STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205138	A. BUILDING _____ B. WING _____	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD A CONTINUING CARE CENTER	220 KENNEDY MEMORIAL DR 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 From 8/28/23 through 8/31/23 on-site visits were conducted at Lakewood A Continuing Care Center for the purpose of conducting the annual Long Term Care Survey Process. It was determined that Lakewood A Continuing Care Center was not in substanital compliance with 42 CFR 481, subpart B-Requirements for Long Term Care Facilities.	F 000		
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. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the facility failed to ensure that portable oxygen was available for 1 of 1 resident (Resident #1 [R1]) to leave their room for activities and to eat in the dining room for breakfast, lunch and supper for 4 of 6 meals served (8/27/23 supper, 8/28/23 breakfast, 8/28/23 lunch, and 8/28/23 supper). Findings: On 8/28/23 at 1:07 p.m. in an interview with a surveyor, R1 stated he/she did not receive lunch and that he/she goes to the dining room to eat, but there were no portable oxygen tanks in storage or available, so was told by staff he/she could not go to the dining room and has to eat in his/her room, and could not attend activities. He/she had to eat in room, where there is an	F 558		

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.

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F 558	Continued From page 1 oxygen concentrator machine, on 8/27/23 supper, 8/28/23 breakfast, 8/28/23 lunch, and 8/28/23 supper. He/she stated there was a portable oxygen machine that someone donated to the facility, but he/she could not use that because it was not holding a charge. On 8/28/23 at 1:15 p.m., in an interview with a surveyor, Registered Nurse #2 [RN#2] stated that R1 was not given lunch today, not sure why, and ate breakfast in his/her room this morning because there were no portable oxygen tanks available for R1's use. A surveyor confirmed with RN#2, at this time, that R1 was not able to go to the dining room for meals, per his/her preference because there were no portable oxygen tanks available for use, and was not offered a choice to go to the dining room or activities.	F 558		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.	F 561		

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F 561	Continued From page 2 §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the facility failed to ensure that portable oxygen was available for 1 of 1 resident (Resident #1 [R1]) to leave their room to eat in the dining room for breakfast, lunch and dinner for 3 of 5 meals served (8/27/23 dinner, 8/28/23 breakfast, and 8/28/23 lunch). Findings: On 8/28/23 at 1:07 p.m. in an interview with a surveyor, R1 stated he/she did not receive lunch and that he/she goes to the dining room to eat, but there were no portable oxygen tanks available or in storage so was told by staff he/she could not go to the dining room and has to eat in his/her room. He/she had to eat in room on 8/27/23 supper, 8/28/23 breakfast, and 8/28/23 lunch, where there is an oxygen concentrator machine. On 8/28/23 at 1:15 p.m., in an interview with a surveyor, Registered Nurse [RN] stated that R1 was not given lunch today, not sure why, and ate breakfast in his/her room this morning because there were no portable oxygen tanks available for R1's use. A surveyor confirmed at this time that	F 561		

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F 561	Continued From page 3 R1 was not able to go to the dining room for meals, per his/her preference because there were no portable oxygen tanks available for use, and was not offered a choice to go to the dining room.	F 561		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are 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	F 584		

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F 584	Continued From page 4 levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in good repair and in a sanitary condition for 3 of 3 Units. (Skilled unit, Dementia unit and Long Term Care unit) for 2 of 2 environmental tours (08/29/23 and 8/31/23) Findings: 1. On 8/29/23 at 1:16 p.m., a surveyor did an environmental tour with the Infection Preventionist in which the following findings were observed: Resident Room 67 - Shared bathroom with a resident tooth brush not labeled for who it belonged to and basin stored on floor not covered. Resident Room 68 - Basin stored on floor not covered. Resident Room 78 - Basin and bedpan stored on floor not covered. On 8/29/23 at approximately 3:00 p.m., a surveyor reviewed the above findings with the Infection Preventionist and confirmed basins should not be stored on the floors, personal items	F 584		

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F 584	Continued From page 5 in shared bathrooms should be labeled. 2. On 8/31/23 from 8:15 a.m. to 8:45 a.m., a surveyor did an environmental tour with the Facilities Maintenance Director in which the following findings were observed: Skilled Unit Resident Room 23 - The privacy curtain is missing hooks and in disrepair. Memory Care unit The sit-to-stand patient lift, by Resident Room 41 had dirt/debris on foot base and had paint chipped on base legs creating uncleanable surfaces. On 8/31/23 at 8:45 a.m., in an interview, the Facilities Maintenance Director confirmed the findings.	F 584		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in	F 623		

