STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205095	A. BUILDING ______ B. WING ______	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENNEBUNK CENTER FOR HEALTH & REHABILITATION, LLC	158 ROSS RD KENNEBUNK, ME 04043

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F 000	INITIAL COMMENTS From 1/13/25 through 1/16/25, on-site visits were conducted at Kennebunk Center for Health & Rehabilitation, Llc. for the purpose of a Recertification Survey and investigating complaints #ME00045973, #ME00046879, #ME00047094, #ME00047182, #ME00048498, #ME00048888, and #ME00049455. It was determined that Kennebunk Center for Health & Rehabilitation, Llc. was not in substantial compliance with 42 CFR 483, Sub-part B Requirements for Long Term Care Facilities.	F 000		
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. §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.	F 561	• Resident # 234 has been discharged from facility • All residents have the potential to be affected by this practice. • SDC/designee will educate facility staff on resident rights pertaining to making their own choice in the clothing they wear. • The Unit manager/designee will complete weekly random audits x 2 months of resident rights to make their own choices in the clothing they wear. The results of these audits will be reviewed with the QAPI committee monthly to ensure compliance is maintained. The DNS is responsible for compliance.	2/20/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Beth Neil | TITLE: Administrator | (X6) DATE: 2/4/2025

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 561	Continued From page 1 §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 interviews and record reviews, the facility failed to ensure that a resident's choice in the area of clothing were followed for 1 of 9 sampled residents (Resident #234). Findings: On 4/18/24 the Department of Licensing and Certification (DLC) received a referral from Adult Protective Services (APS) of an incident that occurred on 4/12/24 around 11:00 p.m. where a tooth became cracked during the removal of a sweater. A surveyor reviewed the facility incident report dated and learned that on the night of 4/12/24, two staff members were getting Resident #234 ready for bed and tried to remove his/her sweater. Resident #234 reportedly told the staff she/he did not want to remove the sweater and bit down on the neck of the sweater to prevent removal. The sweater was removed anyway and Resident #234's tooth broke during the removal. On 1/15/25 at 2:10 p.m. a surveyor spoke with the Director of Nursing about the incident and confirmed that the residents' right to keep the sweater on was not respected despite the resident clearly expressing he/she did not want the sweater removed.	F 561		
F 578 SS=B	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir	F 578		

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F 578	Continued From page 2 CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.	F 578	• Residents # 8, # 3, # 35, # 17 and # 64 have had advanced directives offered. Resident # 18, #19, # 37, # 226 and # 230 have been discharged from the facility. • A house audit was completed by DSS/ designee on advanced directives to ensure that residents were offered advanced directive and provided information on how to formulate an advanced directive. • The Administrator /designee has educated the social service staff, business office mgr, director of admissions and nursing leadership, on the advanced directives regulation and facility process. (residents or representatives were offered and provided information concerning the right to formulate and advanced directive. • The administrator/designee will complete random weekly audits that advanced directives were offered and provided information on how to formulate x 60 days. The results of these audits will be reviewed with the QAPI committee to ensure compliance is maintained. The administrator is responsible for compliance.	2/20/2025

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F 578	Continued From page 3	F 578		

Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on record reviews, and interviews, the facility failed to provide evidence to show Advance Directives were offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an Advance Directive, for 11 of 14 residents reviewed for Advance Directive. (Resident #8, #3, #35, #17, #18, #19, #37, #64, #226 and #230)

Findings:

1. Resident #8 was admitted to the facility on 7/6/20. A review of the electronic medical record and the paper medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive.

On 1/14/25 at 7:19 a.m., during an interview with the Administrator, the above was confirmed.
2. Resident #18 was admitted to the facility on 10/21/24. A review of the electronic medical record and the paper medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive.

3. Resident #19 was admitted to the facility on

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F 578	Continued From page 4 12/17/24. A review of the electronic medical record and the paper medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. 4. Resident #64 was admitted to the facility on 11/21/24. A review of the electronic medical record and the paper medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. 5. Resident #226 was admitted to the facility on 1/7/25. A review of the electronic medical record and the paper medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. 6. Resident #230 was admitted to the facility on 11/16/24. A review of the electronic medical record and the paper medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. On 01/14/25 at 12:04 p.m. a surveyor met with the facility social worker who confirmed the requirements for Advance Directives are not being met. She/he said they will ask upon	F 578		

