STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205134	A. BUILDING _____ B. WING _____	06/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH'S REHABILITATION AND RESIDENCE	1133 WASHINGTON AVE PORTLAND, ME 04103

(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 6/12/23 through 6/15/23, on-site visits were conducted at St. Joseph's Rehabilitation and Residence for the purpose of conducting the annual Long Term Care Survey Process and investigating complaints #ME00040357, #ME00040582, #ME00042086, #ME00042630, #ME00042619, #ME00043180, & #ME00043824. It was determined that St. Joseph's Rehabilitation and Residence was not in substantial compliance with 42 CFR 483, Subpart B-Requirements for Long Term Care Facilities.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		

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

Leeann Matthews RN DON | Director of Nursing | 7-7-2023

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.

F584, 483.10 Safe Environment Findings:
On 6/12/23 at 6:55 a.m. and 6/13/23 at 7:38 a.m. Unit D rooms 22 and 24 shared bathroom had a urine hat stored between the handrail and the wall and a graduate cylinder on the floor next to toilet.
On 6/12/23 at 7:07 a.m. and 6/13/23 at 7:35 a.m. Unit D rooms 18 and 20 shared bathroom had an unbagged plunger on the floor in corner and a container of germicidal bleach wipes on the shelf next to the toilet.
On 6/12/23 at 7:36 a.m. and 6/13/23 at 7:36 a.m. Unit D room 19 had a pink basin on the floor under the sink. Room 21 had a basin and bedpan on the floor under the sink and the shared bathroom for rooms 19 and 21 had a box of tissues and a gray basin on the floor next to the toilet.
On 6/12/23 at 8:06 a.m. and 6/13/23 at 7:32 a.m. Unit D room 14 had a bed pan and a gray basin on the floor under the sink. The shared bathroom for rooms 14 and 16 had a toilet riser and an orange ben pan on the floor next to the toilet, and an unlabeled urinal on shelf
On 6/13/23 at 7:34 a.m. Unit D rooms 15 and 17 shared bathroom had a full toilet paper roll on the floor, individual wipes out of package resting on the top of the toilet plumbing.
On 6/13/23 at 7:39 a.m. Unit D rooms 9 and 11 shared bathroom had a bed pan stored between the handrail and the wall.

F 584, 483.10 Facility Plan of Correction:

- On 6.13.2023 Nurse Manager on Unit D conducted audits of all resident rooms and resident bathrooms. All unlabeled personal items in the shared bathrooms were discarded. New personal items were issued and labeled with resident identifying information and stored with resident belongings.
- On 6.13.2023 the plunger found in the resident bathroom was bagged and returned to Housekeeping/ maintenance for proper storage. Container of germicidal wipes were removed and placed in secured cabinet.
- All residents had the potential to be impacted by this deficiency. The facility has completed audits of all resident rooms on all units by 6/14/2023, any unlabeled personal items found in shared bathrooms or on the floor have been discarded and new personal items have been issued.
- All units will check/change resident personal items weekly to ensure items are properly labeled and stored.
- CNA will provide documentation that personal items have been checked/changed in residents EHR.
- SJRR will provide education to all staff regarding providing a safe home-like environment for our residents. This education will include proper storage of personal items (urinals, bedpans, hats). No storage in the bathroom, no items can be stored on the floor. All cleaning products need to be kept locked. Education will be a verbal presentation with staff sign- in, education will be completed no later than 7.30.2023. Ongoing education will be provided during regular orientation sessions.
- All units A, B, C and D will conduct ongoing weekly audits to ensure all items are properly labeled, dated, stored. This audit will include ensuring there is no storage in resident bathrooms.
- The following audit form will be utilized, auditing will begin on 7/1/2023 and will continue weekly for a minimum of 3 months or until 100% compliance achieved, then will be random monthly audits thereafter.

Date	Urinal/Bedpan/Basin	Labeled/changed	Resident	Initials

- SJRR will be in substantial compliance by 7.30.2023

F655 Baseline Care Plan, 483.21 (a) Findings:
Resident #136's clinical record was reviewed and revealed that it lacked evidence of a baseline care plan that was completed within 48 hours to include the instructions necessary to properly care for Resident #136's immediate health and safety needs for the above concerns. A care plan for Intravenous antibiotics and anticoagulant use was initiated on 6/1/23, 16 days after admission. The care plan for the surgical incision was initiated on 6/12/23, 27 days after admission. In addition, the current comprehensive care plan lacked PICC line information with emergency care, and precaution with weight bearing status and positioning of the right hip.