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F 623	Continued From page 6 paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal	F 623		

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F 623	Continued From page 7 hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).	F 623		

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F 623	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the resident and the resident's representative in writing of the transfers/discharges to an acute care hospital for 3 of 3 residents sampled for hospitalization (Resident #53 [R53], Resident #15 [R15], and Resident #83 [R83]). In addition, the facility failed to notify the State Ombudsman of facility initiated transfer/discharges. Findings: 1. On 8/28/23 at 12:49 p.m., during an interview with a surveyor, R53 stated that he/she was recently admitted to the hospital but did not recall receiving any paperwork from the faciltiy regarding this hospital transfer. On 8/29/23. R53's clinical record was reviewed and indicated the R53 was transferred and admitted to the hospital on 7/12/23 and returned to the facility on 7/18/23. The surveyor was unable to find a transfer/discharge notice in the clinical record. On 8/30/23 at 10:26 a.m., during an interview with a surveyor, the Administrator in Training (AIT) stated she was unable to find evidence of a transfer notice being provided to R53. At 10:50 a.m., the AIT stated that the Ombudsman was not being notified of transfer/discharges. 2. On 8/30/23, R15's clinical record was reviewed and indicated the R15 was transferred to the hospital on 6/25/23 and 6/30/23. The surveyor was unable to find a transfer/discharge notices in the clinical record for either transfer. On 8/30/23 at 10:50 a.m., during an interview with a surveyor, the Administrator in Training (AIT) stated she was unable to find evidence of transfer notices being provided in writing to R15	F 623		

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F 623	Continued From page 9 and R15's resident's representative in writing. At 10:50 a.m., the AIT stated that the Ombudsman was not being notified of transfer/discharges. 3. On 8/30/23, R83's clinical record was reviewed and indicated the R83 was transferred to the hospital on 3/18/23 and 5/27/23. The surveyor was unable to find a transfer/discharge notices in the clinical record for either transfer. On 8/30/23 at 10:50 a.m., during an interview with a surveyor, the Administrator in Training (AIT) stated she was unable to find evidence of transfer notices being provided in writing to R83 and R83's resident's representative in writing. At 10:50 a.m., the AIT stated that the Ombudsman was not being notified of transfer/discharges.	F 623		
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1)	F 625		

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F 625	Continued From page 10 of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the resident and/or the resident's representative in writing of a bed hold notice for 3 of 3 residents sampled for hospitalization (Resident #53 [R53], Resident #15 [R15], and Resident #83 [R83]). Findings: 1. On 8/28/23 at 12:49 p.m., during an interview with a surveyor, R53 stated that he/she was recently admitted to the hospital but did not recall receiving any paperwork from the faciltiy regarding this hospital transfer. On 8/29/23. R53's clinical record was reviewed and indicated the R53 was transferred and admitted to the hospital on 7/12/23 and returned to the facility on 7/18/23. The surveyor was unable to find a bed hold notice in the clinical record. On 8/30/23 at 10:26 a.m., during an interview with a surveyor, the Administrator in Training (AIT) stated she was unable to find evidence of a bed hold notice being provided to R53. 2. On 8/30/23, R15's clinical record was reviewed and indicated the R15 was transferred to the hospital on 6/25/23 and 6/30/23. The surveyor was unable to find bed hold notices in the clinical record for either transfer. On 8/30/23 at 10:50	F 625		

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F 625	Continued From page 11 a.m., during an interview with a surveyor, the Administrator in Training (AIT) stated she was unable to find evidence of bed hold notices being provided in writing to R15 and/or R15's resident's representative in writing. 3. On 8/30/23, R83's clinical record was reviewed and indicated the R83 was transferred to the hospital on 3/18/23 and 5/27/23. The surveyor was unable to find bed hold notices in the clinical record for either transfer. On 8/30/23 at 10:50 a.m., during an interview with a surveyor, the Administrator in Training (AIT) stated she was unable to find evidence of bed hold notices being provided in writing to R83 and/ or R83's resident's representative in writing.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that the Minimum Data Set (MDS) 3.0 was coded accurately for 3 of 22 sampled residents (Resident #87 [R87], Resident #101 {R101}, and Resident #86 [R86]). Findings: 1. On 8/28/23 at 1:05 p.m., a surveyor observed R87 wearing oxygen being administered by nasal cannula. On 8/30/23, R87's clinical record was reviewed and included a physician order, dated 4/28/23, to administer oxygen. Review of R87's most recent quarterly MDS, dated 6/28/23, for	F 641		