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F 578	Continued From page 5 admission but not always document or follow-up. On 1/14/25 at 12:48 p.m. a surveyor discussed concerns with the Director of Nursing who said that if we can't find them in the chart, they don't exist. Stated they placed calls to families for missing documentation yesterday. 7. Resident #3 was admitted to the facility on 11/24/21. A review of the residents electronic medical record and their paper medical record lacked evidence that the facility offered, reviewed, or provided written information concerning the right to formulate an advanced directive to the resident and/or resident representative. 8. Resident #35 was admitted to the facility on 9/18/23. A review of the residents electronic medical record and their paper medical record lacked evidence that the facility offered, reviewed, or provided written information concerning the right to formulate an advanced directive to the resident and/or resident representative. 9. Resident #17 was admitted to the facility on 7/15/24. A review of the residents electronic medical record and their paper medical record lacked evidence that the facility offered, reviewed, or provided written information concerning the right to formulate an advanced directive to the resident and/or resident representative.	F 578		
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	F 584		

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F 584	Continued From page 6 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 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	F 584	- All Residents could be impacted - Room 2 and 4 caulking to be replaced - Room 7 and 9 commode buckets removed, stained flooring will be cleanred to standard or replaced, stained toilet will be cleaned to standard or replaced, toilet caulking will be replaced. - Room 8 and 10 stored gray basin removed. - Laundry Room dust/debris, fans, heater, walls, air vents on clean linen side have been cleaned to standard on Clean Side. Sink, Eyewash Station, windows, pipes and walls have all been cleaned to standard on Dirty Side. - Room 1 back of toilet area cleaned, Room 6 wall fan has been cleaned, Room 8 Heating Unit has been cleaned, Room 14 Bathroom chipped floor tile to be replaced and pink basin removed, Room 21 pink basin has been removed. - Room 17 , 18, 19 and 20 gray basins has been removed from Bathroom area. - DNS/Maintenance Director or designee wil l educate facility staff on proper storage of wash basins. - The DNS/Maintenance Director or designee will complete weekly random audits x 2 months of improperly stored wash basins, cleanliness in Laundry Room and bathroom caulking to ensure standards are met. The results of these audits will be reviewed with the QAPI committee monthly to ensure compliance is maintained. The DNS and Maintenance Director is responsible for compliance.	2/20/2025

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F 584	Continued From page 7 maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable environment on 4 of 4 units (Windermere, Eagle, Sagamore and Regena, and Laundry Room) for 1 of 4 days of survey. Findings: Sagamore unit: On 1/14/25 at 8:09 a.m., observation of the shared bathroom for Room 2 and 4 with a black substance around the base of the toilet and the caulking strip peeled up. On 1/13/25 at 11:32 a.m., and on 1/14/25 at 8:11 a.m., observations of the shared bathroom for Room 7 and 9 with a commode bucket stored on the floor, a large brown circular stain on the floor to the left of the toilet, a brownish tan substance around the base of the toilet and the caulking strip peeled up. On 1/13/25 at 10:29 a.m., observation of the shared bathroom for Room 8 and 10 with a gray basin stored on floor and leaning against the wall. On 1/16/25 at 3:16 p.m., the above was discussed with the Administer. Laundry Room: On 1/15/25 at 08:50 a.m. 2 surveyors observed dust and debris on the 2 fans, a heater on the wall, and 3 air vents on the clean linen side. Above the laundry folding table there was dust and debris on the pipes. On the dirty linen side, the sink was heavily stained and soiled including the eye wash station. The window is covered in dust and cobwebs.	F 584		

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F 584	Continued From page 8 Behind the hot water tank there were multiple areas of dust and cobwebs. The pipes throughout were covered in dust/debris. On 1/16/25 at 10:00 a.m. During a tour of the physical environment the following concerns were observed: Room 1 - Bathroom - Heavy staining around and in back of the toilet Room 6 - Wall fan dusty Room 8 - Heating Unit stained Room 14 - Entry into Bathroom, floor tile chipped Pink basin in the floor Room 21 - Pink Basin on the floor On 1/13/25 at 10:59 a.m. and on 1/14/24 at 12:00 p.m., observation of a shared bathroom for Room 17 with a gray basin stored on floor under the sink. On 1/13/25 at 10:30 a.m. and on 1/14/25 at 12:23 p.m., observation of the shared bathroom for Room 18 with a gray basin stored on the floor to the side of the toilet. On 1/13/25 at 10:48 a.m. and on 1/14/25 at 12:00 p.m., observation of the shared bathroom for Room 19 with 2 gray basins stored on floor under the sink. On 1/13/25 at 10:12 a.m. and on 1/14/25 at 12:22 p.m., observation of the shared bathroom for Room 20 with a gray basin stored under the sink.	F 584		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677		

