STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205128	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLECREST REHAB & LIVING CENTER	174 MAIN ST , MADISON, Maine, 04950

(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
F0000	INITIAL COMMENTS From 7/7/2025 through 7/9/2025, on-site visits were conducted at Maplecrest Rehab & Living Center for the purpose of a Recertification Survey and investigating ME00049346, ME00049712 and ME00052179. It was determined that Maplecrest Rehab & Living Center was not in substantial compliance with 42 CFR 483, Sub-part B Requirements for Long Term Care Facilities.	F0000		
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F0584		08/15/2025

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 reverse for further 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.

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

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F0584 SS = E	Continued from page 1 §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 maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable environment on 3 of 4 Wings (Lakewood, Embden, Clearwater) and the common area/hallway for 2 of 3 days of survey. 1. On 7/7/25 at 9:14 a.m., and on 7/8/25 at 8:11 a.m., observation of room 103B to have trash/debris including tissues, a pen, papers, food and a sticky layer of a dried substance under the bed. 2. On 7/8/25 from 2:41 p.m. through 2:58 p.m., an environmental tour was conducted with Director of Nursing and the Maintenance Director for which the following was observed: Lakewood unit: - Room 101A had a stained ceiling tile above the bed and marred wallpaper at the head of the bed - Room 103's windowsill had chipped paint and was separated from the brick below the window. - Room 104's windowsill had chipped and peeling paint. - The hallway near room 107 and 108 had several cracked tiles spanning the width of the hallway. Embden unit: - Room 209 the cabinet door below the sink has a chunk	F0584		

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F0584 SS = E	Continued from page 2 of missing laminate and the wall next to the bathroom has a large area of marred wall with exposed sheetrock. - The hallway railing had chipped and peeling paint on the wood. - The shower room had several missing tiles around the drain; the edge caulking is brown and orange in color with rust and multiple broken tiles along the shower perimeter. Clearwater Unit: - Room 425's bathroom ceiling tiles above the toilet appear dirty/stained and chipped. - Room 427's heater cover was off exposing the sharp metal fins. The common area across from the nurse's station has multiple areas of marred walls exposing sheetrock. The right corner of the nurse station wall has missing laminate exposing raw wood. The dining room entrance door panel has missing plastic with exposed wood leaving sharp edges, 2 stained ceiling tiles and multiple windowsills with chipped and peeling paint. On 7/8/25 at 2:58 p.m., the Director of Nursing and Maintenance Director confirmed the above concerns.	F0584		
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F0610		08/15/2025

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F0610 SS = D	Continued from page 3 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on facility policy, record review, and interview, the facility failed to notify the State Agency after potential abuse concerns were identified, failed to investigate allegations of potential abuse, and failed to ensure that the facility's investigation was sent to the State Agency within 5 business days of the incident for 1 of 4 incidents reviewed for abuse Facility policy titled "Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property" last revised 10/2018 states "Any nursing home employee or volunteer who becomes aware of abuse, mistreatment, neglect, exploitation or misappropriation shall immediately report to the Nursing Home Administrator". Under Section E: Investigation, Subsection A. Investigation of Abuse "When an incident or suspected incident of "abuse" is reported, the administrator or designee will investigate the incident with assistance of appropriate personnel. The investigation will include: who was involved ...resident statements ... For non-verbal residents, cognitively impaired residents or residents who refuse to be interviewed, attempt to interview resident first. If unable, observe resident. Complete an evaluation of resident behavior, affect and response to interaction, and documentation ... Resident's roommate statements ...involved staff and witness statements of events ...A description of the resident's behavior and environment at the time of the incident... Injuries present including a resident assessment... Observation of resident and staff behaviors during the investigation ...Environmental considerations". On 8/21/24 the Division of Licensing and Certification received a facility reported incident in which a Certified Nursing Assistant (CNA) #4 reported by way of a written letter on 8/19/24, that on 8/18/24 she witnessed the following: between 8:30 a.m. to 9:00 a.m., CNA #5 brushed Resident #31's hair, did not stop when he/she stated "ouch". CNA #4 stated "you are hurting him/her be easy", CNA #5 then stated, "watch this" and brushed Resident #31's hair again causing the resident more pain. CNA #5 proceeded to laugh and apply	F0610		

