STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205091	A. BUILDING _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE CENTER	**27 COOL ST WATERVILLE, ME 04901**

(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 5/28/24 and 5/29/24 an unannounced on site visit was conducted at Oak Grove Center to investigate #ME00046614, #ME00046446, #ME00047414, #ME00046522, and #ME00047526. It was determined that Oak Grove Center is not in substantial compliance with 42 CFR Part 483, Subpart B - Requirements for Long Term Care Facilities.	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to protect and promote a resident's dignity for 1 of 4 resident sampled for hygiene (Resident #1). Findings: Resident #1 was admitted to facility on 9/6/22 with diagnoses to include Alzheimer's disease. Review of Resident #1 Minimum Data Set (MDS) dated 4/19/24 revealed Resident had a Brief Interview for Mental Status (BIMS) of 8 of 15 indicating he/she had moderate cognitive impairment. Further review of MDS revealed	F 557		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205091	A. BUILDING _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE CENTER	**27 COOL ST WATERVILLE, ME 04901**

(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 557	Continued From page 1 Resident was dependent of staff for her activities of daily living (ADL's). Review of Resident#1's care plan initiated 9/6/22 revealed "[Resident #1] is at risk for decreased ability to perform ADL(s) in grooming, personal hygiene, ... requires 1 person extensive assist with bathing, and grooming ..." During observation of breakfast meal on Jewett House on 5/28/24 at 8:20 a..m., Resident #1 was observed sitting at dining room table with a significant amount of facial hair that appeared to be approximatley 1/2 inch in length. During an interview on 5/28/24 at 8:22 a.m., a family member indicated that if his/her mother/father wasn't so impaired he/she would be very upset to be out in public with chin hair. During an interview on 5/28/24 at 1:46 p.m., Certified Nursing Assistant (CNA)1 confirmed Resident #'1 facial har had not been shaved and it should have been before he/she was taken out to breakfast. During an interview on 5/29/24 at 7:35 a.m. the above concern was discussed with Director of Nursing Services.	F 557		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.	F 558		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205091	A. BUILDING _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE CENTER	**27 COOL ST WATERVILLE, ME 04901**

(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 558	Continued From page 2	F 558		

This REQUIREMENT is not met as evidenced by:
Based on interviews and observations, the facility failed to ensure that accommodations were made for residents that included call bell and telephone being within reach for a resident that is capable of using a call bell and telephone for 1 of 1 resident observed for accommodations (Resident #2).

Findings:

Observations of Resident #2 between 5/28/24 at 8:10 a.m., through 5/29/24 at 7:35 a.m., revealed the following:

-On 5/28/24 at 8:10 a.m., Resident #2 was observed in bed with with his/her side table positioned over the bed. A piece of paper was noted with large print indicating names and phone numbers. Residents #2's telephone was noted lying on a wheelchair cushion located to left of resident and not in reach. Call bell was observed to be dangling from Resident #2's right bedside rail, not in reach.

-On 5/28/24 at 10:02 a.m., Resident #2 was observed in bed with with his/her side table positioned over the bed. A piece of paper was noted with large print indicating names and phone numbers. Residents #2's telephone was noted lying on a wheelchair cushion located to left of resident and not in reach. Call bell was observed to be dangling from Resident #2's right bedside rail, not in reach. When asked, Resident #2 indicated that if he/ she needs help, he/she would use the call button but can never seem to find it, so he/she waits for someone to come in the room. Resident #2 further indicated that his/her family calls to check on him/her, but the phone is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205091	A. BUILDING _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE CENTER	**27 COOL ST WATERVILLE, ME 04901**

(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 558	Continued From page 3 in the wheelchair and his/she can't reach it. -On 5/28/24 at 11:42 a.m., Resident #2 was observed in bed with with his/her side table positioned over the bed. A piece of paper was noted with large print indicating names and phone numbers. Residents #2's telephone was noted lying on a wheelchair cushion located to left of resident and not in reach. Call bell was observed to be dangling from Resident #2's right bedside rail, not in reach. -On 5/28/24 at 1:40 p.m., Certified Nursing Assistant (CNA1) was observed leaving Resident #2's room. At this time a surveyor entered Resident #2's room where Resident #2 was observed in bed with with his/her side table positioned over the bed. Residents #2's telephone was noted lying on a wheelchair cushion located to left of resident and not in reach. Call bell was observed to be dangling from Resident #2's right bedside rail, not in reach. During an interview on 5/28/24 at 1:45 p.m., Certified Nursing Assistant (CNA1) indicated Resident #2 is able to make his/her needs known and has the ability to use the call bell and likes his/her phone in reach to call his/her family or receive calls. At this time CNA1 confirmed residents call bell and phone were not in reach. -On 5/28/24 at 2:15 p.m., Resident #2 was observed in bed with with his/her side table positioned over the bed. Residents #2's telephone was noted lying on a wheelchair cushion located to left of resident and not in reach. Call bell was observed to be dangling from Resident #2's right bedside rail, not in reach.	F 558		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205091	A. BUILDING _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE CENTER	**27 COOL ST WATERVILLE, ME 04901**

