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	205079	A. BUILDING _____ B. WING _____	12/04/2024

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BRENTWOOD CENTER FOR HEALTH & REHABILITATION, LLC	**370 PORTLAND ST YARMOUTH, ME 04096**

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F 000	INITIAL COMMENTS From 12/2/2024 through 12/4/2024, on-site visits were conducted at Brentwood Center for Health & Rehabilitation, Llc. for the purpose of a Recertification Survey and investigating complaints #ME00043044, ME00045895 and ME00048972. It was determined that Brentwood Center for Health & Rehabilitation, Llc. was not in substantial compliance with 42 CFR 483, Sub-part B Requirements for Long Term Care Facilities.	F 000		
F 584 SS=D	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	F 584		

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

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F 584	Continued From page 1 in good condition; §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, the facility failed to adequately maintain maintenance services necessary to maintain the facility in good repair and sanitary condition for three of three units. Findings: On 12/4/24 at approximately 9:00 a.m., during a visit to the Laundry, a surveyor observed a heavy amount of dust and debris found on top of all dryers. This was confirmed with the Director of Maintenance at that time. On 12/4/24 at 10:30 a.m., during environmental rounds with the Administrator, the Director of Maintenance, and Director of Housekeeping, the following were discussed/observed: - Room 107 - Closet door hinge needs repair - Room 99 - Cable outlet coming out of wall - Café Sun Room has a stained ceiling above the windows	F 584		

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F 584	Continued From page 2 - Entry into the Café Room has a small stain in the ceiling - The air handling unit across from the Nurses Station is stained with a red liquid substance - The Eagle Unit Dining Room has 4 stained ceiling tiles - Sebago Unit hallway has 3 ceiling lights with dead bugs on the light cover All of the above observations were confirmed with the Administrator at 11:15 a.m.	F 584		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, interviews, and facility policy, the facility staff failed to provide care in accordance with professional standards of quality in the areas of medication and pain management for 2 of 4 residents observed for medication administration (Resident #51 and #170). Findings: A review of the facility's, "Medication Pass" Policy and Procedure, revised 9/23/2024 states, "Always observe resident until they have swallowed all medications that have been administered. Do not leave medication in medication cup at the bedside or on tableside."	F 658		

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F 658	Continued From page 3 1. On 12/2/24 at 9:35 a.m., the surveyor observed Resident #51's medication administration with the Registered Nurse #1 (RN #1). RN #1 prepared the residents' medications, however, did not prepare the Miralax. When she was asked why the Miralax was not prepared, RN #1 stated she will not give the Miralax until later in the afternoon because Resident #51 frequently refuses in the mornings, and he/she does better in the afternoon. At this time, the surveyor asked if Resident #51 had refused the Miralax for this administration, RN #1 stated "no". Review of the physician order dated 9/13/24 for Miralax oral packet 17 GM (grams), give 1 packet by mouth in the morning for constipation, mix in 8 oz of water or juice Hold for loose stools, scheduled for 9:00 a.m., administration. The administration record dated 12/2/24 at 10:02 a.m., states the Miralax was "held" 2. On 12/3/24 at 7:41 a.m., the surveyor observed Resident #170's medication administration with RN #3. RN #3 handed Resident #170 the medicine cup of medication and asked, "Are you ok to take these pills on your own, I'll come back in a few minutes". RN #3 exited the room, leaving the medicine cup with the resident and returned to the medication cart. She then noticed Resident #170 also had an order for Glucerna. While in the Medication Administration Record (MAR), RN #3 documented Resident #170's pain scale of a 2. At this time, the RN#3 had not asked the resident what his/her pain level was. RN #3 then obtained a Glucerna and brought it to the resident. At this time, RN #3 asked Resident #170 what his/her pain level was, the resident stated he/she had no pain. RN #3 then stated, "You want to take the pills with this", pointing to the Glucerna, resident responded "Yes". RN #3 stated, "Ok, I'll be back	F 658		

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F 658	Continued From page 4 in a few", and left the room leaving the cup containing medication with the resident. The surveyor asked if she was finished with Resident #170's medication pass. She stated "yes, but I have to correct the pain level". She then returned to the MAR and corrected the documentation to the pain level of "0". At this time, the surveyor discussed with the RN #3 the above concerns regarding documentation of the resident's pain scale prior to asking the resident and failure to observe the resident consume the medication by leaving medication at the bedside twice. On 12/3/24 at 8:17 a.m., during an interview, the above was discussed with the Director of Nursing and the Regional Director of Clinical Operations.	F 658		
F 730 SS=B	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on review of annual evaluations and interviews, the facility failed to complete a annual performance evaluation for Certified Nursing Assistants (CNA) at least every 12 months, for 2 of 5 CNA's reviewed with employment greater than 1 year. (CNA#1 and CNA#2) Findings: On 12/3/24 and on12/4/24, a surveyor reviewed	F 730		