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F0610 SS = D	Continued from page 4 blue hair dye to the ends of Resident #31's hair. When the resident left the area, CNA #5 stated "I don't like him/her". Around 12:30 p.m.- 12:45 p.m., CNA #4 observed CNA #5 transfer Resident #25 to his/her bed with a stand and pivot machine, the bed was not at appropriate level at the time, causing the resident to cry out in pain upon transfer. Per the letter Resident #25 voiced he/she did not want CNA #5 to provide him/her care. CNA#5 proceeded to climb into bed with Resident #25 and lay down with him/her. Resident #25 proceeded to "freak even more" stating "get away from me" and "don't touch me". Resident #25 then attempted to hit CNA #5, but the CNA grabbed the resident's hand and proceeded to move it like a "car shifter". CNA #4 told CNA #5 to leave the room, CNA#5 got up out of the bed and took the residents glasses away. Around 12:50 p.m.- 1:00 p.m., CNA #4 and CNA #5 were getting Resident #4 changed in bed. Resident #4 rolled toward CNA #5 and hit his leg, CNA #5 stated "don't touch my privates". Resident #4 stated he/she did not touch him there and felt CNA #5 was upset with him/her. CNA #4 needed to provide reassurance. Review of the facility investigation lacked evidence that the abuse allegations were reported immediately by CNA #4, the facility failed to report the allegations of abuse to the State Agency within 24 hours, failed to conduct a thorough investigation, and failed to report the results of the investigation within 5 days of the incident. On 7/8/25 at 9:20 a.m., during an interview, the above information was confirmed with the Director of Nursing.	F0610		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.	F0644		08/18/2025

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F0644 SS = D	Continued from page 5 §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews, the facility failed to ensure that the State mental health authority for Pre-Admission Screening and Resident Review (PASRR) was notified after a resident was newly diagnosed and/or experienced symptoms related to a mental disorder or trauma event to determine if a change in level of service was required for 1 of 1 sampled resident reviewed for PASRR (Resident #14). Review of Resident #14's Minimum Data Set 3.0 (MDS) revealed an Annual Comprehensive Assessment, dated 11/14/24 that indicates an active primary diagnosis of Dementia and an active diagnosis of Post-Traumatic Stress Disorder (PTSD). Resident #14's most recent Quarterly MDS, dated 5/6/25, also includes an active diagnosis of mood disorder and indicates Resident #14 exhibited "Physical behavioral symptoms directed towards others" and "Verbal behavioral symptoms directed toward others." Resident #14's Care Plan, last reviewed 5/8/25 revealed, " ... at risk for alteration in thought process r/t [related to] use of psychoactive medication for management of depression, PTSD, and mood d/o [disorder]..." and "...at risk for anxiety/behaviors, decreased psychosocial well-being and increased isolation related to PTSD, depression, and mood d/o..." Further record review revealed a pre-admission "Notice of PASRR Level I Screen Outcome," dated 11/15/22, that indicated Level II screening was not required and states, "No mental health diagnosis is known or suspected ...There are no known mental health behaviors ...no known recent or current mental health symptoms ..." and lacked evidence that a new screen was submitted for the above diagnoses and symptoms. On 7/8/25 at 11:43 a.m., during an interview, the Director of Social Services stated tracking updated diagnoses and behavioral changes is a team approach with the Director of Nursing (DON) and sometimes the MDS Coordinator, and that it is discussed in the	F0644		

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F0644 SS = D	Continued from page 6 facility's daily morning meeting. After reviewing Resident #14's diagnoses, the Director of Social services stated Resident #14 needs an updated PASRR screening and that she does not even recall the resident being discussed for having mental health diagnoses. On 7/8/25 at approximately 12:00 p.m., the above finding was discussed with the DON. At this time, the DON stated Resident #14 does need a new PASRR, and she will initiate the screening.	F0644		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F0656		08/18/2025

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F0656 SS = D	Continued from page 7 discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and interview, the facility failed to ensure that a care plan was developed in the area of respiratory care for 2 of 5 residents reviewed for respiratory needs (#45 and #10) and in the area of accidents for 1 of 1 reviewed for falls (#43). 1. Review of Resident #45's medical record stated he/she was admitted on 6/6/25 with a diagnosis of chronic obstructive pulmonary disease with acute exacerbation and obstructive sleep apnea requiring the use of Continuous positive airway pressure (CPAP) machine and nebulizers. The medical record lacked evidence that a comprehensive care plan had been developed in the area of a respiratory to include the use of the CPAP and nebulizer. On 7/8/25 at 10:12 a.m., during an interview the above was discussed with the Director of Nursing 2. On 7/7/25 at 9:27 a.m., a surveyor observed Resident #10 wearing oxygen via nasal cannula with the oxygen concentrator set at 3 liters. On 7/8/25 at 1:07 p.m., a surveyor observed Resident #10 asleep and wearing oxygen via nasal cannula with the oxygen concentrator set at 2.5 liters. A review of Resident #10's medical record revealed a physician's order, dated 8/22/24 for "Oxygen (O2) at 2 liters per minute via nasal cannula without humidification. May use as needed for complaints of cluster headaches (effective historically per	F0656		