F655, 483.21 (a) Facility Plan of Correction:

- Resident #136 discharged from the facility effective 6.17.23. This was a closed record review.
- On 6.30.2023 all resident admitted within the last 14 days reviewed to ensure baseline care plans had been developed and implemented that included minimum necessary healthcare information to properly care for the resident. All newly admitted residents had the potential to be impacted by this deficiency.
- All licensed staff will be provided on unit in servicing on how to complete the baseline care plan. Baseline care plan is developed from clinical admission findings and findings are activated. Staff are being re-educated to this process. Education will be verbal and written. Education will be complete on or before 7.30.2023
- Nurse Manager or Designee (charge Nurse)/ nursing supervisor will audit all new admissions within 48 hours to ensure all admission information is complete and accurate include baseline care plan. Audit will occur using Point click care insights (care review). This will allow full review of all assessment data. Individual completing audit will ensure care plan meets minimum necessary healthcare information and will add any information needed. Individual completing audit will send staff a confidential memo for education.
- This audit process for new admissions will begin on 7/1/2023 and will be ongoing. We will add an ongoing audit process to the facility practice.

F684 Quality of Care 483.25
Resident #134 was admitted to the facility on 3/23/23 with diagnosis of acute respiratory failure with adult failure to thrive. On 3/24/23 resident #134's weight was documented as 201 lbs. The next and last documented weight of 192.7 was on 4/24/23. A review of the comprehensive care plan initiated on 4/13/23 states, [Resident] has (acute) pain r/t Fracture (Sacrum) with interventions of; "Observe/report to nurse loss of appetite, refusal to eat and weight loss."
ROM program for resident (#100) A review of CNA documentation failed to locate evidence of CNA's provision of ROM for Resident 100.

F 684, 483.25 Facility Plan of Correction:

- Resident #134 weight was obtained on 6/28/2023 and documented on EHR.
- All residents had the potential to impacted by this deficiency. All units have audited resident records on 6.30.23 to ensure weights obtained as ordered or if resident refused then refusal of treatments is documented, any weight found to be missing was obtained on this date.
- All licensed staff provided education of facility weight policy (weight x4 then monthly unless ordered otherwise). EHR feature added so CNA's can document resident's weight or resident's refusal. Education of all Licensed staff and documentation of education will be complete on or before 7.30.23
- Nurse Manager or designee will run weight/summary audit report weekly starting on 6.30.2023, any missing weights noted on day of report will be obtained on that day unless otherwise noted.
- Care Plan for Resident #100 reviewed, and ROM program updated to be documented in the EHR system by restorative nursing or Certified Nursing assistant.

- All residents who receive ROM/ Restorative programs have the potential to impacted by this deficiency. Care Plans reviewed for all residents on restorative nursing programs. All programs audited to ensure schedule and times are available for documentation by restorative nursing aide or certified nursing aide.
- All clinical staff will be provided education on how to appropriately document in EHR/POC system. Education will be provided via written and oral power point. Employee will sign that they have attended education session, and this will be maintained in employee's personnel file Education will be completed on or before 7.30.23.
- **SJRR** will conduct weekly audit of documentation of restorative ROM programs to ensure compliance with delivery of care. Weekly audit will pull report from PCC for given period. Audit will begin on 7/1/2023.
- **SJRR** will be in substantial compliance by 7.30.2023

F698 Dialysis 483.25 (i)
The care plan, last reviewed 5/10/23, noted Resident #26 went to dialysis on Tuesdays, Thursdays, and Saturdays, and included "fluid restriction per physician orders." The care plan did not include monitoring or care of the vascular access site
Physician block orders, last signed on 6/5/23 noted "fluid restrictions, every shift, record intake per dietician." The orders did not include the amount of fluid restrictions required. In addition, the orders did not include an order for dialysis, or instructions to monitor or provide care to the vascular access site.

F 684, 483.25 (i) Facility Plan of Correction:

- On 6.14.23 resident #26 orders were reviewed. Orders were added to resident's block set to include hemodialysis Tuesday/Thursday/Saturday @ Casco Bay Dialysis. Pick up time of 1015, chair time 1045am. Resident is transported by Atlantic Transportation. Resident to be picked up after treatment at 1615pm.