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F 641	Continued From page 12 Section: O Special Treatments and Programs was not checked on O100C for oxygen use. On 8/30/23 at 11:47 a.m., a surveyor confirmed this finding with the Administrator in Training (AIT). 2. On 8/31/23, R101's clinical record was reviewed and included a physician order, dated 2/11/23, that indicated a Hospice referral was made on 2/8/23. On 8/31/23 at a.m., during an interview with a surveyor, the Resident Assessment Coordinator (RAC) stated she would check on the date that R101 was accepted into the Hospice Program. At this time, R101's Significant Change MDS, dated 2/21/23, was reviewed and it was noted that Section: O Special Treatments and Programs was not checked on O100K for Hospice. At 9:00 a.m., during an interview with a surveyor, the RAC stated that the Significant Change MDS was completed because R101 was accepted into the Hospice Program on 2/13/23, but section O100K was not checked in error. 3. Resident #86 was admitted to the facility on 5/16/23. The MDS 3.0 Admission, dated 5/23/23, under section M-Skin Conditions, 0300B1 was coded to indicate the resident had one stage II pressure ulcer (PU) and 0300D1 was coded to indicate that resident did not have a stage IV PU. On 7/20/23, a Discharge (return not anticipated) MDS 3.0 was completed. Section M 0300B2 was coded to indicate that the resident did not have a stage II PU upon admission/re-entry and section M 0300D2 was coded to indicate that the resident did have a Stage IV PU upon admission/re-entry. On 8/30/23 at approximately 10:00 a.m., a surveyor confirmed with the Director of Nursing that the MDS Admission Assessment was not accurately coded to capture Resident #86's Skin	F 641		

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F 641	Continued From page 13 Conditions for these assessments.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:	F 655		

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F 655	Continued From page 14 (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours that included the instructions needed to provide minimum healthcare information necessary to properly care for 1 of 5 sampled residents admitted for skilled care services (Resident #27 [R27]). Finding: Review of R27's clinical record noted that he/she was admitted to the facility on 6/19/23 with a primary diagnoses of medically complex, morbid obesity, chronic diastolic congestive heart failure, obstructive sleep apnea, bipolar disorder, major depressive disorder, and post-traumatic stress disorder (chronic). The clinical record lacked evidence that the base line care plan was not developed for the use of oxygen to include the instructions necessary to properly care for R27. On 8/30/23 at approximately 1:31 p.m. during an interview with the Skilled Nurse Manager, the surveyor confirmed that that baseline care plan was not developed to include the use of oxygen and the instructions necessary to care for R27.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan	F 656		

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F 656	Continued From page 15 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. (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.	F 656		

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F 656	Continued From page 16 (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 observations, record reviews, and interviews, the facility failed to ensure that care plans were developed to reflect a resident's current needs for 2 of 19 residents reviewed (Resident #87 [R87] and Resident #27 [R27]). Findings: 1. On 8/28/23 at 1:05 p.m., a surveyor observed R87 wearing oxygen being administered by nasal cannula. On 8/30/23, R87's clinical record was reviewed and included a physician order, dated 4/28/23, to administer oxygen. A review of R87's current care plan, last reviewed on 7/5/23, did not include a care area or interventions that identified that R87 used oxygen. On 8/31/23 at 12:14 p.m., a surveyor confirmed this finding with the Administrator in Training (AIT). 2. On 8/28/23 at 12:10 a surveyor observed R27 wearing oxygen that was being administered by a nasal cannula at a rate of 3 liters (L) and a bilevel positive airway pressure (BiPAP) machine on his/her bedside table. On 8/28/23 R27's clinical record was reviewed and there was no evidence of a physicians order for the use of oxygen or the BiPAP machine. A review of R27's nursing notes dated 6/19/23 to 7/11/23 shows documentation of R27 using oxygen daily at a rate of 3L. A review of R27's current care plan last reviewed on	F 656		

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F 656	Continued From page 17 7/11/23 did not include a care area or interventions for the use of oxygen or his/her BiPAP machine. On 8/30/23 at 1:31 p.m. a surveyor confirmed that R27's care plan did not include a care area for the use of oxygen or BiPAP machine with the Skilled Nurse Manager. 3. Review of R27's clinical record noted that he/she was admitted to the facility on 6/19/23 with a diagnosis of post-traumatic stress disorder (PTSD) (chronic). The clinical record lacked evidence that the comprehensive care plan was developed in the care area of PTSD that would list triggers of his/her PTSD and what interventions would assist R27 with dealing with any and all PTSD episodes. On 8/30/23 at approximately 2:00 p.m. during an interview with the Administer in training the surveyor confirmed that that R27's care plan was not developed to include the care area and interventions needed to address R27's PTSD.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		

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F 684	Continued From page 18	F 684		

Based on record review and interview, the facility failed to complete daily assessments and weekly or as needed dressing changes to a midline catheter for 1 of 1 sampled residents reviewed (Resident #53 [R53}).

