STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205109	A. BUILDING _____ B. WING _____	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARSHALL HEALTH CARE AND REHAB	16 BEAL STREET MACHIAS, ME 04654

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS From 6/10/24 through 6/12/24, on-site visits were conducted at Marshall Health Care and Rehab for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification and investigating a complaint #ME00047383. It was determined that Marshall Health Care and Rehab was not in compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when-	F 623		

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

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F 623	Continued From page 1	F 623		

(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part

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F 623	Continued From page 2 C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to notify the resident and/or resident representative in writing for the reason of a transfer/discharge from the facility, for 2 of 3 facility initiated hospital transfers for Resident #44 (R44). In addition, the facility failed to notify the Ombudsman of the transfer/discharges from the facility.	F 623		

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F 623	Continued From page 3 Finding: On 6/11/24, R44's clinical record was reviewed and indicated that R44 was transferred to the hospital on 3/25/24 and 3/28/24. The clinical record indicated that nursing notified the resident representative verbally and lacked evidence of the written transfer/discharge notices being provided to the resident/resident representative. On 6/11/24 at 11:58 a.m., during an interview with a surveyor, the Licensed Social Worker stated she did not send written notices of transfer/discharge notices to the resident representative and that she had not been notifying the Ombudsman of transfer/discharges; she has been working at the facility for 6 months. On 6/11/24 at 12:02 p.m., during an interview with a surveyor, the Administrator stated that she was unaware that written notices must be provided to the resident representatives.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the Annual Minimum Data Set (MDS) 3.0 was coded accurately to indicate that a resident had a state Level II Preadmission Screening and Resident Review (PASRR) for 1 of 2 sampled residents reviewed for PASRR (Resident #11 [R11]).	F 641		

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F 641	Continued From page 4 Finding: On 6/10/24, R11's clinical record was reviewed. On 4/20/23, R11's PASSR was completed and indicated that R11 qualified for Level II services. Review of R11's Annual MDS, dated 10/3/23, Section: A1500 was coded to indicate that R11 did not have a Level II PASRR. On 6/12/24 at 8:29 a.m., during an interview with a surveyor, the Licensed Social Worker (LSW) stated that R11 did have a Level II PASRR and that the MDS was coded inaccurately. The surveyor confirmed this finding during this interview.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced	F 644		

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F 644	Continued From page 5 by: Based on record review and interview, the facility failed to obtain recommendations from the Preadmission Screening and Resident Review (PASRR) level II determination-Maine Summary of Findings for 1 of 1 sampled resident (Resident #11 [R11]). Finding: On 06/10/24, R11's clinical record was reviewed and included a PASRR level II determination explanation, dated 4/20/23 that indicated R11 met the State of Maine's definition for serious mental illness due to a diagnosis of bipolar disorder. R11's PASRR indicated that the nursing facility was required to provide: "ongoing psychiatric services by a psychiatrist to evaluate response and effectiveness of psychotropic medications on target symptoms, modify medication orders, and to evaluate ongoing need for additional behavioral health services." On 6/12/24 at 11:22 a.m., during an interview with a surveyor, the Licensed Social Worker (LSW) stated that she did not realize that R11's PASRR recommended psychiatric services for medication management and that there was provider available to provide these services. She stated that the Social Worker was responsible to obtain these services and could not find documentation that indicated that these services had been offered or refused.	F 644		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning	F 655		

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F 655	Continued From page 6 §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: (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.	F 655		

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F 655	Continued From page 7 (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 reviews, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours that included the problems, interventions, and initial goals needed to provide minimum healthcare information necessary to properly care for 1 of 3 residents that were reviewed for new admissions (Resident #195 [R195]). Finding: R195 was admitted to the facility on 5/21/24. R195's diagnosis list included Chronic obstructive pulmonary disease and admission orders included use of oxygen and nebulizer treatments. The baseline care plan lacked evidence for the use/care of these respiratory treatments. On 6/11/24 at 1:18 p.m., during an interview with the Director of Nursing, a surveyor confirmed this finding.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must	F 656		

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F 656	Continued From page 8 describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement a care plan approach in the area of nutrition for 1 of 2 residents	F 656		

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F 656	Continued From page 9	F 656		

reviewed for nutrition (Resident #31 [R31] and failed to develop a care plan for respiratory care for 1 of 2 residents reviewed for oxygen (R195).

Findings:

1. On 6/11/24 at 9:15 a.m., during an interview with R31, he/she stated that he/she needed help with meals. R31stated that sometimes after their meals he/she still feels hungry and does not get more food to eat.