Check dialysis port to r chest for signs/symptoms of infection. Report signs of infection to provider. Every shift for monitoring

FLUID RESTRICTIONS of 1.5L in a 24-hour period every shift record intake per dietician.

- On 6.29.23 resident #26 care plan was audited and the following was added to the care plan:

Focus	Goal	Intervention
Resident needs dialysis (hemodialysis) r/t ESRD renal failure.	The resident will have immediate intervention should any s/sx of complications from dialysis occur through the review date	Check dressing at access site q shift, dressing changed at dialysis. Document. Encourage resident to go for the scheduled dialysis appointments. Resident receives dialysis (Tuesday, Thursday, Saturday) at (Casco Bay Dialysis).
	The resident will have no s/sx of complications from dialysis through the review date	Monitor intake and output as ordered resident has 1.5L fluid restriction (see DOS/TAR)
		Monitor labs and report to doctor as needed
		Monitor VITAL SIGNS (See DOS/TAR for frequency). Notify PCP of significant abnormalities
		Observe for/document report to PCP s/sx of depression. Obtain order for mental health consult if needed.
		Observe/document/report PRN for s/sx of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds
		Observe/document/report PRN for s/sx of the following: Bleeding, Hemorrhage, Bacteremia, septic shock

- All residents who receive dialysis services had the potential to be impacted by this deficiency. On 6.29.23 all units (A, B,C and D) have completed chart audit of Resident's receiving dialysis. All residents have orders for dialysis included in their block order set, as well as instructions on how to care for vascular access site, fluid restrictions if appropriate. EHR also indicates where resident is receiving dialysis therapy.
- All licensed staff will be educated on order entry process. PCC order entry education sessions are in person and are mandatory for all licensed staff. Education sessions began on 6.22.2023 all current in-house staff are expected to be complete this education by 7.14.23. Education will be ongoing for new staff via new staff orientation. Staff are required to sign in for the education session as proof of attendance.
- Nurse Manager or Designee will run order listing report weekly from Point click care and verify everyone who receives dialysis has appropriate orders and the appropriate interventions are on the resident's care plan. If discrepancies are noted, the individual completing audit note this on the order listing report. The individual completing the audit will then ensure the medical record for the resident is updated to reflect status. Nurse manager/ supervisor will save and file a copy of the order list report. This audit process will begin on 6.30.2023 and will continue weekly.

F761 Label/ store Drugs and Biologicals 483.45(g), 483.45 (h)
1. On 6/13/23 at 8:08 a.m., observation of Unit D middle medication cart with Registered Nurse (RN) #3, the cart contained the following: opened and undated vail of Lantus insulin and 3 Lantus/Glargine pens with manufactures directions of, "use within 28 days after initial use", an opened and undated vial of Degludec insulin with manufactures directions of "After first use store refrigerated or at room temperature for up to 56 days", an opened and undated vial of Novolog insulin with manufactures directions of "discard unused portion after 28 days" and two Victoza Pens one dated 4/11/23 and the other date eligible with manufactures directions of "discard pen 30 days after first use".
2. On 6/13/23 at 8:51 a.m., observation of Unit B medication cart #2 with the Licensed Practical Nurse (LPN) #1, the cart contained an opened bottle of Oyster Shell Calcium 500mg (milligram) tablets with best by date of 5/23.
3. On 6/13/23 at 9:13 a.m., observation of the Unit B Treatment cart with LPN #3, the cart contained two opened vails of Lispro insulin; one undated and the other with an open date of 1/22/23 with manufactures directions of, "discard unused portion 28 days after first opening", a vial of Lantus insulin with an open date of 5/6/23 and an opened and undated Lantus pen with manufactures directions of, "use within 28 days after initial use"
4. On 6/13/23 at 9:36 a.m., observation of Unit A medication cart #1 with LPN #2, the cart contained an opened bottle of Vitamin C 500mg tablets with best by date of 2/23 and in the top draw of the cart was an unlabeled medicine cup filled with multiple pills/tablets. At this time, the LPN #2 stated it was for resident who wanted to eat breakfast first.
5. On 6/13/23 at 9:42 a.m., observation of Unit A medication cart #2 with RN #5, the cart contained an opened and undated vial of Humalog insulin with manufactures directions of "discard unused portion 28 days after first opening" and an opened and undated Victoza pen with manufactures directions of "discard pen 30 days after first use".
6. On 6/15/23 at approx. 9:10 a.m., observation of unlocked and unattended medication cart on Unit B for approx. 5 minutes. Upon return to the cart the Licensed Practical Nurse confirmed the cart was unlocked and unattended with access to unauthorized people.

