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 _____	R 08/13/2024

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 On 8/13/24, on-site re-visit was conducted at Marshall Health Care and Rehab for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification. 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 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 (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 review and interview the facility failed to ensure the attending physician made required visits at least every 30 or every 60 days (dependent on date of admission) and wrote	{F 712}		

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

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{F 712}	Continued From page 1 a progress note for 1 of 4 sampled residents (Resident #5 [R5]). Finding: On 8/13/24 at 2:30 p.m., clinical record review indicated, R5 was seen by the provider on 3/4/24. The next visit would have been due on 5/13/24 (including a 10day grace period). The clinical record indicated the resident was next seen by a provider on 8/9/24 (88 days late). At 2:55 p.m., in an interview with the Administrator, the surveyor confirmed the clinical record lacked evidence that the resident was seen by the provider timely. On 8/14/24 at 9:37 a.m., review of an email from the Administrator indicated the provider had seen R5 on 7/18/24 (66 days late).	{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. §483.60(i)(2) - Store, prepare, distribute and	{F 812}		

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{F 812}	Continued From page 2	{F 812}		

serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observations, and interview, the facility failed to store food in accordance with professional standards by not removing fresh food items timely from walk-in refrigerators and not storing food in a manner that prevents food borne illness for 1 of 1 days of survey (8/13/24).

Findings:

On 8/13/24 from 10:10 a.m. to 10:20 a.m., during a tour of the kitchen and food storage, a surveyor and the Dietary Supervisor observed the following on the shelf and available for use:

In the walk-in refrigerator, located within the kitchen, 4 containers of strawberries observed to be covered in grey mold.

In the walk-in refrigerator, located outside the kitchen:
1 plastic bin containing greater than 25 tomatoes observed to be in varying stages of decay. Mold was observed on all visible tomatoes.
1 box containing zucchini, yellow slime like substance observed on the surface of the zucchinis.
3 pint size containers of cherry tomatoes observed to be moldy and in varying stages of decay. Tomato mucous accumulated at the bottom of the containers and was able to drip down onto box of lemons located on the shelf below.

Additionally, within the walk-in freezer, located outside the kitchen, 1 box of raw hamburger

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{F 812}	Continued From page 3 patties was observed open to the environment. A surveyor observed and confirmed these findings with the Dietary Supervisor at the time of the observations.	{F 812}		
F 867 SS=D	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 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 §483.70(e) 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.	F 867		

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F 867	Continued From page 4 §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 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,	F 867		

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F 867	Continued From page 5	F 867		

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 §483.70(e). 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 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

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F 867	Continued From page 6	F 867		

available data to make improvements.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility's Quality Assurance Committee failed to ensure that the Plan of Correction (POC) for an identified deficiency from the annual Long Term Care Recertification Survey, dated 6/12/24, was effective. The Federal citations F712, and F812 were cited again during the re-visit to the annual Long Term Care Recertification Survey, dated 8/13/24.

Findings:

1. During the annual Long Term Care survey, dated 6/12/24, a deficiency was cited at F712 for the facilities failure 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.

The facility's POC, dated 6/21/24, stated, "Residents #40, #31, #11, #44, and #25's attending physician progress notes have been reviewed, updated, and signed off on per their individual plans of care accordingly. Administrator has provided education to each facility physician individually and reviewed Maine State rules and regulations regarding timeliness and frequency of physician documentation. All residents have the potential to be affected by this practice. To ensure compliance going forward the facility Ward Clerk and/or Designee will fax physician documentation, complete in-person runs to physician offices, and conduct follow-up phone calls to physician offices. The facility will also implement regular medical chart audits to ensure completion of documentation. Physician

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F 867	Continued From page 7	F 867		

progress notes documentation will be reviewed and reported for compliance during monthly Quality Assurance and Performance Improvement (QAPI) meetings for a full quarter. The Administrator and/or Designee will ultimately be responsible for the process going forward," with the POC completion date of 7/1/24.

During the re-visit on 8/13/24, record review revealed 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. It was determined the same tag F712 would be recited.

On 8/13/24 at 3:15 p.m., the above concerns were discussed with the Administrator and Director of Nursing.

2. During the annual Long Term Care survey, dated 6/12/24, a deficiency was cited at F812 for the facilities failure remove fresh food items and outdated meat timely and ensure plumbing fixtures were properly installed to prevent backflow.

The facility's POC, dated 6/21/24, stated, "All non-servable food items were removed immediately. Metal cabinets, juice machine, and ice machine were also cleaned and sanitized accordingly during survey. The Maintenance Director fixed the ice machine air gap during survey as well. All residents have the potential to be affected by this practice. To ensure compliance going forward weekly sanitization audits of kitchen equipment as well as air gap compliance will be conducted for completeness. If deficient practice is identified throughout the audit process, corrective action will be taken

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F 867	Continued From page 8 immediately and education will be provided to the appropriate staff members accordingly. Kitchen equipment sanitization as well as air gap compliance will be reviewed and reported during monthly Quality Assurance and Performance Improvement (QAPI) meetings for a full quarter. The Dietary Supervisor and/or Designee will ultimately be responsible for the process going forward" with the POC completion date of 7/1/24. During the re-visit on 8/13/24, observations of the kitchen and food storage revealed ongoing concerns regarding removal of food items timely. It was determined the same tag F812 would be recited. On 8/13/24 at 3:15 p.m., the above concerns were discussed with the Administrator and Director of Nursing.	F 867		