STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205082	A. BUILDING _____ B. WING _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE HEALTH & REHAB AT SANFORD	1142 MAIN ST SANFORD, ME 04073

(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 2/10/25 to 2/12/25, on-site visits were conducted at Pinnacle Health & Rehab at Sanford to complete the annual Long Term Care Survey Process for Federal Recertification and investigating of complaint #ME00050427. It was determined that Pinnacle Health & Rehab at Sanford is not in compliance with 42 CFR Part 483, Subpart B-Requirements for Long Term Care Facilities.	F 000		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §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;	F 584		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Anne Ashley-Cote | TITLE: Administrator | (X6) DATE: 3/4/25

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 584	Continued From page 1 §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 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 maintain a clean, comfortable and homelike environment on 2 of 2 units. Findings: On 2/12/25 at approximately 9:00 a.m. the following was observed on the First floor: -Resident Room 138 - Wall behind chair in need of repair. -Many pieces of tape hanging from the ceiling in the main dining room -First floor common area has several dark spots on ceiling strapping -Unpainted repaired area on wall in Spa room. On 2/12/25 at approximately 9:30 a.m. the following was observed on the Second floor: -Stained ceiling tile just outside room 213 On 2/12/25 at approximately 10:00a.m. in an interview with the Administrator, the surveyor discussed the environmental observations.	F 584	**F584 Safe/ Clean/ Comfortable/ Homelike Environment** The wall behind the chair in room 138 was repaired on 2/13/25. The tape hanging from the ceiling was removed on 2/11/25. The dark spots on the ceiling strapping in the first-floor common area were cleaned on 2/14/25. The unpainted area in the first-floor spa room was painted on 2/18/25. The stained ceiling tile outside room 213 was replaced on 2/14/25. Nursing staff will continue to perform monthly audits of the units using the attached nursing unit compliance audit. Results of these audits will be reviewed by the DNS quarterly at the facility QA meeting. **Completion Date: 3/7/25**	

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	205082	A. BUILDING _____ B. WING _____	02/12/2025

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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 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	F 656		

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F 656	Continued From page 3 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 interview, the facility failed to ensure a person-centered comprehensive care plan was developed in the area of Activities of Daily Living (ADL's) to meet the preferences and goals which included interventions for assistance needed for each resident to attaining or maintaining his or her highest practicable quality of life for 6 of 14 residents care plans reviewed. (Residents 6, 11, 21, 47, 55, 26, and 61) Findings: 1. Review of Resident #6's current ADL self-care performance deficit care plan lacked interventions which included the assistance needed for him/her in the area of eating, personal hygiene, transfers, lower body dressing, bathing, toileting, bed mobility and ambulating. 2. Review of Resident #11's current ADL self-care performance deficit care plan lacked interventions which included the assistance needed for him/her in the area of eating, personal hygiene, lower body dressing, bathing and oral hygiene. 3. Review of Resident #21's current ADL self-care performance deficit care plan lacked interventions which included the assistance needed for him/her in the area of eating, personal hygiene, transfers,	F 656	**F656 Develop/Implement Comprehensive Care Plans** Care plans for all residents listed (#6, #11, #21, #47, #26, #61, #55) were reviewed and updated to reflect current ADL self-care performance. All resident care plans will be reviewed to ensure that they reflect resident's current ADL self-performance. Education will be provided to all staff responsible for resident care plans on or before 3/14/25. Care plans will be monitored monthly by the DNS or designee using the attached Care Plan audit tool x 3 months and as needed thereafter. Results will be reviewed by the DNS quarterly at the facility QA meeting. **Completion Date: 3/14/25**	

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F 656	Continued From page 4 lower body dressing, bathing, toileting, bed mobility and ambulating. 4. Review of Resident #47's current ADL self-care performance deficit care plan lacked interventions which included the assistance needed for him/her in the area of personal hygiene, lower body dressing, bathing, toileting hygiene and oral hygiene. On 2/11/25 at 1:49 p.m., during an interview, the Licensed Practical Nurse Manager for the first floor stated, in the beginning of the year the Minimum Data Set assessments for "GG - Functional Abilities" were changed, which also changed the residents care plans. This change failed to update the residents' care plan to include the personalization for the assistance needed for each resident to attain or maintain his/her functional abilities. 5. Review of Resident #26's current ADL self-care performance deficit care plan lacked interventions which included the assistance needed for him/her in the area of personal hygiene, lower and upper body dressing, bathing and shower transfers. On 2/11/25 at 2:08 p.m., the finding was discussed with the Director of Nursing. 6. Review of Resident #61's current ADL self-care performance deficit care plan lacked interventions which included the assistance needed for him/her in the area of eating, personal hygiene, transfers, lower body dressing, bathing, toileting and bed mobility. On 2/11/25 at approximately 2:00 p.m. a surveyor discussed the above findings with the Unit	F 656		