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F0656 SS = D	Continued from page 8 resident)." A review of Resident #10's current care plan, dated 6/23/25, did not include Resident #10's use of oxygen. On 7/8/25 at 1:33 p.m., in an interview with the Vice President of Quality Improvement & Nursing Services, the surveyor discussed the observations of Resident #10 and that the care plan did not include the use of oxygen as per physician orders. 3. On 6/26/25 the Department of Licensing received a complaint indicating Resident #43 had a lot of falls and had a fall mat on the wrong side of the bed. Review of Resident #43's medical record included a diagnoses of dementia, vertigo, anxiety, osteoporosis, and a history of fall with fracture. The current care plan last updated on 5/8/25, lacked evidence to include use of a floor mat as an intervention. On 7/7/25 at 1:25 p.m., observation of Resident #43 to have a fall matt on the right side of bed. On 7/7/25 at 3:30 p.m., during an interview, the Director of Nursing confirmed Resident #43 used a fall mat and stated it should be care planned.	F0656		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F0657		08/18/2025

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F0657 SS = D	Continued from page 9 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and interview, the facility failed to ensure a care plan was accurately revised for 1 of 2 residents reviewed for intravenous (IV) antibiotic use and transmission-based precautions (Resident #24). On 7/7/25 at 10:16 a.m., a surveyor observed Resident #24 receiving an IV infusion of the antibiotic Vancomycin. Resident #24 stated he/she had an infection of the right leg and was receiving 2 IV antibiotics. A review of Resident #24's clinical record noted a history of MRSA (methicillin resistant Staphylococcus aureus), a multidrug resistant organism, and recurrent lower extremity cellulitis. The record noted Resident #24 had been treated with IV antibiotics in May, 2025. The record noted on 6/25/25, Resident #24 had a PICC (peripherally inserted central catheter) line placed at the local hospital and was started on IV vancomycin and cefepime. A review of Resident #24's current care plan, last revised on 6/19/25, included the problem area: risk for infection. Resident #24's need for IV antibiotics was not included in the care plan. One intervention stated "use standard precautions unless otherwise indicated." On 7/9/25 at 9:30 a.m., a surveyor observed an Enhanced Barrier Precautions sign had been placed on Resident #24's door. This replaced a previous sign which stated "see nurse for instructions."	F0657		

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F0657 SS = D	Continued from page 10 On 7/9/25 at 10:00 a.m., in an interview with a surveyor, the Nurse Manager stated Resident #24 frequently receives IV antibiotics for recurrent wound infections. On 7/9/25 at 12:30 p.m., in an interview with the Director of Nursing, the surveyor discussed that the current care plan had not been revised to address Resident #24's need for IV antibiotics. In addition, the care plan instructed staff to use standard precautions, while a sign on the resident's door advised of the need for Enhanced Barrier Precautions. The Director of Nursing confirmed that Contact Precautions were indicated while Resident #24 was being treated for an active infection.	F0657		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and interviews, the facility failed to ensure that the resident's environment was free of accident hazards by failing to maintain a clutter-free pathway in the resident's room for 1 of 1 sampled resident reviewed for accidents (Resident #14). On 7/7/25 at 9:02 a.m. and 7/8/25 at 8:33 a.m., a surveyor observed a clear plastic bag containing two siderails, located on the floor next to Resident #14's bed, two wheelchair footrests and multiple pairs of shoes on the floor next to Resident #14's recliner, and a pair of shoes on the floor in front of the recliner. A review of Resident #14's most recent Fall Risk Screen, dated 4/30/25, indicated he/she is at high risk	F0689		08/18/2025