F 761, 483.45 (g), 483.45 (h) Facility Plan of Correction:

- On 6.13.2023 Medications that were observed on units A, B and D to be outdated, undated or expired were removed and discarded/destroyed. A new supply of Medication was ordered to replace outdated/ discarded supply.
- All medication and treatment carts on units A, B, C and D were audited for medications/ treatments that were outdated. Any outdated medication/treatments found were discarded and replacements ordered this was completed by 6.14.23.

Saint Joseph's Rehabilitation and Residence Plan of Correction for Survey conducted 6.15.2023

- All licensed staff will attend mandatory training and will be provided education on facility policy regarding medication administration (dating of multi dose medications, residents medications are labeled properly) and medication storage (medication carts are secure). All licensed staff will be required to sign and acknowledge understanding of facility policy. Copy of signed facility policy will be kept with individual's employee's records. This education will be completed on or before 7.30.2023
- Expired Medication Audit- All units A, B, C and D will conduct weekly medication/ treatment cart/ medication rooms audits. Weekly audits will ensure all multidose medications are properly labeled with "date opened" (date opened stickers have been provided to all units for utilization), review medications found to expire within the next 30 days. Any expired medication will be discarded, and new supply ordered. Any medication due to expire within 7 days will be replaced. The below Audit form will be utilized. Weekly Audits will begin 7/1/2023 and will continue for a minimum of 3 months or until 100% compliance reached. Then transition to monthly Medication Cart audits.

Date: Unit	Meds found to expire within next 7 day:	Notify Charge Nurse/ Manager (Y/N)	Other Actions	Comments
Med Cart 1				
Med cart 2				
Med Cart 3				
Treatment Cart 1				
Med Room OTC supply				
Med room Refrigerator				
Med carts locked				

- On 6.15.2023 Medication Cart was observed unlocked. Cart was immediately locked upon licensed nurse return and on-spot education provided. All licensed staff will be required to attend mandatory training to review SJRR medication storage policy (ensuring medication carts are locked so unauthorized personnel do not have access). Education will be completed on or before 7.30.2023.
- Locked Medication Cart Audit- All units (A, B, C, and D) will conduct a minimum of 5 (each unit) random observations over all 3 shifts to ensure medication/ treatment carts are properly secure and locked. Locked Medication Audits will utilize the form below. Audits will begin on 7/1/2023 and will continue for a minimum 3 months or until 100% compliance reached, we will then reduce auditing to (4) random monthly audits.

Unit:	Date/ Time Observation	Medication/Treatment Cart	Cart Secure Y/N	Comments

F802: Sufficient Dietary Support Personnel

*No residents were impacted from this deficiency.

*All residents had the potential to be impacted by this deficiency.

*Updated advertising campaign for dietary employees will be instituted in print and social media. Joel Rogers, Administrator will run this initiative.

Completion date: July 14, 2023

*Outside service hired (see attached) to deep clean entire kitchen areas. Monthly inspections conducted by Administrator to determine compliance standards being met. Continuing the need to hire outside cleaning support will be reviewed with Facilities Director after each inspection as the need to have ServPro return.

Completion Date: July 31, 2023, ongoing.

*A Policy updated to clarify only the Administrator/DON/House Supervisor can authorize use of paper/disposable dining-ware, unless an Emergent situation presents itself.

Completion Date: July 14, 2023.

*Administrator attended post Survey Resident Council meeting to discuss the commitment of SJR to serve with china and dining-ware for all meals. To express a further commitment to offer Steam Table services for all communities for enhancing the dining experience. B Community already has capability and D Community will come online in July. A July date was scheduled to allow any/all residents who wanted to offer suggestions for meals to be added to the monthly menu that they talked about at RC Meeting.

Completion Date: July 1, 2023, ongoing.

*CNA Tutor and ASST. HR Director will be assigned to interview and follow all new ESL hires for Dietary. ESL applicants are applying in high numbers for the CNA Program, and we have had success in getting them to take positions in other departments while being paid to learn.

Completion Date: July 14, 2023, Ongoing.