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F 656	Continued From page 5 Director who confirmed that this information didn't automatically transfer with the new Electronic Medical Record system and would need to be added. Review of Resident #55s current ADL self-care performance deficit care plan lacked interventions which included the assistance needed for him/her in the area of personal hygiene, lower and upper body dressing, bathing and shower transfers. On 2/11/25 at approximately 3:00 p.m. the finding was discussed with the Director of Nursing	F 656		
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 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.	F 755		

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F 755	Continued From page 6 §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 2 of 2 units reviewed. Findings: A review of the facility's "Shift Count" policy and procedure dated: 2/3/2000, stated under Procedure, 1. "All schedule II-V medications will be counted at the change of each shift by the off-going and the on-coming nurse. 3. If the count is correct, the keys change hands and the shift count sheet is signed by both nurses." On 2/11/25 at 11:00 a.m., during a medication storage observation of the Second Floor Medication Room, 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	F 755	**F755 Pharmacy Srvce/Procedures/ Pharmacist/Records** Nursing employees responsible for completing shift count per facility policy will be re-educated about the shift count procedure on or before 3/14/25. Shift count will be performed per facility policy to include signatures during every shift count going forward. Shift count will be audited using the attached medication room auditing tool weekly X 3 months and as needed thereafter. Results will be reviewed by the DNS quarterly at the facility QA meeting. **Completion Date: 3/14/25**	

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F 755	Continued From page 7 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. On 2/11/25 at 11:45 a.m., the surveyor confirmed the findings with the Unit Manager. On 2/11/25 at 3:30 p.m., the findiing was discussed the findings with the Administrator. On 2/11/25 at 4:00 p.m., during a medication storage observation of the First Floor Medication Room, a surveyor reviewed the Controlled Substance Books and Shift Counts. 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. On 2/11/25 at 4:20 p.m., the surveyor confirmed the findings with the Charge Nurse. On 2/12/25 at 10:15 a.m., the surveyor discussed that multiple days on both units were missing staff signatures for verification and completion of the controlled medication count on the following dates: 6/16/24, 9/13/24, 10/2/24, 10/3/24, 11/3/24, 11/6/24, 11/16/24, 11/23/24, 12/2/24, 12/12/24, 12/29/24, 1/3/25, 1/18/25, 1/24/25, 1/25/25, 1/26/25 (both units), 1/27/25, 2/9/25, and 2/10/25.	F 755		
F 761 SS=D	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	F 761		

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F 761	Continued From page 8 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and the Centers for Disease Control (CDC) guidance, the facility failed to ensure vaccines were stored in a refrigerator without a freezer compartment for 1 of 3 medication storage refrigerators. Finding: A review of the "United States (U.S.) Centers for Disease Control and Prevention: Vaccine Storage and Handling Toolkit" dated "3/24/24 stated " ...Do not store any vaccine in a dormitory-style or bar-style combined refrigerator/freezer unit under any circumstances."	F 761	**F761** **Label/store drugs & biologicals** All vaccines noted to be in the "dormitory style" refrigerator were removed on 2/11/25 while the state surveyor was in the medication room. All nurses will be educated regarding the proper storage of vaccines. Our Infection Preventionist completed a training on 2/27/25 through the CDC in regards to Immunization storage and handling (see attached certificate for Lisa Ireland). Vaccines will not be stored in a "dormitory style" refrigerator going forward. Storage of vaccines will be audited weekly X 3 months and as needed thereafter using the attached Insulin and refrigerator audit tool. Results will be reviewed by the DNS quarterly at the facility QA meeting. **Completion Date: 3/14/25**	

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F 761	Continued From page 9 On 2/11/25 at 4:00 p.m., during an observation of the First Floor Unit's Medication Room, a surveyor observed a dormitory style refrigerator (small combination refrigerator/freezer unit that is outfitted with one exterior door). The refrigerator contained several vials of purified protein derivative (for tuberculosis testing), and unit dose syringes of pneumococcal and influenza vaccines. On 2/11/25 at 4:20 p.m., the finding was confirmed by the charge nurse and the Infection Preventionist. On 2/12/25 at 10:15 a.m., the finding was discussed with the Administrator.	F 761		

Nursing Unit Compliance Walk Through

Instructions: Place a √ in the space provided after each question. Please provide comments/recommendations in the space provided. To be completed monthly and as needed.

