

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/04/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205091	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/24/2025
NAME OF PROVIDER OR SUPPLIER OAK GROVE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 27 COOL ST WATERVILLE, ME 04901		
(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 From 3/18/25 through 3/21/25 and 3/24/25, on-site visits were conducted at Oak Grove Center for the purpose of completion of the annual Long Term Care Survey Process for Federal Recertification, and investigation of complaints #ME00047110, #ME00047934, #ME00048025, #ME00048086, #ME00048193, #ME00048347, #ME00048692, #ME00048735, #ME00048983, #ME00048989, #ME00049204, and #ME00050894. It was determined that Oak Grove Center is not in compliance with 42 CFR Part 483, Subpart B-Requirements for Long Term Care Facilities.	F 000			
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives	F 578			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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 578	Continued From page 1 and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that the resident and/or resident representative were provided with written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advanced directive, was completed for 2 of 22 residents reviewed for advanced directives. (Residents #27, and #79) Findings: 1. Resident #27 was admitted to the facility in 10/2024. A review of the entire medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive.	F 578			

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F 578	Continued From page 2 On 3/19/25 at 11:56 a.m., in an interview, the Market Clinical Advisor confirmed that medical records lacked evidence that the facility offered or reviewed with the residents and/or resident representatives or that the residents and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. 2. Resident #79 was admitted in February 2025. Social Services assessment, dated 2/14/25, states, "...Resident Rights/Healthcare Decision Making/Advance Directives ...Resident unable to hear or communicate with staff, trying to reach spouse...." Further review of the clinical record lacked evidence that the facility offered or reviewed with the resident and/or resident representative, or that the resident and/or resident representative were provided, written information concerning the right to formulate an advanced directive. On 3/18/25 at 9:02 a.m., during an interview, Resident #79 stated he/she is severely hard of hearing, even with hearing aids in, and cannot read well. On 3/19/25 at 11:32 a.m., during an interview, the finding was reviewed with the Market Clinical Advisor. On 3/19/25 at 12:47 p.m., during an interview, the Director of Social Services stated he might have spoken to Resident #79's spouse a couple weeks ago about formulating an advanced directive but did not document the conversation.	F 578			

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F 578	Continued From page 3	F 578			
F 584	Further review of Resident #79's clinical record lacked evidence of the conversation.				
SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584			
	§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; §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				

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F 584	Continued From page 4 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 3 units (Wyeth Unit, Jewett Unit and Millay Unit) and the laundry room for 1 of 1 facility tour. Findings: On 3/20/25 from 11:00 a.m. to 11:30 a.m., a surveyor conducted an Environmental Tour with the Senior Maintenance Director, Administrator and the Maintenance Director in which the following findings were observed: Jewett Unit - Resident Room 3 - The bathroom had urine around the base of the toilet and had a very strong odor of urine. - Resident Room 4 - The sink countertop had chipped/missing laminate on the front edge. The sink overflow drain hole was broken open and rusty. The right side drawers under the sink were off-track and wouldn't close. The entire bathroom floor was dirty and dirty around the base of the toilet. The walls behind the head of the beds had paint that was chipped/gouged and missing, creating uncleanable surfaces. - Resident Room 8 - There was a bed pan on the floor behind the toilet and a urine hat on top of	F 584			

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F 584	Continued From page 5 glove box and both were unlabeled and unbagged. Millay Unit - Resident Room 24 - The room wall, by the thermostat, had chipped/missing paint and was gouged exposing sheetrock which created an uncleanable surface. Wyeth Unit - The dining room walls had chipped/missing paint and were marred with black marks. - Resident Room 36 - The baseboard heater had chipped/missing paint. The floor was dirty around the base of the toilet. There was dust and debris in the bathroom light lens. - Resident Room 39 - The baseboard heater had chipped/missing paint and was broken apart with metal hanging down. - Resident Room 41 - There was dust and debris in the bathroom light lens. The room baseboard heater had chipped/missing paint creating an uncleanable surface. There was an unlabeled urinal on the floor by the toilet and an unlabeled urinal on the toilet tank in the shared bathroom. There was a dirty plunger on the floor next to the toilet. - Resident Room 45 - The room entrance door frame had chipped/missing paint. The baseboard heater had chipped/missing paint. The walls around the room had chipped/missing paint and had black marks on them. This created uncleanable surfaces. Laundry - There were 3 laundry carts with wheels that had untreated wooden bases creating uncleanable surfaces. - There was a cracked/broken 4-foot ceiling light	F 584			

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F 584	Continued From page 6 lens. - There were 2 ceiling lights that were missing their 4-foot ceiling light lenses. On 03/20/25 at 11:30 a.m., in an interview, the Senior Maintenance Director, the Administrator and the Maintenance Director confirmed the findings.	F 584			
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of	F 623			

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F 623	Continued From page 7 this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402,	F 623			

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F 623	Continued From page 8 codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on record reviews, and interviews, the facility failed to issue a written transfer/discharge notice to a resident or their legal representative for a facility-initiated transfer/discharge for 2 of 6 Resident's reviewed for hospitalization (Resident # [R66] and [R10]). Findings: 1. Review of [R66]'s clinical record revealed he/she was transferred to an acute care hospital	F 623			

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F 623	Continued From page 9 and subsequently admitted from 2/11/25 through 2/18/25 and from 3/9/25 through 3/15/25. The clinical record lacked evidence that the facility issued a written discharge/transfer notice to include appeal rights to the resident and/or resident representative. During an interview on 3/21/25 at 8:20 a.m., Resident [R66] stated he/she remembered going to the hospital clearly each time, but state he/she was not provided with a written transfer notice. During an interview with Director of Nursing and Market Clinical Advisor (MCA) on 3/21/25 at 8:25 a.m., the MCA stated they have been doing audits to make sure the transfer notices are filled out but have not been making sure they are provided in writing, but will make sure they start to look at that as well. 2. Review of [R10]'s clinical record revealed he/she was transferred to an acute hospital on 11/16/24. The clinical record lacked evidence that the facility issued a written discharge/transfer notice to include appeal rights to the resident and/or resident representative. During an interview on 3/18/25 at 10:56 a.m., Resident [R10] stated he/she was sent to the hospital after sustaining falls for 2 days in a row, diagnosed with pneumonia and treated with antibiotics. He/she did not remember if the facility provided a written notice of transfer/discharge at the time. On 3/21/25 at 10:00 a.m., in an interview with a surveyor, the Director of Nursing confirmed she was unable to locate a transfer/discharge notice from 11/16/25.	F 623			