(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 558	Continued From page 4 -On 5/29/24 at 7:18 a.m., Resident #2 was observed in bed with with his/her side table positioned over the bed. Residents #2's telephone was noted lying on a wheelchair cushion located to left of resident and not in reach. Call bell was observed to be dangling from Resident #2's right bedside rail, not in reach. On 5/29/24 at 7:35 at a.m., Director of Nursing and a surveyor observed Resident lying in bed, side table was positioned over the be, phone was noted on Residents left side on wheelchair, not in reach. Call bell dangling from right side bar not in reach.	F 558		
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the	F 626		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205091	A. BUILDING _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE CENTER	27 COOL ST WATERVILLE, ME 04901

(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 626	Continued From page 5	F 626		

facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges.

§483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there.
This REQUIREMENT is not met as evidenced by:
Based on record review, and interview, the facility failed to ensure provider documentation of resident needs that cannot be met and facility attempts to meet those needs during a facility initiated discharge for 1 of 2 residents reviewed for discharge (Resident #4).

Finding:

On 5/10/24 the Department of Licensing & Certification received a complaint indicating on 5/9/24 Resident #4 was transferred to an acute care hospital and the facility refused to take [him/her] return, because they are unable to provide the appropriate level of care for this resident.

Review of Resident #4's medical record reveals he/she was admitted to the facility on 4/21/24 with diagnoses including dementia and encephalopathy. Review of intake Minimum Data Set (MDS) dated 5/6/24 revealed Brief Interview for Mental Status (BIMS) score of 3 of 15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205091	A. BUILDING _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE CENTER	27 COOL ST WATERVILLE, ME 04901

(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 626	Continued From page 6 indicating Resident #4 was significantly impaired. Review of Resident #4's clinical record revealed "progress note" dated 5/9/24 stating: "It was brought to my attention from upper management that I had a resident leaving the building. ... I was informed that [he/she] disengaged the alarm which lets staff know of elopement. ... It was unsafe for [him/her] to keep the door alarm disengaged. resident was transported for safety concerns for himself and other residents with wandergaurds." During and interview with Respiratory Therapist (RT) on 5/28/24 at 2:14 p.m. it was revealed that the resident did have a reputation to be "handsy" with staff and there had been multiple assaults on staff. RT recalled that the facility was attempting to move the resident to a locked facility and that the Resident #4 was known to tamper with items such as heaters or his/her wander guard which were safety concerns to the facility. Review of Resident #4's entire clinical record lacked evidence that a provider participated/was consulted in facility's decision to not allow Resident #4 to return to the facility. During an interview on 5/29/24 at 2:27 p.m., with two surveyors, Director of Nursing (DON), indicated that the facility had been trying to transfer Resident #4 to another facility for some time because he/she posed a safety risk to himself/herself and other residents due to his/her behaviors. At this time DON confirmed a provider was not involved in the decision to refuse Resident #4 to return to the facility.	F 626		
F 646 SS=D	MD/ID Significant Change Notification	F 646		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205091	A. BUILDING _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE CENTER	27 COOL ST WATERVILLE, ME 04901

(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 646	Continued From page 7 CFR(s): 483.20(k)(4) §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to notify the physician of significant change in condition for 2 of 2 residents reviewed for signifian change in condition (Residents #2 and #3). Findings: 1.On 2/20/24 at 9:08 a.m., the Department of Licensing received a complaint indicating Resident #2 had been complaining about abdominal pain all day. After family intervention Resident #2 was transferred to an acute care hospital and underwent surgery for a perforated bowel and splenectomy. Resident #2 was admitted to facility on 3/13/23 with diagnoses to include morbid severe obesity, constipation, and history of small bowel obstruction with resection in 2011. Review of Resident #2's clinical record revealed "Nursing Documentation" dated 1/27/24 at 4:45 p.m., stating "Patient complaining of abdominal pain in the morning. Patient received [Malox] and had a large BM. Patient still complaining of pain. Given tums. Patient did not eat lunch. VSS. [Borborgamy] [rumbling sounds] in all four quadrants. Daughter and daughter in law came in	F 646		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205091	A. BUILDING _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE CENTER	27 COOL ST WATERVILLE, ME 04901