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F0689 SS = D	Continued from page 11 for falls. Review of Resident #14's care plan, updated 5/8/25, includes, "...at risk for falls...keep environment free from clutter and pathways clear of obstacles," and "...frequently incontinent...implement safety measures (keep path to bathroom clear and well lit...)," and "...ability to see in adequate light is impaired...Keep areas free of obstructions to reduce the risk of falls or injury..." On 7/8/25 at 9:48 a.m., a surveyor and the Director of Nursing (DON) observed the siderails, footrests, and shoes on Resident #14's floor. The DON stated Resident #14 gets out of bed and transfers himself/herself to the chair at times and the environment was cluttered.	F0689		
F0695 SS = E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews, interviews and the facility policy, the facility failed to maintain a sanitary environment to help prevent the development and transmission of disease and infection related to respiratory care for 4 of 5 residents reviewed for respiratory care (Resident #45, #151, #29 and #35). In addition, the facility failed to ensure physician orders were followed for 1 of 5 residents receiving oxygen therapy (Resident #10) Oxygen use & Storage Policy last revised on 6/25 states under respiratory care "A Sanitary environment must be maintained to prevent the transmission of disease and infection." A. Nasal Cannula's will be discarded and changed every 2 weeks. The respiratory set up bag will be labeled with resident's name and the date the equipment was changed or the date changed can be directly labeled on	F0695		08/18/2025

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F0695 SS = E	Continued from page 12 the cannula with a piece of tape. When the nasal cannula is not in use, on both the concentrator and portable tank, the cannula will be stored in a plastic bag to avoid the risk of it becoming contaminated. B. Nebulizer parts should be rinsed after each use, allowed to air dry while being covered with a paper towel and placed in respiratory set up bag once dried. Respiratory set-ups for nebulizers will be changed every 2 weeks. Nebulizer filters will be rinsed every 2 weeks and changed on a monthly basis. D. Staff changing the tubing should document on the Treatment Administration Record (TAR) when the tubing has been changed following this policy. E. When the tubing is changed, the filter in the concentrator must also be removed and rinsed off to ensure the filter remains free from dust. Continuous positive airway pressure (CPAP)/ Bilevel positive airway pressure (BIPAP) Management policy last revised on 6/25 states under "Daily Cleaning Recommendations" Mask and/or nasal pillows wash in warm soapy water, allow to air dry, out of direct sunlight or wipe down with a recommended CPAP wipe. Once completed, place clean equipment into plastic bag. Water chamber empty any remaining water after treatment. 1. On 7/7/25 at 10:01 a.m., and on 7/8/25 at 8:11 a.m., observations of Resident #151's nasal cannula with foam protectors taped to the tubing, unlabeled and stored on the bedside dresser. Review of the medical record lacked evidence of nursing changing the nasal cannula every 2 weeks. 2. On 7/7/25 at 9:20 a.m., and on 7/8/25 at 8:11 a.m., observations of Resident #45's nebulizer pipe and tubing, unlabeled and stored on top of the bedside dresser and a Continuous positive airway pressure (CPAP) mask draped over the CPAP machine. There was no respiratory set up bag for storage observed. Review of Resident #45's Treatment Administration Record lacked evidence of the changing and/or cleaning of the Nebulizer tubing/pipe and CPAP mask.	F0695		

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F0695 SS = E	Continued from page 13 On 7/8/25 at 10:12 a.m., during an interview, the above was observed and confirmed with the Director of Nursing (DON). On 7/8/25 at 2:58 p.m., an additional observation of Resident #45's CPAP mask draped over the machine and hanging between the wall and the bedside dresser. At this time, it was again confirmed with the DON 3. On 7/7/25 at 9:27 a.m., a surveyor observed Resident #10 wearing oxygen via nasal cannula with the oxygen concentrator set at 3 liters. On 7/8/25 at 1:07 p.m., a surveyor observed Resident #10 asleep and wearing oxygen via nasal cannula with the oxygen concentrator set at 2.5 liters. A review of Resident #10's medical record revealed a physician's order, dated 8/22/24 for "Oxygen (O2) at 2 liters per minute via nasal cannula without humidification. May use as needed for complaints of cluster headaches (effective historically per resident)." A review of Resident #10's Treatment Administration Records (TAR) for June and July, 2025, noted no documentation for the use of oxygen, though the oxygen tubing was changed every 2 weeks per facility policy. On 7/8/25 1:33 p.m., in an interview with the Vice President of Quality Improvement & Nursing Services, the surveyor discussed the observations of Resident #10 and the lack of documentation for Resident #10's oxygen use. The Vice President of Quality Improvement and Nursing Services confirmed the findings did not reflect the physician's order and stated she would clarify the correct order at this time. 4. On 7/7/25 at 9:03 a.m. and on 7/8/25 at 10:15 a.m., observation of Resident #29's unbagged nebulizer mask and tubing on the bedside table dated 1/21. Review of Resident #29's clinical record indicated an active physician order for Albuterol Sulfate Inhalation	F0695		