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F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to issue written bed hold notices to include cost of care to the resident and /or legal representative for 2 of 5 sampled residents reviewed for transfer to an acute care hospital. (Resident #10[R10] and #66[R66]).	F 625			

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F 625	Continued From page 11 Findings: 1. Review of [R66] clinical record revealed he/she was transferred to an acute care hospital and subsequently admitted from 2/11/25 through 2/18/25 and from 3/9/25 through 3/15/25. The clinical record lacked evidence that the facility issued a written bed hold notice that included cost of care for these hospitalizations. During an interview on 3/21/25 at 8:20 a.m. [R66] stated he/she remembered going to the hospital clearly each time, but state he/she was not provided with a written bed hold notice that included cost of care. During an interview with Director of Nursing and Market Clinical Advisor (MCA) on 3/21/25 at 8:25 a.m., the MCA stated they have been doing audits to make sure the bed hold notices are filled out but have not been making sure they are provided in writing, but will make sure they start to look at that as well. 2. Review of [R10] clinical record revealed he/she was transferred to an acute care hospital on 11/16/25. The clinical record lacked evidence that the facility issued a written bed hold notice that included cost of care for these hospitalizations. During an interview on 3/18/25 at 10:56 a.m., [R10] stated he/she was sent to the hospital and diagnosed with pneumonia. [R10] did not remember if the facility informed him/her if the bed would be held or if a written bed hold notice was provided. On 3/21/25 at 10:00 a.m., in an interview with a surveyor, the Director of Nursing confirmed she was unable to locate a bed hold notice from	F 625			

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F 625	Continued From page 12 11/16/25.	F 625			
F 644 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. §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 interview, the facility failed to ensure that the State mental health authority for Pre-Admission Screening and Resident Review (PASRR) Level II was implemented for 1 of 6 sampled residents reviewed for PASRR (Resident #20, (R20). Findings: 1. Review of R20's PASRR Level II, dated 2/25/25, indicated R20 was approved for specialized services to include "Initial psychiatric evaluation to determine diagnosis and develop plan of care."	F 644			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/04/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205091	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/24/2025
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F 644	Continued From page 13 Review of R20's care plan, updated 2/16/25 states: "Resident/Patient meets PASRR II Level of care with diagnosis of Bipolar and Anxiety: Serious Mental Illness: Resident/Patient will receive appropriate specialized services as indicated on PASRR Level II thru next review date. Resident will be offered/engage with behavioral health services. Resident will engage/ be offered counseling services to develop coping skills. " Review of Resident #20's current orders, dated 3/20/25 lacked evidence that an order was placed for Medi tele (psyche services). During an interview on 3/20/25 at 3:3:24 p.m., the Jewett Unit Manger (JUM) reviewed R20's active orders and confirmed there was no order placed for psyche services, and R20 was not taking any psychotropic medicines. During an interview on 3/21/25 at 12:48 p.m., the Licensed Social Worker (LSW) states he has been working at the facility since November 2024 and recently realized his predecessor did not follow through with PASRR's. The LSW stated the Unit Manager(JUM) for Long Term Care does the referrals, and he uploaded her PASRRII on 3/4/25. The LSW stated he did not follow up with (JUM) to see if this was done. During an interview on 3/21/25 at 1:25 p.m., the Director of Nursing provided a surveyor with a progress note dated 3/20/25 stating "This nurse approached the pt[patient] about Medi Tele services and educated the patient on the service. This nurse asked the pt[patient] if they would like to be seen by Medi Tele and receive services.	F 644			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 644	Continued From page 14 The pt[patient] agreed and gave this nurse verbal consent to complete the referral form. The referral was completed and sent." DNS further stated, she could not find, and documentation indicated R20 was previously offered/refused Psyche Services.	F 644			
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 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	F 656			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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F 656	Continued From page 15 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 record review, observations, interviews, and facility policy, the facility failed to implement a care plan for 3 of 4 sampled residents (Resident (R20, R21, and R66). Findings: Review of the "Person-Centered Care Plan" policy dated 10/24/22 states "a comprehensive person-centered care plan must be developed for each patient and must describe the following: ...any specialized services or specialized rehabilitative services the Center will provide as a result of PASRR recommendations.... Care plans will be: . Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments, and as needed to reflect the response to care and changing needs and goals..." 1. During an interview on 3/18/25 at 7:53 a.m.,			F 656			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 656	Continued From page 16 R20 stated his/her dental bridge fell out a while ago and is still waiting for it to be replaced. At this time R20 opened his/her mouth and a surveyor observed multiple missing teeth and what appeared to be a broken bridge on the inside of his/her mouth. R20 stated his/her gums were really sore. Review of R20's Physician progress note dated 2/12/25 states "We saw [R20] for an emergency apt concerning [his/her] missing bridge. [R20] wanted bridge recemented inside [his/her] mouth. Had to explain, the patient had teeth removed and thus the bridge no longer fits and will never fit. Referred pt[patient] to dentist to start partial denture process. Review of R20's care plan updated 2/25/25 lacked evidence that a care plan was established for dental. During an interview on 3/20/25 at 3:24 p.m., the Jewett Unit Manger (JUM) reviewed and confirmed R20's care plan did not include goals and interventions in the area of dental. During an interview on 3/20/25 at 3:30 p.m., the above was discussed with the Director of Nursing (DON). 2. Review of R21's care plan updated 1/7/24 states "Self administration of medication, saline nasal spray, seasonal allergies. Patient will correctly and safely: self-administer medication. Ensure availability/adequate supply of medication(s) for self administration. To Ensure patients ongoing functional and cognitive skills permit continued safe medication self-administration. Observe for indications of the	F 656			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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F 656	Continued From page 17 patient skipping doses or refusing to take medication." During an interview on 3/20/25 at 12:09 p.m., JUM reviewed and confirmed R21's clinical record did not contain evidence he/she was assessed for use of duo neb or inhaler per care plan intervention. 3. Review of R66 Provider orders active for March 2025 revealed he/she was taking a diuretic medication: Lasix for congestive heart failure (CHF), opioid medication: Tramadol for pain, and anticoagulant medication: Clopidogrel Bisulfate for blood clot prevention, and has 3 stage II wounds on the left lower extremity (left lower leg). Review of R66's care plan updated 2/11/25 lacked evidence that goals and interventions were put into place for the use of diuretics, opioid, or anticoagulant use, and stage II pressure sores on the left lower extremity. During an interview on 3/20/25 at 3:20 p.m., JUM reviewed and confirmed R66's care plan did not reflect above concerns, stating" I will update the care plan."	F 656			
F 657 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.	F 657			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 657	Continued From page 18 (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. (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 interviews and record review, the facility failed to review and revise the care plan by an interdisciplinary team (IDT), that included, to the extent possible, participation of the resident and/or his/her representative after each Minimum Data Set (MDS) assessment for 1 of 4 residents reviewed for care planning (Resident #41). Finding: Review of Resident #41's clinical record revealed a Minimum Data Set (MDS) Quarterly Assessment was completed on 1/6/25. Further review of the clinical record lacked evidence that an interdisciplinary team (IDT) meeting was held	F 657			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 657	Continued From page 19 within 7 days following the assessment. During an interview on 3/24/25 at 8:37 a.m., the Director of Social Services confirmed Resident #41's last IDT meeting was held 11/13/24 and that Resident #41's clinical record lacked evidence that an IDT meeting was held within 7 days of the MDS Quarterly assessment.		F 657				
F 689 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, interviews, and a review of Safety Data Sheets (SDS), the facility failed to ensure that the resident's environment was free of accident hazards relating to the storage of an unlabeled medicated cream and chemicals being properly secured for 2 of 2 observations for 1 of 4 days of survey. (3/18/25) Findings: The Safety Data Sheet for Clinical Silicone Cream noted the following: 4. First Aid Measures: Eye Contact: Flush eyes with large amounts of water for at least 15 minutes. Remove contact lenses, if worn. If irritation, seek medical attention.		F 689				