F812: Food Procurement, Store/Prepare/Serve-Sanitary

*No residents were impacted by this deficiency.

*All residents had the potential to be impacted by this deficiency.

*Outside cleaning company, ServPro, contracted to deep clean entire kitchen area. SJR Facilities Management will perform any repairs discovered during this project.

*Administrator will conduct monthly inspections with Facility Director to determine the need to have ServPro return. This will occur for a minimum of three consecutive deficient inspections occur.

Completion Date: July 31, 2023

*SJR will initiate a media initiative to recruit new hires and assign interviews to the HR Director & CNA Tutor to assist in procuring new hires & retention.

Completion Date: July 14, 2023

CML Services Inc dba SERVPRO of Portland and South Portland

CML Services Inc dba SERVPRO of Portland and South Portland
9 Hutcherson Dr.
Gorham, ME 04038
Office: 207-772-5032
Office@SERVPROPortland.me
TIN: 200504442

Insured:	Saint Joseph's Rehabilitation Center	Home:	(207) 632-1902
Property:	1133 Washington Ave Portland, ME 04101	E-mail:	cdoustou@sjrme.org
Estimator:	Chandler Brooks	Business:	(207) 650-6331
Business:	9 Hutcherson Dr Gorham, ME 04038	E-mail:	chandler@servproportland.me

Claim Number: **Policy Number:** **Type of Loss:**

Coverage	Deductible	Policy Limit
Dwelling	$0.00	$0.00
Other Structures	$0.00	$0.00
Contents	$0.00	$0.00

Date of Loss:		Date Received:	
Date Inspected:		Date Entered:	6/30/2023 11:26 AM

Price List:	MEPO8X_JUN23 Restoration/Service/Remodel	Depreciate Material:	Yes	Depreciate O&P:	No
		Depreciate Non-material:	Yes	Depreciate Taxes:	Yes
Estimate:	SAINT_JOSEPHS_REHAB	Depreciate Removal:	No		

CML Services Inc dba SERVPRO of Portland and South Portland

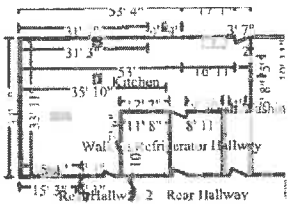
CML Services Inc dba SERVPRO of Portland and South Portland
9 Hutcherson Dr.
Gorham, ME 04038
Office: 207-772-5032
Office@SERVPROPortland.me
TIN: 200504442

SAINT_JOSEPHS_REHAB

1st Floor

General Provisions

CAT	SEL / CALC	QTY	ACT DESCRIPTION	REMOVE	REPLACE	TAX	TOTAL
21. HMR	PPEG6		+ Personal protective gloves - Disposable (per pair)				
	28	28.00 EA		0.00+	0.34 =	0.00	9.52
Totals: General Provisions						**0.00**	**9.52**



Kitchen

Height: 9' 9"

1571.60 SF Walls	1414.15 SF Ceiling
2985.74 SF Walls & Ceiling	1414.15 SF Floor
157.13 SY Flooring	160.17 LF Floor Perimeter
181.33 LF Ceil. Perimeter	

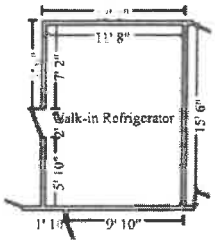
Door	**2' 6" X 6' 7"**	**Opens into REAR_HALLWAY**
Door	**2' 6" X 6' 7"**	**Opens into WALKIN_REFR**
Door	**3' 7" X 6' 7"**	**Opens into Exterior**
Missing Wall - Goes to Floor	**4' X 6' 8"**	**Opens into HALLWAY**
Missing Wall - Goes to Floor	**5' X 6' 8"**	**Opens into DISH_WASHING**
Window	**5' 8" X 3' 7"**	**Opens into DISH_WASHING**
Window	**4' X 4' 6"**	**Opens into Exterior**
Window	**4' X 4' 6"**	**Opens into Exterior**
Door	**3' 7" X 6' 7"**	**Opens into Exterior**

CAT	SEL / CALC	QTY	ACT DESCRIPTION	REMOVE	REPLACE	TAX	TOTAL
3. CLN	AV+		+ Clean more than the walls - Heavy				
	W+F	2985.74 SF		0.00+	0.57 =	0.00	1,701.87
11. HMR	HEPAVAS		+ HEPA Vacuuming - Detailed - (PER SF)				
	C	1414.15 SF		0.00+	0.97 =	0.00	1,371.73
18. CLN	HDC+		+ Clean range hood - Commercial - Heavy				
	2	2.00 EA		0.00+	39.95 =	0.00	79.90