On 6/11/24 at 10:43 a.m., during record review for R31 his/her record has documentation that shows he/she has had an 8-pound weight loss in a 5-month time span. R31's care plan for nutrition was initiated on 4/23/24 to address swallowing precautions, with an approach that he/she needed dietary staff to provide him/her with pureed meals with large portions with enough calories. Review of R31's diet order slip used by the dietary staff, does not include the large portions for meals.

On 6/11/24 at 2:20 p.m., during an interview with the Director of Nursing and the Administrator a surveyor confirmed the above finding.

2. On 6/10/24 at 2:29 p.m., a surveyor observed R195 wearing oxygen via nasal cannula and observed a nebulizer treatment setup in the room on a nightstand. R195's clinical record indicated that the resident was admitted to the facility on 5/21/24 and the admission orders included use of oxygen and nebulizer treatments. R195's admission minimum data set (MDS) 3.0 care area assessment (CAA) was completed and signed on 6/3/24, making the care plan due to be completed within 7 days thereafter, or 6/10/24.

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F 656	Continued From page 10 On 6/11/24 at 2:00 p.m., R195's comprehensive care plan was reviewed with the Director of Nursing and the surveyor confirmed that the care plan lacked evidence of a care area and interventions related to R195's respiratory treatments which included the use of oxygen and nebulizer treatments.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657		

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F 657	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to update a care plan for services outlined on the Preadmission Screening and Resident Review (PASRR) level II determination-Maine Summary of Findings, dated 4/20/23, for 1 of 1 sampled resident (Resident #11 [R11]). Finding: On 06/10/24, R11's clinical record was reviewed and included a PASRR level II determination explanation, dated 4/20/23 that indicated R11 met the State of Maine's definition for serious mental illness due to a diagnosis of bipolar disorder. R11's PASRR indicated that the nursing facility was required to provide: "ongoing psychiatric services by a psychiatrist to evaluate response and effectiveness of psychotropic medications on target symptoms, modify medication orders, and to evaluate ongoing need for additional behavioral health services." On 6/12/24 at 11:22 a.m., during an interview with a surveyor, the Licensed Social Worker reviewed R11's care plan which did include a care area "Mental Wellbeing" and mentioned PASRR Level II but she was unable to find an intervention about psychiatrist medication management. The surveyor confirmed this finding during this interview.	F 657		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes,	F 692		

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F 692	Continued From page 12	F 692		

both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-

§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews, and record review, the facility failed to follow physician orders and care plan for 1 of 4 residents reviewed for weight loss (Resident #40 [R40]).

Finding:

On 6/10/24, R40's clinical record was reviewed and indicated that on 2/06/24, the resident weighed was 137.4 pounds (lbs) and on 4/30/2024, the resident weighed 126.4 pounds, which was an 8.01 percent loss. R40's physician orders for diet, dated 4/10/24, included carnation instant breakfast (CIB) mixed with thrive supplement, to be provided with breakfast, lunch, and supper, and a physician order, dated 3/6/24, for adaptive equipment-Kennedy cup (light weight, easy to grip with handle, spill proof cup).

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F 692	Continued From page 13	F 692		

R40's nutrition care plan, dated 5/8/24, indicated that the staff were to provide all drinks in Kennedy cups and the that a thrive shake was to be provided 3 times a day.

On 6/10/24 at 12:40 p.m., a surveyor observed R40 in the dining room, and noticed that there was an empty round cup with a straw poked thru the plastic wrap over the top of the cup on the table by R40, but there was no Kennedy cup.

On 6/11/24 at 9:07 a.m., two surveyors observed R40 done eating breakfast, with a large plastic cup with no handles, with some beverage left in the cup. During an interview with two surveyors, the cook, who was in the room because he had plated the breakfast meal from the steam table, was unsure what a Kennedy cup was. The cook had R40's meal slip that identified the "adaptive equipment" as a Kennedy cup was to be used for R40.

On 6/11/24 at 12:40 p.m., during an interview with a surveyor, Certified Nursing Assistant (CNA)1 and CNA2 stated they were unaware that R40 needed a Kennedy cup for beverages. CNA2 stated that R40 did not get her CIB shake at lunch time because the plastic wrap with writing fell into the cup (provided from the kitchen in what was not a Kennedy cup).

