STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205170	A. BUILDING ______ B. WING ______	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODD FELLOWS HEALTH CARE CENTER	**85 CARON LANE AUBURN, ME 04210**

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F 000	INITIAL COMMENTS	F 000		

F 000 INITIAL COMMENTS

From 3/18/25 through 3/20/25, on-site visits were conducted at Odd Fellows Health Care Center for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification and investigating complaint #ME00049342 & #ME00050789. It was determined that Odd Fellows Health Care Center was not in substantial compliance with 42 CFR 483, subpart B-Requirements for Long Term Care Facilities.

F 550 SS=B Resident Rights/Exercise of Rights
CFR(s): 483.10(a)(1)(2)(b)(1)(2)

§483.10(a) Resident Rights.
The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her

Provider's Plan of Correction — F 550

F550
DON spoke with the CNAs immediately regarding having the residents properly covered at all times. They were informed that residents will not be allowed to come into a common area in just a johnnie, If not dressed and covered then they are to be wearing a robe that covers all exposed areas. — 04/03/2025

The DON made sure all residents had a bathrobe to ensure proper coverage if wearing a johnnie. — 04/03/2025

The DON instructed all direct care staff that at no time will residents be in public spaces without being fully dressed or in a bathrobe. The nurse on duty will monitor this each shift. — 04/03/2025

The DON will have direct care staff sign a paper acknowledging they have been so read and understand. — 04/18/2025

At an upcoming all nursing home staff mandatory inservice, all staff will be advised of this and instructed to let direct-care staff know if a resident is improperly dressed so the situation can be corrected. — 05/04/2025

The DON will conduct random audits at least weekly to assure compliance and report findings quarterly to the QAPI committee

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

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F 550	Continued From page 1	F 550		

rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observations and interviews, the facility failed to promote care for residents in a manner that maintained the residents' dignity and respect when staff failed to cover the resident's briefs during resident observations and failed to dress a resident prior to being seated for breakfast on 1 of 3 days of survey (3/18/25) (Resident #116, #1 and #66).

Findings:

1. On 3/18/25 at 8:58 a.m., Resident #116, was being assisted during ambulation with a walker, to his/her room from the dining room; the surveyor observed that his/her jonnie was open exposing his/her incontinence brief. At this time, the surveyor discussed the dignity concern with the Activities staff who was assisting the resident. The Activities staff stated she was just helping him/her walk back because the floor was wet. The staff continued to allow Resident #116 to ambulate with his/her incontinence brief exposed.

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F 550 Continued From page 2 F 550

2. On 3/18/25 at 9:05 a.m., during observation of dining, Resident #1 was sitting at the dining room table eating breakfast, wearing a jonnie and a zip up sweatshirt. In a brief interview with Resident #1, the surveyor asked if it bothered him/her that he/she is eating breakfast in a jonnie, he/she stated, "yes". The surveyor asked if he/she would like to be dressed prior to eating breakfast, he/she stated "Yes" and he/she likes to get dressed daily.

3. On 3/18/25 at 9:25 a.m., during observation of dining, Resident #66 was observed walking in the dining room to his/her bedroom with assistance from CNA #1, at this time the surveyor observed his/her jonnie was open exposing his/her incontience brief. At 9:27 a.m., during an interview with CNA #1 reguarding dignity concerns, the CNA stated that she usually covers the residents up so that their incontinence brief is not showing. The CNA then states they were just taking him/her to the bathroom.

On 3/20/25 at 11:37 a.m., the above was discussed with the Administrator and the Director of Nursing.

F 641 SS=D Accuracy of Assessments F 641
CFR(s): 483.20(g)

§483.20(g) Accuracy of Assessments.
The assessment must accurately reflect the resident's status.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility

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F 641	Continued From page 3 failed to ensure that Minimum Data Set (MDS) Version 3.0 Assessments were accurately coded in the area of Active Diagnosis for 1 of 21 sampled resident. (#5) Finding: Review of the resident's medical record indicated he/she had diagnoses of Hypertension, Hyperlipidemia and Diabetes. Resident #5's Quarterly MDS assessment dated 1/27/25 and Quarterly MDS Assessment dated 11/8/24 lacked coding under "Active Diagnosis" to indicate the resident had a diagnosis of Hypertension, Hyperlipidemia and Diabetes. On 3/19/25 at approximately 3:40 p.m. in an interview with the Director of Nursing, surveyor confirmed the MDS assessment dated 1/27/25 were not coded accurately to reflect the current status of the resident.	F 641	F641 The DON and the ADON reviewed the files to identify resident #5. The PCP on her next visit will be notified to change these diagnoses to inactive. The DON and ADON will assure that that the doctor's progress notes match their current active diagnoses with the MDS, and will audit them quarterly. The DON will report findings quarterly to the QAPI committee	04/16/2025
F 656 SS=E	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	F 656		

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F 656	Continued From page 4 physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews the facility failed to update/implement goals and interventions for 2 of 2 residents reviewed for pain management, 1 of 1 resident reviewed for Chronic Obstructive Pulmonary Disease (COPD), 1 of 1 resdients reviewed for	F 656		