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F 677	Continued From page 9 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to provide Activities of Daily Living (ADL) care for 6 of 6 resident reviewed for ADL's (Resident #126, #6, #19, #64, #226 and #230). In addition, the facility failed to follow the care plan in the area of oral hygiene for 1 of 1 reviewed. (Resident #6). Findings: The facilities ADL Policy and Procedure issued 6/23 states, "Purpose: To provide the level of care required by each individual resident" and "Procedure: Staff provide assistance to complete ADL activities per their person centered evaluation and care plan. These activities are broken down into eight areas. #1.Bathing/showering ... #8 Personal hygiene and grooming." 1. On 4/10/24 the Division of Licensing and Certification received a complaint that Resident #126 did not receive appropriate care with his/her Activities of Daily Living (ADL). He/she was found wearing the hospital jonnie a day after admission and for the 2 weeks Resident #126 was at the facility, his/her underwear were only changed twice, and he/she had the same socks on for 3 days in a row. Resident #126 was admitted on 3/8/24 for skilled services following a Chronic Obstructive Pulmonary Disease acute exacerbation. The care plan for "ADL self-care performance deficit" instructed nursing to provide bathing/showering,	F 677	• Resident #6 and Resident#64 are receiving their person centered ADLs and staff documented in PCC . Residents # 19, #226, # 230 have been discharged from facility • Unit Managers/designee House audit of ADL's bathing/showers, oral care, personal hygiene and grooming observation and documentation to ensure no other residents are affected by this practice • The SDC/designee will educate the C.N.A and license staff on the ADL policy/procedure • The SDC/ designee will complete random daily (mon-fri) audits x 2 months then weekly x 1 month of ADLs and documentation in EMR. The results of these audits will be reviewed with the QAPI committee monthly x 3 months to ensure compliance is maintained The DNS is responsible for compliance.	2/20/2025

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F 677	Continued From page 10	F 677		

dressing and toilet use with extensive assist by 1 staff and bed mobility, transfers and personal hygiene/oral care with limited assistance by 1 staff.

Review of Resident #126's Certified Nurses Aid (CNA) documentation for March 2024 lacked evidence of Activities of Daily Living which included bathing, dressing, oral hygiene, bladder and bowel elimination, bed mobility and transfers being provided on 3/8/24 both 3pm-11pm and 11pm-7am shifts and both 3/9/24 and 3/10/24 for the 3pm-11pm shifts.

On 1/16/25 at 2:22 p.m., the above was discussed with the Director of Nursing who confirmed the lack of ADL documentation could not suggest Resident #126 received the appropriate ADL care.

2. On 1/13/25 at 10:31 a.m., observation of Resident #6, sitting upright in bed, his/her teeth were coated with a thick white/yellow debris at the gum line. In a brief interview, Resident #6 stated, staff help him/her with brushing his/her teeth.

On 1/14/25 at 8:16 a.m. and at 11:56 a.m., observation of Resident #6 sitting upright in bed, his/her teeth were coated with a thick whitish/yellow/brown in color debris at the gum line. At this time, the resident was asked again if staff help him/her with brushing his/her teeth. He/she stated, "yes". He/she was asked when the last time his/her teeth were brushed, the resident answered, "I don't know"

On 1/16/25 at 8:36 a.m., observation of Resident #6 sitting up in bed, his/her hair is combed back into a ponytail, his/her teeth were thickly coated

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F 677	Continued From page 11 with whitish/yellow/ brown debris at the gum line. Review of Resident #6's care plan stated "Resident has oral/dental health problems Poor nutrition, Poor oral hygiene" dated 5/17/23. Instructs nursing to "Monitor/document/report PRN any s/sx of oral/dental problems needing attention: Pain (gums, toothache, palate), Abscess, Debris in mouth, Lips cracked or bleeding, Teeth missing, loose, broken, eroded, decayed, Tongue (black, coated, inflamed, white, smooth), Ulcers in mouth, Lesions" and "Provide mouth care as per ADL personal hygiene." Review of the Certified Nursing Aid (CNA) documentation from 1/3/25 through 1/15/25 for "ORAL HYGIENE: The ability to use suitable items to clean teeth ..." Each day had documented oral care was completed. On 1/13/25 oral care was documented as completed with "substantial /Max Assist: Helper does more than half the effort". On 1/14/25 oral care was documented as completed twice, with one "Set-up or clean-up. Helper sets up or cleans up only" and one with "Dependent: Helper does all the effort". On 1/15/25 oral care was documented as completed with "Supervision/touch assist: Helper gives verbal cues or touch assist." On 1/16/25 at 9:27 a.m., both the surveyor and the Director of Nursing (DON) observed Resident #6's teeth. The DON asked the resident if he/she would like help brushing his/her teeth, stating it looked like he/she needed his/her teeth brushed, the resident stated "yes". 3. On 1/13/25 at 9:20 a.m., a surveyor interviewed Resident #230 and learned that she/he was hoping to get a shower today because the CNAs couldn't do it yesterday, which	F 677		

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	205095	A. BUILDING ____ B. WING ____	01/16/2025