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F0695 SS = E	Continued from page 14 Nebulization Solution 2.5 mg/3 mL (0.083 %) with directions to use every 6 hours as needed. Review of the medication administration record/treatment administration record indicated that his/her last time using the nebulizer was on 5/26/25. On 7/8/25 at 10:15 a.m., the above information was confirmed with the DON. 5. On 7/7/25 at 8:57 a.m. and on 7/8/25 at 8:26 a.m., Resident #35's unbagged nebulizer mask was observed hanging on the nebulizer machine on his/her nightstand. Review of Resident #35's active physician orders revealed an order for, "ipratropium 0.5mg-albuterol 3mg (2.5mg base)/3mL...Nebulization As Needed ..." Review of Resident #14's Treatment Administration Record lacked evidence of when the nebulizer tubing has been changed. On 7/8/25 at 9:56 a.m. a surveyor observed Resident #35's unbagged nebulizer mask with the DON. At this time, the DON stated after a nebulizer treatment is administered, the mask should be rinsed and air dried, then stored in a bag.	F0695		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must	F0755		08/18/2025

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F0755 SS = D	Continued from page 15 employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations and interviews the facility failed to ensure that two people who are authorized to administer medications signed the Narcotic Bound Book [a logbook used to record medication] Shift Count page indicating that they counted all the controlled substances at the change of shift for multiple shifts on 2 of 3 units observed for medication storage (Embden and Clearwater Control log). 1.On 7/7/25 at 8:35 a.m. a review of Embden and Clearwater unit control log with Certified Nursing Assistant/Medication Technician (CNA-M) #3 revealed the following: -control log lacked evidence of oncoming signature during the day shift on 7/4/25 at 06:00, on 6/6/25 at 06:00, on 6/10/25 at 06:00, on 6/27/25 at 06:00, on 6/24/25 at 14:00, and on 6/29/25 at 14:00. -control log lacked outgoing signature on 6/27/25 at 18:00, on 6/29/25 at 22:00, on 6/6/25 at 1:30 p.m., on 6/10/25 at14:00, on 6/11/25 at 11:00, on 6/27/25 at 22:00, on 6/30/25 at 18:00, and on 6/29/25 at 22:00. At this time CNA-M #3 stated that everytime the keys are handed over at the end of shift, the incoming and outgoing staff are supposed to sign the narcotic count book. On 7/7/25 at 9:07 a.m., the above was discussed with	F0755		

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F0755 SS = D	Continued from page 16 Director of Nursing	F0755		
F0761 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 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 interviews, the facility failed to adequately store controlled substances in a permanently affixed compartment and double locked for 1 of 1 medication refrigerator reviewed (nurses station), and failed to ensure controlled medications were stored appropriately for 1 of 3 medication carts observed (Embden and Clearwater medication cart), in addition, the facility failed to ensure treatment carts were locked when unattended on 1 of 1 unit (Margarette Chase Smith Unit) for 1 of 3 days of survey. 1. During a review of Embden and Clearwater medication cart with Certified Nursing Assistant/Medication Technician (CNA-M) #3 on 7/7/25 at 8:35 a.m., CNA-M #3 confirmed the cart contained controlled medications and proceeded to open the metal box with a lock on the top, using her pinky fingernail, sticking it under the lid	F0761		08/18/2025

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F0761 SS = E	Continued from page 17 and popping the lid open. The metal box contained approximately 15 cards of controlled medications. At this time, CNA-M #3 stated she did not close the lid all the way, which would engage the lock and she should have. 2. During an observation of medication storage refrigerator with Registered Nurse (RN) #2 on 7/7/25 at 8:42 a.m., 4 boxes of liquid Lorazepam were observed in the bottom draw of the refrigerator, not in a permanently fixed compartment. At this time RN #2 stated this is her first day at the facility, and she thought it was odd that the controlled medications weren't in a fixed compartment but had not asked about it yet. On 7/7/25 at approximately 2:45 p.m., the above was discussed with the Director of Nursing. 3. On 7/7/25 at 9:41 a.m., a surveyor observed an unlocked and unattended treatment cart on the Margret Chase Smith Unit, at this time the surveyor opened the treatment cart, which contained multiple vials of insulin, blood thinners, and Narcan. Approximately 3 minutes later, the surveyor observed Registered Nurse #3 coming out of room 309 where she was then made aware of the unlocked and unattended treatment cart. On 7/7/25 at 10:11 a.m. the above information was discussed with the Director of Nursing.	F0761		
F0812 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	F0812		08/15/2025