On 6/11/24 at 12:52 p.m., during an interview with a surveyor, the Dietary Manager stated that the CNA was responsible for transferring the beverages over to the Kennedy cups. The surveyor explained that R40 did not get her shake today because the plastic wrap with writing fell into the beverage and that Kennedy cups were

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F 692	Continued From page 14 not being used.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide respiratory care consistent with professional standards of practice by failing to follow physician orders for oxygen administration, failing to date and label oxygen tubing/nebulizer set ups, and/or failing to ensure that respiratory equipment was clean, for 2 of 2 sampled residents (Resident #195 [R195] and R2). Findings: 1. On 6/10/24 at 2:29 p.m,. a surveyor observed R195 wearing oxygen via nasal cannula with the concentrator set at 1.5 liters per minute (LPM). The surveyor also observed a nebulizer treatment setup with neither the oxygen or nebulizer setup dated to indicate when the tubing/setup was last changed and the concentrator filter located on the back of the machine was dusty. On 6/11/24 at 7:55 a.m., a surveyor observed R195 wearing oxygen via nasal cannula with the	F 695		

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concentrator set at 1.5 LPM and the concentrator filter was still dusty.

A review of R195's clinical record included physician orders included the following:
-5/21/24 - apply oxygen at 2 LPM for shortness of breath and/or oxygen saturations of less than 90% and Albuterol Sulfate nebulization solution as needed.

The surveyor was unable to find treatments that directed staff to document when the tubing/nebulizer setup was changed and the equipment to be cleaned on the treatment record.

On 6/11/24 at 1:18 p.m. the Director of Nursing (DON) and surveyor observed R195 wearing oxygen with the concentrator set at 1.5 LPM, and not the physician ordered 2 LPM. R195 also stated that he/she had to ask for the oxygen tubing to be changed recently because he/she wasn't getting any air out of it. R195 stated that the nebulizer setup was changed this morning. The surveyor also confirmed that the concentrator filter was dirty with the DON at this time. After this observation, the DON stated that she was adding a treatment for R195 to change the tubing setups and clean the filter weekly.

2. On 6/10/24 at 2:27 p.m., a surveyor observed R2 wearing oxygen via nasal cannula and the concentrator filter was dusty. A picture of the dusty filter was taken at this time.

On 6/11/24 at 10:21 a.m., a surveyor observed R2 wearing oxygen via nasal cannula and the concentrator filter was dusty.

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F 695	Continued From page 16 R2's treatment administration (TAR) was reviewed and there are orders for cleaning of the concentrator filters 1 x wk, Tuesday PM (one time per week on Tuesday evenings). On 6/12/24 at approximately 10:00 a.m. during an interview with the Administrator, a surveyor showed the picture of the dusty concentrator, and confirmed that R2's concentrator filter was dusty. The TAR was signed that the concentrator filter was cleaned on 6/4/24 as directed; however, the amount of dust on the filter was not consistent with being cleaned 6 days prior to 6/10/24's observation.	F 695		
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the physician reviewed the resident's total program of care, which included	F 711		

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F 711	Continued From page 17 signing orders for medications and treatments listed on the Physician Orders (block orders) in a timely manner for 1 of 4 newly admitted residents reviewed (Residents #40 [R40]). Finding: On 6/12/24, R40's clinical record was reviewed and indicated R40 was admitted to the facility on 1/30/24. The Physician signed the admission orders on 2/5/24 and these were in effect for 30 days. The next Physician Orders (block orders), including a 10-day grace period, needed review and the Physician's signature by 3/16/24, but weren't signed until 3/19/24, 3 days late; these orders were in effect for 30 days. The next Physician Orders (block orders), including a 10-day grace period, needed review and the Physician's signature by 4/28/24, but were signed on 5/1/24, 3 days late. On 6/12/24 at 7:51 a.m., a surveyor confirmed with the Administrator that the Physician Orders were signed late.	F 711		
F 712 SS=E	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs	F 712		

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(c)(4) and (f) of this section, all required physician visits must be made by the physician personally.

§483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section.
This REQUIREMENT is not met as evidenced by:
Based on clinical record reviews and interviews, the facility failed to ensure the attending physician made required visits, at least every 30 or every 60 days (depending on date of admission) and wrote a progress note for 5 of 11 sampled residents (Resident #25 [R25,] R31, R11, R40, R44).

Findings:

1. Documentation in R25's clinical record, under the progress notes section, indicates that R25 had a Physician visit on 2/23/24. His/her next Physician visit would have been due on 5/3/24 (this includes a 10-day grace period). Documentation in R25's clinical record indicates that the next Physician visit was completed on 5/31/24 making it 28 days overdue and beyond the 10-day grace period.