Finding:

The facility's policy and procedure, "Vascular Access Devices (VADS): Ongoing Assessment, Site Care, and Dressing Change," indicated that a sterile dressing is applied and maintained on all peripheral, nontunneled, peripherally inserted central catheters, and access implanted VADs.

Midline catheter site care and dressing changes are performed at established intervals, and immediately when the integrity of the dressing is compromised; if moisture, drainage, or blood is present; or for further assessment if site infection or inflammation is suspected. Gauze dressings are changes every 2 days, transparent semipermeable membrane dressings are changed every 5 to 7 days.

R53 returned from the hospital on 7/18/23 with a midline catheter in place so intravenous (IV) medications could still be received. A nurses note, dated 7/18/23 2:34 p.m., indicated "patient noted with midline in right brachial vein. Dressing is intact, clean and dry with noted dried blood."

Review of physician orders indicated the facility was flushing the midline catheter twice a day from 7/18/23 until it was removed on 8/6/23.

A physician order was added on 8/1/23 which directed staff to change midline catheter dressing once a week starting on Wednesday 8/2/23, 14

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F 684	Continued From page 19 days after R53 returned to the facility. A review of a nurses note, dated 8/6/23 at 7:40 a.m., indicated the "IV dressing full of blood. Resident states its been that way since Registered Nurse (RN) care 8/2/23." On 8/6/23 at 8:39 a.m., an additional note indicated "Midline discontinued per order of Doctor. Site had been very blood with old/new blood under dressing. Gauze saturated. Resident states it has been that way since dressing change/bath 8/2/23." On 8/30/23 at 9:14 a.m., during an interview with a surveyor, the Administrator in Training (AIT) stated that the first documented dressing change was 8/2/23. At 1:31 p.m., the AIT stated that the midline (daily) assessment should have included arm circumference, flushing of the catheter, and monitoring of the dressing status. Surveyor confirmed that the facility was flushing the line but there was no evidence of monitoring of the dressing /arm circumference daily. The surveyor confirmed also that if staff was completing a daily assessment of the site, that the dressing should have been changed when it was soiled.	F 684		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 686		

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F 686	Continued From page 20 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure weekly pressure ulcer documentation were completed as per facility policy for 1 of 1 residents reviewed for pressure ulcers (Resident #68 [R68]. Finding: The facility's policy and procedure, "Pressure Injury and Wound - Elsevier", directed staff to use the organization-approved assessment tool (located in the computer software) to complete assessments. Areas that needed to be documented included: anatomic location on the body, type of pressure injury (PI) or wound, extent of tissue involvement, color, type, and percentage of tissue involved, length, width, and depth measures in centimeters, presence of undermining at the PI or wound edges, tunnels, or sinus tracts (measure and record depth and direction of each), amount, color, and consistency of exudate, presence of foul odor, and periwound skin integrity and to document this in the clinical record. On 8/29/23, R68's clinical record was reviewed and included a physician order for treatment to measure weekly on Thursdays which started on 6/29/23 for a Stage III pressuer injury. The surveyor was unable to find evidence in the clinical record of weekly wound assessments being documented with all the required areas completed.	F 686		

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F 686	Continued From page 21 On 8/31/23 at 12:00 p.m., during an interview with the Administrator in Training (AIT), the surveyor confirmed that the documentation provided did not include weekly assessments for all weeks from 6/29/23 to current and what assessments were completed did not include all required areas in the assessments.	F 686		
F 688 SS=B	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on interviews and observations, the facility failed to provide equipment (wheelchair) to maintain and/or improve residents' highest level of mobility for 1 of 1 resident reviewed for positioning and mobility (Resident #27). Finding:	F 688		