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F0812 SS = E	Continued from page 18 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, record review and interviews, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for floors and walls for 1 of 3 days of survey (7/7/25) and failed to monitor refrigerator, freezer and the steam table/tray line temperatures for 3 of 4 months reviewed. 1. On 7/7/25 from 8:33 a.m. to 9:00 a.m., a surveyor conducted a kitchen tour with the Food Service Director in which the following findings were observed and confirmed: -There was trash and food debris on the floor under the equipment and around the edges of the floor. -The first-floor food storage room had a hole in the wall exposing sheetrock, making the surface uncleanable. -In the kitchen by the fire extinguisher there was exposed sheetrock, making the surface uncleanable. 2. On 7/8/25 a surveyor reviewed the facilities "Freezer and Refrigerator Temperatures Form" which indicates temperatures are to be taken in the morning and at night. Further review showed the following missing temperatures: May 2025: - The diet kitchen freezer and refrigerator showed 5 out of 31 days missing. - The dairy cooler, upright freezer, and chest freezer showed 8 out of 31 days missing. - The bread freezer showed 9 out of 31 days missing.	F0812		

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F0812 SS = E	Continued from page 19 - The true freezer showed 4 out of 31 days missing. - The upright refrigerator (veg) showed 10 out of 31 days missing. - The dietary refrigerator showed 6 out of 31 days missing. - The cooks freezer showed 1 out of 31 days missing. - The cooks refrigerator showed 2 out of 31 days missing. April 2025: -The Bread freezer, true freezer, upright freezer, chest freezer, and upright refrigerator showed 8 out of 30 days missing. - The dairy cooler showed 9 out of 30 days missing. - The dietary refrigerator showed 11 out of 30 days missing. 3. On 7/8/25 a surveyor reviewed April 2025 through June 2025 facilities "Steam Table and Tray Line Temperature Record" which indicates temperatures are to be taken 3 times daily with meals. Further review showed the following missing meal temperatures: - Breakfast 26 out of 91 days are missing. - Lunch 26 out of 91 days are missing. - Dinner 41 out of 91 days are missing. On 7/8/25 at 12:30 p.m., the above was reviewed and confirmed with the Food Service Director.	F0812		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F0880		08/15/2025

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F0880 SS = E	Continued from page 20 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F0880		

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F0880 SS = E	Continued from page 21 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review and interview, the facility failed to maintain an Infection Control Program designed to help prevent the development and transmission of disease and infection by failing to conduct ongoing surveillance, tracking and educations to prevent the spread of Infections, failed to apply appropriate interventions including Transmission Based Precautions (TBP) and Enhanced Barrier Precautions (EBP), and failed to develop and implement elements of a Legionella Water Management Program. This has the potential to affect all 47 residents. Infection Control: Multidrug-Resistant Organism (MDRO's) policy, last revised 4/18/24 states Enhanced Barrier Precautions (EBP): gowns and gloves are worn during high-contact resident care activity. Examples of high-contact activity are: Preforming ADLS (activity of daily living) - bathing, dressing, transfers and toileting. Providing device care and/or wound care. Device are would include central lines, catheters ... Under procedure states, Residents being treated for an active MDRO infection will be placed on Contact precautions. Residents who have competed treatment for MDRO's will then be placed on Enhanced Barrier Precautions (EBP). Gloves and Gowns will be used when preforming high-contact care activities. 1. On 7/7/25 at 9:14 a.m., observation of Resident #45's room door with a small "Stop see nurse for instructions" sign posted on the door frame, no directions on what Personal Protective Equipment (PPE) to utilize prior to entering the room. Directly inside the room was a cart containing Personal Protective Equipment (PPE). Resident #45 was receiving an Intravenous (IV) antibiotics via a peripherally inserted central catheter (PICC) line. At this time,	F0880		