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F 677	Continued From page 12 is his/her regular bathing day. A review of Resident #230 Electronic Medical Record (EMR) showed their last documented shower was on 12/17/24 but no other documentation of showers, baths or refusals. On 1/13/25 at 9:30 a.m. a surveyor interviewed Resident #64 who was admitted to the facility on 11/21/24. Resident #64 stated that he/she had refused most of his/her showers due to illness. A review of Resident #64's EMR showed no bathing documentation until 12/17/24, which was a refusal. A shower was documented on 12/24/24 and then no other bathing documentation. On 1/14/25 at 1:34 p.m., a surveyor interviewed Resident #226 and learned they do not get regular weekly showers or baths. A review of Resident #226's EMR showed no documentation of showers, baths or refusals since admission. On 1/14/25 at 1:45 p.m. A surveyor interviewed Resident #19 and learned they have not had a shower or a bath since admission on 12/17/24. She/he would very much like to have a shower, but the CNAs told him/her it takes too long because they have to wrap their arm and leg. A review of Resident #19's Electronic Medical Record failed to show any documentation of showers, baths or refusals. On 1/14/25 at 2:30 p.m. a surveyor met with the Director of Nursing (DON) and learned that CNAs are expected to document showers or baths in the EMR and if there is a refusal, they tell the nurse, and a progress note would document the refusal. A surveyor discussed the above findings with the DON.	F 677		

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F 684	Continued From page 13	F 684		
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: Based on facility policy, record review and interviews, the facility failed to adequately evaluate a resident after an unwitnessed fall and complete neurological assessments as per facility policy for 1 of 2 residents reviewed for falls (Resident #125). Findings: The facilities "Fall Prevention Program", last revised 3/23 states, "If a fall occurs ... Monitor resident's status for 72 hours. Some injuries may not be apparent immediately after the fall." The facilities "Neurological Evaluation Policy, revised 4/23 states, "The licensed nurse performs neurological evaluations whenever there is a possibility of a head injury, change in mentation, or an unwitnessed fall" "Purpose: Accurate evaluation and monitoring of changes in residence neurological status to allow prompt medical notification treatment" "Procedure: The neuro care flow sheet includes vital signs temperature, pulse, respirations, and blood pressure and information regarding pupil	F 684	• Neurological assessments are being completed per facility policy/procedure • All residents have the potential to be affected by this practice • The SDC/ designee will educate all license nurses on policy/procedure of falls pertaining to (neurological evaluations procedure post fall unwitnessed and when resident sustains a head injury) • The DNS/designee will complete daily Monday -Friday random audits x 3 months of residents that sustain a fall and meet requirement for neurological evaluations for completion. The results of these audits will be reviewed with the QAPI committee monthly to ensure compliance is maintained. The DNS is responsible for compliance.	2/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 684	Continued From page 14	F 684		

reaction of both eyes, level of consciousness, motor function, speech, facial symmetry, and headache ...
#2. Any resident, who has had an unwitnessed or witnessed fall and is on an anticoagulant/antiplatelet therapy, will have an initial neurological evaluation by the Licensed Nurse or Registered Nurse per state regulation followed by neurological monitoring per policy"
#3. "After the initial evaluation, the neurological exam is repeated every 15 minutes x4 (1hr), every 30 mins x4 (2 hrs), every 2 hrs. x 4 (8 hrs), then every shift x3."
#5. Any resident requiring Emergency Room treatment for injuries relating to a fall and head injury suspected, upon their return to the facility, the neurological evaluation will be initiated/re-initiated.

Resident #125 was admitted on 9/12/24 with diagnosis of COVID-19 and orthostatic hypotension. Review of the medical record shows a care plan for "Resident has had a fall with/without injury due to: Unsteady gait, poor insight" initiated on 9/17/24 had a nursing intervention of "Neuro-checks per facility protocol." From admission through discharge on 10/18/25, the resident had 4 unwitnessed falls. Review of facility documentation relating to the falls states the following:

1. A nurses noted dated 9/24/24 at 6:31 a.m., states "Found resident on the bathroom floor. Left-side lying facing the bathroom door. Denies pain. Neuro-check initiated, within patient's baseline ...will continue to monitor." The residents' medical record lacked evidence of Neurological monitoring per policy.