(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 646	Continued From page 8	F 646		

and requested patient go to ED for evaluation. This nurse called on call .... [agreeded] with sending patient." Further review of Resident #2's clinical record lacked evidence that a provider was notified of Residents change in condition.

During an interview on 5/29/24 at 10:26 a.m., Registered Nurse (RN)1 indicated Resident #2 "had been having loose stool for a while" was eating less and less. Had been a little withdrawn. At this time RN1 reviewed clinical records and confirmed residents record lacked evidence that a provider was notified of these concerns. RN1 further indicated that there are normally providers onsite daily until 5 p.m., when the on call provider would take over.

During an interview on 5/29/24 at 2:18 p.m., Licensed Practical Nurse (LPN)1 indicated that Resident #2 had been complaining of abdominal pain all morning, saying "my belly hurts." LPN 1 gave [him/her] Maalox and [he/she] had a very large bowel movement, but still complained of abdominal pain so LPN 1 gave [him/her] tums with no effect. LPN 1 further indicated that Resident #2's family member came in later in the day and said they wanted [him/her] to go to the hospital for evaluation. When asked if LPN1 contacted the provider to notify them of Resident #2's ongoing complaints of abdominal pain even after having a BM, LPN1 indicated that she did not attempt to contact the provider, who was "probably in the building" and is not sure why.

During a telephone interview on 5/29/24 at 3:54 p.m., Certified Nursing Assistant (CNA) #4 indicated that Resident #2 had been having very loose stools for a few days prior to being sent out and she had notified the nurse on duty.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205091	A. BUILDING _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE CENTER	**27 COOL ST WATERVILLE, ME 04901**

(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 646	Continued From page 9 During an interview 5/29/24 at 12:32 p.m., Marketing Clinical Advisor confirmed residents clinical record lacked evidence that a provider was notified of Resident #2's change in condition. 2.On 2/13/24 the Division of Licensing and Certification received a complaint, which indicated Resident #3 choked on food during lunch on 2/5/24 necessitating the Heimlich maneuver to be provided by nursing staff. Resident #3 was originally admitted to facility on 9/25/23 with diagnoses to include William's Syndrome. Review of facility "Incident and Audit Report" dated 2/5/24 states "CNA [Certified Nursing Assistant] alerted nursing staff that Resident #3 was choking in the dining room at lunch time." Registered Nurse (RN) performed Heimlich Maneuver with positive results and Resident #3 was assessed by the RN with no additional complaints. Review of Resident #3's entire clinical record lacked evidence that the medical provider was notified/consulted at the time of above incident. Review of facility policy titled "Accidents/Incidents" last revised 3/1/24 states "The nurse will: Create an event in PCC [Point Click Care] Risk Management Portal. Events should be entered ...no later than end of the shift in which the event occurred...Documentation will include ...notifications ...Notify the physician/APP of the accident/incident, report the physical findings and extent of injuries, and obtain orders if indicated."	F 646		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205091	A. BUILDING _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE CENTER	**27 COOL ST WATERVILLE, ME 04901**

(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 646	Continued From page 10 During an interview on 5/29/24 at 12:28 p.m., Marketing Clinical Advisor (MCA) confirmed that Resident #3's clinical record lacked evidence that the provider was informed of choking incident.	F 646		
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 resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205091	A. BUILDING _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE CENTER	27 COOL ST WATERVILLE, ME 04901

(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 656	Continued From page 11 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record reviews, interviews the facility failed to update/implement a care plan in the area of constipation for 1 of 1 care plan reviewed (Resident #2). Findings: Resident #2 was admitted to facility on 3/13/23 with diagnoses to include severe morbid obesity, constipation, and history of small bowel obstruction with restriction in 2011. Review of Residents 2's "care plan" initiated 3/5/23 lacked evidence that goals and interventions were put in place for constipation. During an interview 5/29/24 at 12:32 p.m., Marketing Clinical Advisor and a surveyor reviewed Resident #2's care plan and confirmed no goals /interventions were put in place for constipation.	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205091	A. BUILDING _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE CENTER	**27 COOL ST WATERVILLE, ME 04901**