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F 656	Continued From page 5 congestive heart faliure and a cardiac pacemaker (Resident #1, #6, #14). Findings: 1. On 3/18/25 at 9:05 a.m., and on 3/19/25 at 7:25 a.m., observations of Resident #1 in the dining room with oxygen at 2 Liters Per Minute (LPM) via a nasal cannula. Review of the medical record showed a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) requiring continuous use of oxygen supplementation and peripheral neuropathy requiring pain management with most recent increase of Gabapentin 200 mg (milligrams) on 1/7/25. Review of Resident #1's care plan recently updated with a target date of 3/2025, lacks evidence of goals and interventions for either COPD or pain management. 2. On 3/18/25 at 9:05 a.m., and on 3/19/25 at 7:25 a.m., observations of Resident #6 in the dining room with oxygen at 2 LPM via a nasal cannula. Review of the medical record showed a diagnosis of congestive heart failure and respiratory failure requiring continuous use of oxygen supplementation and presence of a cardiac pacemaker with pacemaker checks every 3 months. Review of Resident #6's care plan recently updated with a target date of 3/31/2025, lacked evidence of goals and interventions for either congestive heart failure or the presence of a cardiac pacemaker. On 3/18/25 at 2:52 p.m., the above was discussed with the Assistant Director of Nursing. 3. Review of Resident #14 medical record shows an active medication order for Tramadol 50 mg	F 656	F656 ADON corrected all care plans with COPD, pacemaker, and pain management to include goals and interventions. The ADON will assure that all residents on admission will have appropriate goals and interventions for residents with a COPD diagnosis or pain management or pacemaker in their Care plans. The ADON will monitor quarterly when she does the MDS/Care Plans The DON will review this ongoing and report findings quarterly to the QAPI committee	04/04/2025

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F 656 Continued From page 6 F 656

take 1 tablet 2 times daily, with the start date of 9/16/24. Further review of Resident #14 medical record lacks evidence of goals and interventions being put into place for pain management.

On 3/19/25 at 2:02 p.m., the above information was confirmed with the Director of Nursing.

F 677 SS=E ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) F 677

§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary 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 review the facility failed to provide Activities of Daily Living (ADL) care in the area of personal hygiene for 1 of 1 residents reviewed for ADL care (Resident #1) for 3 of 3 days of survey.

Findings:

On 3/18/25 at 9:05 a.m., Resident #1 was observed in the dining room with his/her right hand having several rings, the pinky ring had white coated debris stuck to the ring. At 9:18 a.m., A Certified Nurses Aid (CNA) and him/her if he/she would like to get dressed and freshened up for the day, the resident agreed. At 10:14 a.m., the resident was observed in his/her recliner and dressed appropriately. The pinky ring was still coated with the white dried debris.

On 3/19/25 at 7:25 a.m., on 3/20/25 at 7:55 a.m., and at 9:15 a.m., Resident #1 was observed, by 2 surveyors, in the dining room with his/her pinky

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F 677	Continued From page 7 ring coated with white dried debris. Review of the Minimum Data Set (MDS) 3.0 Quarterly assessment dated 11/29/24, section GG - Personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands states Resident 31 requires substantial/maximal assistance to complete the task. Review of the CNA documentation for March 2025 indicates Resident #1 is dependent to substantial assist for personal hygiene. On 3/20/25 at 11:37 a.m., the above was discussed with the Administrator and the Director of Nursing.	F 677	F677 The DON cleaned the ring immediately on learning of the issue. The DON will instruct all direct care staff that resident # 1 and all residents who need dependent to substantial assist for personal hygiene will attend to the cleanliness of all jewelry being worn or being put on and assure their cleanliness at all times. The charge nurses will monitor this daily. At an upcoming inservice, all staff will be advised of this and instructed to let direct-care staff know if a resident is wearing dirty jewelry so the situation can be corrected. The (IP) person will audit this weekly and report to the DON. The (IP) or the DON will report findings quarterly to the QAPI committee	03/20/2025 04/18/2025 05/04/2025
F 678 SS=E	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure all facility staff maintain training in cardiopulmonary resuscitation ("CPR") for Healthcare Providers. Findings: On 3/20/25 at 11:17 a.m., During an interview with the Director of Nursing (DON) and Assistant	F 678		

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F 678	Continued From page 8 Director of Nursing (ADON) state that it is not a requirement for facility staff to have their CPR certification besides nurses. Review of employee records show there are 2 full time staff members who are CPR certified and 2 per-diem staff members who are CPR certified. A review of the facility staffing with CPR certification for the month of March had the following shifts where there were no staff available with current CPR certification: -3/2/25 night and evening shift did not have any staff who were current in their CPR certification. -On 3/3/25 evening shift did not have any staff who were current in their CPR certification -On 3/4/25 evening and night shift did not have any staff who were current in their CPR certification -On 3/5/25 night shift did not have any staff who were current in their CPR certification -On 3/6/25 evening and night shift did not have any staff who were current in their CPR certification -On 3/7/25 night shift did not have any staff who were current in their CPR certification -On 3/8/25 day and night shift did not have any staff who were current in their CPR certification -On 3/9/25 5 hours on day shift and all of evening shift did not have any staff who were current in their CPR certification - On 3/10/25 night shift did not have any staff who were current in their CPR certification -On 3/11/25 evening and night shift did not have any staff who were current in their CPR certification -On 3/12/25 evening and night shift did not have any staff who were current in their CPR	F 678	F678 The DON will review and revise the facility CPR policy to reflect the appropriate CPR training for Nursing homes. According to regulations, all licensed nursing staff now have valid CPR training. And there is now a licensed nurse with CPR training in the facility 24/7 The business office will monitor the training certificates of licensed personnel to assure they are up-to-date and report to the DON when there is a need to update their certification, and the documentation will be maintained in their personnel file. At an upcoming inservice, all nurses will be advised of the requirement for CPR certification. The DON will review this ongoing and report findings quarterly to the QAPI committee	04/18/2025 03/26/2025 03/26/2025 05/04/2025