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F0880 SS = E	Continued from page 22 the resident stated he/she has an infection in the wound on the coccyx which requires daily dressing changes and is followed by infectious disease. On 7/8/25 at 8:11 a.m., an additional observation of resident #45's room to have only a stop see nurse for instructions sign posted on the door frame. There were no additional directions on what type of precautions or what PPE to wear prior to going into the room. Review of the medical record confirmed he/she has a diagnosis of an unstageable coccygeal pressure ulcer with osteomyelitis containing Methicillin-resistant Staphylococcus aureus (MRSA) and Extended-Spectrum Beta-Lactamases (ESBL) Klebsiella, both a Multidrug - Resistant Organism (MDRO's) with an active order for a dressing to the coccyx wound daily. On 7/8/25 at 2:58 p.m., both the Director of Nursing (DON) and the Surveyor observed Resident #45 room to have the small "Stop see nurse for instructions" sign on the door frame. The surveyor asked the DON what precautions were needed and why when caring for resident #45. The DON stated, he/she is being treated for an active infection involving MDRO's and contact precautions should be utilized when providing wound care and enhanced barrier precautions when providing IV care. At this time, the surveyor asked why the precaution is not posted and which precaution is to be used, being that they are 2 very different types i.e., Contact requires appropriate PPE when entering the room while EBP requires PPE using gowns and gloves during specific high-contact resident care activities. The DON did not have an answer. On 7/9/25 at 11:14 a.m., observation of Resident #45's room to now have an EBP sign posted on the door instructing staff to use gloves and gowns when performing high-contact resident care activities. At this time, Registered Nurse (RN #1) stated he/she is on EBP for both the wound and the IV line, has an active infection and is on 2 different antibiotics to "treat 3 different bugs" since admission. The surveyor asked what organism or "bug" he/she is being treated for. RN #1 stated, "I'm not sure, one is MRSA, I think". The surveyor asked what type of precautions he/she should be on while being treated for an MDRO. RN#1 stated, EBP and "originally I had put [resident #45] on contact precautions when [he/she] came to us" and she is not sure why or when it was changed. At this time, the	F0880		

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F0880 SS = E	Continued from page 23 surveyor discussed the facilities policy of when a resident has an active MDRO infection, they are to be Contact precautions. RN #1 did not have response. 2. On 7/7/25 at 10:23 a.m., and on 7/8/25 at 10:20 a.m., observation of Resident #47 to have bilateral feet wrapped in kerlix and wearing orthopedic shoes. At this time in an interview, he/she confirmed both feet had surgical wounds which required dressing changes. Review of the medical record states Resident #47 was admitted 6/11/25 with diagnosis of chronic osteomyelitis resulting in amputation of toes on both feet and surgical wounds requiring treatments every other day. In addition, he/she has a stage 2 pressure ulcer on the right hip requiring treatment three times daily. The room lacked notification/posting of Enhanced Barrier Precautions and available personal protective equipment. 3. On 7/7/25 at 9:14 a.m., a surveyor observed a small red and white "Stop, See Nurse for Instructions" sign on Resident #16's door frame. There was no Personal Protective Equipment (PPE) outside or inside the room, and there was no additional signage on the door. At this time, Certified Nurse Medication Aide (CNA-M) #3 was exiting the room, and a surveyor asked about the sign. CNA-M #3 stated the sign indicates precautions, but she is not sure what type of precautions this resident is on because today is her first day back as agency staff. On 7/7/25 at 10:53 a.m., during an interview, Registered Nurse (RN) #2 stated today is her first day at the facility and she is agency staff and is not sure if Resident #16 is on precautions. RN #2 then checked Resident #16's clinical record and stated Resident #16 has MRSA (methicillin-resistant staphylococcus aureus), and that she is not sure where PPE is located but thinks she was told in the closet next to the nurses' station. On 7/7/25 at 2:14 p.m., during an interview, CNA #1 stated today is her first day as a permanent staff member and that she is not sure if any residents on the Clearwater unit are on precautions and that she was not told where to find PPE but that she is training with CNA #2.	F0880		

