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ST JOSEPH'S REHABILITATION AND RESIDENCE	**1133 WASHINGTON AVE PORTLAND, ME 04103**

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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

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F 584	Continued From page 1 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to maintain a safe, clean, comfortable, and homelike environment on 1 of 4 units (Unit D), for 2 of 4 days of survey. 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 bed	F 584		

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F 584	Continued From page 2 pan 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. On 6/13/23 at 10:21 a.m., during an environmental tour, the surveyor and the Registered Nurse Unit Manager observed the above concerns in resident's rooms and shared bathrooms.	F 584		
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-	F 655		

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F 655	Continued From page 3 (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: (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 interview and record review, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours that included the instructions needed to provide	F 655		

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F 655	Continued From page 4 minimum healthcare information necessary to properly care for 1 of 9 new admission residents (#136). Finding: Resident #136 was admitted to the facility on 5/16/23 with a primary diagnosis of: Infection of right hip joint prosthesis with a newly placed Peripherally Inserted Central Catheter (PICC) line requiring Intravenous antibiotic treatment, a right hip surgical incision with precautions for weight bearing and positioning and receiving an anticoagulant medication. 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. On 6/15/23 at approx. 3:00 p.m., during exit interview, a surveyor discussed this finding with the Director of Nursing.	F 655		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		

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F 684	Continued From page 5	F 684		

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:
Based on record review, and interview the facility failed to ensure weights were obtained and monitored as per the facilities policy and residents care plan for 1 of 6 residents reviewed for nutrition (#134) and failed to provided passive range of motion (PROM) for 1 of 1 resident reviewed for mobility (#100).

Findings:

Facilities Policy interpretation and implementation: Weight Assessment and Intervention, effective 9/2017 #1 states, "The nursing staff will measure residents weight on admission and weekly for four weeks thereafter (monthly for duration of skilled stay, if not otherwise noted per provider's orders). If no weight concerns are noted at this point, weight will be measured monthly thereafter."

1. 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."

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F 684	Continued From page 6 On 6/14/23 at 1:02 p.m., during an interview with Unit D Registered Nurse (RN) manager, she stated weights are obtained upon admission and then monthly unless otherwise specified. At this time the RN could not find any additional weights and confirmed the weights were obtained as they should've been. On 6/14/23 at 1:24 p.m., during an interview with the Director of Nursing (DON), she stated weights are obtained upon admission, then weekly for 4 weeks, then monthly unless otherwise ordered differently. At this time, the DON confirmed resident #134 only had 2 documented weights and he/she should've had weekly and then monthly weights. 2. On 6/12/23 at 8:06 a.m., in an interview with a surveyor, Resident #100 stated she had been receiving passive range of motion (ROM) daily, but "then a couple weeks ago, the CNA (Certified Nursing Assistant) who provided it stopped coming and I don't know why." A review of Resident #100's clinical record noted he/she was admitted to the facility on 12/10/21. Diagnoses included Diabetes with neuropathy and osteoarthritis. A review of the Annual Minimum Data Set (MDS) 3.0, completed on 3/26/23, Section C, Cognitive Patterns, revealed the results of the Brief Interview for Mental Status (BIMS) score was 14, indicating Resident #100 was cognitively intact.	F 684		

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F 684	Continued From page 7 The care plan, last revised on 4/10/23, noted a focus area which stated Resident #100 "has impaired range of motion related to impaired mobility and obesity. Interventions included, "Provide extensive assist for active range of motion exercise." A provider note, dated 5/23/23, stated Resident #100 "does not get out of bed. He/she has been working with the restorative program, who is with the patient just prior to my visit, working on passive lower extremity ROM." A review of CNA documentation failed to locate evidence of CNA's provision of ROM for Resident 100. On 6/13/23 at 3:00 p.m., in an interview with a surveyor, the Director of Nursing (DON)stated the facility's electronic medical record did not include ROM provided by staff and that the ROM team had limited going onto units with cases of COVID-19 during the past 2 weeks. On 6/13/23 at 3:48 p.m., in another interview with a surveyor, the DON stated that one of the unit CNAs could have provided ROM as it is part of the resident's care plan. In addition, the DON stated she would work to correct the inability for CNA staff to document ROM provided in the electronic medical record.	F 684		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the	F 698		