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F 688	Continued From page 22 On 8/28/23 at 12:20 p.m., during an interview with Resident #27, he/she stated they are stuck in their room because they do not have a wheelchair that fits him/her. They can't go to activities or even leave the room due to not having a wheelchair that fits him/her. During clinical record review the surveyor reviewed Physical Therapy (PT) treatment notes with dates from 6/20/23 to 7/7/23. The notes indicate that Resident #27 was having his/her personal wheelchair delivered over the weekend, on 6/28/23 a wheelchair trial was attempted, and it is documented that he/she did not fit well and was unable to keep feet on foot pedals he/she was extremely uncomfortable. On 6/30/23 documentation supports resident refusing to use the wheelchair and requested a chair that fits him/her, treatment session was limited due to Resident not able to tolerate use of wheelchair. On 7/1/23 Resident #27 requested a wheelchair that would accommodate their size. On 7/6/23 Resident #27 was asking PT about how to obtain a chair that allows him/her to get out of bed. On 7/7/23 discharge note, Resident #27 was being discharged from skilled services due to progress had ceased. Resident #27 was upset that a wheelchair had not been provided to allow him/her to get out of bed comfortably. On 8/31/23 at approximately 12:00 p.m. during an interview with the Skilled nurse manager, he stated the hospital had provided a wheelchair that fit her (bariatric) as that was one of the conditions the facility would accept her as an admission. He stated the chair was kept in the bathroom of her room when skilled nurse manager and surveyor observed the bathroom the bariatric wheelchair	F 688		

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F 688	Continued From page 23 and Resident #27's personal wheelchair was not there. The skilled nurse manager then stated they must have come to get it back. Resident #27 then stated that she would like to have a chair that fits him/her so he/she could leave his/her room and socialize. On 8/31/23 at approximately 12:40 p.m. during an interview with the Administer in Training the surveyor confirmed the facility did not have a wheelchair to accommodate Resident #27's needs.	F 688		
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 observations and interviews, the facility failed to ensure that the resident environment remained free from the potential risk of accidents, for 1 of 1 days of survey (8/28/23), when they failed to ensure a toilet was secured to the floor in a resident bathroom. Finding: On 8/8/23 at 12:26 p.m., a surveyor observed Resident #83's bathroom toilet to be loose and not secured to the floor. On 8/8/23 at 12:29 p.m., in an interview,	F 689		

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F 689	Continued From page 24 Registered Nurse [RN] #2, he stated that Resident #83 does use the toilet and that there has been trouble with this toilet before. 0n 8/28/23 at 12:33 p.m., in an interview, the Facilities Maintenance Director confirmed that Resident #83's toilet was not properly secured to the floor and was a potential accident hazard. The Regional Facilities Director had the toilet immediately fixed by a maintenance worker. 0n 8/28/23 a 1:17 p.m., a surveyor discussed the finding with the Administrator in training [AIT], the Director of Nursing [DON], and the Interim Administrator.	F 689		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure physician orders were followed for oxygen administration, failed to obtain a physician order for the use of oxygen, failed to ensure that oxygen tubing was changed weekly, and failed to ensure that respiratory equipment was clean for 4 of 4 sampled residents reviewed for respiratory care (Resident #87 [R87], Resident #27 [R27],	F 695		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 25 Resident #4 [R4], and Resident #34 [R34]). Findings: 1. On 8/29/23 at 8:25 a.m., a surveyor observed R87's oxygen concentrator's vents located on the back of the machine were dusty. On 8/30/23, at 9:54 a.m., a surveyor observed that the oxygen setting on the concentrator was set at 2 LPM and that the vents on the back of the oxygen concentrator were still dusty. On 8/30/23 at 10:00 a.m., during an interview with a surveyor, Registered Nurse (RN) #1 reviewed R87's clinical record and stated that the oxygen LPM should be set a 3 (per physician order dated 4/28/23). The surveyor and RN #1 then observed R87's oxygen concentrator and the surveyor confirmed that the oxygen setting was not being administered per physican order and that the concentrator vents were dusty. 2. On 8/28/23 at 12:10 p.m. a surveyor observed R27 wearing oxygen that was being administered by a nasal cannula (NC) at a rate of 3 liters (L). On 8/28/23 R27's clinical record was reviewed and there was no evidence of a physician's order for the use of oxygen. A review of R27's nursing notes dated 6/19/23 to 7/11/23 shows documentation of R27 using oxygen daily at a rate of 3L per minute by nasal cannula. R27's clinical record review shows documentation that on 7/7/23 R27 transitioned from skilled care to long term care, the facility continued to monitor his/her use of oxygen daily until 7/11/23 (4 days after skilled services ended). R27's clinical record lacked evidence that R27's had a physician's order for the use of oxygen. A surveyor observed the oxygen concentrator and the vents located on the back of the machine were covered in dust.	F 695		