2. Documentation in R31 clinical record, under the progress notes section, indicates that R31 had a Physician visit on 2/6/24. His/her next Physician visit would have been due on 5/15/24 (this includes a 10-day grace period). Documentation in R31's clinical record indicates that the next Physician visit was completed on 5/23/24 making it 8 days overdue and beyond the 10-day grace period.

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On 6/12/24 at 1:00 p.m., during an interview with the RN, ICP/Unit Manager and the Administrator, a surveyor confirmed that the above residents R31 and R25's physician visits were not completed timely.

3. On 6/11/24, Resident #11's clinical record was reviewed and included Physician progress notes for a visit completed on 11/8/23. The next 60-day Physician visit was due by 1/17/24 (including a 10-day grace period) but the resident's next 60-day Physician visit wasn't completed until 2/28/24, 42 days beyond the grace period. The next 60-day Physician visit was due by 5/8/24 (including a 10-day grace period) but the resident's next 60-day Physician visit wasn't completed until 5/24/24, 16 days beyond the grace period.

On 6/12/24 at 12:59 p.m., during an interview with RN, ICP/Unit Manager and the Administrator, a surveyor confirmed this finding. The RN ICP/Unit Manager stated she thought they were due every 90 days.

4. On 6/11/24, R40's clinical record was reviewed and indicated that R40 was admitted to the facility on 1/30/24. R40's first 30 day Physician visit was completed on 2/8/24 with the next 30 day Physician visit due on 4/18/24 (including a 10-day grace period) but was not completed until 5/24/24, 36 days beyond the grace period.

On 6/12/24 at 7:51 a.m., during an interview with the Administrator, a surveyor confirmed this finding.

5. On 6/11/24, R44's clinical record was reviewed

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F 712	Continued From page 20 with the Director of Nursing and Administrator and included Physician progress notes for a visit completed on 5/19/23. The next 60-day Physician visit was due by 7/28/23 (including a 10-day grace period) but the resident's next 60-day Physician visit wasn't completed until 9/11/23, 42 days beyond the grace period. The next 60-day Physician visit was due by 11/20/23 (including a 10-day grace period) but the resident's next 60-day Physician visit wasn't completed until 12/14/23, 16 days beyond the grace period. The next 60-day Physician visit was due by 2/22/24 (including a 10-day grace period) but the resident's next 60-day Physician visit wasn't completed until 3/13/24, 18 days beyond the grace period. On 6/11/24 at 1:02 p.m., during an interview with the Administrator and Director of Nursing, a surveyor confirmed these findings.	F 712		
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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§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 and interviews, the facility failed to remove fresh food items and out dated meat timely from the walk in cooler for 1 of 1 initial tours (6/10/24). In addition, the facility failed to ensure that plumbing fixtures were properly installed to prevent backflow as required by the Maine State Plumbing Code and failed to ensure that equipment/cabinets were kept clean on 2 of 3 survey days (6/10/24 and 6/11/24).

Findings:

1. On 6/10/24 at 11:30 a.m., an initial tour of the kitchen was completed with the Dietary Manager and a surveyor. The following were observed:

- In the walk in cooler
Cooked Turkey bacon in plastic bag, dated 5/11/24, and 12 heads of celery that had some brown, slimy stalks. The Dietary Manager stated that the bacon was good for 5 days. All items were removed from the stock available for use at the time of observation.

A metal cabinet with doors, where dishes were stored, had dirty shelves.

A photo was taken of the ice machine air gap for review as equipment needed to be moved in order to properly view. The air gap did not appear to be in compliance in the photo.

2. On 6/11/24 at 8:17 a.m., during an interview

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F 812	Continued From page 22 with the Maintenance Director, a surveyor reviewed the photo of what appeared to be an improper air gap on the ice machine. On 6/11/24 at 1:50 p.m., two surveyors returned to the kitchen as the Maintenance Director had moved the equipment out of the way so a surveyor could properly observe the ice machine air gap. During this observation, a surveyor confirmed with the Maintenance Director that the air gap was not in compliance and was in violation of the 10-114 State of Maine Rules Chapter 226, definition Section A, which defines an Air-Gap Separation - A physical separation between the free-flowing discharge end of a potable water supply pipeline and an open or non-pressure receiving vessel. An air-gap separation shall be at least twice the diameter of the supply pipe measured vertically above the overflow rim of the vessel - in no case less than one inch (2.54 cm). During this visit to the kitchen, two surveyors also observed dust on the back of the juice machine and on the front of the ice maker with the Dietary Manager.	F 812		
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	F 883		

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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 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

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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 record reviews and interview, the facility failed to ensure residents were offered pneumococcal vaccinations in accordance with the Centers for Disease and Prevention Control (CDC) recommendations for 5 of 6 residents reviewed for immunizations (Resident #5 [R] , R18, R2, R39, and R244).