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	Continued From page 20 • Skin Contact: If irritation develops, wash area with water. Get medical attention if irritation persists. Inhalation: Remove victim to fresh air and keep at rest in a position comfortable for breathing. Seek medical attention if discomfort continues or if you feel unwell. Ingestion: Never give anything by mouth to an unconscious person. Consult a physician if necessary. The Safety Data Sheet for FunkAway Beads Odor Eliminator noted the following: 4. First Aid Measures: Eye Contact: Rinse cautiously with water for several minutes. Remove contact lenses, if present and easy to do. Continue rinsing. If eye irritation persists, get medical advice/attention. • Skin Contact: Wash skin with plenty of water. • Inhalation: Remove person to fresh air and keep comfortable for breathing. Ingestion: If swallowed, rinse mouth with water(only if the person is conscious). Do not induce vomiting. Obtain emergency medical attention. • On 3/18/25 at 9:19 a.m., a surveyor observed of Room 45 (Wyeth Unit) an unlabeled medicated cream and a chemical sitting on a small table in the shared bathroom between resident Rooms 45 and 46. One was a 12-ounce container of FunkAway Odor elimination beads and the other one was a 4-ounce tube of Clinical Silicone Cream. On 3/18/25 at 9:35 a.m., the Market Clinical	F 689			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	Continued From page 21 Advisor observed the chemicals with the surveyor and confirmed that the unlabeled medicated cream and the chemical should not have been in the bathroom and it was an accident hazard.	F 689			
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 facility policy, the facility failed to provide 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 [R] R13, R21, R46 and R65). Findings: Review of policy "Nebulizer: Small Volume" dated 11/1/23 states: "...Upon completion of the treatment, ...Rinse SVN, mouthpiece, and "T" piece with sterile water and dry. Place in treatment bag labeled with patient name and date ..." 1. On 3/19/25 at 8:41 a.m., observation of Room 3, 3/19/25 at 7:30 a.m., and 11:39 a.m. revealed nebulizer located on top of Resident R13's side	F 695			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 695	Continued From page 22 table with tubing attached with/to nebulizer pipe which is resting/stored on top of a stuffed animal without a barrier between the nebulizer pipe and the stuffed animal allowing potential cross contamination. On 3/19/25 at 11:30 a.m. observation and interview with Licensed Practical Nurse (LPN), she confirmed nebulizer tubing was not bagged, and stated she does not know why the nebulizer was in the room because R13 only needed it for an exacerbation and hadn't used it in over a week. Review of R13's orders active March 2025 revealed [he/she] last used the nebulizer on 3/13/25. On 3/19/25 at 11:47 a.m. the above was discussed with Director of Nursing. 2. On 3/18/25 at 8:24 a.m., and 3/19/25 at 7:38 a.m., observation of Room 6-1, a nebulizer was observed on R21's nightstand with tubing attached to pipe which is resting/stored on top of dresser without a barrier between the nebulizer pipe and the side table allowing potential cross contamination. During an interview on 3/19/25 at 7:34 a.m., the Licensed Practical Nurse (LPN) confirmed the above findings. 3. On 3/18/25 08:23 a.m., and 3/19/25 at 7:45 a.m., and on 3/20/25 at 11:45 a.m., observations of a Nebulizer on top of R46's tv stand tubing attached to mask dated 3/16 - stored in top draw and resting on personal items without a barrier between the nebulizer mask and personal items allowing potential for cross contamination. During an observation of R46 on 3/20/25 at 11:45	F 695			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 695	Continued From page 23 a.m. with Jewett Unit Manager (JUM), she confirmed above findings. 4. On 3/19/25 at 8:19 a.m., during an observation, Resident #65's unbagged continuous positive airway pressure (CPAP) mask was lying on the floor underneath his/her bed. On 3/19/25 at 8:30 a.m., during an interview, Registered Nurse (RN) #6 stated when CPAP masks are not in use, they are stored in a plastic drawstring bag or sometimes the original device packaging. On 3/19/25 at 8:40 a.m., during an observation with a surveyor the Millay Unit manager confirmed the finding for Resident #65.	F 695			
F 699 SS=E	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, 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 interview, the facility failed to identify a resident's current diagnosis of Post-Traumatic Stress Disorder (PTSD)/trauma to determine what trigger(s) might cause re-traumatization for 3 of 3 sampled resident reviewed with a current diagnosis of PTSD	F 699			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 699	Continued From page 24 (Resident #(R)15, R27 and R35). Findings: 1. Resident (R) 35 was admitted in 2024 and has diagnoses to include post-traumatic stress disorder. Review of R35's care plan updated 1/22/25 lacked evidence that a trauma informed care plan was established to include triggers for this resident's PTSD diagnoses. Review of R35's admission Minimum Data Set (MDS) 3.0, Section I, Active Diagnoses, Psychiatric/Mood Disorder, I6100 was coded to indicate R35 had an active diagnosis for Post Traumatic Stress Syndrome (PTSD). The surveyor was unable to find information in the clinical record that indicated what R35's PTSD was caused by or what events might cause re-traumatization. During an interview with 4 surveyors on 3/21/25 at 3:00 p.m., Market Clinical Advisor confirmed Resident #35 did not have a trauma informed care plan. 2. Resident #15 was recently admitted and has diagnoses to include Post-Traumatic Stress Disorder. Review of Resident #15's Admission Minimum Data Set (MDS), Section I, 16100. Post Traumatic Stress Disorder (PTSD), indicated Resident #15 has an active diagnosis of PTSD. Review of Resident #15's care plan, revised 3/18/25, includes, "Focus: PASSR Level II:	F 699			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/04/2025
FORM APPROVED
OMB NO. 0938-0391