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F 695	Continued From page 26 On 8/29/23 at 9:25 a.m. a surveyor observed that R27's oxygen concentrator continued to be covered in dust. At 10:00 a.m. a surveyor confirmed with the Skilled Unit Manager that R27's oxygen concentrator was covered in dust. At this time the Skilled Nurse Manager stated he was not sure who was responsible for the cleaning of the oxygen concentrators either the maintenance department or the nursing department. On 8/30/23 at various times throughout the day R27's oxygen concentrator and vents were observed to remain covered in dust. On 8/31/23 at 11:30 a.m. a surveyor and the Skilled Unit Manager were in R27's room, making an observation, and R27's oxygen concentrator remained covered in dust. This finding was confirmed by the surveyor at the time of the observation. 3. On 8/29/23 at 8:35 a.m., a surveyor observed R4's oxygen concentrator's vents located on the back of the machine were dusty. At this time, Licensed Practical Nurse [LPN] #2 confirmed that the oxygen concentrator's vents were dusty. 4. On 8/29/2023 at approximately 10:00 a.m., a surveyor observed Resident #34 wearing oxygen and did not see any date on the with oxygen tubing not dated. On 8/29/23 at approximately 11:00 a.m., a surveyor spoke with the Infection Preventionist (IP) asking about when the oxygen tubing is changed. The IP stated that it is changed once a week and documented in the Treatment Administration Record (TAR) located in the Electronic Medical Record (EMR) and that the	F 695		

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F 695	Continued From page 27 tubing itself is not expected to be dated. On 8/31/2023 at 09:35 a.m., a surveyor and LPN#4 reviewed the TAR for the past month for Resident #2. LPN#4 was unable to provide documentation that indicated the oxygen tubing was changed weekly.	F 695		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to identify a resident's current diagnosis of Post-Traumatic Stress Disorder (PTSD)/trauma to determine what trigger(s) might cause re-traumatization for 1 of 1 sampled resident reviewed with a current diagnosis of PTSD (Resident #27 [R27]). Finding: 1. On 8/28/23, R27's clinical record was reviewed and indicated the resident was admitted to the facility on 6/19/23 with a diagnosis of PTSD. R27's admission minimum data set (MDS) 3.0 was dated 6/26/23. This MDS indicated, under "Active Diagnosis" Section I6100, that the resident had PTSD. The surveyor was unable to find information in the clinical	F 699		

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F 699	Continued From page 28 record that indicated what R27's PTSD was caused by or what events might cause re-traumatization. On 8/30/23 at approximately 2:00 p.m.., during an interview with the Administer in training a surveyor confirmed the finding that the facility had not obtained information regarding R27's PTSD or what triggers/events might cause traumatization.	F 699		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.	F 732		

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F 732	Continued From page 29 §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to post the current daily nurse staffing information that included a separate breakdown of hours for each shift for registered nurses (RN's), licensed practical nurses (LPN's), and certified medical assistants (CNA's) for 3 of 4 survey days (8/28/23, 8/29/23, and 8/30/23). The facility also failed to port the current daily nurse staffing information for 1 of 4 survey days (8/30/23). Findings: On 8/28/23 at 11:15 a.m., a surveyor observed staff posting on the wall by the front hallway across from the reception desk. This posting did not include the hours for each shift for RN's, LPN's, and CNA's working. On 8/29/23 at 1:15 p.m., a surveyor observed staff posting on the wall by the front hallway across from the reception desk. This posting did not include the hours for each shift for RN's, LPN's, and CNA's working. On 8/30/23 at 3:00 p.m., a surveyor observed	F 732		

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F 732	Continued From page 30 staff posting on the wall by the front hallway across from the reception desk. This posting was not for the current day, 8/30/23. This posting was dated for 8/29/23, the previous day, and did not include the hours for each shift for RN's, LPN's, and CNA's working. On 8/30/23 at 3:04 p.m., a surveyor confirmed this finding with the Administrator in Training.	F 732		
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, interviews, the facility's "Purchasing, Receiving, Storage, and Issuance of Food and Supplies" Policy/Procedure #: FNS-4, and The facility's "Sanitation, Infection Control, HACCP and Safety" Policy/Procedure #: IC-FNS-	F 812		

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F 812	Continued From page 31	F 812		

8, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for wall fans, a hanging pot rack, and hood filters; failed to ensure that staff with facial hair utilized beard restraints; and failed to ensure that food is stored, served and prepared in a safe, sanitary manner as evidenced by improper food storage in the walk-in freezer on 1 of 1 days of kitchen observations (8/28/23). In addition, the facility failed to monitoring for sanitizer solution levels in sanitizing buckets and failed to ensure that the dish machine was maintaining proper temperature ranges for proper cleaning and sanitizing. This has the potential to affect all residents.

