STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205187	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIPER SHORES	**15 PIPER ROAD SCARBOROUGH, ME 04074**

(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 9/9/2024 through 9/11/2024, on-site visits were conducted at Piper Shores for the purpose of a Recertification Survey and investigating complaint #ME00048149. It was determined that Piper Shores was not in substantial compliance with 42 CFR 483, Sub-part B Requirements for Long Term Care Facilities.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide	F 582		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205187	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIPER SHORES	15 PIPER ROAD SCARBOROUGH, ME 04074

(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 582	Continued From page 1 notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Skilled Nursing Facility Advance Beneficiary Notices (SNFABN) Form 10055, which included appeal rights and liability of payment, were provided at least 2 days prior to the resident's last covered day, for 2 of 3 residents whose Medicare Part A services were discontinued, and remained in the facility (#13, #21). Findings: 1. Resident #13 who remained in the facility, had a SNFABN which indicated he/she's last day of	F 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205187	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIPER SHORES	15 PIPER ROAD SCARBOROUGH, ME 04074

(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 582	Continued From page 2 Skilled services was on 9/8/24. Resident #13 was not provided the SNFABN until 9/9/24, the day after services ended. 2. Resident #21 who remained in the facility, had a SNFABN which indicated he/she's last day of Skilled services was on 7/1/24. Resident #21 was not provided the SNFABN until 7/2/24, the day after services ended On 9/9/24 at 1:07 p.m., in an interview with the surveyor, the Social Worker stated she was unaware that the SNFABN notices should be provided to resident and/or resident representative 48 hours prior to services being terminated.	F 582		
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.	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205187	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIPER SHORES	15 PIPER ROAD SCARBOROUGH, ME 04074

(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 584	Continued From page 3 §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 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 observation and interview the facility failed to provide maintenance services necessary to maintain a sanitary and comfortable interior on 2 of 2 units observed (Prouts Neck Walkway and Higgins Beach Walkway). Findings: On 9/11/24 from 10:02 a.m., during a tour of the facility, the Director of Nursing confirmed the following: 1. Prouts Neck Walkway in the Personal Care room, the exhaust fan was coated with dust, the shower room had orange/brown color-stained tiles from the shower rail to the floor and the base of the shower had what appeared to be white	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205187	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIPER SHORES	15 PIPER ROAD SCARBOROUGH, ME 04074

(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 584	Continued From page 4 tape with the corners lifting up and areas of discolored black and orange colors. 2. Higgins Beach Walkway in the Personal Care room, the exhaust fan was coated with dust.	F 584		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment.	F 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205187	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIPER SHORES	**15 PIPER ROAD SCARBOROUGH, ME 04074**

(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 640	Continued From page 5 (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to transmit a quarterly Minimum Data Set (MDS) electronically to the State MDS database within 14 days of completion date for 1 of 2 system selected residents reviewed for Resident Assessment (Resident #31). Finding: Resident #31's quarterly MDS was completed on 7/15/24. This assessment was required to be electronically submitted to the State MDS database within 14 days after completion, as of 9/10/24 the MDS had not submitted to the State MDS database. On 9/10/24 at 12:04 p.m., during an interview, the MDS Coordinator stated that she will submit Resident #31's quarterly MDS today and was unaware that it wasn't transferred until the	F 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205187	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIPER SHORES	15 PIPER ROAD SCARBOROUGH, ME 04074

(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 640	Continued From page 6 surveyor asked about it.	F 640		
F 678 SS=E	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews and facility policy, the facility failed to ensure all facility staff maintain training in cardiopulmonary resuscitation (CPR) for Healthcare Providers. Findings: On 9/11/24 at 10:11 a.m., the Staff Development Coordinator stated the facility does not track or ensure their staff including the Licensed Nurses and Certified Nursing Assistants (CNA's) have an active CPR certification and that CPR is not a requirement. On 9/11/24 at 10:11 a.m., the facility provided documentation of current CPR certifications for 10 of 17 Registered Nurses (RNs), 2 of 7 Licensed Practical Nurses (LPNs), 9 of 44 CNAs, 1 of 2 Personal Support Staff (PSS), 1 of 3 Activity staff, and 0 of 2 administrative personnel. On 9/11/24 at 10:53 a.m., during an interview, the DON, stated he himself was not CPR certified and hasn't been since he is not working the floor. In addition, he confirmed there is 1 of the 36 residents who is "Full Code" and could potentially	F 678		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205187	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIPER SHORES	15 PIPER ROAD SCARBOROUGH, ME 04074