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F 699	Continued From page 25 Diagnosed with PTSD..." but lacked evidence that a trauma informed care plan was established to include Resident #15's trigger(s) for PTSD. During an interview on 3/21/25 at 3:10 p.m., the Market Clinical Advisor confirmed Resident #15 did not have a trauma informed care plan. 3. Resident #27 was admitted to the facility on 10/19/24 to include a diagnosis of PTSD. On 3/21/25, a review of Resident #27 's clinical record, in the Minimum Data Set (MDS) 3.0, Section I, Active Diagnoses, Psychiatric/Mood Disorder, I6100 was coded to indicate Resident #27 had an active diagnosis for PTSD. The surveyor was unable to find information in the clinical record that indicates what Resident #27 's PTSD was caused by, what trigger(s) might cause re-traumatization, and measures to avoid trigger(s) that might cause re-traumatization. On 3/21/25 at 3:15 p.m., in an interview, the Market Clinical Advisor confirmed that Resident 27's care plan lacked what indicated what Resident #27 's PTSD was caused by, what trigger(s) might cause re-traumatization, and measures to avoid trigger(s) that might cause re-traumatization.	F 699			
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with	F 725			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 725	Continued From page 26 the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure sufficient direct care staff were scheduled and on duty to meet the needs of residents that reside on 3 of 3 units. Findings: 1. On 3/18/25 at 8:45 a.m., in an interview with a surveyor, RN5 stated the facility had changed to primary nursing and had taken away the medication technician position approximately 1	F 725			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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F 725	Continued From page 27 month ago. This change has resulted in nurses having to administer their own medications and treatments, often up to an hour late. On this day, the nurse had a discharge scheduled at 9:00 a.m., as well as an IV antibiotic to administer. RN5 stated wound care would be provided late due to lack of staffing. 2. On 3/20/25 at 11:20 a.m., a surveyor requested to observe wound care for Resident #9. LPN2 stated he/she would not be able to get to the twice daily wound care until 1:30 - 2:00 p.m. due to the workload and tasks to be completed. LPN2 stated he/she usually tries to complete the wound care before lunch, but today, he/she is unable to complete the wound care on time as there are only 2 licensed nurses, and 2 CNA's (Certified Nursing Assistants) on the unit. There are 2 admissions, and 2 discharges scheduled today, and on LPN2's assignment, 1 extensive wet to dry dressing change, Resident #9's dressing change, Resident #50's dressing change, and a new resident requiring care for 2 draining fistulas. LPN2 stated he/she also was responsible for all medication administration, blood glucose testing and insulin administration. 3. Review of Payroll Based Journal staffing report revealed the facility triggered for low weekend staffing during the first quarter of 2025 (October 1, 2024 - December 31, 2024). On 3/19/25 at 3:00 p.m., during an interview, Resident #10 stated the primary concern at Resident Council meetings is lengthy call bell response times and that when staff come in to answer a call bell, they do not ask the other resident in the room if they need anything.	F 725			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 725	Continued From page 28 On 3/20/25 at 11:05 a.m., during an interview Registered Nurse (RN) #4 stated the unit manager does not work the floor on the Wyeth unit and only does direct care if staff really needs help. RN #4 then stated that under the new staffing model, the medication tech (MT) goes home at 2:00 p.m., and the nurse takes over and administers all medications and treatments between 2:00-6:00 p.m. and then, the MT comes back from either 5:00-9:00 p.m. or 6:00-10:00 p.m. RN #4 then stated that last night, a resident fell at 3:30 p.m., and she had barely finished admitting another resident, when a third resident fell, all while she should be giving medications because the MT left. On 3/24/25 between 9:43 -10:15 a.m., during an interview, a surveyor reviewed weekend staffing for October 1, 2024 through December 31, 2024 with the Staffing Coordinator, and the Director of Nursing (DON). The DON stated she was aware of the shortages in the first quarter and confirmed the facility did not have enough staff to meet resident needs on the weekends.	F 725			
F 755 SS=E	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	F 755			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 755	Continued From page 29 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 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 reviews, observations and interviews, the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation by failing to ensure that two people who are authorized to administer medications signed the Shift Count page indicating that they counted all controlled substances at the change of shift for multiple shifts, on 1 of 3 units reviewed (Wyeth). Findings: A review of the facility's policy and procedure: Controlled Drugs: Management Of, State of Maine, last revised 7/1/24, page 6, Section 5. Ongoing Inventory of Controlled Substances	F 755			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 755	Continued From page 30 (Shift Count): 5.1 stated, "Follow the Index Page to perform a complete count of all Schedule II to IV controlled substances at the change of shifts or at any time in which narcotic keys are surrendered from one licensed nursing staff to another. 5.1.3. Both medication nursing staff members participating in the count must: 5.1.3.3. Sign the shift count page in the 'Controlled Substances Book' to acknowledge a correctly reconciled count." On 3/20/25 at approximately 12:30 p.m., during a medication storage observation of the Wyeth unit medication cart, a surveyor reviewed the Controlled Substance Books and Shift Counts which indicated the facility counts at the change of each shift, approximately 3 times a day. The person authorized to administer medications coming on duty or the person authorized to administer medications going off duty both failed to sign the Shift Count page of the Controlled Substances Book that indicated the controlled substances count was completed on multiple days. At this time, the findings were discussed and confirmed with (Registered Nurse) RN #3 and RN #4. On 3/20/25 at 12:50 p.m., in an interview with the Director of Nursing and the Market Clinical Advisor, the surveyor discussed that multiple days on the Wyeth unit were missing staff signatures for verification and completion of the controlled medication count on the following dates: 11/25/24, 11/26/24, 11/29/24, 2/3/25, 2/4/25, 2/24/25, 2/25/25 (a.m. and p.m.), 3/6/25 (a.m. and p.m.), 3/7/25 (a.m. and p.m.), 3/11/25, 3/12/25, 3/18/25, and 3/19/25.	F 755			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 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	F 758			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 758	Continued From page 32 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 clinical record review and interview, the facility failed to demonstrate evidence of monitoring for mood, behavior, and side effects of psychotropic medications for 1 of 5 residents reviewed for unnecessary medications (#10). Findings: A review of Resident #10's clinical, Physician orders included the following medications: Risperidone (an antipsychotic) 2 mg (milligrams) by mouth one time a day; Lithium carbonate (used as a mood stabilizer) 300 mg by mouth twice daily; Lamotrigine (an anticonvulsant used as a mood stabilizer) 250 mg by mouth twice daily, and Trazodone (an antidepressant) 100 mg once daily to treat insomnia. Resident #10's care plan, last revised 2/6/25, identified the "risk for complications related to the use of psychotherapeutic medication." Interventions included "Monitor for side effects and consult physician and/or pharmacist as needed. Report the continued need of medication as related to behavior and mood." Also identified, Resident #10 "exhibits or is at risk for distressed/fluctuating mood symptoms." Interventions included, "Observe for	F 758			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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F 758	Continued From page 33 signs/symptoms of worsening sadness/depression/anxiety/fear/anger/agitation. Observe for worsening signs/symptoms of existing psychiatric disorder. Notify physician/advanced practice practitioner as needed."	F 758			