Findings:

On 8/28/23 from 11:30 a.m. to 12:05 p.m., an initial Kitchen Tour was conducted with the Kitchen Manager in which the following findings were observed:

1. >The dish room wall fan was dusty and dirty.
>The pot hanging rack had areas of rust build-up on it.
>Wall fan by in the kitchen over a food preparation area was dusty and dirty.
>The hood filters were heavily soiled with dust.

2. Two male staff with beards and mustaches were observed without beard restraints.
The facility's "Sanitation, Infection Control, HACCP, and Safety" Policy/Procedure #: IC-FNS-8, last revised on 12/30/2020 noted the following: Procedure - General Principles - f. Staff shall wear clean outer clothing and aprons. Head and facial hair shall effectively be restrained through the use of Nets or other clean hair coverings

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F 812	Continued From page 32 while in food preparation and service areas. 3. The walk-in freezer had two opened packages of tater tots, one package of hash browns, several packages of pancakes, one package of chicken strips and two cakes that were not labeled and dated. The facility's "Purchasing, Receiving, Storage, and Issuance of Food and Supplies" Policy/Procedure #: FNS-4, last revised on 12/7/2020 noted the following: Section 5. Storage l. All foods prepared on site will be stored in refrigerators and will be covered, labeled, and dated. s. All foods will be covered, dated (to include date prepared), and identified; Stock will be rotated. jj. Food, whether raw or prepared, if removed from the container or package in which it is obtained, shall be stored in a clean and sanitized container and be labeled (identified), covered, and dated, all foods not currently being used will be properly stored and covered slash seal to protect food products. 4. In an interview, the Kitchen Manager confirmed that the facility does not monitor or maintain records of results of sanitizer solution checks of the sanitizing buckets (to ensure correct levels in parts per million [ppm] for proper sanitizing) and that the sanitizing buckets are filled first thing in the morning and are not changed throughout the day. The facility's "Sanitation, Infection Control, HACCP, and Safety" Policy/Procedure #: IC-FNS-8, last revised on 12/30/2020 noted the following: Procedure - General Principles - 8. Sanitizers are available. Clearly labeled sanitizers of the correct concentration must be used to sanitize all food	F 812		

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F 812	Continued From page 33 contact surfaces of stationary equipment (e.g., work counters, tables): stationary equipment: spray bottles. Each work station should have its own sanitizing solution container for holding wiping cloths. Sanitizing solutions must be checked(using sanitizer test strips) throughout the day to assure correct concentration. Spray bottles with sanitizing solutions also may be used for sanitizing of workstation work services. 5. Observations were made by the surveyor and the kitchen manager of the dish machine's wash and rinse cycles revealing that wash temperatures were140 degrees Fahrenheit[F] and rinse temperatures were 158 degrees Fahrenheit. The dish machine was run five separate times and could not reach proper washing and rinse sanitation temperatures. Upon checking the hot water booster for the dish machine, the kitchen manager determined that the booster had kicked out and would not stay on when reset. He stated the booster helps heat the water up to 180 degrees for sanitation. The dish machine temperature documentation for the morning of 8/28/23 noted wash temperature at 150 degrees Fahrenheit and rinse temperature at 182 degrees Fahrenheit. The kitchen manager stated this documentation could not be correct as the dish machine did not reach proper temperatures for sanitation when repeatedly tested now. The kitchen manager stated that he was not aware that the dish machine was not running at the proper wash and rinse temperatures to ensure sanitizing of the dishes. He stated that it had not been reported to him by staff and that he had no idea how long the dish machine was not washing and rinsing at the required/appropriate temperatures ensure cleaning and sanitizing of	F 812		

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F 812	Continued From page 34	F 812		

the dishes. The surveyor observed a sign on the front of the dish machine that noted: Note!! Please make sure you have at least 180 degrees Fahrenheit rinse water temp[temperature] by running several empty racks through before washing any dishes. Record temp[temperature] on chart behind you... (alert your supervisor immediately if there are any problems!!)

On 8/28/23 at 12:05 p.m., in an interview, the Kitchen Manager confirmed the findings.
The kitchen manager immediately placed a call to Ecolab to service the dish machine. On 8/28/23 at 2:45 p.m., Ecolab arrived and hooked the dish machine up to a chemical sanitizer dispenser. The dish machine would now sanitize the dishes at temperatures over 120 degrees. The facility was instructed to test and make sure the ppm were between 50 and 100 at each test once each meal.

0n 8/28/23 at1:17 p.m. , a surveyor discussed the finding with the Administrator in training [AIT], the Director of Nursing [DON], and the Interim Administrator.

