STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205095	A. BUILDING _____ B. WING _____	C 02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENNEBUNK CENTER FOR HEALTH & REHABILITATION, LLC	158 ROSS RD KENNEBUNK, ME 04043

(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 2/25/25 an unannounced on site visit was conducted at Kennebunk Center for Health and Rehabilitation to investigate complaint #ME00050460. It was determined that Kennebunk Center for Health and Rehabilitation is not in substantial compliance with 42 CFR Part 483, Subpart B - Requirements for Long Term Care Facilities.	F 000		
F 554 SS=E	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy, the facilities interdisciplinary team failed to determine if it was clinically appropriate for a resident to keep a medication at bedside and self-administer medications for 4 of 5 residents reviewed. (Resident ##2, #3, #4 and #5). Findings: 1. On 2/25/25 from approx. 8:15 through 9:02 a.m., the following was observed: Resident #2 had a medicine cup with an unknown cream on the bedside tray table. Resident #3 had a medicine cup with an unknown cream on the beside dresser. Resident #4 had pump bottle of Bio freeze and a tube of Triad Hydrophilic wound dressing paste on the bedside dresser. Resident #5 had a medicine cup with an unknown	F 554	FTag 554 1.Resident # 5 had a self-administration eval completed and an MD order to self-administer and updated care plan (medications are stored in locked storage). Residents #2, #3 and # 4 medications/treatments are being administered by nurses and secured in locked storage area(s). 2. The DNS/designee completed a house audit of all residents who are self-administering treatments/meds to ensure no other residents were affected by this practice. 3.The SDC/designee has will complete education on self-administration policy/procedure to license nurses/med techs. 4. The DNS /designee will complete random daily auditing (Monday – Friday) on residents who self-administer meds x 60 day then and random weekly x 30 days. The results of these audits will be reviewed with the QAPI committee to ensure compliance is maintained. The DNS is responsible for compliance.	3/18/2025

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

Administrator 3/13/2025

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 554	Continued From page 1 opaque color cream with a plastic cup over it on the bedside tray table. 2. Review of Resident #2's medical record lacked evidence of a provider order for any cream treatment other than house stock lotions, an order for self-administration, a self-administration evaluation and a care plan for self-administration. 3. Review of Resident #3's medical record contained a provider order, dated 8/6/24, for Biofreeze External Gel 4 % (Menthol (Topical Analgesic)). Apply to bilateral knees and shoulders topically every day and evening shift for OA (osteoarthritis), and an order dated 1/6/25 for Voltaren External Gel 1 % (Diclofenac Sodium (Topical))Apply to area of pain on feet topically two times a day for pain 2gm (grams). Further review, the record lacked evidence of a physician order for self-administration, a self-administration evaluation and a care plan for self-administration. 4. Review of Resident #4's medical record contained a provider order, dated 2/10/25, for Biofreeze Professional External Gel 5 % (Menthol (Topical Analgesic)) Apply to legs topically every shift for leg pain. Further review, the record lacked evidence of a physician order for Triad Hydrophilic wound dressing paste, an order for self-administration, a self-administration evaluation and a care plan for self-administration. 5. On 2/25/25 at approx. 9:02 a.m., Resident #5 was observed sitting on the side of the bed with the bedside tray table in front of him/her. On the table was a medicine cup with an unknown opaque color cream with a plastic cup over it and 2 medicine cups of applesauce with a spoon. At this time, in a brief interview, Resident #5 stated	F 554		

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F 554	Continued From page 2 that the nurse was giving him/her medications, but they were too big to swallow, so she is cutting them in half. The surveyor asked what the unknown cream was for. Resident #5 stated, "for arthritis pain". Surveyor asked if the nurse applies the cream, he/she stated, "I do". At 9:05 a.m., the nurse entered the room with a cup of pills, upon leaving the room, the "arthritis cream" was left on the table. Review of Resident #5's medical record contained a provider order, dated 4/3/24, states, "Voltaren External Gel 1% (Diclofenac Sodium (Topical)) Apply to bilateral hips topically every day and evening shift for Pain lower extremities, apply 4G (grams) of 1% gel to affected area (maximum 16g per joint per day)". Further review of the medical record lacked evidence of a doctors order for self-administration, a self-administration evaluation and a care plan for self-administration. Review of facility policy "Self-Administration", dated 10/2024 states " and it request to self-administer medications, a self-administration evaluation is completed by the licensed nurse to evaluate the resident's safety and understanding of their medication/treatments. If the evaluation determines it is safe for the resident to self-administer, the licensed nurse will obtain an order from the health care provider for self-administration for the specific medication(s)/treatments. Upon obtaining the order for the medication treatment the licensed nurse will instruct the resident in the process of storing the medications safely which should include a locked box. The licensed nurse is responsible to account for every medication treatment on the EMAR and TAR ... the IDT will initiate person-centered care plan for self-administration of medications/treatments."	F 554		

