STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205078	A. BUILDING _____ B. WING _____	C 01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINSHIP GREEN CENTER FOR HEALTH & REHAB, LLC	51 WINSHIP ST BATH, ME 04530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/13/25, an on-site visit was completed at Winship Green Center for Health and Rehab for the purpose of complaint investigation #ME00050156. It was determined that Winship Green Center for Health and Rehab, is not in compliance with 42 CFR Part 483, Subpart B-Requirements for Long Term Care Facilities.	F 000		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive	F 758	Ftag 758 • Resident #1 no longer resides at the facility. • The DNS completed a house audit of residents on anti-psychotic medications to ensure no other residents were affected by this practice. • The SDC/ designee will complete education with licensed nurses on the regulatory requirements of antipsychotic utilization. (to include who can sign for consent, when to sign a new consent, what is the drug classifications of anti-psychotic medications and review the black box warning)	2/5/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Paul R Winchell — TITLE: Administrator — (X6) DATE: Jan 22 2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 758	Continued From page 1 psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to provide evidence that the Resident Representative was informed of a physician order for an antipsychotic medication, informed of the side effects of that medication and given the opportunity to agree or disagree with the use of medication for 1 of 3 sampled residents reviewed for unnecessary medications (#1). Finding: A review of the clinical record Resident #1 had been admitted to the facility on 12/24/24 from an acute care hospital. Admission diagnoses included Urinary Tract Infection, Metabolic Encephalopathy, Delirium, Insulin Dependent Diabetes Mellitus, Chronic Kidney Disease, Major	F 758		

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F 758	Continued From page 2 Depressive Disorder, Obsessive Compulsive Disorder, Congestive Heart Failure, Aortic Stenosis, and a history of frequent falls. On 12/25/24, Resident #1 experienced agitation, increased confusion and became aggressive and combative to staff and other residents. Efforts to redirect were ineffective and Resident #1 was transferred to the Emergency Department via ambulance for evaluation. Resident #1 was treated for a urinary tract infection, prescribed antibiotics, and returned to the facility. Over the next 5 days, Resident #1 continued to display an altered mental status with confusion, wandering, and combative behaviors at times. A provider note, dated 12/26/24, stated "the discharge summary included the addition of Risperidone (an antipsychotic) 0.5 mg (milligrams) tablets twice daily as needed, without clarification of diagnosis." A review of facility admission orders, dated 12/24/24, included an order for Risperdone 0.5 mg by mouth every 12 hours as needed for behavioral disturbances X(times) 14 days. On admission, Resident #1 signed a facility Psychoactive Medication Consent Form, dated 12/24/24. The form was signed by the facility representative, a licensed practical nurse (LPN). It was noted to have been incorrectly completed with Risperidone entered as a Mood Stabilizer and listed possible side effects for the wrong class of medications. The form noted the Food and Drug Administration had issued a Black Box Warning for antipsychotic medication use in the elderly, however, the form did not indicate this was the type of medication prescribed.	F 758	• The DNS/designee will complete daily audits Monday-Friday at clinical rounds x 2 months, then random weekly x 1 month verifying that new orders for anti-psychotic medications have a consent with appropriate drug class selected and signed by the appropriate designee (self, HCP, DPOA or guardian) as well as when a new consent is required. • The results of these audits will be reviewed at the monthly QAPI committee x 3 months to ensure compliance is maintained. The DNS will be responsible for compliance.	

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F 758	Continued From page 3 On 12/30/24, a brief interview for mental status (BIMS) test was completed. Resident #1 scored 12, indicating moderate cognitive impairment. A provider note, dated 12/30/24 stated "Patient definitely with altered mental status at times. Will follow closely. Risperidone started at hospital for behavioral disturbances. Nursing not using appropriately. Will schedule twice daily and follow for improvement in behaviors." The medication order was changed to Risperidone 0.5 mg by mouth twice daily for anxiety and agitation. There was no evidence in the clinical record that Resident #1's representative had been informed of this change or the potential risks and benefits of the medication. On 1/13/25 at 12:25 p.m., the prescribing provider stated that Resident #1 had been given Risperidone at the hospital and continued to demonstrate behavioral disturbances. Staff were not giving the medication as needed, therefore the provider scheduled Risperidone twice daily. The surveyor asked if the dosing change had been discussed with Resident #1's family. The provider stated he/she had not had the opportunity. On 1/13/25 at 3:30 p.m., at the exit interview with the facility's Administrator and the Corporate Nurse Practice Educator, the surveyor discussed that Resident #1's clinical record showed no evidence that the representative was aware of and involved in the decision to prescribe a scheduled antipsychotic. Additionally, Resident #1 had been experiencing delirium due to infection and although he/she was his/her own decision maker, was not demonstrating the ability to make an informed decision when he/she signed the	F 758		

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F 758	Continued From page 4 psychoactive medication consent form, nor was there evidence that Resident #1 understood or consented to an increase in dosage. A review of the facility's policy for Psychotropic Medications, last revised 5/2023, stated "The resident and/or responsible party will be notified when the dose of the psychoactive medication has been changed by the Healthcare Provider."	F 758		