(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 678	Continued From page 7 require CPR however, all residents are at risk for choking. Facility Policy's and Procedure and Job Descriptions: Policy for Cardiopulmonary Resuscitation (CPR), revised on 6/13/24, under "Policy Explanation and Compliance Guidelines" States, "Staff will maintain current CPR certification for health care providers through a CPR provider who evaluates proper technique through in person demonstration of skills. CPR certification which includes an online knowledge component yet still requires in person skills demonstrations to obtain certification or recertification is also acceptable." The facilities Job Description for a Charge Nurse, dated 7/2023, under qualifications: states, "Current CPR certification/IV certification desired". On 9/11/24, at approximately 11:00 a.m. the above information was confirmed with the Director of Nursing and the Staff Development Coordinator.	F 678		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to be free of medication	F 759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205187	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIPER SHORES	15 PIPER ROAD SCARBOROUGH, ME 04074

(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 759	Continued From page 8 error rate of 5% or more. There was a total of 2 medication errors out of 29 opportunities. The medication error rate was 6.9%. Finding: On 9/11/24 at approximately 8:47 a.m., a surveyor observed the Certified Nursing Assistant (CNA-M) prepare medications for Resident #9, which included physician orders for: Senna Plus (senna 8.6 mg (milligrams) with ducosate sodium 50 mg) Give 1 tablet by mouth twice a day for constipation and Aspirin 81 mg tablet, delayed release, give 1 tablet by mouth every day for heart health. The CNA-M dispensed one tablet of the Senna 8.6 mg and Aspirin 81 mg chewable into the medicine cup. At this time the surveyor intervened, questioning the dosage of tablets dispensed of both the Senna and Aspirin. The CNA-M reviewed the medications in the medicine cup and confirmed she did not dispense the correct medications of Senna Plus and the delayed release Aspirin. On 9/11/24 at approximately 9:45 a.m., the above findings were discussed with the Director of Nursing.	F 759		
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	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205187	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIPER SHORES	15 PIPER ROAD SCARBOROUGH, ME 04074

(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 761	Continued From page 9	F 761		

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 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 observation and interviews, the facility failed to ensure that expired over the counter medications were removed from the supply that were available for use in 1 of 1 medication storage room and failed to ensure the medication room refrigerator was maintained at an acceptable temperature range for 15 of 39 days. In addition, the facility failed to ensure medications were stored properly by having an unlocked, unattended medication cart allowing residents and unauthorized persons access to medications on 1 of 3 survey days.

Findings:

1. On 9/9/24 at 1:50 p.m., during a medication supply cabinet review with the Registered Nurse (RN #1), and a surveyor observed the following

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205187	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIPER SHORES	15 PIPER ROAD SCARBOROUGH, ME 04074

(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 761	Continued From page 10	F 761		

expired over the counter medications: 2 unopened bottles of Healthstar Aspirin 325 milligrams (mg) with an expiration date of 1/24, 4 unopened bottles of Gericare Aspirin 325 mg with an expiration date of 4/24 and 2 unopened bottles of Gericare Multivitamin with an expiration date of 8/24.