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F 554	Continued From page 3 On 2/25/25 at 10:05 a.m., the surveyor and the Director of Nursing (DON) observed the above creams at bedside. The DON stated if a resident is administrating own medications, then there should be an MD order and evaluation completed.	F 554		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of Safety Data Sheets (SDS), the facility failed to ensure that the resident's environment was free of accident hazards relating to the storage of a chemical not being properly secured for 1 of 1 days of survey (2/25/25). Findings: The Safety Data Sheet for " HDX Disinfectant Spray Linen Scent 19 oz" noted the following: Description of first aid measures: Inhalation Remove to fresh air. Eye contact Rinse thoroughly with plenty of water for at least 15 minutes, lifting lower and upper eyelids. Consult a physician. Skin contact Wash skin with soap and water. Ingestion Rinse mouth.	F 689	FTag 689 free of accident hazards 1.Resident # 1 disinfectant spray is being stored in a secured area. 2.The Unit managers/designee completed a House audit of resident rooms/areas for accident hazards disinfectants sprays to ensure no other residents were affected by this practice. 3 The SDC/ designee will complete education on environmental safety protocol (to facility staff and send out education to families) 4. The DNS/designee will complete random daily audits (Monday thru Friday) of resident environment for chemical free safety x 30 days then random weekly x 60 days. The results of these audits will be reviewed with the QAPI committee x 3 months to ensure compliance is maintained. The DNS is responsible for compliance.	3/18/2025

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F 689	Continued From page 4 On 2/25/25 at 8:31 a.m., the surveyor observed Resident #1 to have a can of Great Value Disinfectant Spray Linen Scent on his/her bedside dresser. In a brief interview, Resident #1 stated he/she uses it for when it smells, and it's his/her personal can. On 2/25/25 at 10:05 a.m., the surveyor and the Director of Nursing (DON) observed Resident #1's can of Great Value Disinfectant Spray Linen Scent on the bedside dresser. At this time, the DON stated she was unaware of the disinfectant in the room and confirmed it should not be in the room or available for the resident to use.	F 689		
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. §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	F 761	FTag 761 Label/store drugs and biologicals 1) Residents # 2, # 3, #4 and #5 medications are being stored properly. 2) The ADNS/designee has completed a house audit of all resident areas and med storage areas to ensure no other residents were impacted by this practice of label and storage 3) The SDC/designee will educate license nurses and med techs on label/ storage medications per regulatory requirements. 4) The DNS/designee will complete random daily Monday through Friday audits of resident rooms/ areas and med storage areas x 2 months then random weekly x1 month. The results of these audits will be reviewed with the QAPI committee to ensure compliance is maintained. The DNS is responsible for compliance	3/18/2025

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F 761	Continued From page 5	F 761		

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, interviews and record reviews, the facility failed to ensure medications including treatments were stored properly on 2 of 4 units observed (Sagamore and Regina units). for 1 of 1 day of survey. (2/25/25)

Findings:

1. On 2/25/25 at 9:02 a.m., Resident #5 was sitting on the side of the bed with the bedside tray table in front of him/her. On the table was a medicine cup filled with an unknown opaque color cream with a plastic cup over it and 2 medicine cups of applesauce with a spoon. At this time, in a brief interview, Resident #5 stated that the nurse was giving him/her medications, but they were too big to swallow, so she is cutting them in half. The surveyor asked what the unknown cream was for. Resident #5 stated, "for arthritis pain". Surveyor asked if the nurse applies the cream, he/she stated, "I do". At 9:05 a.m., the nurse entered the room with a cup of pills, upon leaving the room, the "arthritis cream" was left on the table.

2. On 2/25/25 at 10:05 a.m., the surveyor rounded with the Director of Nursing (DON) and observed the following:
Sagamore unit:
> Resident #2 had a medicine cup filled with an unknown/unlabeled cream on the bedside tray table. At this time, Resident #2 stated to both the