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F 684	Continued From page 15 2. A nurses note dated 10/6/24 at 10:26 a.m., states, "Resident found on floor in bathroom. States [he/she] slid off the toilet after getting dizzy. ROM (range of motion) and neuro intact, new skin tear measuring 0.2 x 6.5 cm to right forearm. Steri-strips and dressing applied. Denies pain ..." Review of the neurological monitoring initiated on 10/6/24 at 7:30 a.m., has the following vitals documented with a time of 8:13 a.m., a Blood Pressure of 107/66, Pulse 88 regular, respirations 18, and a temperature of 98.3. Review of the 1st 15 minutes through the 4th 30 minutes, a total of 8 neurological evaluations, had the vitals documented with the same readings as the initial vitals at 8:13 a.m. In addition, the 3rd and 4th 2 hour evaluations and the 1st and 2nd shift evaluations were not completed. 3. A nurses note dated 10/13/24 at 9:30 a.m., states, "Resident found with bruising on the side of [his/her] face, reporting that [he/she] fell overnight and feels "foggy." TEH contacted and received new orders to send resident to ED for a CT scan to rule out head injury." A late entry nurses noted, effective 10/12/24 at 11:15 p.m., states, "this writer found resident laying on left side on floor in room next to bed, large amount of water on floor, side table turned upside down on floor next to resident. Upper and lower extremities checked for any clicks/disfigurement. Resident transferred into bed with 2 staff members via hoyer lift. Full body assessment performed. Multiple old bruising and ecchymosises noted to body. Vital signs and neuro checks initiated ..."	F 684		

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F 684	Continued From page 16 Review of the medical record states the resident returned from the Emergency Room on 10/13/24. Further review, the medical record lacked evidence of neurological monitoring after the fall and upon return from the Emergency Room visit. On 1/16/25 at 2:22 p.m., both the surveyor and the Director of Nursing reviewed the above 3 falls. The Director of Nursing confirmed the neurological monitoring did not occur and/or the documentation for the neurological monitoring was incorrect with the vitals being the same throughout the monitoring.	F 684		
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 and interviews, the facility failed to maintain a sanitary environment to help prevent the development and transmission of disease and infection related to respiratory care for 2 of 3 residents reviewed for respiratory care (Resident # 16 and #20). In addition, the facility failed to follow physician orders for 1 of 3 reviewed for respiratory care (Resident #16). Findings:	F 695	• Resident # 16 and Resident # 20 are receiving nebulizer respiratory care per manufacturers guidelines. • House audit of residents with orders for nebulizer treatments to ensure no other residents are affected by this practice. • The SDC/designee will educate the license nurses and medication technicians on manufacturers guidelines for nebulizer manufactures guidelines. (Facility has added nebulizer manufacturers guidelines to batch orders in EMR) • The Unit manager/designee will complete random weekly respiratory care audits x 2 months of residents with nebulizer orders. The results of these audits will be reviewed with the QAPI committee monthly to ensure compliance is maintained. The DNS is responsible for compliance.	2/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 695	Continued From page 17	F 695		

The facilities "Nebulizer Treatments" Policy and Procedure revised 2/23, states, post treatment, "disconnect the reservoir from the compressor and clean per manufacturer's Instructions, Place reservoir in a plastic bag"

Manufactures Instruction Manual for Power Neb Ultra Compressor Nebulizer, under section cleaning and maintenance states, "clean after every use ...disassemble mouthpiece or mask from cap ...wash all items, except tubing in a hot water/dishwashing detergent solution. Rince under hot tap water for 30 seconds to remove detergent residue. Allow to air dry". Under section , Filter Change states, "Filter should be changed every 6 months or sooner if filter discolors."

1. On 1/13/25 at 11:32 a.m., observation of Resident #16's nebulizer machine on the bedside dresser with mouthpiece/pipe stored on the back of the machine and the tubing dated 12/30. At this time, Resident #16, stated, he/she only needs it when he/she is congested.

On 1/14/25 at 1:33 p.m., observation of Resident #16's nebulizer machine on the bedside dresser with mouthpiece/pipe stored on the back of the machine and the tubing dated 12/30.

Review of Resident #16 physician orders dated 1/7/24 states, "Change Nebulizer unit and tubing every night shift every Sun for Prophylaxis". Review of the Treatment Admission Records (TAR) for December 2024 states the nebulizer unit and tubing were changed on 12/29/24. The TAR for January 2025 states the nebulizer unit and tubing were changed on 1/5/25 and 1/12/25. In addition, the medical record lacked evidence of the filter being changed as per manufactures

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F 695	Continued From page 18 recommendations. On 1/16/25 at 12:59 p.m., during an interview with the Director of Nursing (DON), the surveyor discussed the above and asked how often the nebulizer filters are changed. The DON stated she was unsure and would get back to the surveyor. On 1/16/25 at 1:06 p.m., the DON returned and stated they do not have a record of changing nebulizer filters. 2. On 11/13/25 at 11:07 a.m., on 1/14/25 at 12:10 p.m., and on 1/15/25 at 1:51 p.m., Observation of Resident #20's unbagged and unlabeled nebulizer pipe and tubing stored on their bedside table. On 1/15/25 at 1:51 p.m. the above information was confirmed with the Regional Director of Clinical Operations.	F 695		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.	F 725		