(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 689	Continued From page 12 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 observations and interviews, the facility failed to ensure a safe environment by allowing access to a potentially unsafe environment on 1 of 3 units observed for (Jewett House). Findings: On 5/28/24 at 8:21 a.m., During an initial observation of Jewitt small dining room, 2 surveyors observed a large hole in the ceiling with an obvious leak. A yellow plastic "wet floor" sign was under the hole. A yellow mop bucket was approximately 4 feet away from the sign containing about 4 inches of dirty water. There were no barriers noted to prevent access to this area. Follow-up observations of Jewitt House small dining room on 5/28/24 between 9:45 a.m., and 3:45 p.m. revealed the following: -On 5/28/24 at 9:45 a.m., during a follow up facility, Ombudsman indicated the ceiling in Jewett small dining room has been leaking for quite some time and she is not aware of the current plan for repair. At this time Resident #6	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205091	A. BUILDING _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE CENTER	**27 COOL ST WATERVILLE, ME 04901**

(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 689	Continued From page 13	F 689		

was observed self-ambulating in wheelchair and grabbing yellow mop bucket containing dirty water and Resident #7 was observed using walker wandering around in Jewett small dining room, walking under the hole in the ceiling. Multiple staff walking under hole to refrigerator.
-Observation 5/28/24 at 11:42 a.m., Resident #6 was observed self-ambulating in his/her wheelchair in Jewett small dining room, under hole in ceiling. Review of quarterly Minimum Data Set (MDS) dated 5/6/24 revealed Resident #6 had a Brief Interview for Mental Status (BIMS) 5 of 15 indicating severe cognitive impairment.
-Observation 5/28/24 at 11:45 a.m., Resident #7 was observed self-ambulating with walker in Jewett Small dining room. Review of quarterly MDS revealed BIMS of 0 of 15 indicating he/she had severe cognitive impairment.
-Observation on 5/28/24 at approximately 3:45 p.m., Resident #7 was again observed wandering in Jewett small dining room under the hole in the ceiling, Multiple staff members were observed to be walking under it past the yellow hazard sign to go into refrigerator.

During an interview on 5/28/24 at 8:17 a.m., Clinical Research Coordinator (MDS) indicated the leak has been there for quite a while and they are getting estimates to have it fixed. MDS further indicated they have not been allowing residents in the dining room for safety reasons.

During an interview on 5/28/24 at 8:52 a.m., Maintenance Director indicated that the leak has been there since January 2-24 and the company is making him get 3 estimates, they currently have 2 and have been having a difficult time getting a third. Maintenance Director confirmed there were no barriers put into place to prevent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205091	A. BUILDING _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE CENTER	27 COOL ST WATERVILLE, ME 04901

(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 689	Continued From page 14 access to this area. During an interview on 5/28/24 at 3:56 p.m., Registered Nurse (RN)2 was asked if there was a reason why the dining room was deemed not safe for residents to eat in it, but they continued be able to sit or walk under the hole/leak or why staff continued to use the refrigerator in that area. RN2 indicated that it had been that way for quite a while and confirmed that it was unsafe for residents and staff to go in that area. At this time RN2 and another staff member made an effort to block the area. During an interview on 2/28/24 at 3:50 p.m., Director of Nursing (DON) indicated that the hole/leak had been there for approximately 6 weeks, and they were in the process of getting bids to repair it. DON further indicated that they had discussed blocking the area off but thought that the residents with dementia wouldn't understand and would try to get through it, which could potentially cause an accident.	F 689		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(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(i) Medical records. §483.70(i)(1) In accordance with accepted	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205091	A. BUILDING _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE CENTER	27 COOL ST WATERVILLE, ME 04901

(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 842	Continued From page 15	F 842		

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(i)(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(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205091	A. BUILDING _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE CENTER	27 COOL ST WATERVILLE, ME 04901

(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 842	Continued From page 16	F 842		

§483.70(i)(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 services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record reviews, interviews, and facility policy, the facility failed to ensure that clinical records were complete and contained accurate information for 4 of 5 residents reviewed for documentation (Resident's #1 and #2, #3 & #5).

