STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205128	A. BUILDING _____ B. WING _____	C 12/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 12/11/24, an unannounced on-site visit was conducted at Maplecrest Rehabilitation and Living Center to investigate facility reported incident #ME00049692 and complaint #ME00049710. It was determined that the Maplecrest Rehabilitation and Living Center was not in compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not	F 561		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205128	A. BUILDING _____ B. WING _____	C 12/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 1 interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that a resident's choice in the area of bathing was followed for 1 of 3 sampled residents [Resident #1 (R1)]. Finding: On 12/11/24 at 12:30 p.m., during an interview with a surveyor, R1 stated he/she had not been offered a shower since they broke their leg. R1 stated "my hair is long overdue for a washing." On 12/11/24, clinical record review indicated R1 fell from a Hoyer lift resulting in a fracture to the left leg on 11/20/24. R1 had a brief interview for mental status (BIMS) score of 15 on 12/2/24, which indicates the resident is cognitively intact. The care plan states, "[R1] has a self care deficit related to [Multiple Sclerosis (MS)] as evidenced by residents inability to perform [activities of daily living (ADLs)] without assist." The orthopedic provider signed orders on 12/4/24 stating "1. Continue [left] knee brace, may remove for hygiene" and "2. May transfer [from] bed to chair with brace in place as comfort allows". The record lacked evidence that the resident was offered, provided, or refused a shower after 11/20/24. On 12/11/24 at 1:55 p.m., during an interview, a surveyor and the Director of Nursing reviewed R1's clinical record. At this time the surveyor confirmed the above finding.	F 561		
F 656 SS=D	Develop/Implement Comprehensive Care Plan	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205128	A. BUILDING _____ B. WING _____	C 12/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 2 CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future 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.	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205128	A. BUILDING _____ B. WING _____	C 12/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 3 (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, and interviews, the facility failed to ensure a care plan was updated in order to meet the physical needs of a resident for 1 of 2 residents reviewed during a complaint investigation [Resident #1 (R1)]. Finding: R1 was admitted on 3/25/19 with a diagnosis of Multiple Sclerosis (MS). On 11/20/24 R1 experienced a fall from a Hoyer lift resulting in a fracture of the left knee. The provider order dated 11/21/24 states "wear left knee immobilizer as tolerated." On 12/4/24, the orthopedic physician signed an order stating "(1) Continue [left] knee brace, may remove for hygiene. (2) May transfer [from] bed to chair with brace in place as comfort allows. (3) While in chair should have [left] leg supported. (4) Strictly [non weight bearing] on [left] leg. (5) [follow-up] 4 weeks for re-[check] xray." On 12/11/24, review of R1's care plan indicated, "[R1] has a self care deficit related to MS as evidenced by residents inability to perform [activities of daily living (ADLs)] without assist." The surveyor was unable to locate a care plan for the management of a left knee fracture or use of a knee immobilizer.	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205128	A. BUILDING _____ B. WING _____	C 12/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 4 On 12/11/24 at 1:55 p.m., during an interview with a surveyor, the Director of Nursing stated the knee immobilizer should be addressed in the care plan. At this time the surveyor confirmed the above finding.	F 656		