CML Services Inc dba SERVPRO of Portland and South Portland
9 Hutcherson Dr.
Gorham, ME 04038
Office: 207-772-5032
Office@SERVPROPortland.me
TIN: 200504442

CONTINUED - Kitchen

CAT	SEL CALC	ACT DESCRIPTION QTY	REMOVE	REPLACE	TAX	TOTAL
19. CLN	LAB	+ Cleaning Technician - per hour				
	6*4	24.00 HR	0.00+	52.95 =	0.00	1,270.80
20. LAB	LBR	+ General Laborer - per hour				
	4*7	28.00 HR	0.00+	49.75 =	0.00	1,393.00
Time to work on ladders to wipe down the walls and vacuum the ceilings						
Totals: Kitchen					**0.00**	**5,817.30**



Walk-in Refrigerator **Height: 8'**

418.21 SF Walls	180.83 SF Ceiling
599.04 SF Walls & Ceiling	180.83 SF Floor
20.09 SY Flooring	51.83 LF Floor Perimeter
54.33 LF Ceil. Perimeter	

Door **2' 6" X 6' 7"** **Opens into KITCHEN**

CAT	SEL CALC	ACT DESCRIPTION QTY	REMOVE	REPLACE	TAX	TOTAL
5. CLN	AV+	+ Clean more than the walls - Heavy				
	W+F	599.04 SF	0.00+	0.57 =	0.00	341.45
13. HMR	HEPAVAS	+ HEPA Vacuuming - Detailed - (PER SF)				
	C	180.83 SF	0.00+	0.97	0.00	175.41
Totals: Walk-in Refrigerator					**0.00**	**516.86**

CML Services Inc dba SERVPRO of Portland and South Portland
9 Hutcherson Dr.
Gorham, ME 04038
Office: 207-772-5032
Office@SERVPROPortland.me
TIN: 200504442

Hallway **Height: 9' 9"**

327.03 SF Walls	102.04 SF Ceiling
429.08 SF Walls & Ceiling	102.04 SF Floor
11.34 SY Flooring	28.58 LF Floor Perimeter
44.17 LF Ceil. Perimeter	

Missing Wall - Goes to Floor	**8' X 6' 8"**	**Opens into DISH_WASHING**
Missing Wall - Goes to Floor	**4' X 6' 8"**	**Opens into KITCHEN**
Door	**3' 7" X 6' 7"**	**Opens into REAR_HALLWA1**

CAT	SEL / CALC	ACT DESCRIPTION / QTY	REMOVE	REPLACE	TAX	TOTAL
7. CLN	AV+	+ Clean more than the walls - Heavy				
	W+F	429.08 SF	0.00=	0.57 =	0.00	244.58
14. HMR	HEPAVAS	+ HEPA Vacuuming - Detailed - (PER SF)				
	C	102.04 SF	0.00+	0.97 =	0.00	98.98
Totals: Hallway					**0.00**	**343.56**

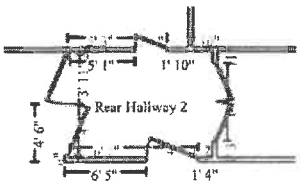
Dish Washing Station **Height: 7' 9"**

596.99 SF Walls	390.04 SF Ceiling
987.03 SF Walls & Ceiling	390.04 SF Floor
43.34 SY Flooring	77.83 LF Floor Perimeter
90.83 LF Ceil. Perimeter	

Missing Wall - Goes to Floor	**5' X 6' 8"**	**Opens into KITCHEN**
Window	**5' 8" X 3' 7"**	**Opens into KITCHEN**
Missing Wall - Goes to Floor	**8' X 6' 8"**	**Opens into HALLWAY**

CAT	SEL / CALC	ACT DESCRIPTION / QTY	REMOVE	REPLACE	TAX	TOTAL
8. CLN	AV+	+ Clean more than the walls - Heavy				
	W+F	987.03 SF	0.00+	0.57 =	0.00	562.61
15. HMR	HEPAVAS	+ HEPA Vacuuming - Detailed - (PER SF)				
	C	390.04 SF	0.00+	0.97 =	0.00	378.34
Totals: Dish Washing Station					**0.00**	**940.95**