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F 678	Continued From page 9	F 678		

certification
-On 3/13/25 night shift did not have any staff who were current in their CPR certification
-On 3/15/25 4 hours on evening shift and all of night shift did not have any staff who were current in their CPR certification
-On 3/16/25 evening and night shift did not have any staff who were current in their CPR certification
-On 3/17/25 night shift did not have any staff who were current in their CPR certification
-On 3/18/25 night shift did not have any staff who were current in their CPR certification
-On 3/19/25night shift did not have any staff who were current in their CPR certification

Review of the facilities Cardiopulmonary Policy states: "Personnel have completed training on the initiation of Cardiopulmonary resuscitation (CPR) and basic life support (BLS), including defibrillation, for victims of sudden cardiac arrest" ... "Preparation for Cardiopulmonary Resuscitation 1. Obtain and/or maintain American Red Cross or American Heart Association certification in BLS/CPR for key clinical staff members who will direct resuscitative efforts, including non-licensed personnel" ... "4. Select and identify a CPR team for each shift in case of an actual cardiac arrest. To the extent possible, designate a team leader on each shift who is responsible for coordinating the rescue efforts and directing other team members during the rescue effort" ... "5. The CPR team in this facility shall include at least one nurse, one Licensed Practical Nurse, and two Certified Nursing Assistance, all of whom have received training and certification in CPR/BLS.

On 3/20/25 at 3:00 p.m., the Facility Administrator

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F 678	Continued From page 10 confirmed there are 4 of 24 residents who are a "Full Code" and could potentially require CPR however, all residents are at risk for choking.	F 678		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, 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 2 of 3 residents reviewed for respiratory care (Resident # 1 and #6). Findings: 1. On 3/18/25 at 9:05 a.m., and on 3/19/25 at 7:25 a.m., observations of Resident #1 in the dining room with Oxygen (O2) at 2 Liters Per Minute (LPM) via a nasal cannula. The nasal cannula (nc) prongs were discolored with an orange color and the tubing was not dated. Review of the medical record showed a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) requiring continuous use of oxygen supplementation and a physician order dated 12/23/19 for O2 2LPM via NC for COPD" and an	F 695		

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F 695	Continued From page 11 order dated 3/12/18 to "Change O2 tubing monthly on the 19th of each month". Review of the Treatment Administration Record (TAR) for February and March of 2025 indicated the O2 nasal cannula tubing is changed monthly. 2. On 3/18/25 at 9:05 a.m., observation of Resident #6 in the dining room with Oxygen at 2 LPM via an undated nasal cannula. On 3/19/25 at 7:25 a.m., observations of Resident #6 in the dining room with the nasal cannula, dated 2/22/25. Review of the medical record showed a diagnosis of congestive heart failure and respiratory failure requiring continuous use of Oxygen supplementation. A physician order dated 3/23/23 for O2 at 2LPM via nc continuous and an order dated 6/22/23 for O2 tubing change monthly on the 22nd. Review of the Treatment Administration Record (TAR) for February and March of 2025 indicated the O2 nasal cannula tubing is changed monthly. The facilities "Oxygen Tubing change" policy updated 10/20/24 states, "Oxygen tubing will be changed at least every 2 weeks or as needed. Changing will be done by a nurse and they will document in the TAR." On 3/19/25 at 11:05 a.m., during an interview, the Director of Nursing confirmed the above stating, oxygen tubing should be changed every 2 weeks as per the policy.	F 695	F695 The TAR has been corrected to state that the O2 tubing will be changed every two weeks and the O2 tubing will be dated for the day it was changed. The DON will instruct the licensed nursing staff on proper cleaning and documenting required for nasal cannula tubing. Staff so instructed will sign a paper acknowledging so, At an upcoming inservice, all nurses will be reminded. The DON will review this ongoing and report findings quarterly to the QAPI committee	04/07/2025 04/18/2025 05/04/2025
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent,	F 699		

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F 699	Continued From page 12 trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to identify a resident's past history of Post-Traumatic Stress Disorder (PTSD)/trauma to determine what trigger(s) might cause re-traumatization for 1 of 1 resident reviewed with a diagnosis of PTSD (Resident #14) Finding: On 3/19/25, review of Resident #14's medical record contained several providers progress notes dated 1/28/25, 1/16/25, 11/26/24, 11/16/24, 10/22/24, and on 10/8/24 under the section "Past Medical History" indicates he/she has a diagnosis of "Post Traumatic Stress Disorder". Further review of his/her medical record lacked evidence that the facility assessed the resident for what triggers they might have and ways to prevent re-traumatization. In addition, Resident #14's care plan lacked evidence of a trauma informed care plan with identified triggers and interventions to prevent re-traumatization. On 3/19/25 at 9:47 a.m., During an interview, the Licensed Social Worker states that the facility does not assess residents for PTSD/trauma informed care. At this time the above information was confirmed with the Director of Nursing and the Licensed Social Worker.	F 699	F699 The Administrator will develop a policy for assessing residents for Trauma Informed Care. All residents will be assessed by the Social Services Director for "Post Traumatic Stress Disorder" on admission. New residents ongoing will also be assessed. The assessment will document any evidence of what triggers they might have and ways to prevent re-traumatization. A Care plan will be created for all residents and for new residents moving forward that identifies triggers and interventions to prevent re-traumatization. The DON will review this ongoing and report findings quarterly to the QAPI committee	05/04/2025 04/25/2025 04/25/2025 05/04/2025
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		

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F 761	Continued From page 13	F 761		

§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 adequately date and properly dispose of open medications according to manufacturer specifications, failed to ensure expired medications were removed from the supply available for use and failed to ensure only residents medications were in the medicine cart for 1 of 1 medication cart observed and 1 of 1 medication room observed.