F 761 SS=E	Further review of the clinical record revealed monitoring for mood, behaviors and side effects of the psychotropic medication use was not initiated until 3/12/25. Additionally, Resident #10 was noted to have a DHHS (Department of Health and Human Services) appointed guardian. The record contained a psychotherapeutic informed consent form for the above medications which was not dated and had been signed by Resident #10. On 3/21/25, at 1:15 p.m., the surveyor discussed the findings with the Director of Nursing. 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.	F 761			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 761	Continued From page 34 §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, interviews and record reviews, the facility failed to ensure medications and treatments were stored properly, including removal of expired medications from available supply, on 3 of 5 days of survey (3/18/25, 3/19/25, 3/20/25). Additionally, the facility failed to obtain physician orders for medications located at a resident's bedside, for 2 of 2 sampled resident (Resident #65 and #79). Findings: Review of policy "Medication Self-Administration," revised 10/15/2024, states, "Patients who wish to self-administer medications will be evaluated for safe and clinically appropriate capability ...If it is determined that the patient is able to self-administer: A physician/advanced practice provider (APP) order is required ...Self-administration and medication self-storage must be care planned ...patient must be provided with a secure, locked area to maintain medications ..." Review of policy, "Bedside Medication Storage," dated 1/2024, states, "The interdisciplinary team (IDT) will review and approve resident	F 761			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 761	Continued From page 35 competencies and understanding prior to permission of bedside storage of medications ...A written order for the bedside storage of medications is present in the resident's medical record ...Bedside storage of medications is indicated on the resident medication administration record (MAR) ...the manner of storage prevents access by other residents. Lockable drawers or cabinets are required ..." The facility's policy, titled 4.1 Storage of Medication, dated 1/25, stated, "Procedures 4. Medications should be stored so that various routes of administration are separated. Internally administered medications are stored separately from medications used externally, such as lotions, creams, ointments, and suppositories." Section 12 stated, "Insulin products should be stored in the refrigerator until opened. Note the date on the label for insulin vials and pens when first used. The opened insulin vial may be stored in refrigerator or at room temperature. (Refer to specific product labeling for additional detail). Opened insulin pens should be stored at room temperature. Do not freeze insulin. If insulin has been frozen, do not use." Section 14 stated, "Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal." According to the Institute for Safe Medication Practices website, Safety Tips for Storing Insulin, states "Write the date you open the insulin on the product. On the day you open the insulin vial, pen, or cartridge, or start keeping it outside the refrigerator, write the date on the label. This will	F 761			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 761	Continued From page 36 help you remember when to stop using it. Insulin expires 28 days after it is opened." 1. On 3/18/25 at 7:50a.m., during an observation of Resident #65's room, a Fluticasone/Salmeterol 250mcg-50mcg inhalation device was located on Resident #65's over-the-bed table. Review of Resident #65's clinical record lacked evidence of an order to self-administer medications. Further review of the clinical record lacked evidence of an IDT assessment. On 3/18/25 at 2:39 p.m., during an interview, Registered Nurse (RN) #1 stated she left Resident #65's Advair inhaler at the bedside so he/she could take his/her dose after breakfast. At this time, RN #1 stated medications should not be left at the bedside, and that Resident #65 does not have an order to self-administer medications. During an interview on 3/18/25 at 2:45 p.m., the finding was reviewed with the Millay Unit Manager. 2. On 3/19/25 at 8:24 a.m., during an observation of Resident #79's room, a 1.5 fluid ounce bottle of "Deep Sea Premium Saline 0.65% nasal moisture spray" was located on the windowsill next to Resident #79's recliner. At this time, Resident #79 stated he/she was given the medication in the hospital and uses the medication a couple times a day. Review of Resident #79's active orders lacked evidence of a physician order for the saline nasal spray and lacked evidence of an order to self-administer medications. Further review of the clinical record lacked evidence of an IDT	F 761			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/04/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205091	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/24/2025
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F 761	Continued From page 37 assessment. On 3/19/25 at 8:40 a.m., a surveyor and the Millay Unit Manager observed the nasal spray on Resident #79's windowsill. At this time, the Unit Manager stated residents who self-administer medications must have an assessment to determine if it is safe to self-administer, an order to self-administer, a physician order for the medication, and the medication must be stored in a lock box. On 3/19/25 at approximately 11:00 a.m., the above findings were discussed with the Market Clinical Advisor. 3. On 3/18/25 at 9:45 a.m., during a medication storage observation of Medication Cart B on Millay Unit, the following topical medications were observed undated when opened and stored in a drawer with oral medications: Therahoney, Anasep wound gel, zinc oxide skin protectant cream, Diclofenac gel, Prevent silicone cream. Oral medications stored among the topical medications included: Lactulose oral solution and Guaifenesin liquid. Also observed with these medications was a bottle of antifungal powder prescribed to Resident #9. (Registered Nurse) RN #1 stated the medication had been discontinued "a while ago." Another bottle of antifungal powder had the pharmacy label torn off and was open and available for use. A review of the provider orders for Resident #9 noted the order for antifungal powder had been discontinued on 3/5/25. 4. On 3/20/25 at 9:00 a.m., during a medication administration observation on the Millay Unit, a surveyor observed an Insulin Lispro Kwik-Pen	F 761			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/04/2025
FORM APPROVED
OMB NO. 0938-0391