Findings:

1. R5 was admitted to the facility on 1/28/17. The CDC recommendation was to review, offer and/or receive one dose of Prevnar 20 which had not been done.

2. R18 was admitted to the facility on 7/17/23. The CDC recommendation was to administer one dose of Prevnar 20 which had not been done.

3. R2 was admitted to the facility on 6/1/18. The CDC recommendation was to review, offer and/or receive one dose of Prevnar 20 which had not been done.

4. R39 was admitted to the facility on 4/2/24. The CDC recommendation was to review, offer and/or receive one dose of Prevnar 20 which had not been done.

5. R244 was admitted to the facility on 6/11/24. The CDC recommendation was to review, offer and/or receive one dose of Prevnar 20 which had

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F 883	Continued From page 25 not been done. R244'a pneumococcal vaccination status was reviewed for pneumococcal vaccines that did not include a Prevnar 20 vaccination. On 6/12/24 at 9:45 a.m. in an interview with the Unit Manager-Infection Preventionist and the Director of Nursing, a surveyor confirmed they are not following CDC recommendations and were unaware of the CDC recommendation to review, offer, and administer the Prevnar 20 vaccination.	F 883		

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T 001	Initial Comments From 6/10/24 through 6/12/24, on-site visits were conducted at Marshall Health Care and Rehab for the purpose of completing the annual Long Term Care Survey Process for Recertification and to investigate complaint #ME00047383. It was determined that Marshall Health Care and Rehab is not in substantial compliance with 10-144 Chapter 110-Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities.	T 001		
T 222	9.A.4. Minimum Staffing Rules The nursing staff-to-resident ratio is the number of nursing staff to the number of occupied beds. Nursing assistants in training shall not be counted in the ratios. The minimum nursing staff-to-resident ratio shall not be less than the following: a. On the day shift, one direct-care provider for every 5 residents; b. On the evening shift, one direct-care provider for every 10 residents; and c. On the night shift, one direct-care provider for every 15 residents The definition of direct care providers and direct care is found in Chapter 1 of these Regulations.	T 222		

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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) COMPLETE DATE
T 222	Continued From page 1	T 222		

This Regulation is not met as evidenced by:
Based on review of the staffing schedules, daily resident census, and interview, the facility failed to ensure staffing minimums were met in accordance with the "State of Maine Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities," Chapter 9.A.4.A., for 8 days out of 42 days reviewed for minimum staffing.

Findings:

The "State of Maine Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities," Chapter 9.A.4.A., indicates the minimum nursing staff-to-resident ratio shall not be less than one direct care provider for every 5 residents on the day shift; not be less than one direct care provider for every 10 residents on the evening shift, and not be less than one direct care provider for every 15 residents on the night shift. "Direct Care" means hands-on care provided to residents, including, but not limited to feeding, bathing, toileting, dressing, lifting, moving residents, treatments, and medication administration per the definition in Chapter 1 of the regulations.

1. On 10/7/23, the facility had a census of 43 residents which required 9 direct care staff to be on duty. The facility's schedule indicated that 8 staff worked on that day shift.

2. On 10/8/23, the facility had a census of 43 residents which required 9 direct care staff to be on duty. The facility's schedule indicated that 8 staff worked on that day shift.

3. On 10/14/23, the facility had a census of 45

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205109	A. BUILDING: _____ B. WING _____	06/12/2024

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residents which required 9 direct care staff to be on duty. The facility's schedule indicated that 8 staff worked on that day shift.

4. On 10/21/23, the facility had a census of 44 residents which required 9 direct care staff to be on duty. The facility's schedule indicated that 8 staff worked on that day shift.

5. On 11/4/23, the facility had a census of 43 residents which required 9 direct care staff to be on duty. The facility's schedule indicated that 8 staff worked on that day shift.

6. On 11/5/23, the facility had a census of 43 residents which required 9 direct care staff to be on duty. The facility's schedule indicated that 8 staff worked on that day shift.

7. On 11/17/23, the facility had a census of 42 residents which required 9 direct care staff to be on duty. The facility's schedule indicated that 8 staff worked on that day shift.

8. On 11/17/23, the facility had a census of 42 residents which required 9 direct care staff to be on duty. The facility's schedule indicated that 8 staff worked on that day shift.

On 6/12/24 at 1:30 p.m., in an interview with the surveyor, the above findings were confirmed with the Administrator.