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F 725	Continued From page 19 §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure sufficient direct care staff were scheduled and on duty to meet the needs of residents that reside in the facility. This has the potential to affect all residents needing assistance with Activities of Daily Living (ADL's). Findings: Review of Payroll Based Journal staffing report revealed the facility triggered for excessively low weekend staffing during the fourth quarter of 2024 (July 1 - September 30). On 1/15/25 at 3:47 p.m., a surveyor met with the Administrator and reviewed weekend staffing for July 1, 2024, through September 30, 2024, the Administrator confirmed the facility did not have enough staff to meet resident needs on the weekends.	F 725	• The facility is currently providing sufficient direct care staffing. • All residents have the potential to be impacted by this deficient practice. • The DNS/ designee has educated the nurse leadership team and the scheduler on the regulatory requirement of sufficient staffing. • The DNS/designee will audit the staffing daily x 60 days to ensure there is sufficient staffing Then weekly x1 month. The results of these audits will be reviewed with the QAPI committee to ensure compliance is maintained. The DNS is responsible for compliance.	2/20/2025
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		

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	205095	A. BUILDING ______ B. WING ______	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761	Continued From page 20 §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 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 observations, and interviews, the facility failed to maintain adequate pharmaceutical services to ensure that outdated medications, were removed from the medication carts making them no longer available for use in 1 of 3 medication carts. Findings: On 1/14/25 at 9:06 a.m., a surveyor observed in medication cart on Eagle Wing a medication card	F 761	• The expired medication was removed and discarded. • A house audit was completed by Unit Managers/designee to ensure there were no other expired medications in med storage areas. • The SDC/designee has re-educated nursing staff on facility medication storage policy/procedure. • The DNS/designee will complete random medication storage audits daily Monday-Friday x 30 days then twice a week x 30 days. The results of these audits will be reviewed monthly with the QAPI committee to ensure compliance is maintained. The DNS is responsible for compliance.	2/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 761	Continued From page 21 for Ondansetron HCL 4 milligrams (mg) for Resident #13 had expired on 5/30/24. The surveyor confirmed the finding with the Licensed Practical Nurse (LPN) #1. at 9:12 a.m. On 1/14/25 at 9:30 a.m., a surveyor discussed the above findings with the Director of Nursing.	F 761		
F 812 SS=E	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, record review and the facility's own Personal Appearance and Dress guidelines and the Personal Hygiene for Food Handlers policy and procedures, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner, failed to serve food in accordance with professional standards for food	F 812	- Kitchen floor/piping around/under prep sink / 3 bay sink area has been cleaned. - The kitchen prep sink and ice machine air gaps have been replumbed to standard. - The tray line table lower shelf has been cleaned. - The shelving unit area has been cleaned. - The dish washer hood exhaust has been cleaned - The walk-in freezer area has been cleaned. - The walk-in refrigerator fan has been cleaned , expired food has been properly disposed. - The food mixer safety shield and cage have been properly cleaned. - The Dining Staff will receive re-education on PPE proper use of face masks and wearing Identification Badges according to standards. - The Dining Staff will receive re-education on Use of Gloves and Safe Food Handling and Cooking and Holding Temperatures of Food including when to take and record food temperature. - FSD/designee will complete random daily (mon-fri) audits x 2 months then weekly x1 month on Cleaniness, PPE /Facemask Use, Use of Gloves, Temperature Standards , Use of Identification Badges. The results of these audits will be reviewed with the QAPI Committee monthly x 2 months and then weekly x 1 to ensure compliance is maintained. The FSD is responsible for compliance.	2/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205095	A. BUILDING ____ B. WING ____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 22	F 812		

service safety, failed to monitor food temperatures to prevent food borne illness prior to serving residents for 1 of 2 days of survey (1/13/25), and failed to ensure that plumbing fixtures were properly installed to prevent backflow as required by the Maine State Plumbing Code. This has the potential to affect all residents in the facility.

Findings:

The facilities "Personal Hygiene for Food Handlers", revised on 2/22 states, Hair restraints such as hats, hair coverings or nets, and beard restraints are worn at all times when in the kitchen" and Facial hair should be neatly trimmed and covered by mask or beard guard".

The 10-114 State of Maine Rules Chapter 226, definition Section A, defines an Air-Gap Separation - A physical separation between the free-flowing discharge end of a potable water supply pipeline and an open or non-pressure receiving vessel. An air-gap separation shall be at least twice the diameter of the supply pipe measured vertically above the overflow rim of the vessel - in no case less than one inch (2.54 cm) and the Code of Federal Regulation, Title 21, Part 1250, Section 1250, 30 (d) states "all plumbing shall be so designed, installed, and maintained as to prevent contamination of the water supply, food, and food utensils."