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F 761	Continued From page 38 prescribed to Resident #4, in use and undated when opened stored in Medication Cart B. The surveyor brought this to the attention of the RN who threw it away at this time. 5. On 3/20/25 at 12:00 p.m., during an observation of the nurse treatment cart on the Jewett Unit, a surveyor observed the following 7 insulin pens that were all prescribed to current residents and were open and available for use: > 2 - Undated when opened Insulin glargine-yfgn (U100) > Insulin Lispro Kwikpen (U100) labeled as opened on 2/16/25 (expired) > Undated Insulin Lispro Kwikpen (U100) > Insulin Lispro Kwikpen (U100) labeled as opened on 1/27/25 (expired) > Undated Insulin Glargine Solostar pen > Undated Basaglar Kwikpen (U100) On 3/20/25 at 12:05 p.m., the surveyor brought the above insulin pens to the JUM (Jewett Unit Nurse Manager). 6. On 3/20/25 at 12:10 p.m., during an observation of the Jewett Unit Medication Room with RN #2, a surveyor observed the emergency stock of intravenous antibiotic medications, stored in 3 plastic boxes with compartments. The following were noted: > 2 vials of Zosyn (piperacillin 3 grams/tazobactam 0.375 grams) - expired 1/25 > 2 vials of Cefazolin 1 gram - expired 11/24 7. The small medication refrigerator located on the floor was observed to have a large ice buildup. A stack of insulin pens were observed	F 761			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/04/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205091	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/24/2025
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F 761	Continued From page 39 stored next to the ice buildup. At this time, the surveyor brought the expired antibiotics to the JUM and notified him/her of the ice buildup in the medication refrigerator. 8. On 3/20/25 at approximately 12:30 p.m., during an observation of the treatment cart on Wyeth Unit with RN #3, a surveyor observed 3 vials of single dose Shingrix vaccine stored in a plastic bag with a sticker which stated "Keep Refrigerated." RN #3 removed the vaccines from use at this time. On 3/20/25 at 12:50 p.m., the surveyor discussed the above findings with the Director of Nursing and the Market Clinical Advisor.	F 761			
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to maintain garbage storage areas in a sanitary condition to prevent the harborage and feeding of pests for 1 of 3 dumpsters for 1 of 4 days(3/18/24) and 1 of 3 dumpsters for 3 of 4 days of survey. (3/18/25, 3/19/25, and 3/20/25) Findings: 1. On 3/18/25 at 6:30 a.m., a surveyor observed 1 dumpster with the right-side slide door open exposing trash. Additionally, there was trash/debris on the ground. Another dumpster had a right-side top cover that was broken and	F 814			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/04/2025
FORM APPROVED
OMB NO. 0938-0391