CML Services Inc dba SERVPRO of Portland and South Portland
9 Hutcherson Dr.
Gorham, ME 04038
Office: 207-772-5032
Office@SERVPROPortland.me
TIN: 200504442

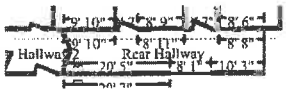


Rear Hallway 2 **Height: 7' 9"**

167.29 SF Walls	92.81 SF Ceiling
260.10 SF Walls & Ceiling	92.81 SF Floor
10.31 SY Flooring	18.50 LF Floor Perimeter
39.00 LF Ceil. Perimeter	

Door	**4' X 6' 7"**	**Opens into Exterior**
Door	**6' 1" X 6' 7"**	**Opens into REAR_HALLWA1**
Door	**2' 6" X 6' 7"**	**Opens into KITCHEN**
Door	**4' X 6' 7"**	**Opens into Exterior**
Door	**3' 11" X 6' 7"**	**Opens into Exterior**

CAT	SEL CALC	ACT DESCRIPTION QTY	REMOVE	REPLACE	TAX	TOTAL
9. CLN	AV+	+ Clean more than the walls - Heavy				
	W+F	260.10 SF	0.00+	0.57 =	0.00	148.26
16. HMR	HEPAVAS	+ HEPA Vacuuming - Detailed - (PER SF)				
	C	92.81 SF	0.00+	0.97 =	0.00	90.03
Totals: Rear Hallway 2					**0.00**	**238.29**



Rear Hallway **Height: 7' 9"**

530.85 SF Walls	319.69 SF Ceiling
850.54 SF Walls & Ceiling	319.69 SF Floor
35.52 SY Flooring	72.50 LF Floor Perimeter
85.75 LF Ceil. Perimeter	

Missing Wall	**8' 3" X 7' 9"**	**Opens into Exterior**
Door	**3' 7" X 6' 7"**	**Opens into HALLWAY**
Door	**3' 7" X 6' 7"**	**Opens into Exterior**
Door	**6' 1" X 6' 7"**	**Opens into REAR_HALLWAY**
Window	**8' 1" X 5' 9"**	**Opens into Exterior**

CAT	SEL CALC	ACT DESCRIPTION QTY	REMOVE	REPLACE	TAX	TOTAL

CML Services Inc dba SERVPRO of Portland and South Portland
9 Hutcherson Dr.
Gorham, ME 04038
Office: 207-772-5032
Office@SERVPROPortland.me
TIN: 200504442

CONTINUED - Rear Hallway

CAT	SEL CALC	ACT QTY	DESCRIPTION	REMOVE	REPLACE	TAX	TOTAL
10. CLN	AV+		+ Clean more than the walls - Heavy				
	W+F	850.54 SF		0.00+	0.57 =	0.00	484.81
17. HMR	HEPAVAS		+ HEPA Vacuuming - Detailed - (PER SF)				
	C	319.69 SF		0.00+	0.97 =	0.00	310.10
Totals: Rear Hallway						**0.00**	**794.91**
Total: 1st Floor						**0.00**	**8,661.39**
Line Item Totals: SAINT_JOSEPHS_REHAB						**0.00**	**8,661.39**

Grand Total Areas:

3,611.97	SF Walls	2,499.56	SF Ceiling	6,111.53	SF Walls and Ceiling
2,499.56	SF Floor	277.73	SY Flooring	409.42	LF Floor Perimeter
0.00	SF Long Wall	0.00	SF Short Wall	495.42	LF Ceil. Perimeter
2,499.56	Floor Area	2,628.28	Total Area	3,611.97	Interior Wall Area
2,442.53	Exterior Wall Area	281.50	Exterior Perimeter of Walls		
0.00	Surface Area	0.00	Number of Squares	0.00	Total Perimeter Length
0.00	Total Ridge Length	0.00	Total Hip Length		