Findings:

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F 761	Continued From page 14 On 3/18/25 from 8:20 a.m., through 8:42 a.m., during observation of the medication room and medication cart with the Licensed Practical Nurse #2 (LPN #2), the following was observed: The medication room refrigerator contained an opened and unlabeled vial of Tuberculin Purified Protein Derivative with manufactures instructions, "Once entered. Vial should be discarded after 30 days." The medication cart, top draw, had 2 opened bottles of Lumigan eye drops, one with expiration date of 2024/08 and the second with the expiration date of 2025/02. In addition, there was an unlabeled medicine cup with a small white pill in it. The LPN #2 stated the pill was one of the house cat's daily medicines. Upon further review, the cats medicine bottle containing Phenobarbital 16.2 milligrams (mg) tabs were stored in a cabinet in the medication room. LPN #2 stated it's the nurse's responsibility to give the cat the pill, and it was in the medication cart because she could not find him. On 3/19/25 at 11:05 a.m., the above was discussed with the Director of Nursing	F 761	F761 A nurse will be assigned monthly to check medications for expiration date. DON will inform nurses that cat medicine cannot be stored in the medication cart. At an upcoming inservice for licensed nurses, these issues will be reviewed. The DON will audit monthly to assure that the nurses follow the proper procedure. The DON will review this ongoing and report findings quarterly to the QAPI committee.	04/11/2025 05/04/2025
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	F 812		

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F 812	Continued From page 15 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 and interviews, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for floors, walls, and the dish washer for 3 of 3 days of survey. Furthermore, the facility failed to ensure staff were wearing proper hair/beard coverings and maintaining proper hand hygiene while serving food for 1 of 3 days of survey. Findings: 1. On 3/18/25 through 3/20/25, a surveyor observed the following: > The kitchen floor was dirty with food debris and trash around the entire floor and under the equipment and shelving. > The kitchen walls were covered with dirt and food debris. > The dish washer was covered with dirt and debris. >The stand mixer was covered with dirt and debris >The food processor was covered with dirt and debris On 3/18/25 at 11:50 a.m., the above information	F 812	F812 The dietary staff will receive one-on-one education about cleaning of the dietary areas and use of hair and beard nets while on duty. At an upcoming inservice for Dietary staff, these issues will be reviewed. The Dietary Supervisor will monitor dietary staff to assure they follow the proper procedure and report findings quarterly to QAPI committee The CNAs who serve meals have been educated immediately by the DON that they are to wear a hairnet and to properly use hand hygiene when serving food. Hairnets have been placed on the bottom of the steam cart for easy access and there is hand sanitizer kept on top of the steam cart at all times, and the staff found not wearing a hairnet or a beardnet have been spoken to. The (IP) person will do weekly audits to observe staff serving meals to assure that proper hair and hand hygiene is being followed and will discuss the findings with the DON. At an upcoming all-staff meeting, the hairnet issue will again be reviewed. The Dietary Supervisor will review this ongoing and report to the QAPI committee	04/11/2025 05/04/2025 04/11/2025 03/20/2025 05/04/2025

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F 812	Continued From page 16	F 812		

confirmed with the Director of Food Services. On 3/20/25 at 8:27 a.m., the above information was confirmed with the Facility Administrator.

2. On 3/19/25 at 7:25 a.m., Observation of Certified Nursing Assistant #1 (CNA) serving 11 trays without hair protection. Hair protection was applied at 7:35 a.m. with surveyor intervention. The surveyor then observed CNA#1 serve 4 more trays without doing proper hand hygiene after touching her hair and clothing, after surveyor intervention the CNA then washed her hands.

Review of facility policy "Hygiene Staff Cleanliness" last revised on 1/24/25 states "Wear a hair-net or hat continuously during shift in kitchen, dish room, and dining room" and "Staff should wash their hands: ...after touching any part of the body- ie. Forehead, chin, ears, etc. (including clothes)".

On 3/19/25 at 9:16 a.m., During an interview with the Facility Administrator, the above information was confirmed.

3. On 3/19/25 at 7:50 a.m., Observation of a Kitchen Cook prepping food with no beard protection.

On 3/19/25 at 8:05 a.m., Observation of a Dietary Aid in the kitchen not wearing a hair net.

Review of facility policy "Hygiene Staff Cleanliness" last revised on 1/24/25 states "Wear a hair-net or hat continuously during shift in kitchen, dish room, and dining room" and "All facial hair must be covered with an effective hair restraint which must be worn continuously throughout shift while in kitchen, dish room, and

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F 812	Continued From page 17 dining room". On 3/19/25 at 9:16 a.m., the above information was confirmed with the dietary supervisor.	F 812		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse,	F 842		

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F 842	Continued From page 18 neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interviews, observations and record reviews and interview, the facility failed to ensure that clinical records were complete and contained accurate information for 1 of 3 residents observed for medications (Resident #6) and 1 of 1 reviewed	F 842		