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F 730	Continued From page 5 the following employee files: 1. CNA #1 was hired on 2/17/21. The employee file showed evidence of annual review being filled out and signed only by the Division Head, lacking evidence of employee signature. Further review of the employee file lacked evidence of an annual review being completed since date of hire. On 12/4/24 at 8:16 a.m. during a phone interview, CNA #1 states they have not received an annual review since their date of hire. 2. CNA #2 was hired on 7/13/2009. The employee file lacked evidence of an annual review being completed since date of hire. On 12/4/24 at 8:39 a.m., during an interview, CNA#2 states they have not received an annual review since their date of hire. On 12/4/24 at 9:00 a.m. the above information was confirmed with the Regional Director of Operations.	F 730		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures	F 755		

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F 755	Continued From page 6	F 755		

that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-

§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on record review, observations and interviews the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation by failed to ensure that two people who are authorized to administer medications signed the Shift Count page indicating that they counted all controlled substances at the change of shift for multiple shifts reviewed between 9/25/24 through 2/3/24 on 5 of 5 units.

Findings:

A review of the facility's "Controlled Substances" Policy and Procedure, dated 11/17 states, "At shift change, a physical inventory of controlled

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medications, as defined by state regulation, is conducted by two licensed clinicians and is documented on an audit record."

1. On 12/2/24 at 9:09 a.m., during review of the Sebago Unit Narcotic book shift count, pages 294 through 298 from 9/25/24 thorough 12/2/24 with the Registered Nurse #2 (RN #2). The surveyor observed that the facility counts at the change of each shift, approx. 3 times a day. The licensed nursing staff coming on duty and/or the licensed nursing staff nurse going off duty failed to sign the Shift Count page of the Controlled Substances Book that indicated the controlled substances count was completed on the following dates: 9/25/24, 10/9/24, 10/16/24, 10/21/24, 11/1/24, 11/8/24 and 11/14/24. In addition, the surveyor noted that RN #2 failed to sign the shift count page for "nurse coming on duty" this morning upon accepting the narcotic keys. At this time, RN #2 confirmed she had not signed the shift count book this morning.

2. On 12/2/24 at 9:21 a.m., during review of the Eagle Unit Narcotic book shift count, pages 278 through 280 from 10/24/24 thorough 12/2/24 with RN #1. The licensed nursing staff coming on duty and/or the licensed nursing staff nurse going off duty failed to sign the Shift Count page of the Controlled Substances Book that indicated the controlled substances count was completed on the following dates: 10/24/24, 10/27/24, 11/12/24 and 11/22/24. In addition, the surveyor noted that RN #1 failed to sign the shift count page for the "nurse coming on duty" this morning upon accepting the narcotic keys. At this time, RN #1 confirmed she had not signed the shift count book this morning and immediately signed the book.

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F 755	Continued From page 8 3. On 12/2/24 at 9:57 a.m., during review of the Short Hall and Kitchen Hall narcotic books with the Licensed Practical Nurse #1 (LPN #1) the surveyor noted the LPN #1 had signed the nurse coming on duty but had also presigned the "nurse going off duty" in both of the narcotic books indicating the narcotic count was correct prior to the end of her shift. At this time, LPN #1 confirmed she should not have signed the "nurse going off duty" until the nurse coming on duty counted with her. 4. On 12/3/24, review of the Passport Unit Narcotic book shift count, pages 293 and 294 from 10/23/24 through 12/3/24. The licensed nursing staff coming on duty and/or the licensed nursing staff nurse going off duty failed to sign the Shift Count page of the Controlled Substances Book that indicated the controlled substances count was completed on the following dates: 10/30/24, 11/6/24 and 11/9/24. On 12/3/24 at 8:17 a.m., the above concerns were again discussed with the Director of Nursing.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and	F 758		

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F 758	Continued From page 9 (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 758		

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F 758	Continued From page 10 Based on record reviews and interviews, the facility failed to ensure that "as needed" (PRN) psychotropic medication orders were limited to 14 days, for 1 of 5 residents reviewed for unnecessary medications (Resident #121). Findings: On 12/3/24, during a review of Resident #121's physician orders, a surveyor noted an order dated 11/18/24 for "Lorazepam (a psychotropic medication) 0.5 milligrams (mg) by mouth every 24 hours as needed (PRN) for Anxiety for 3 months." The surveyor noted no 14-day limit (or stop date) for the PRN order and no provider documentation supporting a PRN order for this medication extending beyond the 14-day limit. On 12/3/24 at 1:58 p.m. a surveyor reviewed the above findings with the Administrator.	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		

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§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 observations and interviews, the facility failed to remove expired medications from the supply available for use in 1 of 4 medication carts observed (Sebago unit) and failed to properly secure medications on 1 of 4 units (Eagle unit).