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F 814	Continued From page 40 open exposing trash. 2. On 3/19/25 at 8:00 a.m., a surveyor observed a dumpster had a right-side top cover that was broken and open exposing trash. 3. On 3/20/25 at 8:00 a.m., a surveyor observed a dumpster had a right-side top cover that was broken and open exposing trash. On 3/19/25 at 7:45 a.m., during an interview, the Cook stated the dumpsters are always supposed to be closed, but one of them has had a broken flap for a couple of weeks and she's not sure what they are doing about it. On 3/20/25 at 1:00 p.m., in an interview, the Administrator confirmed the findings.	F 814			
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;	F 842			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/04/2025
FORM APPROVED
OMB NO. 0938-0391

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F 842	Continued From page 41 (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, 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	F 842			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F 842	Continued From page 42 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 record reviews and interviews, the facility failed to ensure that clinical records were complete and contained accurate information for 5 of 7 sampled residents reviewed for respiratory (Resident #[R] R15, R20, R21, R41 and R44). Findings: 1. Review of R20's Preadmission Screening and Resident Review (PASRR) level II dated 2/25/25 revealed [he/she] has a Mental health disability and is qualified for "Specialized services: You will need to be provided the following specialized services: Service or Support: Initial psychiatric evaluation to determine diagnosis and develop plan of care." Review of R20's clinical record lacked evidence this was done. Review of R20s clinical record revealed order with start date of 2/13/25 states. Is resident free from side effects of psychotherapeutic medications? (if no, document side effects in PN) every shift AND as needed. Review of R20's care plan updated 2/13/25 states "is at risk for complications related to the use of psychotropic drugs Medication as ordered. Resident will have the smallest most effective dose without side effects for 90 days. Monitor for side effects and consult physician and/or	F 842			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F 842	Continued From page 43 pharmacist as needed" Review of R20's medication orders lacked evidence that R20 had any psychotropic medication orders. During an interview on 3/20/25 at 3:3:24 p.m., the Jewett Unit Manger (JUM) reviewed R20's active orders and confirmed there was no order placed for psyche services, and R20 was not taking any psychotropic medicines. 2. Review of R21's active provider orders for March 2025 revealed order with start date of 10/30/24 to "Please give patient 4 duo nebs to room daily for his own QID use every day shift." And order with start date of 4/17/24 for "Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate) 2 puff inhale orally two times a day for sob Ok to have inhaler by bedside." Review of R21's "Self -Administration of Medications Evaluation" dated 9/20/23 states:" What type(s) of medications has the patient requested to self-administer? :Nasal Saline" Further review of clinical record lacked evidence that a self-administration evaluation was completed for R21 for the use of duo nebs or inhaler. Review of R21's care plan updated 1/7/24 states "Self-administration of medication, saline nasal spray, seasonal allergies. Patient will correctly and safely. Self-administer medication. Ensure availability/adequate supply of medication(s) for self-administration. Ensure patients ongoing functional and cognitive skills permit continued safe medication self-administration. Observe for indications of the patient skipping doses or refusing to take medication." Review of clinical	F 842			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/04/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205091	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/24/2025
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F 842	Continued From page 44 record lacked evidence that R21 was assessed to self-administer duo nebs or inhaler. During an observation on 3/20/25 at 12:00 p.m., Resident R21 was observed in [his/her] room, and was holding a nebulizer pipe in [his/her] lap. At this time R21 stated he/she keeps [his/her] duo nebs and inhaler in [his/her] desk and uses them when [he/she] needs to. At this time R21 opened his/her desk draw and pointed to [his/her] medications. R21 stated the last time [he/she] used the inhaler was this morning and just finished a nebulizer treatment. When asked how long [he/she] has kept the medications in [his/her] room R21 replied "It's been a while." During an interview on 3/20/25 at 12:09 p.m., the Jewett Unit Manger (JUM) reviewed R21's clinical record and confirmed it did not contain evidence he/she was assessed for use of duo neb or inhaler. The above was discussed with the Market Clinical Advisor (MCA) on 3/20/25 at approximately 1:00 p.m. Review of Falls Management policy, revised 3/15/24, states, " ... in the event a fall occurs, an assessment will be completed to determine possible injury... Document circumstances of the fall, post-fall assessment, and patient outcome..." 3. Resident #44 has diagnoses to include repeated falls. Review of Resident #44's clinical record revealed he/she sustained a fall on 11/14/24, 11/22/24, and 3/8/25 and lacked evidence that a post-fall fall risk assessment was completed following the falls.	F 842			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205091	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/24/2025
NAME OF PROVIDER OR SUPPLIER OAK GROVE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 27 COOL ST WATERVILLE, ME 04901		
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F 842	Continued From page 45 During an interview on 3/20/25 at 11:05 a.m. Registered Nurse (RN) #4 stated after a resident falls, a post-fall risk assessment is completed. During an interview on 3/21/25 at 1:38 p.m., the finding was discussed with the Director of Nursing, the Administrator, and the Market Clinical Advisor. At this time, the Director of Nursing reviewed Resident #44's entire clinical record and confirmed that it lacked evidence of a post-fall fall risk assessment for the above falls. 4. Resident #15 diagnoses include anxiety, Bipolar disorder, and psychotic disturbance. Review of Resident #15's active physician orders revealed: -Order with a start date of 3/18/25 for "Seroquel 100mg oral tablet, give 1 tablet by mouth one time a day for bipolar d/o [disorder] with agitation" - Order with a start date of 2/1/25 for "Quetiapine Fumarate Oral Tablet 300mg, give 1 tablet by mouth at bedtime for psychosis" Review of Review of Resident #15's Care plan, updated on 2/25/25, revealed, "Resident is at risk for complications related to the use of psychotropic meds ...Monitor for side effects ..." Further review of the clinical record lacked evidence of monitoring for side effects for the above medications. 5. Resident #41 has diagnoses to include End Stage Renal Disease (ESRD) and is dependent on dialysis. Review of Resident #41's Care Plan, updated	F 842			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205091	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/24/2025
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F 842	Continued From page 46 2/26/25 includes, "Central tunneled jugular dialysis catheter for ESRD and dialysis...." Review of Resident #41's active physician orders revealed: -Order with a start date of 1 2/10/24 for, "Transfer to hemodialysis unit ...on MWF [Monday, Wednesday, Friday] for treatment" -Order with a start date of 2/25/25, "Do not shower while still on tunneled dialysis catheter in place." Record review revealed a nursing progress note, dated 3/15/25, states, "Patient had shower today. Skin assessment done ..." Review of Resident #41's bathing task revealed he/she received a shower on 3/10/25 and "resident refused" a shower on 3/15/25. Review of the nursing documentation on the March 2025 Treatment Administration Record (TAR) indicates Resident #41 has not received a shower during the month of March. During an interview on 3/21/25 at 1:42 p.m., the above findings were confirmed with the Director of Nursing.	F 842			
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the	F 867			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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F 867	Continued From page 47 following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that	F 867			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 867	Continued From page 48 improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and	F 867			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 867	Continued From page 49 available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility's Quality Assurance Committee failed to ensure that the Plan of Correction for identified deficiencies from the Annual Long Term Care Survey Process for Federal Recertification dated 2/1/24, were effective. The Federal citations F584, F625, F655, F656, F689, F725, F842 and F880 were cited again during the annual Long Term Care Recertification Survey dated 3/24/25. Findings: During the Annual Long Term Care Survey	F 867			