0n 8/31/23 at 11:00 a.m., in an interview, Facilities Manager observed the dish machine with the surveyor and stated that he was not aware the dish machine was not washing and rinsing to temperature to ensure proper cleaning and sanitizing.

The facility's "Sanitation, Infection Control, HACCP, and Safety" Policy/Procedure #: IC-FNS-8, last revised on 12/30/2020 noted the following:
Procedure - General Principles -
l. Pots are hand washed and then run through the dishwasher where they are rinsed at 180 degrees

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F 812	Continued From page 35 for proper sanitation. M. Dishes and silver will be washed by machine at wash temperature of 150 degrees[Fahrenheit] and above and the final rinse at least 180 degrees [Fahrenheit] (120[Fahrenheit] chemical rinse, if applicable). Temperatures will be recorded after each meal. x. Food and Nutrition Services Department equipment and facilities are on the plant operations preventive maintenance schedule. Any equipment found to be defective or in questionable repair is reported to engineering immediately for corrective action. cc. The director and or designee will conduct sanitation slash safety inspections of the entire department, and make appropriate assignments. 4. Mechanical cleaning and sanitizing a period where washing machines and their auxiliary components shall be operated in accordance with manufacturer's instructions and procedures for testing shall be provided and used.	F 812		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and the facility's "Sanitation, Infection Control, HACCP, and Safety" Policy/Procedure #: IC-FNS- 8, the facility failed to ensure that the kitchen high temperature dish machine was maintained in good repair and in safe operating condition for 4 of 4 dish machine observations (8/28/23, 8/29/23, 8/30/23 and 8/31/23) and failed to ensure proper cleaning and sanitizing of dishes for 1 of 4 kitchen	F 908		

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F 908	Continued From page 36 tours (8/28/23). Findings: The facility's "Sanitation, Infection Control, HACCP, and Safety" Policy/Procedure #: IC-FNS-8, last revised on 12/30/2020 noted the following: Procedure - General Principles - l. Pots are hand washed and then run through the dishwasher where they are rinsed at 180 degrees for proper sanitation. M. Dishes and silver will be washed by machine at wash temperature of 150 degrees[Fahrenheit] and above and the final rinse at least 180 degrees [Fahrenheit] (120[Fahrenheit] chemical rinse, if applicable). Temperatures will be recorded after each meal. x. Food and Nutrition Services Department equipment and facilities are on the plant operations preventive maintenance schedule. Any equipment found to be defective or in questionable repair is reported to engineering immediately for corrective action. On 8/28/23 from 11:30 a.m. to 12:05 p.m., during an Initial Kitchen Tour, a surveyor observed that the high temperature dish machine had a large bus bucket underneath it, half full of dirty water. When the dish machine was run, water leaked from somewhere under the dish machine into the bus bucket. The surveyor also observed the dish machine's wash temperatures were 140 degrees Fahrenheit[F] and rinse temperatures were 158 degrees Fahrenheit. On 8/28/23 at 12:05 p.m., in an interview, the kitchen manager confirmed that a dish machine had a leak somewhere underneath it and he was not sure how long it had been leaking. The	F 908		

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kitchen manager also confirmed that the dish machine was not washing and rinsing at the correct temperatures according to the manufacturer's recommendations to ensure proper sanitation of dishes. He stated that he was unaware that the dish machine was not washing and rinsing at proper temperatures and that he had not been notified by his staff. He additionally stated that the hot water booster for the dish machine would not stay on and that it kept kicking out.

0n 8/28/23 at1:17 p.m. , a surveyor discussed the finding with the Administrator in training [AIT], the Director of Nursing [DON], and the Interim Administrator.

0n 8/29/23 at 9:00 a.m., a surveyor observed that when the dish machine was run, water leaked from somewhere under the dish machine into the bus bucket.

0n 8/30/23 at 8:30 a.m., a surveyor observed that when the dish machine was run, water leaked from somewhere under the dish machine into the bus bucket.

0n 8/31/23 at 8:05 a.m., a surveyor observed that when the dish machine was run, water leaked from somewhere under the dish machine into the bus bucket.

0n 8/31/23 at 8:15 a.m., in an observation of the kitchen dish machine, the Facilities Director confirmed that the dish washing machine was leaking and not maintained in good repair. The Facilities Director stated that he had not been made aware of the dish machine leak, had not been made aware of the dish machine not

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD A CONTINUING CARE CENTER	**220 KENNEDY MEMORIAL DR 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 908	Continued From page 38 washing and rinsing properly and had not been made aware of the problem with the hot water booster.	F 908		