STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205128	A. BUILDING _____ B. WING _____	C 10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLECREST REHAB & LIVING CENTER	174 MAIN ST MADISON, ME 04950

(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 10/28/24, an unannounced on-site visit was conducted at Maplecrest Rehab & Living Center for the purpose of investigating complaint #ME00049328. It was determined that Maplecrest Rehab & Living Center is not in substantial compliance with 42 CFR 483, Sub-part B Requirements for Long Term Care Facilities.	F 000		
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 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	F 656		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lou Kamm — TITLE: Administrator — (X6) DATE: 11/14/24

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.

Maplecrest Rehab and Living Center
Survey Date: 10/28/2024
Plan of Corrections

Please note the filling of this plan does not constitute an admission of guilt to the allegations set forth in the statement of deficiencies. The facility is filing this plan of corrections in accordance with applicable law.

F 656 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)

How corrective action will be accomplished for those residents found to have been affected by the deficient practice;

Resident # 1 and #2 Care plan has been reviewed and updated to reflect the changes per the SOD.

How the facility will identify other residents having the potential to be affected by the same deficient practice;

Care plans will be reviewed and updated by DNS or designee by 11/22/24.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur;

Education will be given to staff in reference to policy and regulation on Comprehensive person -centered care planning. By 11/22/24

How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur; and

The facility will Audit the Care plans for each week that a Resident comes thru IDT. Care plans will be reviewed each week for a month then for 3 months and presented to the quarterly QAPI meeting.

The date that each deficiency will be corrected. Corrections must be no later than December 12,2024

11/22/2024