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F 867	Continued From page 50 Process for Federal Recertification dated 3/24/25, it was determined that F584, F625, F655, F656, F689, F725, F842 and F880 would be recited for the same reasons: F584 for failure to adequately provide housekeeping and maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable environment; F625 failure to issue a written bed hold notice to include cost of care to the Resident and/or resident representative; F655 for failure to ensure a baseline care plan was developed and implemented within 48 hours; F656 for failure to implement a comprehensive person-centered care plan; F689 for failure to ensure that the resident's environment was free of accident hazards relating to the storage of chemicals being properly secured; F725 for failure to ensure sufficient direct care staff were scheduled and on duty to meet the needs of residents; F842 for failure to ensure that clinical records were complete and contained accurate information and F880 for failure to maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases. On 3/24/25 at 12:28 p.m., during an interview, the above findings were discussed with the Administrator.	F 867			
F 880 SS=D	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	F 880			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	Continued From page 51 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 circumstances. (v) The circumstances under which the facility	F 880			

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F 880	Continued From page 52 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 observations, interviews, clinical record review, and facility policy review, the facility failed to maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases for residents requiring Enhanced Barrier Precautions (Resident #33) on 1 of 3 facility units. Findings: On 3/18/25 at 1:20 p.m., a surveyor observed 2 CNAs (Certified Nursing Assistants) wearing gloves enter Resident #33's room with a mechanical hoist. The resident's door was posted with a Contact Precautions sign which included a picture of a person wearing a gown, gloves, mask and face shield. The instructions stated "Perform hand hygiene before and after	F 880			

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F 880	Continued From page 53 patient contact, contact with environment and after removal of PPE (personal protective equipment). Wear N95/approved KN-95 respirator, gown, face shield and gloves upon entering this room. Change gown after EACH patient contact (written in red). Keep room door closed. Patient must wear a face mask when out of room and maintain social distancing. Perform all procedures/tests in patient room, if able. Pull curtain between roommates. Please do not remove dedicated or single use disposable equipment from this room. When dedicated equipment is not possible, disinfect shared patient equipment with EPA-approved disinfectant." The surveyor observed Resident #33 had a foley catheter hanging from the bed. One CNA picked up the foley catheter and placed it across the resident's legs while the other CNA was hooking the hoier pad to the hoier lift. At this time the surveyor requested to speak with both CNAs and asked them what type of PPE they should be wearing. One CNA stated "gloves." The surveyor noted the posted sign and asked if the resident required the PPE as per the posted precautions. The CNA stated the resident was on "Advanced Barrier Precautions," and that only when staff provide foley or pericare is a gown required, otherwise, only gloves are required. On 3/18/25 at 1:25 p.m., the surveyor asked LPN #1, what type of precautions Resident #33 required. LPN #1 stated the resident had ESBL (Extended-Spectrum Beta-Lactamase) in the urine, and an SP (supratubic) tube. The LPN stated when providing care for the foley (SP tube), "we gown up."	F 880			

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F 880	Continued From page 54 On 3/18/25 at 1:30 p.m., in an interview with the surveyor, the Unit Manager (JUM) stated Resident #33 had a history of ESBL which had been treated in November, 2024. However, the resident had been treated in the emergency department (ED) over the weekend and was diagnosed with a urinary tract infection (UTI). The JUM stated he/she was not sure what kind of precautions the resident was currently on. A review of Resident #33's record noted a provider note, dated 3/18/25, which stated "recent ED visit with diagnosis of UTI - per culture and sensitivity - Pseudomonas aeruginosus, Serratia marcescens." Resident #33's care plan, last revised 3/18/25, stated the resident required Enhanced Barrier Precautions. On 3/19/25 at 10:25 a.m., a surveyor observed Resident #33's door with the same Contact Precautions sign. On 3/19/25 at 11:30 a.m., in an interview with the surveyor, the Director of Nursing (DON) and the Market Clinical Advisor stated Resident #33 was previously on Enhanced Barrier Precautions for ESBL in the urine and use of an indwelling urinary catheter. At some point, the signage on the door was changed to Contact Precautions. The resident was seen in the ED over the weekend and was currently undergoing treatment for an active UTI. The DON stated Resident #33 required Enhanced Barrier Precautions at the present time and confirmed that staff were not following correct precautions as posted when observed yesterday. The Market Clinical Advisor stated staff received education last night on proper procedures for use of Enhanced Barrier Precautions.	F 880			

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F 880	Continued From page 55 The facility's policy regarding Enhanced Barrier Precautions, with a revision date of 12/16/24, stated "In addition to Standard Precautions, Enhanced Barrier Precautions (EBP) will be used (when Contact Precautions do not otherwise apply) for novel or targeted multi-drug resistant organisms (MDROs)." Section 4, Implement Contact Precautions versus EBP per following table, stated under Patient Status: Has a wound or indwelling medical device without secretions or excretions that are unable to be covered or contained and not known to be infected or colonized." United States Centers for Disease Control and Prevention (CDC) recommendations poster for use of EBP's, dated 7/31/22, stated, "Providers and staff must also wear gloves and a gown for the following high contact resident-care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, wound care: any skin opening requiring a dressing."	F 880			