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F 842	Continued From page 19 for Activities of Daily Living (ADL's) (Resident #1). Findings: 1. On 3/19/25 at 7:29 a.m., during observation of medication administration with the Licensed Practical Nurse #2 (LPN#2). The LPN#2 signed off the Medication Administration Record (MAR) that she put Resident #6's bilateral hearing aids on in the AM. She then stated, "I sign them off but not put them in. Only when [him/her] family comes in, unless family request it." Review of the physician orders dated 10/6/23 stated, "bilateral hearing aids on in AM, off at HS (hour of sleep)". The most recent care plan with a goal target date of 3/31/25 states, "Give [him/her] hearing aids when family requests. Do not use them routinely, per family." Further review of the MAR indicates by nursing documentation that Resident #6 as having his/her hearing aids put in and taken out daily for the month of February and March of 2025. 2. On 3/20/25 during review of Resident #1's ADL documentation from Certified Nurses Aides lacked completed documentation for ADL care for 3 of 19 days reviewed. On 3/20/25 at 11:37 a.m., the above was discussed with the Administrator and Director of Nursing.	F 842	F842 1. The MAR order for hearing aides on this resident was changed to reflect the care plan of hearing aides are only to be put in when the family visits and asks for them. The nurse on duty will provide the hearing aide on family's request and document appropriately. At an upcoming inservice, this will be reviewed. The DON will monitor monthly to assure that this care plan is followed and report to the QAPI committee. 2. Each CNA has been reminded that all ADL care documentation will be completed every day, and will sign a paper acknowledging that. At an upcoming inservice for CNAs, this will be reviewed. The charge nurses will monitor this daily and the ADON or DON will monitor to assure appropriate charting is done. The DON will review this ongoing and report to the QAPI committee.	04/11/2025 05/04/2025 04/18/2025 05/04/2025
F 880 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	F 880		

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comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§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

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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 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 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 for a Healthcare-Associated Infections (HAI,) failed to apply appropriate interventions including Transmission Based Precautions (TBP) to prevent further spread of a gastrointestinal symptoms, failed to develop and implement elements of a Legionella Water Management Program, failed the wear appropriate personal protective equipment (PPE) while administering eye drops and failed to ensure the facility cats remain off the kitchenette countertops and the dining room table. This has the potential to affect all 23 residents.

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Findings:

1. On 3/3/25, the Division of Licensing and Certification received an anonymous complaint stating, from the end of February into March, both residents and staff had experienced gastrointestinal symptoms of nausea, vomiting and diarrhea which started on the Residential Care side and spread to the Long-Term Care residents and staff, and stated the Director of Nursing/Infection Preventionists (DON/IP) "claimed" she tested residents for COVID-19, but only had some people wearing regular masks, failed to provide appropriate PPE when the symptoms started to spread rapidly and no precautions were being taken for the residents or the workers.

From 3/18/25 through 3/20/25 the above complaint was investigated. During this investigation several interviews were completed with staff, who wish to remain anonymous.

Staff interview #1: The surveyor asked this staff about any recent outbreaks or sickness including nausea, vomiting and diarrhea (n/v/d). The staff stated, "maybe Norovirus", "It was fast and furious, bunch of people sick" including him/herself. "We had some people sent home". The surveyor asked what PPE was available, staff stated, gloves, no gowns, we have masks. The surveyor asked if gowns were accessible, staff stated, they are down in the stock room. The surveyor asked if PPE and Transmission Based Precaution signage was placed outside of the resident's rooms who were sick, the staff stated, "No, we kept people in their room and brought them liquids and broth, if they didn't vomit

Provider's Plan of Correction:

1. F880

The DON will be relinquishing her DON duties to the new DON who will start. — 04/28/2025

The former DON will commit 24 hours/week of her time to infection control as the official Infection Preventionist (IP) of the facility. — 04/28/2025

The staff will be educated at an upcoming inservice to assure that they understand their responsibilities during an infections outbreak of any kind. — 05/04/2025

The (IP) will use a line-list if there is an outbreak. — 05/04/2025

The (IP) will create a guide for quick response for the staff to use upon learning of an infection which will include isolation, signage PPE procedures and management notification. — 05/04/2025

The (IP) will ensure that the facility has testing kits on hand for norovirus in addition to the flu tests and COVID-19 tests on-hand. — 04/25/2025

The (IP) will review and update the Infection control policies and use the policies during the upcoming infection control inservice. — 05/04/2025

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODD FELLOWS HEALTH CARE CENTER	**85 CARON LANE AUBURN, ME 04210**

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F 880	Continued From page 23	F 880		

overnight, they came out the next day." The staff stated both the DON and the Assistant DON knew about the gastrointestinal symptoms occurring.

Staff interview #2: The surveyor asked this staff about any recent outbreaks or sickness including n/v/d. This staff stated, "nothing I could name, nothing diagnosed, we had some about 24-48 hours, diarrhea mainly a couple people vomited ...If they had diarrhea and vomiting, we kept them in their rooms, it was 1 -2 people at a time." The surveyor asked if the residents with only diarrhea were kept in their rooms, he/she stated "No". They were only kept in their rooms if they had both vomiting and diarrhea. The surveyor aske if PPE is available, he/she stated, "we have everything always available, gowns, shields, masks N95 ... In the storage room" The surveyor asked, if during this time with the residents n/v/d, were PPE carts and TBP signs posted at the resident's doors, he/she stated, "I don't believe so".

Staff interview #3: The surveyor asked this staff about any recent outbreaks or sickness including n/v/d. The staff stated, "a few weeks back there was a nausea, vomiting and diarrhea, we had that" including him/herself, "Some did". The surveyor asked if any residents and staff were tested, he/she stated, "Not that I'm aware of." The surveyor asked how long was the gastrointestinal symptoms in the facility, he/she state, "Maybe about a week." The surveyor asked if TBP were put into place, he/she stated, "Not really, I did my own, I wore gloves and washed my hands." The surveyor asked if he/she had worn a gown in addition to the gloves and mask while providing care to a resident who had n/v/d, he/she stated,

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"No gowns up here, they have some downstairs." The surveyor asked, if during this time with the residents n/v/d, were PPE carts and TBP signs posted at the resident's doors, he/she stated, "no". The surveyor then asked if he/she was given education on what to do and what to wear while providing care for a sick resident, he/she stated, "I was told to wash my hands, there was a sign on the door (main entrance) that we had flu like symptoms."