Findings:

Review of facility policy titled "Activities of Daily Living (ADL's)" dated 5/1/23 states "Documentation of ADL care is recording in the medical record and is reflective of the care provided by nursing staff. ADL care will be documented in real time ... ADL care is documented every shift by the nursing assistant."

1. Review of Resident #1's clinical record "Tasks" dated May 2024 lacked evidence that Resident #1 received assistance with "toileting" during the day shift on 5/6/24, 5/11/24 or 5/28/24,during the evening shift on 5/10/24 and 5/28/24 or during the night shift on 5/1/24, 5/5/24, 5/10/24 5/18/24 or 5/24/24. Further review of Resident #1's "Task" dated May 2024 lacked evidence that Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205091	A. BUILDING _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE CENTER	**27 COOL ST WATERVILLE, ME 04901**

(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 842	Continued From page 17	F 842		

#1 received "hygiene assistance" during the day shift on 5/6/24, 5/11/24, or 5/28/24. During the evening shift on 10/10/24, or during the night shift on 5/1/24, 5/2/24, 5/4/24, 5/5/24, 5/8/24, 5/9/24, 5/10/24, 5/12/24, 5/13/24, 5/15/24, 5/16/24, 5/17/24, 5/18/24, 5/20/24, 5/21/24, 5/22/24, 5/23/24, 5/24/24, 5/25/24 or 5/27/24.

2. Review of Resident # 2 "Tasks" record dated May 2024 laced evidence that Resident #2 received assistance with toileting during the day shift on 56/24, 5/11/24 or 5/28/24. During the evening shift on 5/10/24. Or during the night shift on 5/2/24, 5/2/24, 5/4/24, 5/5/24, 5/6/24, 5/8/24, 5/9/24, 5/10/24, 5/12/24, 5/13/24, 5/14/24, 5/16/24, 5/17/24, 5/18/24, 5/20/24, 5/22/24, 5/23/24, 5/24/24, 5/25/24, 5/26/24 or 5/27/24.

3. Review of Resident #3's clinical record "Tasks" dated May 2024 lacked evidence that Resident #3 received assistance with "toileting" during the day shift on 5/9/24 or 5/15/24; during the evening shift on 5/6/24, 5/13/24, and 5/27/24; or during the night shift on 5/3/24, 5/6/24, 5/8/24 5/15/24, 5/24/24 or 5/25/24.

Further review of Resident #3's "Tasks" dated May 2024 lacked evidence that Resident #3 received "hygiene assistance" during the day shift on 5/9/24 or 5/15/24; during the evening shift on 5/13/24; or during the night shift on 5/3/24, 5/6/24, 5/8/24 5/15/24, 5/24/24 or 5/25/24.

4. Review of Resident #5's clinical record "Tasks" dated February 2024 lacked evidence that Resident #5 received assistance with "toileting" during the day shift on 2/2/24, 2/3/24 or 2/4/24 during the evening shift on 2/3/24, 2/8/24 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205091	A. BUILDING _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE CENTER	**27 COOL ST WATERVILLE, ME 04901**

(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 842	Continued From page 18 2/12/24; or during the night shift on 2/4/24, 2/5/24, 2/6/24 or 2/12/24. Further review of Resident #5's "Task" dated February 2024 lacked evidence that Resident #5 received "hygiene assistance" during the day shift on 2/3/24 or 2/4/24; during the evening shift on 2/3/24, 2/8/24 and 2/12/24; or during the night shift on 2/4/24, 2/5/24, 2/6/24 or 2/12/24. During an interview on 5/29/24 at 10:11 a.m., Certified Nursing Assistant (CNA) #3 indicated that direct care staff have access to tablets for real time documentation. During an interview on 2/28/24 at 2:45 a.m., Certified Nursing Assistant (CNA)1 indicated that they do not normally document anything until the end of their shift, but they should definitely document. During an interview on 5/29/24 at 7:35 a.m., the above concern was discussed with Director of Nursing Services. During an interview on 5/29/24 at approximately 3:00 p.m., two surveyors confirmed the inaccurate records with the Marketing Clinical Advisor and Director of Nursing.	F 842		
F 880	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	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205091	A. BUILDING _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE CENTER	**27 COOL ST WATERVILLE, ME 04901**

(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 880	Continued From page 19 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 §483.70(e) 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 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	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205091	A. BUILDING _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE CENTER	27 COOL ST WATERVILLE, ME 04901

(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 880	Continued From page 20	F 880		

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 a sanitary environment related to the storage of personal toiletries, and urine collection devices for 1 of 3 units observed (Wyeth House).