Findings:

1. On 12/2/24 at 9:09 a.m., observation of the Sebago unit medication cart with the Registered Nurse #2 (RN #2) the following was observed: one opened bottle of Naproxen Sodium 220mg (milligram) with an expiration date of 7/24, one opened bottle of Vitamin D 10mcg (microgram) with an expiration date of 11/24, and one opened bottle of Oyster Shell Calcium 500mg with an expiration date of 10/24. At this time, the RN#2 confirmed and removed the expired meds.
On 12/2/24 at 10:09 a.m., during an interview, the above was discussed with the Director of Nursing.

2. On 12/2/24 at 10:06 a.m. a surveyor observed an unlocked and unattended medication cart located in the Eagle Unit hallway for approximately 2 minutes. Observation of residents nearby. At 10:08 a.m. through surveyor

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F 761	Continued From page 12 intervention, RN #1 was made aware of the unlocked medication cart. On 12/2/24 at 12:07 p.m. the above information was discussed with the Director of Nursing.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for undated and unlabeled food, 2 trays of unlabeled and undated meat, moderate level of staining on ceiling tiles (17), dirty equipment. Findings:	F 812		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 13 On 12/2/24 at 8:50 a.m., during the initial kitchen observation, a surveyor observed 2 trays of meat in the walk-in that was undated and unlabeled. Also observed was seventeen ceiling tiles that are stained or dirty. Cook stated that she has been with the facility for 12 years and the ceiling has not been done since she has been here. She was informed of the findings at that time. On 12/4/24 at 8:30 a.m., during a kitchen observation, a surveyor observed the ice machine, located in a kitchen on the Passport Unit, to have a moderate level of dirt on the inside of the lid, 0bserved a small amount of dried debris on the food slicer, observed a moderate amount of dried dirt and debris on the large mixer. The above finding were confirmed with the Administrator at 9:00 a.m.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-	F 842		

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	205079	A. BUILDING _____ B. WING _____	12/04/2024

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F 842	Continued From page 14 (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident;	F 842		

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F 842	Continued From page 15 (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure the Medication Administration Record (MAR) was accurately documented for removing a Lidocaine patch for 1 of 4 residents observed during medication administration review. (#170) Finding: A review of Resident #170's physician order dated 12/1/24, instructs nursing to "Lidocaine External patch 5%, apply to effected area topically one time a day for pain" and "remove lidocaine patch nightly". The MAR indicated, by nursing documentation, that on the evening of 12/2/24 the Lidocaine patch was removed. On 12/3/24 at 7:41 a.m., a surveyor observed Registered Nurse #3 (RN #3) administering a new Lidocaine patch to Resident #170's lower back. The RN #3 had to remove an old patch on the residents lower back to then replace it with the new Lidocaine patch. At this time, RN #3 confirmed the old Lidocaine patch should have been removed the evening prior. On 12/3/24 at 8:17 a.m., during an interview, the above was discussed with the Director of Nursing	F 842		

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F 842	Continued From page 16 and the Regional Director of Clinical Operations.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		

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F 880	Continued From page 17 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to maintain an Infection Control Program designed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to hand hygiene for 1 of 2 medication administration observations (Eagle unit) for 1 of 3 days of survey. (12/2/24)	F 880		

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F 880	Continued From page 18 Finding: On 12/2/24 at 9:35 a.m., during medication administration observation on the Eagle unit, Registered Nurse #1 (RN #1) prepared and administered medications to Resident #51. She then discarded the medicine cup, grabbed a tissue and wiped her hands. She then prepared and administered medications to Resident #52 and discarded the used drink cup and medicine cup. Next, she prepared and administered medications to Resident #9. On 12/2/24 at 9:49 a.m., the surveyor intervened and discussed the lack of hand hygiene between each resident's medication administration. RN #1 acknowledged she had not performed hand hygiene and stated there was not any hand sanitizer on the medication cart.	F 880		