Staff interview #4: The surveyor asked this staff about any recent outbreaks or sickness including n/v/d. He/she stated, "some resident's sick. One day it was this room the next day the other rooms, not at the same time" The surveyor asked what PPE was worn while caring for the residents with the symptoms, he/she stated, "Usually have mask and gloves at nurses' station, gloves are in the rooms. If symptoms they stay in room." The surveyor asked if he/she wore gowns, the staff stated, "No, mask and gloves and wash hands all the time." The surveyor asked, if during this time with the residents n/v/d, were PPE carts and TBP signs posted at the resident's doors, he/she stated, "No, when we had covid". The surveyor asked how long was the gastrointestinal symptoms in the facility, he/she state, "About 2 weeks, some staff, some patients, but not that long." The surveyor asked if he/she had access to gowns, he/she stated, "Yes, we have it. If something serious they have a cart set up for us."

Staff interview #5: The surveyor asked this staff about any recent outbreaks or sickness including n/v/d. He/she stated that there was a "GI bug, nausea, vomiting and diarrhea going around, not last week but the week before", including him/herself. The surveyor asked how long this GI

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F 880	Continued From page 25 Bug lasted in the facility, he/she stated, "No more than 2 weeks, it was like a few, then another few, but not all at the same time. Then the next day another person would get it." The surveyor asked if any of the residents experiencing the GI bug were placed on TBP and had a PPE cart outside of their rooms. The staff stated, "No, we kept them in their rooms and doorways and gave them broth." The surveyor asked if he/she had access to PPE, he/she stated, "We have gloves and masks". The surveyor asked if he/she had worn gowns in addition to the mask and gloves, while providing care for residents with the gastrointestinal symptoms, the staff stated, "We were not instructed to where them. I know where they are." The surveyor asked if he/she was instructed to wear masks, he/she stated, "It was optional". On 3/20/25 at 8:17 a.m., during an interview, the DON/IP was asked if the facility had a system in place for tracking and identifying infection trends. The DON/IP stated forms are filled out if a resident has symptoms and if an antibiotic is prescribed. The surveyor requested the facilities tracking forms for infections/outbreaks for the past 3 months. The DON/IP stated she doesn't have an all-inclusive form but uses different forms that she has to fill out when a resident is placed on an antibiotic. The surveyor asked if the facility had any recent outbreaks or sickness including nausea, vomiting and diarrhea. She stated, "We have had a couple people with diarrhea. It was very, very quick started on ResCare" ... "it came so quickly. I tested 5 residents for influenza and COVID, all came back negative. By the time I got the results back they were all done." The surveyor asked if the facility had Point of care (POC) tests for COVID-19 and rapid influenza	F 880		

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F 880	Continued From page 26 tests, she stated, "No, we don't have those. I swabbed them and sent them out." The surveyor asked again about the POC COVID tests due to previously in the interview the DON/IP stated she would test staff in the parking lot if they had symptoms of COVID, she stated, "Oh, we have plenty of the COVID tests, we don't have the rapid influenza." The surveyor asked if the POC COVID test was used on residents or staff during this sickness, "No, we had one staff go to the hospital and her flu and covid test came back negative, so they presumed it was Norovirus. By that time, it was all done." The surveyor asked if she had tested residents for norovirus, she stated "No, we had 5 in the nursing home, they were kept in their room, they were kept on clear liquids for the day and but the next day they were all done." The Surveyor asked if PPE was placed out, she stated, "Yes, we had mask, gowns and gloves, we had carts out." At this time, the surveyor requested the resident and staff line list for this n/v/d that occurred. The DON/IP stated she only had a list of who had symptoms that she had emailed to the Center for Disease Control. She provided an email list, dated 3/10/25 which had names of 14 Residential care residents, 5 nursing home residents and 26 facility staff. This "list" lacked the dates of when the symptoms began and ended, what the symptoms were, if TBP were initiated and resolved, if testing was completed and results. Review of the medical records from the end of February through March for the 5 nursing home residents provided on the list of symptoms, lacked evidence of any gastrointestinal symptoms, doctor and/or family notification, TBP in place or any measures put into place during the time period of the above gastrointestinal	F 880		

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symptoms occurred.

Review of the facility provided infection control reporting form for February 2025 had only one resident experiencing respiratory symptoms. As of the recertification exit on 3/20/25 at 5:15 p.m. the requested infection control surveillance and tracking for March had not been provided

The facilities policies and procedures include: "Surveillance of Infections" policy updated on 6/12/24 states, "The infection preventionist will conduct ongoing surveillance of Healthcare-Associated Infections (HAI) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions." ... "Data collection and recording:
1. For residents with infections that meet the criteria for definition of infection for surveillance, collect the following data as appropriate:
a. Identifying information (i.e., residents name, age, room number, unit, and attending physician)
b. Diagnosis
c. Admission date, date of onset of infection (may list symptoms, if known, or date of positive diagnostic test).
d. infection site
e. pathogens
f. invasive procedures or risk factors
g. Pertinent remarks (additional relevant information ... other symptoms ...)
h. treatment measures and precautions (interventions and steps taken that may reduce risk) ...
3. Daily: record detailed information about the residents and infection on an individual infection report form.

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4. Monthly: collect information from individual resident infection reports and enter line listing of infections by resident for the entire month ..."

"Infection Preventionist" updated on 10/20/24 states, "The Infection Preventionists (IP) will ensure that: staff appropriately use PPE including, but not limited to, the following: ... An isolation gown is worn for direct resident contact if the resident had uncontained secretions or excretions ... The IP will determine that appropriate Transmission-Based Precautions are implemented ...For a resident with an undiagnosed respiratory infection: staff follow standard, contact, and droplet precautions (i.e., facemask, gloves, isolation gown) with eye protection when caring for a resident unless the suspected diagnosis requires airborne precautions ... For a resident with known or suspected COVID-19: staff wear gloves, isolation gown, eye protection and an N95 or higher level respirator if available ... That there is signage on the use of specific PPE (for staff) posted in appropriate locations in the facility (e.g., outside of a residence room, wing, or facility wide) ... that appropriate staff are aware of process/protocols for transmission-based precautions and how staff is monitored for compliance."

