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{F 000}	INITIAL COMMENTS On 5/20/25 and 5/21/25, on-site visits were conducted at Oak Grove Center for the purpose of conducting a re-vist fror annual survey completed on 3/25/25. 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 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	{F 656}		

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

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{F 656}	Continued From page 1	{F 656}		

resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on record review, interviews, and facility policy, the facility failed to implement a comprehensive care plan for 1 of 3 residents reviewed for psychotropic medications (Resident[R]4). In addition the facility failed to develop/implement a respiratory care plan for 1 of 3 residents reviewed (R5).

Findings:

Review of the "Person-Centered Care Plan" policy dated 10/24/22 states " 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.R4 was originally admitted 11/2024 and has

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{F 656}	Continued From page 2 diagnoses to include psychosis. Review of R4's care plan updated 5/13/25 states "Resident is at risk for complications related to the use of psychotherapeutic medication antipsychotic, antidepressant and anti-anxiety ...Complete behavior monitoring flow sheet. Monitor for side effects and consult a physician and /or pharmacist as needed, monitor for continues need of medications as related to behavior and mood ..." Review of R4's clinical record lacked evidence that he/she was being monitored for behaviors or side effects of antipsychotic medication. During a review of R4's clinical record on 5/21/25 at 9:30 a.m., Clinical Marketing Advisor (CMA) confirmed the above findings. 2. R5 was admitted 11/2023 and has diagnoses to include chronic obstructive pulmonary disorder (COPD) and is taking medication Ipratropium-albuterol solution 0.5-2.5 (3) MG/ML (ipratropium Albuterol 3ml inhale orally via nebulizer every 4 hours as needed for shortness of breath/wheezing, and Prednisone oral tablet 10 mg (Prednisone). Give 3 tablets by mouth in the morning for COPD exacerbation. Review of care plan most recently updated 5/10/25 laced evidence that a respiratory care plan was developed/initiated for R5. During an interview with Director of Nursing (DON), CMA, and Administrator on 5/21/25 at 10:02 a.m., The DON confirmed this tag was part of the plan of correction, but they only did audits on dental, self administration of Medications, pain Medicaion, diuretic use, and anitcoagulants, but will go through all the record again to ensure the care plans are meeting resident needs.	{F 656}		

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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}		

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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 3 residents reviewed for unnecessary psychotropic medications (Resident [R]4).

Findings:

R4 has diagnoses to include depression, psychosis, and epilepsy. Review of R4 clinical record revealed order for [anticonvulsant] Diazepam Rectal Gel 20 mg, [anti-epileptic] Keppra Solution 100 MG/ML, [antipsychotic] Quetiapine Fumarate 25 mg, and [anti-depressant] Sertraline HCL 100 mg.

Review of R4 active orders revealed order with start date of 3/12/25 for "is resident free from side effects of psychotherapeutic medicines? (if no, document side effects in PN): Related diagnoses: major depressive disorder, R/t Sertraline."

Review of R4's care plan most recently updated 5/12/25 revealed: "Resident is at risk for complications related to the use of psychotherapeutic medication antipsychotic, antidepressant, and anti-anxiety; Resident will

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{F 758}	Continued From page 5 have the smallest most effective dose without side effects, monitor for side effects and consult physician and/or pharmacist as needed. Monitor for continued need of medication as related to behavior and mood ..." Review of R4's clinical record with Clinical Market Advisor (CMA) on 5/21/25 at 9:32 a.m., revealed order "Is resident Free from side effects of psychotherapeutic medications?...related diagnoses: major depressive disorder; [R/T] Sertraline ..." Further review of clinical record lacked evidence that R4 was being monitored for side effects/behaviors for use of antipsychotic and anti-anxiety medications.	{F 758}		
{F 761} SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	{F 761}		

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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 facility policy, the facility failed to ensure medications and treatments were stored properly, including removal of expired medications from available supply, on 2 of 3 units (Millay Unit, Wyeth Unit).