CML Services Inc dba SERVPRO of Portland and South Portland

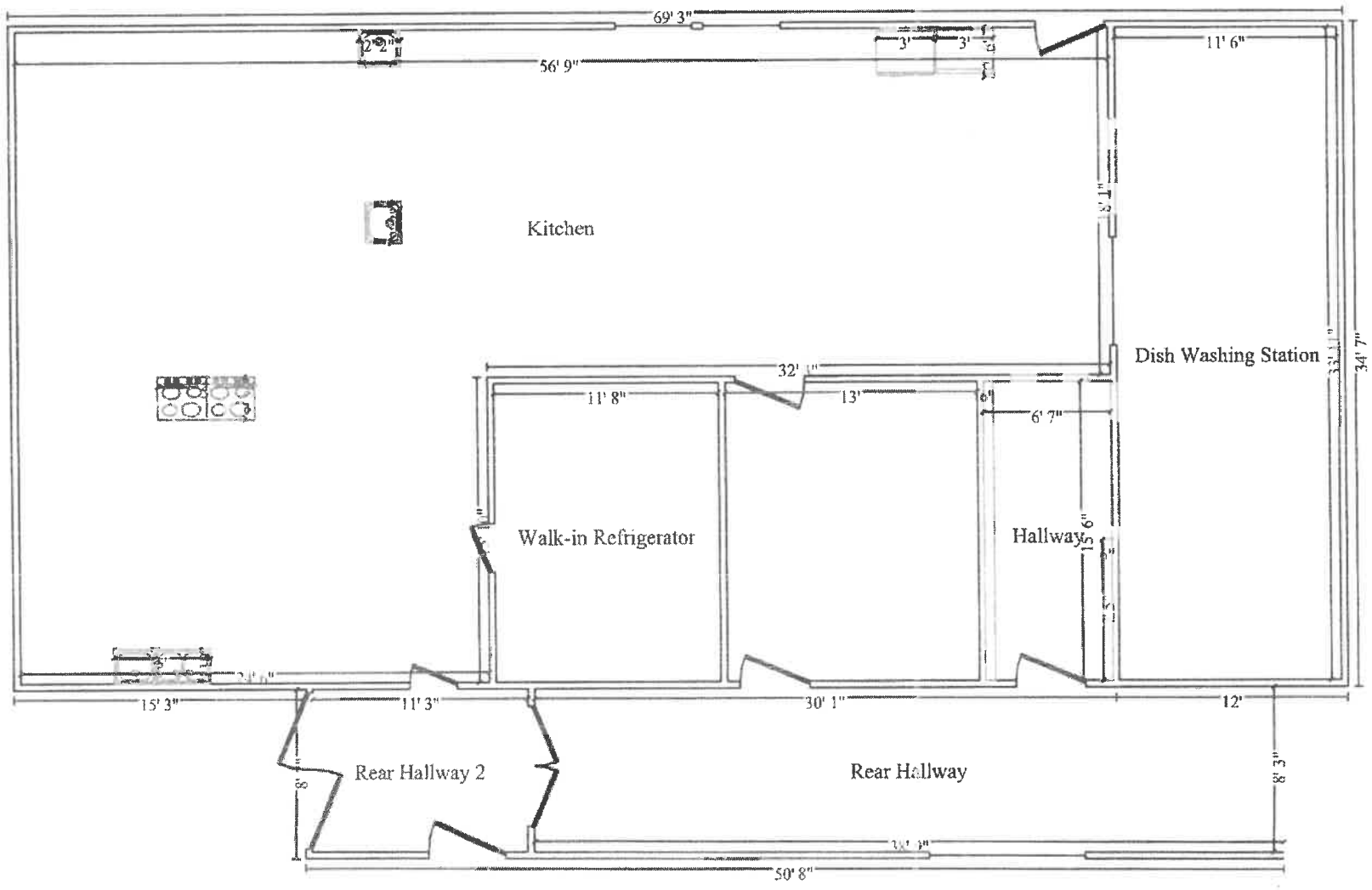
CML Services Inc dba SERVPRO of Portland and South Portland
9 Hutcherson Dr.
Gorham, ME 04038
Office: 207-772-5032
Office@SERVPROPortland.me
TIN: 200504442

Summary for Dwelling

Line Item Total	8,661.39
Replacement Cost Value	**$8,661.39**
Net Claim	**$8,661.39**

Chandler Brooks

7/3/23


69' 3"
56' 9"
11' 6"
Kitchen
Dish Washing Station
32' 1"
11' 8"
13'
6' 7"
Walk-in Refrigerator
Hallway
15' 6"
34' 7"
15' 3"
11' 3"
30' 1"
12'
Rear Hallway 2
Rear Hallway
8' 3"
50' 8"
N

1st Floor