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F 761	Continued From page 6 surveyor and the DON, the cream was for the itch on his/her legs, which he/she will apply independently when needed. > Resident #3 had a medicine cup with an unknown/unlabeled cream on the bedside dresser. > Resident #4's bedside dresser was littered with treatment supplies including a pump bottle of Bio freeze and a tube of Triad Hydrophilic wound dressing paste. Regina Unit: > Resident #5 had a medicine cup with an unknown/unlabeled opaque color cream with a plastic cup over it on the bedside tray table. 3. Review of Resident #2's medical record lacked evidence of a provider order for any cream treatment other than house stock lotions. 4. Review of Resident #3's medical record contained a provider order dated 8/6/24 for Biofreeze External Gel 4 % (Menthol (Topical Analgesic)). Apply to bilateral knees and shoulders topically every day and evening shift for OA (osteoarthritis) and an order dated 1/6/25 for Voltaren External Gel 1 % (Diclofenac Sodium (Topical))Apply to area of pain on feet topically two times a day for pain 2gm (grams). 5. Review of Resident #4's medical record contained a provider order dated 2/10/25 for Biofreeze Professional External Gel 5 % (Menthol (Topical Analgesic)) Apply to legs topically every shift for leg pain. Further review, the record lacked evidence of a physician order for Triad Hydrophilic wound dressing paste. 6. Review of Resident #5's medical record	F 761		

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F 761	Continued From page 7 contained a provider order dated 4/3/24 for, "Voltaren External Gel 1% (Diclofenac Sodium (Topical)) Apply to bilateral hips topically every day and evening shift for Pain lower extremities, apply 4G (grams) of 1% gel to affected area (maximum 16g per joint per day)". At this time, the DON confirmed the unknown/unlabeled creams were stored improperly and removed the items from the above resident's rooms.	F 761		
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- (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-	F 842	FTag 842 Resident records 1) Resident #5 treatment is being documented on the TAR when treatment is performed. 2) The Unit manager /designee completed a house audit of treatments/MD order(s) and documentation to ensure no other resident was affected by this practice. 3) The SDC/designee will complete education on treatment documentation protocol, whether the patient self-administers, or nurse administers treatment. 4) The DNS/designee will complete random daily audits Monday through Friday of treatment documentation/MD orders 30 days, then weekly x 30. The results of these audits will be reviewed with the QAPI committee to ensure compliance is maintained. The DNS will be responsible for compliance.	3/18/2025

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F 842	Continued From page 8 (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; (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	F 842		

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F 842	Continued From page 9 services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interview, the facility failed to ensure that clinical records were complete and contained accurate information for 1 of 5 residents reviewed for medications (Resident #5). Finding: On 2/25/25 at approx. 9:02 a.m., Resident #5 was sitting on the side of the bed with the bedside tray table in front of him/her. On the table was a medicine cup with an unknown opaque color cream with a plastic cup over it and 2 medicine cups of applesauce with a spoon. At this time, in a brief interview, Resident #5 stated that the nurse was giving him/her medications, but they were too big to swallow, so she is cutting them in half. The surveyor asked what the unknown cream was for. Resident #5 stated, "for arthritis pain". Surveyor asked if the nurse applies the cream, he/she stated, "I do". At 9:05 a.m., the nurse entered the room with a cup of pills, upon leaving the room, the "arthritis cream" was left on the table. On 2/25/25 from 10:05 a.m., through 10:17 a.m., during a walk through with the Director of Nursing (DON), both the surveyor and DON observed the above cream in a medicine cup, at this time, the DON removed the cream. Review of Resident #5's provider order dated 4/3/24 states, "Voltaren External Gel 1% (Diclofenac Sodium (Topical)) Apply to bilateral hips topically every day and evening shift for Pain lower extremities, apply 4G (grams) of 1% gel to	F 842		

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F 842	Continued From page 10 affected area (maximum 16g per joint per day)". The Treatment Administration Records (TAR) states, the Voltaren gel is being applied twice daily and was applied topically on 2/25/25 at 10:03 by the nurse with the location of where the gel was applied as "not recorded". On 2/25/25 at 10:21 a.m., in an additional interview, the surveyor discussed the documentation on the TAR for Resident #5's Voltaren gel being administered at 10:03 a.m., when both the DON and surveyor began the walk through at 10:05 and viewed several concerns before observing R#5's cream at the bed side and the resident states he/she applies the gel independently to his/her neck and right groin. At this time, the DON stated, maybe the nurse went back in and applied the gel. On 2/25/25 at 11:57 a.m., in an additional interview, Resident #5 was asked if the nurse applied the arthritis cream this morning. He/she stated "no, I do it myself." The surveyor asked where he/she applies the cream, he/she replied "On the back of my neck and right here" (rubbing his/her right groin area) stating, "I have a patch on by back but it doesn't do anything for the front, I actually have 2 patches on my back". The surveyor asked if it was "Voltaren", Resident stated, "Yes, that is it". The surveyor then asked, how often does he/she use Voltaren. Resident stated, "Only when I ask for it, I only use it if I need it." Again, the surveyor asked if nursing has applied the Voltaren, he/she stated, "No, I do it myself". On 2/25/25 at approximately 1:15 p.m., the above was discussed with as discussed during exit with	F 842		

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F 842	Continued From page 11 both the Administrator and the DON.	F 842		