"COVID-19 Testing and Monitoring" updated on 10/12/24, states " ... Staff - if they are at the facility, will be given a test and if positive, sent home to isolate ... Residents - if residents have symptoms they will be tested, if positive, the resident will be isolated to their room or another room if necessary and they will be put on extra precautions for staff entering the room."

"Personal Protective Equipment - Using Gowns"

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F 880	Continued From page 29 updated on 2/20/25, states "To protect soiling of clothing with infectious material. To prevent splashing or spilling blood or body fluids onto clothing or exposed skin." 2. Review of the provided Water Management program was a one page "Legionella Water Management Policy" updated on "10/14/25" which stated, "Odd Fellows' and Rebekah's Home conducts bi-weekly testing of water temperature at all faucets and bathing areas ... Additional surveillance checks will be performed if the following situations occur: control limits are not met, major maintenance or water service change, diseases associated with the water system and changes in law, regulations, standards or guidelines." The policy lacks evidence of the buildings water systems flow diagram, what control measures are in place and where, monitoring of the controls including testing protocols, acceptable ranges, documents of testing results and ways to intervene when control limits are not met. On 3/19/25 at 9:45 a.m., during an interview with the Administrator, the surveyor requested additional information which was lacking from the policy provided. The Administrator stated the city of Auburn does the water testing of legionella and the one paper he provided (Legionella Water Management Policy) was all he had. As of the recertification exit on 3/20/25 at 5:15 p.m. the above requested documents were not provided. 3. On 3/19/25 at 7:29 a.m., during the medication administration observation with the Licensed Practical Nurse #2 (LPN#2), the following was	F 880	2. F880 The Director of Maintenance will develop a Legionella Water Management Policy that meets all regulations and maintain the appropriate testing The Director of Maintenance will review this ongoing and report to the QAPI committee	05/04/2025

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F 880	Continued From page 30 observed: LPN#2 opened the bottle of artificial tears and without applying gloves, she opened each eye by pulling the lower lid down and administered the drops. She then handed the resident a tissue to use for both eyes. At this time, the surveyor asked LPN #2, when administering eye drops should you wear gloves? She stated, "Yes. I should have worn gloves". Review of the Facilities policy on "Instillation of Eye Drops" updated on 10/20/24 states, "Steps in Procedure...Put on gloves... gently pull the lower eyelid down. Instruct the resident to look up. Drop the medication into the mid lower eyelid ...Gently dry the eyelid with cotton ball if dripping occurs. (Note: Use only one cotton ball per wipe.) ...Remove gloves and discard into designated container. Wash and dry your hands thoroughly." On 3/19/25 at 11:05 a.m., the above was discussed with the Director of Nursing. 4. On 3/19/25 at 2:26 p.m., a surveyor observed a cat sitting on a dining room table (East side) with a Certified Nurse Aid documenting at the same table, allowing the cat to remain on the table for approx. 1 min. The surveyor discussed the observation with the Assistant Director of Nursing. 5. Review of the Facility Pet Policy last reviewed on 10/20/24 states "The pets are to be kept off tables and desks and when they violate this they are to be removed and the area disinfected. On 3/18/25 at 3:30 p.m., Observation of 2 white cats walking on the Long-Term Care Unit kitchenette countertops. Further observation shows the countertops containing food, coffee	F 880	3. The DON will educate the nurse in question about the proper procedure for eyedrop administration This was done and a warning given. At an upcoming inservice, this policy will be reviewed. The (IP) will monitor monthly that the nurses follow the proper procedure. The results will be provided to the DON who will report to the QAPI committee 4&5. F880 The DON will review with each licensed nurse, CNA and housekeeper their responsibilities to keep cats from desks tables and countertops at all times and to disinfect the area any time that a cat has violated the rule. Sani-wipes have been placed on the kitchenette counter for easy access and staff have been instructed to removed cats immediately from any surface and immediately disinfect the surface. At an upcoming inservice for licensed nurses, this will be reviewed. Al staff will monitor this every shift. The DON will monitor review this ongoing and report to the QAPI committee.	04/03/2025 05/04/2025 04/18/2025 04/07/2025 05/04/2025

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F 880	Continued From page 31 pots, toasters, face masks, and a microwave. On 3/18/25 at 3:36 p.m., During an interview with Licensed Practical Nurse (LPN) #1, who states that the cats often jump on the kitchenette countertops, but staff try to keep them off as much as possible. Follow up questions disclose that the countertops are mainly cleaned once a shift and not after each time the cats are on the countertops. On 3/19/24 at 7:24 a.m., the above information was confirmed with the Director of Nursing On 3/19/25 at 2:26 p.m., Observation of a white cat on the east side dining room table with a Certified Nursing Assistant documenting at the same table, not attempting to remove the cat from the table. At this time the surveyor got the Assistant Director of Nursing to observe the above infromation. On 3/20/25 at 12:09 p.m., the above information was confirmed with the Director of Nursing.	F 880		
F 882 SS=E	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training,	F 882		