1. On 1/13/25 from 9:18 a.m. to 9:40 a.m., a surveyor completed a tour of the kitchen with the Food Service Manager (FSM) in which the following findings were observed:

- The Kitchen floor around and under the prep

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205095	A. BUILDING ____ B. WING ____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 23	F 812		

sink and the 3 bay sink had crumbs, food, dirt and debris throughout.
- The kitchen prep sink air gap was not plumbed in accordance with code requirements to prevent food contamination.
- The kitchen ice machine air gap was not plumbed in accordance with code requirements to prevent food contamination.
- The tray line table lower shelf was heavily soiled with dirt and debris.
- The shelving unit containing cereal was visibly dirty with dirt and debris.
- The dish washer hood exhaust was coated with thick dust.
- The walk-in freezer had a large brown ice puddle, a cookie wrapper, crumbs and debris on the floor.
- The walk-in refrigerators fan was coated with a thick layer of dust, a container containing egg salad with an exp. date of 1/10 and a wrapped chicken salad sandwich with exp. date of 1/12.
- The food mixer safety shield and cage were visibly soiled with white debris/dried liquid

2. On 1/13/25 from 11:32 a.m. to 11:56 a.m., a surveyor observed the Kitchen staff at the steam table and tray line preparation serving lunch, in which the following was observed: Cook #1 had a scruff mustache/beard without a hair restraint. Cook #2 had a mustache with a patchy beard on his chin without a hair restraint, and no name tag. Dietary Aid #1 had a mustache and beard without a hair restraint. Dietary Aid #3 had a mustache without a hair restraint.

Cook #1 prepared the residents plates, during this time, he picked up a grilled cheese sandwich with his gloved hands and cut off the edges, then placed it on a plate. Next, using his hand, he

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F 812	Continued From page 24 picked up a piece of steak. Then he opened the steamer cabinet and removed a cup of soup. With the same gloved hands, he picked up a piece of fish and plated it. Then again opened the steamer cabinet and obtained another cup of soup and handed it off to Cook 2. At approx. 11;44 a.m., the surveyor alerted the FSM, of the lack of hair restraints and hand hygiene. Without intervention, the FSM continued to observe, Cook #1 plate another piece of fish using the same gloved hands. Then he obtain a chicken salad sandwich in a bag. He removed it from the bag, cut off the edges and placed it back into the bag and handed it back to Cook #2. He then picked up another grill cheese sandwich, cut off the edges and plated it. Again, he picked up another piece of fish, held it with the same gloved hands and cut it up. At this time, the above observations were confirmed with the FSM. 3. On 1/13/25 at 11:56 a.m., both the FSM and the surveyor reviewed the "Kitchen Production Report: Lunch" team table temperatures. Temperatures were not obtained prior to serving, for the gravy (separate from steak), mashed potatoes, grilled cheese sandwiches, peas/carrots and chicken salad sandwich. 4. On 1/14/25 from 6:18 a.m. to 6:32a.m., an additional tour of the kitchen in which the following findings were observed again observed: - Cook #2 had a mustache with a patchy beard on his chin without a hair restraint. At this time, the above was confirmed with the FSM.	F 812		
F 847 SS=E	Entering into Binding Arbitration Agreements CFR(s): 483.70(m)(1)(2)(i)(ii)(3)-(5)	F 847		

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F 847	Continued From page 25 §483.70(m) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(m)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(m)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(m)(4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility.	F 847	- All residents have the potential to be affected by this practice - Administrator and Admissions director were educated on the process and binding arbitration agreements. Admissions director will thoroughly explain arbitration agreements to residents upon admissions or designated representatives. If the representative is unavailable AD will instruct them to contact her during the signing of the agreement to review. Anyone who signs an arbitration agreement will receive a reminder within the first 30 days that they have the right to rescind the agreement for 30 days. Admin or designee will complete random weekly audits x 3 months of signed arbitration agreements and ask residents who have entered into such agreement if they understand agreement. All audits will be entered into qapi by administration and reviewed for 3 months.	2/20/2025

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F 847	Continued From page 26	F 847		

§483.70(m)(5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k).

This REQUIREMENT is not met as evidenced by:

Based on interviews and record review, the facility failed to ensure the terms and conditions of a binding arbitration agreement were clearly communicated to the residents or their representatives and not required as a condition of admission due to the agreement being a part of the admission paperwork for 5 of 5 residents reviewed for Arbitration (Resident #126, #230, #23, #64, and #19).

Findings:

1. On 1/13/25 at 9:15 a.m., a surveyor conducted an entrance conference with the Administrator and the Director of Nursing and was told, when asked, that no residents in the facility had signed an arbitration agreement.

During a record review for Resident #19, a surveyor located a signed Arbitration agreement in Resident #19's Electronic medical Record (EMR).

2. On 1/16/25 at 9:32 a.m., during an interview, the Admissions and Marketing Director stated she is responsible for having the resident/family representative sign the admission packet which also contains the Resident and Facility Arbitration Agreement upon admission or within 48 hours.