Findings:

On 5/28/24 at 8:20 a.m., 11:12 a.m. and 5/29/24 at 7:15 a.m., observervations of Room 44 shared bathroom belonging to Resident's #3 and #8 revealed a wooden shelf containing an unlabeled and unbagged bedpan, 1 opened and unlabeled bottle of body lotion,1 unlabeled bottle of men's 3 in 1 wash, and 1 opened and unlabeled bottle of mouthwash available for use.

On 5/28/24 at 11:43 a.m., and 5/29/24 at 7:16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205091	A. BUILDING _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE CENTER	27 COOL ST WATERVILLE, ME 04901

(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 880	Continued From page 21 a.m., shared bathroom belonging to Rooms 45/46: contained unlabeled, unbagged bed pan on floor behind toilet, visible debris around toilet base, 8 oz bottle of cleansing spray, and 2.5 oz bottle of hand cream observed on shelf, available for use. During an interview on 5/28/24 at 11:45 a.m., Registered Nurse (RN)1 indicated that resident personal belongings should be labeled and stored appropriately, and bedpans should be labeled and bagged. During a tour of Wyeth Hall on 5/29/24 at 7:35 a.m., the Director of Nursing confirmed personal belongings and bed pan unlabeled and available for use and debris around toilet.	F 880		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to provide a safe, comfortable homelike environment on 2 of 3 units observed during complaint investigations (Jewett and Wyeth House). Findings: Observations of Jewett House between 5/28/24 at 8:21 a.m. and 5/28/24 at 10:26 a.m., revealed the following:	F 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205091	A. BUILDING _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE CENTER	**27 COOL ST WATERVILLE, ME 04901**

(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 921	Continued From page 22	F 921		

On 5/28/24 at 8:21 a.m., during an initial tour two surveyors noted a very strong odor resembling a "litter box" in the hall starting at the Beauty Parlor located at the end of the main corridor and continuing onto all halls of the Jewitt and Wyeth Houses.

On 5/28/24 at 9:45 a.m., during a facility tour Regional Ombudsman (OMB), indicated that both Wyeth and Jewett Houses have had a very strong urine odor and Jewett has also had a strong musty odor for quite some time At this time OMB further indicated she's asked the facility management multiple times what their plan was to fix it and never received an answer.

During an interview on 5/28/24 at 8:17 a.m., Clinical Research Coordinator (MDS) indicated that the strong musty odor is coming from the leaky roof and it's been there for quite a while. MDS further indicated the facility is getting estimates to have it fixed. MDS went on to confirm that both Jewett and Wyeth Houses' have a strong urine odor.

During an interview on 5/28/24 at 8:52 a.m., Maintenance Director (MD) indicated they were aware of the strong urine odor on both Wyeth and Jewitt Houses, as well as the "musty" odor on Jewett House. At this time MD indicated he believed the urine odors on Jewett and Wyeth are likely coming from in between the floor and subfloor. MD also confirmed the must odor was more than likely coming from the ceiling and it should be remedied once the roof and ceiling are repaired.

During an interview on 5/28/24 at 12:56 p.m., with 2 surveyors, Housekeeping Manager (HM) and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205091	A. BUILDING _____ B. WING _____	C 05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE CENTER	27 COOL ST WATERVILLE, ME 04901

(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 921	Continued From page 23 Regional Maintenance Director, HM indicated he was aware of strong urine odors on Jewett and Wyeth units, as well as musty odor on all of Jewet House, and they had been ongoing. HM further indicated he did not believe it was a housekeeping issue, as he felt it because nursing staff leave soiled briefs in the trashcans in resident rooms. During an interview on 5/29/24 at 10:15 a.m., Certified Nursing Assistant -Medication Technician (CNA)5 indicated that "Jewett and Wyeth both smell like a cat box most days and it is worse when is humid outside." CNA5 further indicated that Jewett has had a very moldy smell for quite a while. During an interview on 5/29/24 at 10:26 a.m., Registered Nurse (RN)1 indicated that Wyeth and Jewett always "smells like a cat box", stating "I guess it's been so long I'm just used to it." During an interview on 5/28/24 at 3:50 p.m., the above concerns were discussed with Director of Nursing.	F 921		