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F0880 SS = E	Continued from page 24 On 7/7/25 at 2:52 p.m., during an interview, CNA #2 stated no residents on the Clearwater unit are on EBP or TBP and that there are gowns in the linen closet and trash cans in the supply closet, and trash cans get put in front of the door for residents on precautions. On 7/7/25 at 2:58 p.m., during a follow-up interview, CNA-M #3 stated she worked here as an agency staff member from December 2024-June 2025, and typically, residents have the red and white "Stop" signs hanging outside the door but no signage is posted indicating what type of precautions the resident is on, and if a resident on precautions, a trash can and a 3-drawer bin with gowns and gloves is placed outside the door. CNA-M #3 then stated residents with Foley catheters or wounds are not placed on EBP and that there are no residents on the Clearwater unit on EBP or TBP but she knows Resident #14 has a foot wound and Resident #7 has a Foley catheter. 4. Review of Resident #14's clinical record indicated Resident #14 has a right lateral midfoot diabetic ulcer. Further record review revealed an active physician order for "Right lateral foot Cleanse wound for at least 1 minute Apply Medihoney to wound bed ...Apply Mepilex ...Dressing change daily ..." On 7/8/25 at 8:30 a.m., a surveyor entered Resident #7 and Resident #14's shared room, and there was no "Stop" sign or other signage on the door and no PPE outside or inside the room. At this time, Resident #7 stated he/she has a Foley catheter, and when the Certified Nursing Assistants (CNAs) empty the drainage bag or the nurses change the catheter, they wear gloves but he/she has not noticed anyone wearing a gown or other PPE. On 7/8/25 at 1:08 p.m.-1:45 p.m., during an interview, the above concerns were discussed with the DON and Infection Preventionist (IP), and the DON stated "Stop" signs are placed outside a resident's door but no signage indicating what type of precautions or what type of PPE is required is placed on the resident's door. The surveyor asked how new staff are educated on infection control upon hire, as CNA #1, CAN-M #3, and RN #2 were day 1 staff on the Clearwater unit yesterday and could not tell a surveyor the location of PPE or if residents were on precautions and what type. The DON then stated Infection Control education is provided as part of a comprehensive orientation, but that does not	F0880		

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F0880 SS = E	Continued from page 25 take place on day 1 and is provided within the first week of employment. At this time, a surveyor requested additional evidence of the facility's ongoing surveillance and tracking for EBP and TBP and evidence of staff education on infection control measures. Review of the provided "Educational Program Sign-In Sheet ...Topic: Infection Control" Enhanced Barrier Precautions," dated 6/24/25 indicates 23 staff members attended, and of those, only 9 were nursing staff (8 CNAs, IP). Review of the provided f "Enhanced Barrier Precautions" surveillance census was dated 7/9/25 (after survey start date) and indicates 10 residents in the facility are on EBP. The census did not indicate Resident #14 and Resident #47 were on precautions, despite a surveyor previously discussing this with the DON and IP. On 7/9/25, at 12:03 p.m., during a follow-up interview with the DON, a surveyor discussed concern with recent EBP education only including 9 nursing staff and no evidence of EBP/TBP surveillance prior to the survey. The DON stated she posts a monthly calendar of mandatory annual training offerings, but if all required staff does not attend, she posts another calendar the following month offering the training again. At this time the DON confirmed the facility did not have ongoing EBP and TBP surveillance, tracking, and education in place. 5. Review of policy, "Legionnaires Prevention Program Policy," dated 7/19, states, " ...Establish a water management team ...The following employees will be on the Water Management Team ... The Administrator ...The Infection Control Specialist ...The Maintenance Director ...Corporate Plant Manager ...Describe Your Building Water Systems Using a Flow Diagram ...Identify Areas Where Legionella Could Grow & Spread on the flow diagram ...Decide where Control Measures should be applied & how to monitor them ...You will need to monitor to ensure your control measures are performing as designed ....Staff, residents and their representatives will be informed of the in place to keep the building water systems safe. A copy of the plan will be shared upon request ..." Further review of the policy lacked evidence of the description of the water system or a flow diagram and did not specify control measures or how the control measures are being	F0880		

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F0880 SS = E	Continued from page 26 monitored. On 7/8/25 at 1:08 p.m., during an interview with the Director of Nursing (DON) and Infection Preventionist (IP), a surveyor requested evidence of the facility's water management program. The DON stated she had asked the Administrator about water testing but could not provide a written plan. On 7/9/25 at 2:01 p.m., during a follow-up interview and after multiple surveyor requests, the DON stated she could not provide evidence of the facility's Legionella Water Management Program.	F0880		
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must	F0883		08/15/2025

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F0883 SS = D	Continued from page 27 develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure a resident who had elected to receive a Pneumococcal immunization received the immunization, for 1 of 5 resident records reviewed for immunizations (Resident #25) Review of Resident #25's clinical record revealed a signed Immunization Consent Form, dated 7/24/24, indicating Resident #25's legal representative consented to the Pneumococcal immunization. Further review of the clinical record lacked evidence that Resident #25 received or refused the Pneumococcal immunization. On 7/9/25 at 12:52 p.m., during an interview with two surveyors, the Infection Preventionist stated the Director of Nursing handles immunization tracking. On 7/9/25 at 12:57 p.m., two surveyors reviewed the above findings with the Director of Nursing.	F0883		