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F 847	Continued From page 27	F 847		

The admission packet is now digital stating, "We use Docusign, they can do it at home. I either do it with the resident or family. I email to family, the resident is with me, I go over it with them and ask, Can sign I for you. I need to know who is signing before I go, because I have to generate the packet with who is going to sign ...it's easier than going through each individual piece of paper for them to sign." The surveyor asked how she explains the arbitration agreement to residents or family, she stated, "My talking points, the Center offers arbitration for legal matters. If you accept you are waiving your right to a judge or jury, that's my spiel, if they want more detail I'll explain if you go to court with a lawyer or arbitration." The Surveyor asked, if the admission contract is emailed how does she explain the arbitration agreement, "They have to read it and call me if they have any questions. Everything is self-explanatory for them to be able to do it on their own."

On 1/16/25 at 11:06 a.m., during an additional interview with 3 surveyors present, the Admissions and Marketing Director was asked if she explained that signing an arbitration, after 30 days, it's binding even after discharge and readmission. She stated, "I don't think it's a forever signature" and "they get a new one with every admission".

At this time, the surveyors and the Admissions and Marketing Director reviewed the facilities arbitration agreement which states, "The Resident also understands that: (1) he/she has the right to seek legal counseling concerning this agreement and (2) this agreement may be rescinded by written notice to the Facility from the Resident within 30 days of the Resident's

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F 847	Continued From page 28	F 847		

signature below. If not rescinded within 30 days, this agreement shall remain in effect for all care and services subsequently rendered at the Facility, even if such care and services are rendered following the Resident's discharge and readmission to the Facility." The Admissions and Marketing Director confirmed she was unaware that an arbitration agreement would be a permanent decision and believed with each new admission a new agreement could be made.

3. On 4/10/24 the Division of Licensing and Certification received a complaint from Resident #126's representative stating, "I should have been alerted when they had me sign a Resident and Facility arbitration agreement upon admission."

On 1/17/25 at 3:28 p.m., during a telephone interview with Resident #126's representative, she stated, "The woman that was in charge of the admittance, she said, "Oh, you have to sign all these papers", she didn't really explain a lot of stuff to me. At that point I was exhausted. I've been going back to Southern Maine Medical everyday and at that point I just wanted to get [Resident #126] in there. So, I signed whatever paperwork I needed." The surveyor asked if it was clearly explained that signing the arbitration agreement was not a requirement for admission, she stated, "Not that I can remember. I signed the paperwork because it was pressure from her but also pressure on my part because there wasn't any other facilities available. At that point, it was like, I'll do what I have to do to get [Resident #126] in there."

On 1/16/25 at 11:32 a.m., during an interview with 3 surveyors, the Administrator and the Admissions and Marketing Director the above

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F 847	Continued From page 29 was discussed; the arbitration is in the admission packet, residents or families are signing all the paperwork for an admission. At this time, the surveyor expressed the concern that the Admissions and Marketing Director was not fully aware of the terms and conditions of an arbitration and therefore would not be able to clearly explain those terms and conditions appropriately to residents and family representatives. 4. On 1/16/25 at 10:10 a.m., a surveyor met with Resident #19 and asked if he/she signed an arbitration agreement with the facility during admission. He/She did not think so but said there were so many documents. It was overwhelming. A surveyor let him/her know that she had signed an arbitration agreement and explained what that meant. Resident #19 stated, I would not have signed that if I had understood. I don't remember anyone explaining that. 5. On 1/16/25 at 10:20 a.m. a surveyor met with Resident #64 who had overheard the conversation about the arbitration agreement and wanted to know if she/he had signed one. After confirming that Resident #64 had signed one and it was in their EMR. Resident #64 stated that no one explained this and she/he thought all the forms had to be signed for admission to the facility. 6. On 1/26/25 at 10:45 a.m., a surveyor met with Resident #230 after locating a signed arbitration agreement in their EMR. Resident #230 was unaware this was not a required part of the admission packet. Upon explaining what an arbitration agreement meant, Resident #230	F 847		

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F 847	Continued From page 30 stated I probably would not have signed that had I known. 7. On 1/26/25 at 11:00 a.m., a surveyor met with Resident #23 after locating a signed arbitration agreement in their EMR. After a surveyor explained the agreement and asked if anyone had explained this before she/he signed it. She/he stated that she does not remember anyone explaining this agreement. There were so many papers to sign when I got here and she didn't know what she was signing. I thought they were just admission papers. On 1/6/25 at 2:30 p.m., a surveyor met with the Administrator and the Admissions Coordinator with 3 other surveyors present. At this time the Administrator apologized for saying there were no arbitration agreements. He was not feeling well on Monday (1/13/25). They were both unaware that residents did not understand they had signed a binding agreement that limits their rights to choose a dispute resolution method.	F 847		