2. On 9/9/24 at 2:00 p.m., a surveyor and RN #1 observed the medication storage room refrigerator on the Holbrook unit. The refrigerator contained insulin, immunizations and controlled liquid medications. A temperature log sheet, located on the counter above the refrigerator dated for the month of August and September 2024, states, "Acceptable temperature range 36 - 46 degrees Fahrenheit" and "The temperature of each medication refrigerator must be checked daily and recorded on this log. If an out-of-range temperature is found, notify Clinical Engineering and document your response."
A review of the temperature log sheet had multiple days when temperatures were documented below 36 degrees Fahrenheit and lacked evidence of documentation of action taken to correct the low temperatures. The refrigerator temperatures were as follows:

On 8/1/24 documentation of 35 degrees Fahrenheit
On 8/7/24 documentation of 35 degrees Fahrenheit
On 8/8/24 documentation of 35 degrees Fahrenheit
On 8/9/24 documentation of 34 degrees Fahrenheit
On 8/19/24 documentation of 35 degrees Fahrenheit
On 8/20/24 documentation of 34 degrees

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205187	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIPER SHORES	**15 PIPER ROAD SCARBOROUGH, ME 04074**

(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 761	Continued From page 11	F 761		

Fahrenheit
On 8/21/24 documentation of 34 degrees Fahrenheit
On 8/23/24 documentation of 35 degrees Fahrenheit
On 8/24/24 documentation of 35 degrees Fahrenheit
On 8/30/24 documentation of 35 degrees Fahrenheit
On 9/1/24 documentation of 34 degrees Fahrenheit
On 9/4/24 documentation of 35 degrees Fahrenheit
On 9/5/24 documentation of 34 degrees Fahrenheit
On 9/7/24 documentation of 34 degrees Fahrenheit
On 9/8/24 documentation of 35 degrees Fahrenheit

On 9/9/24 at 2:10 p.m., a surveyor confirmed the above findings with the Director of Nursing.

3. On 9/10/24 at 9:28 a.m., a surveyor observed the medication cart in the hallway outside resident Room #203. The cart was unlocked and there was no staff member near the cart. A surveyor opened 2 drawers of the medication cart and observed over the counter and prescription medications labeled for residents. At 9:35 a.m., (7 minutes later) the Certified Nursing Assistant - Med Tech (CNA-M) returned to the medication cart. During an interview with a surveyor. The CNA-M acknowledged that the medication cart should have been locked.

On 9/10/24 at 10:00 a.m., a surveyor discussed the finding of the unlocked, unattended medication cart with the Director of Nursing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205187	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIPER SHORES	15 PIPER ROAD SCARBOROUGH, ME 04074

(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 SS=D	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 and interviews, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner relating to the ceiling air intakes vents and the over-the-stove exhaust hood in the main kitchen on the third floor. Findings: On 9/9/24 at 8:40a.m., during the initial kitchen observation, a surveyor noted the two main air intake vents were covered with a moderate to heavy amount of dirt and debris. In addition, one-half of the over the stove exhaust hood was covered with a heavy amount of a grease like substance.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205187	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIPER SHORES	15 PIPER ROAD SCARBOROUGH, ME 04074

(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 At this time, the above was confirmed with the Food and Nutrition Director.	F 812		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on Certified Nursing Assistant (CNA) employee education record review, the facility failed to monitor and ensure that the CNA attended the required 12 hours of annual in-service education training and the mandatory yearly training for dementia care 2 of 5 randomly selected CNAs employed greater than 1 year (CNA #3 and CNA #4). Findings:	F 947		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205187	A. BUILDING _____ B. WING _____	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIPER SHORES	15 PIPER ROAD SCARBOROUGH, ME 04074

(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 947	Continued From page 14 On 9/10/2024 and 9/11/2024, a surveyor reviewed the following employee education files: 1. CNA #3 was hired 5/7/2021. Review of CNA #3 Employee In-service/attendance 2ecords stated, she has 1 of the 12 hours required for continuing education and lacked evidence of dementia training for the year of 2023. 2. CNA #4 was hired 6/19/2017. Review of CNA #4 Employee In-service/attendance records stated, she has 2.25 of the 12 hours required for continuing education and lacked evidence of dementia training for the year 2023. On 9/11/2024 at 11:40 a.m., the above information was confirmed with the Director of Human Resources.	F 947		