Findings:

Review of policy, "Storage of Medication," dated 1/25, states, " ... Insulin products should be stored in the refrigerator until opened. Note the date on the label for insulin vials and pens when first used ...Opened insulin pens should be stored at room temperature ...Outdated, contaminated, discontinued or deteriorated medications ...are immediately removed from stock, disposed of according to procedures for medication disposal..."

1. On 5/20/25 at 8:20 a.m., during an observation of the Millay Unit medication room with Registered Nurse (RN) #1, a surveyor observed a bottle of Vitamin B Complex with an expiration date of 3/2025 and a 3-ounce tube of Perrigo Muscle Rub Cream with an expiration date of 8/2024. At this time, RN #1 removed the expired medications.

2. On 5/20/25 at 8:35 a.m., during an observation of Medication Cart A on the Millay Unit with Licensed Practical Nurse (LPN) #1, a surveyor observed an opened 100-tablet bottle of Iron 27

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{F 761}	Continued From page 7 milligrams (mg) with an expiration date of 4/2025. Additionally, the following insulin pens, that were prescribed to current residents, were open and available for use: - Insulin Degludec 200 unit/milliliter (mL) pen, undated - Insulin Lispro 100 unit/mL pen, undated - Insulin Lispro 100 unit/mL pen, undated. On 5/20/25 at 9:00 a.m., the above findings were discussed with the Millay Unit Manager, who removed the medications and stated she probably missed the expired medications during her audits of the medication carts and storage room. 3. On 5/20/25 at 9:10 a.m., during an observation of the medication cart on the Wyeth Unit with RN #2, a surveyor observed a 100-tablet bottle of Iron 27mg, marked open 5/18/25, with an expiration date of 4/2025. At this time, RN #2 removed the expired medication from the medication cart. On 5/20/25 at 9:35 a.m. during an interview, the above findings were discussed with the Director of Nursing (DON), and the DON stated that as part of the facility's Plan of Correction, unit managers were educated to go through every medication, in every drawer when performing weekly audits of the medication carts and medication rooms.	{F 761}		
{F 842} SS=D	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.	{F 842}		

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(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(h) Medical records.
§483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, 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

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unauthorized use.

§483.70(h)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(h)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and interview, the facility failed to ensure that clinical records were complete and contained accurate information for 2 of 3 residents reviewed for falls (Residents #1, #3). and in the area of psychotropic medicaion use for 1 of 3 residents reviewed during a re-vist (Resident #4).

Findings:

1. Resident #1 has diagnoses to include unsteadiness on feet and repeated falls. Review of Resident #1's clinical record revealed he/she sustained a fall on 5/19/25. Further review of the clinical record revealed a Fall Risk Evaluation,

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{F 842}	Continued From page 10 dated 5/19/25, and sections 2 through 4 of the evaluation were incomplete. 2. Resident #3 has diagnoses to include unsteadiness on feet and falls. Review of Resident #3's clinical record revealed he/she sustained a fall on 5/15/25. Further review of the clinical record revealed a Fall Risk Evaluation, dated 5/15/25, and sections 2 through 4 of the evaluation were incomplete. On 5/21/25 at 10:47 a.m. the above findings were discussed with Market Clinical Advisor. At this time, the Market Clinical Advisor reviewed Resident #1's and Resident #3's entire clinical record and confirmed that sections 2 through 4 of the Fall Risk Evaluations were incomplete. 3. Resident #4 was originally admitted 11/2024 and has diagnoses to include psychosis. Review of Resident #4's active medication orders dated 5/2025 revealed: -Order with start dated 2/24/24 for antidepressant "Sertraline HCL Oral tablet 100 mg. Give 1 tablet by mouth one time a day for depression." -Order dated 3/12/25 "Is resident free from side effect of psychotherapeutic medications? ...every shift for R/T Sertraline." -Order with start date of 2/25/25 for antipsychotic medication "Quetiapine fumarate oral tablet 25 mg. Give 12.5 mg by mouth at bedtime for psychosis." Review of clinical record lacked evidence of an order to monitor Resident #4 for side effects of antipsychotic medication. During a review of Resident #4's clinical record on 5/21/25 at 9:30 a.m., Clinical Marketing	{F 842}		