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F 698	Continued From page 8 comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the clinical record contained information necessary to meet the professional standards of practice for 1 of 1 residents reviewed for dialysis (#26). Findings: On 6/12/23 at 10:24 a.m., in an interview with a surveyor, Resident #26 stated he/she went to dialysis on Tuesdays, Thursdays and Saturdays. Resident #26 stated he/she was on a "little bit" of a fluid restriction and showed the surveyor his vascular access site: a double lumen central line catheter located at the right chest with a transparent dressing over the insertion site. A review of Resident #26's clinical record revealed diagnoses which included, Congestive Heart Failure, Diabetes Mellitis, and Chronic Kidney Disease, Stage 4. 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 698		

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F 698	Continued From page 9 A review of Resident #26's medication and treatment administration record for the month of June, 2023, lacked evidence that staff were monitoring the vascular access site. On 6/14/23 at 2:00 p.m., in an interview with the nurse manager of the B unit, the surveyor discussed that Resident #26's orders did not include an order for dialysis, monitoring of the vascular access site, or the current fluid restriction amount. The nurse manager reviewed Resident #26's provider orders and confirmed an order for dialysis and monitoring of the vascular access site had been omitted. Additionally, the nurse manager confirmed that an order from 5/1/23 to change fluid restrictions from 2 liters to 1.5 liters per day had not been implemented.	F 698		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for	F 761		

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storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on record review, observation and interview, the facility failed to adequately date, properly dispose of open biologicals according to manufacturer specifications for 5 of 6 medication/treatment carts observed and failed to ensure that medications were stored properly by having an unlocked, unattended medication cart allowing residents and unauthorized persons access to medications, on 1 of 4 days of survey. (Unit B)

Findings:

Storage of Medications, policy and procedure reviewed on 10/2022, instructs nursing staff of: "The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed" and "Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used in transport to transport such items shall not be left unattended if opened or otherwise potentially available to others."
Administering medications, policy and procedure reviewed on 10/2022, instructs nursing staff of: "Medications are prepared for one resident at a time; the practice of "pre pouring" medications is

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not accepted" and "If the drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall be documented in the EHR/MAR, and include rationale for medication not administered for that drug and dose."

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".

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F 761	Continued From page 12 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". On 6/13/23 at 3:23 p.m., during an interview, the above concerns were discussed with the Director of Nursing. 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		
F 802 SS=D	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity	F 802		

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and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

§483.60(a)(3) Support staff.
The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.

§483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii).
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews and record review, the facility failed to provide adequate competent dietary staff to be able to accomplish basic tasks of the Kitchen and are serving the residents with plastic cutlery and paper/plastic dishware.

Findings:
On 6/13/23 07:51 a.m., observed breakfast pass on Unit C. All residents were served with disposable dishes and utensils.

On 6/13/23 at approximately 1:00 p.m. during an interview with Food Service Manager, she stated that the facility went from a census of 98 to 150 with no increase in dietary support staff. She stated that she is very short staffed. She stated that in the past they have used Clip Board temporary staffing but the facility's account is currently "On hold".

On 6/14/23, at 8:20 a.m. during an interview with the Food Service Manager, when asked why the

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 802	Continued From page 14 facility was serving residents with disposable plates and utensils she said, "Because I do not have the staff to run all the dishes through the machine. With only 2 staff members at times, I do not have enough help to cook, do the tray line, deliver the food and wash all the dishes for approximately 150 residents." On 6/14/23, at 8;20 a.m. in an interview with the Food Service Manager, the surveyor confirmed the lack of sufficient dietary support staff.	F 802		
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 observation and interview, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for 2 of 2 kitchen tour	F 812		

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F 812	Continued From page 15 observations. Findings: 1- On 6/12/23 at 6:15 a.m. during the initial kitchen tour, a surveyor observed four ceiling light covers with heavy amounts of dirt, debris, and dead insects. In addition, two ceiling tiles with deep gouges were observed and a general observation of dirt & debris on the high areas of the walls and ceiling. On 6/12/23 at 6:15 a.m., the surveyor confirmed the above observations with the morning cook. 2- On 6/14/23, at 7:45 a.m. during a return tour of the kitchen, observed in the dish room, on the floor under and behind the dish machine, a large amount of food and dirt debris. In an interview with the Dietary Manager regarding the cleaning schedule of the high areas, she stated that the facility's managment does that [cleaning], and could not provide any date/time when it was last completed. On 6/14/23, at 7:45 a.m., the surveyor confirmed the dish room floor and under the dish machine had a large amount of food and dirt debris, in an interview with the Food Service Manager.	F 812		