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F 882	Continued From page 32 experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to designate a qualified staff member to function as the Infection Preventionist who works at least part time and who is responsible for the facility's Infection Control Program. This has the potential to affect all residents in the facility. Finding: On 3/19/25 at 11:05 a.m., during an interview, the Director of Nursing (DON) confirmed she works full time in the DON capacity, and she is also the Infection Preventionist (IP) for the facility and completed her online education on 3/30/22. At this time, the surveyor confirmed the facility did not have a dedicated IP who worked at least 24 hours in the IP role. The DON stated she was unaware that she could not function in the capacity of both the full time DON and the IP which requires 24 hours.	F 882	F882 The DON will be relinquishing her DON duties to the new DON who will start. The former DON will commit 24 hours/week of her time to infection control as the official Infection Preventionist (IP) of the facility.	04/28/2025 04/28//2025
F 883 SS=E	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,	F 883		

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F 883	Continued From page 33 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 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	F 883		

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F 883	Continued From page 34 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, interview and the facility's immunization policy, the facility failed to implement their pneumococcal immunization policy for 4 of 9 residents whose immunization records were reviewed (1, #3, #7, #69). Findings: On 3/20/25, clinical record review indicated: 1. Review of Resident #1's medical record stated he/she had the Pneumococcal conjugate vaccine 13 on 11/24/15. The record lacked evidence that Resident #1 had received, been offered, or refused further pneumonia vaccines. 2. Review of Resident #3's medical record stated he/she was admitted in March of 2023. The record lacked evidence that Resident #3 had received, been offered, or refused the pneumonia vaccines. On 3/20/25 at 9:29 a.m., the Assistant Director of Nursing (ADON) reviewed Resident #3's chart and stated, "There is no proof of one, but [he/she] said [he/she] had it about 10 years ago." At this time, the ADON confirmed Resident #3 had not been offered and/or refused the pneumonia	F 883	F883 The Social Service Director will create an addendum to the Admission contract for the resident to provide proof of vaccinations being received offered or refused. They will be asked to sign this document that affirms what shots they have received and that they have been offered the shots and whether they accept or decline. The DON will assure that all forms have been filled out and that the shots requested are given. The ADON and DON will monitor new admissions and ongoing to assure that the appropriate records are maintained. The DON will review this ongoing and report to the QAPI committee.	04/25/2025 04/25/2025

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F 883	Continued From page 35	F 883		

vaccine.

3. Review of Resident #7's medical record stated he/she was admitted in February of 2023. The record lacked evidence that Resident #37 had received, been offered, or refused the pneumonia vaccines.

4. Review of Resident #69's medical record stated he/she had a pneumonia vaccine in 1998. The record lacked evidence that Resident #69 had received, been offered, or refused further pneumonia vaccines.

On 3/20/25 at 9:59 a.m., during an interview, the ADON confirmed the above stating, "I know it hasn't been offered because we haven't had a clinic."

The facilities "Vaccination of Residents" policy and procedure updated 2/20/25 states, "All residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated, or the resident has already been vaccinated" and "All new residents shall be assessed for current vaccination status upon admission."

Pneumococcal Vaccine Policy and Procedure updated on 2/20/25 states, "Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated." and "assessment of pneumococcal vaccine status will be conducted within five (5) working days of the resident's admission if not conducted prior to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205170	A. BUILDING ______ B. WING ______	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODD FELLOWS HEALTH CARE CENTER	**85 CARON LANE AUBURN, ME 04210**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 36 admission."	F 883		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on Certified Nursing Assistant (CNA) employee education record review and interview, the facility failed to monitor and ensure that the CNA attended the required 12 hours of annual in-service education training for 5 of 5 randomly selected CNAs employed greater than 1 year. Furthermore, the facility failed to ensure that the CNA attended the mandatory yearly Dementia, Resident Rights, and Abuse and Neglect training for 3 of 5 CNA's employed greater than 1 year. (CNA #2, CNA #3, CNA #4, CNA #5, and CNA #6).	F 947	F947 All CNAs will have 12 hours of inservice education per year. We will provide 12 or more mandatory inservices. We will also provide 6 take-home education packets with a test to complete for their files or 6 hours of on-line training options that give proof of completion, for them to have the ability to complete their training. The 12 hours of training will include at least one hour of resident abuse training and dementia management training. CNAs who do not have the requisite 12 hours of inservice credits by December 1st will not be able to work until that requirement is met. The office staff will maintain the records of the inservices and the hours of the CNAs and will provide the DON with an updated list by December 1st, and as needed for the report that the DON will be making quarterly to the QAPI committee regarding CNA education status.	05/04/2025

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 947	Continued From page 37	F 947		

On 3/20/25 a surveyor reviewed the following employee files:

1. CNA #2 was hired on 7/2021. Review of CNA #2 Employee In-service/attendance Records lacked evidence of the required 12 hours for continuing education for the year 2024.

2. CNA #3 was hired on 10/2017. Review of CNA #3 Employee In-service/attendance Records lacked evidence of Resident Rights and Abuse and Neglect training for 2024. Furthermore, the record lacked evidence of the required 12 hours for continuing education for the year 2024.

3. CNA #4 was hired on 8/2012. Review of CNA #4 Employee In-service/attendance Records lacked evidence of Dementia, Resident Rights, and Abuse and Neglect training for 2024. Furthermore, the record lacked evidence of the required 12 hours for continuing education for the year 2024.

4. CNA #5 was hired on 3/2018. Review of CNA #5 Employee In-service/attendance Records lacked evidence of the required 12 hours for continuing education for the year 2024.

5. CNA #6 was hired on 2/2021. Review of CNA #6 Employee In-service/attendance Records lacked evidence of Resident Rights and Abuse and Neglect training for 2024. Furthermore, the record lacked evidence of the required 12 hours for continuing education for the year 2024.

On 3/20/25 at 2:30 p.m., the above information was confirmed with the Director of Nursing