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{F 842}	Continued From page 11 Advisor (CMA) confirmed above findings.	{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 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	{F 867}		

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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 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

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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 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

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	205091	A. BUILDING _____ B. WING _____	R 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE CENTER	27 COOL ST WATERVILLE, ME 04901

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{F 867}	Continued From page 14 ensure that the Plan of Correction for identified deficiencies from the Annual Long Term Care Survey Process for Federal Recertification, dated 3/24/25, were effective. The Federal citations F656, F758, F761, F842, and F880 were cited again during the re-visit for the Annual Long Term Care Recertification Survey, completed 5/21/25. Finding: During the follow-up survey on 5/20/25-5/21/25, it was determined that F656, F758, F761, F842 and F880 would be re-cited for the same reasons: F656 for failure to implement a comprehensive care plan; F758 for failure to monitor for side effects of psychotropic medications; F761 for failure to ensure medications were stored properly, including removal of expired medications from available supply; 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 for residents (see F656, F758, F761, F842, and F880). On 5/21/25 at 12:55 p.m., during an interview, the above was discussed with the Administrator, Market Clinical Advisor, and the Director of Nursing.	{F 867}		
{F 880} SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	{F 880}		

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{F 880}	Continued From page 15	{F 880}		

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

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the

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circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observations and interviews, the facility failed to handle, store, process, and transport linens so as to prevent the spread of infection. This has the potential to affect all residents in the facility.

Findings:

Review of the facility policy, Linen Handling, revised 5/1/23 states, all linen will be handled, stored, transported, and processed to contain and minimize exposure to waste products.
Instructions to: Keep clean linen covered and Transport clean linen in covered carts or bags.

On 5/20/25 at 8:15 a.m., Laundry Aide (LA) was

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observed pushing an uncovered laundry cart that contained folded bed linens down the hall of Wyeth unit. At this time LA stated she knew it should be covered but she forgot and will go get one right now.

Observation of laundry room with LA on 5/20/25 at 8:20 a.m. revealed 4 white bedsheets folded and placed on top of a garbage can located underneath the sink, and a pile of unfolded washcloths on top of a blue tote cover located underneath the folding table on the floor available for use. At this time LA stated the bed sheets are clean but have stains on them, so they use them to cover the clean linen carts when they deliver laundry to the residents, and the washcloths are for the kitchen, and they do the dishes with them.

During an observation of the laundry room with the Director of Nursing (DON) at 8:25 a.m., the above findings were confirmed. At this time DON stated that clean linen carts are supposed to be covered when they are transported in facility.

During a follow up observation of the laundry room on 5/20/25 at 8:40 a.m., LA was observed wearing gloves and no gown holding soiled resident laundry to her chest. LA used her left gloved hand to hold the soiled laundry to her chest and her right gloved hand to open the washing machine. LA then used both hands to place the laundry in the washing machine. At this time a surveyor asked if this was the clean or dirty side of the laundry room. LA confirmed it was the dirty side, and once the laundry is washed, she will bring it over to the dryer, then will fold and deliver clean items to residents. A surveyor asked if LA had received education in Infection Control, use of personal protective

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{F 880}	Continued From page 18 equipment (PPE), and proper procedures to handle soiled laundry. LA stated she was hired about a month and a half ago and she did receive the education and was told she needed to wear a gown and gloves when handling soiled laundry but just forgets to put the gown on sometimes. At this time the Administrator was walking by the laundry room, and a surveyor asked her to observe LA through the laundry room window. The Administrator stated that the facility does require all laundry staff to wear gowns and gloves when handling soiled laundry.	{F 880}		