #338 was admitted on 12/10/24. Review of the clinical record lacks evidence of a vaccine history or that he/she was provided education on the benefits and potential side effects, offered and/or administered the 2024-2025 COVID-19 vaccine as of his/her discharge on 12/20/24. 8. Resident #339 was admitted on 12/10/24. Review of the clinical record lacks evidence of a	{F 887}	<i>see attached POC</i> <i>1/16/25</i>		

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{F 887}	Continued From page 23 vaccine history or that he/she was provided education on the benefits and potential side effects, offered and/or administered the 2024-2025 COVID-19 vaccine as of his/her discharge on 12/21/24. On 12/30/24 at 2:00 p.m., 2 surveyors observed 3 boxes of the 2024-2025 COVID-19 vaccines available in the facilities medication refrigerator. On 12/30/24 at 2:15 p.m., during an interview, the Infection Preventionist (IP) confirmed the above, lack of offering and/or administration of the 2024-2025 COVID-19. At this time, both the surveyor and the IP reviewed the resident "Immunization Consent Form" which states, "I have been offered and given the appropriate Vaccine Information Sheet (VIS)". The Surveyor asked if the VIS sheets with the benefits and side effects are given to the resident and/or representative when she has them sign the immunization consent form. The IP stated she does not provide the VIS sheets. The surveyor asked how the resident and/or representative are educated on the benefits and side effects of the vaccine. The IP stated she does not educate the resident and/or representative and has the 2024-2025 COVID-19 vaccine in house.	{F 887}	<i>See attached poc</i>		<i>1/16/25</i>