CRITERIA	YES	NO	COMMENTS **********
Hallways clear of obstacles			
Gait belts available to CNAs			
Personal hygiene to include shaving and any treatments are provided in private areas?			
Sharps containers less than 2/3/rd full			
Oxygen is stored properly i.e., in a rack that would prevent it from falling over not freestanding, no flammables stored within 5 feet of oxygen tanks.			
Wet floor signs are in appropriate position			
Wheelchairs are clean and in good repair, over the bed tables clean and no peeling or cracking noted			
Med carts are locked			
No holes in walls or unpainted areas noted, no tape hanging from walls or ceilings			
Ceiling tiles and ceiling strapping not stained or dirty			
No extension cords in use			
Chemicals locked up/put away			
Resident privacy maintained during care i.e. curtain pulled/door shut			
No food or drink in work area or nurses station			
Any rips or tears noted in wheelchair/recliner chair arms or shower chair seat, or floor matts			
Call bell or hand bell within reach and answered timely?			
18 in. clearance from ceiling			
Commodes and catheter bags covered, catheter tubing not touching floor			
Bedpans and urinals are labeled with resident's name?			
Bedpans and urinals are stored in a contained area out of sight?			
Clean linen is carried away from the body when being delivered to resident rooms?			
Soiled linen is bagged in the resident's room or other area and brought to the dirty utility room and rinsed out by nursing prior to placing in the dirty linen receptacle? No lingering odors noted?			
Clean and dirty utility room doors are closed and locked?			

Comments/Recommendations

_____

_____

_____

_____

Unit _____ **Date Completed** _____

Completed By: _____

Date: _____

Weekly Audit: Audit Residents weekly to ensure ADL Care Plan is personalized.

Follow IDT care plan schedule weekly x 3 months

RESIDENT	ADL care plan is present and includes B-G-D-Eating, Transfers, toileting and ambulation. Y or N	Is the care plan updated to reflect resident's current status? Y or N	Follow up

Signature of Auditor: _____

Medication Room Audit

Criteria	Met	Not Met	N/A	Comments
Medication room is clean and orderly.				
Internal/External meds. Stored separately.				
No unlabeled medications present.				
Discontinued medications removed.				
No personal items stored in med room.				
Emergency medication list up to date.				
Refrigerator temperatures (36-46 F)				
All opened vials dated with date opened.				
No expired medications noted in vaccine fridge.				
No expired medications noted in med fridge.				
Sharps containers < 3/4 full.				
Lab tubes in lab draw kit no expired.				
No missing signatures in narcotic books.				

Comments/Recommendations:

_____

_____

_____

_____

_____

Completed By: _____ **Date:** _____

The Centers for Disease Control and Prevention (CDC)

certifies that

Lisa Ireland

U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION

has participated in the following educational activity

Immunization: You Call the Shots-Module Ten-Storage and Handling - 2025 (Web Based) - WB4905

WB4905

and is awarded

1 Contact Hour(s)

on

02/27/2025

JOINTLY ACCREDITED PROVIDER™
INTERPROFESSIONAL CONTINUING EDUCATION

In support of improving patient care, the Centers for Disease Control and Prevention is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

The Centers for Disease Control and Prevention designates this activity for 1.0 nursing contact hour(s).

Lutrisha S. King

Lutrisha S. King, PhD, MHA, MCHES®
Team Lead, Continuing Education Accreditation Team
Education and Training Services Branch (ETSB)
Centers for Disease Control and Prevention (CDC)
1600 Clifton Road NE, MS V24-5
Atlanta, GA 30333

Date:

Insulin and Refrigerator Temperature Log Audit (First Floor)

Resident Name	Type of Insulin	Date Opened	Date Expired

Glucose/Glucagon House Stock (First Floor)

CART I	In Stock? Yes/No	Expiration Date	Comment
Glucose	Yes (1)		
Glucagon (Emergency Use Only)	Yes (1)		
CART II	**Yes/No**	**Expiration Date**	**Comment**

Refrigerator Temperature Log

1st Floor Medication Refrigerator- Yes ____ No ____

1st Floor Vaccine Refrigerator- Yes ____ No ____

Vaccines are stored in a refrigerator without a freezer compartment Yes ____ No ____

Any holes or temperature discrepancies noted should be reported to the appropriate nurse manager or shift supervisor as well as the DNS

Instructions remain in med room for staff to verify process of counting insulin expiration dates when opening a new pen.

Signature of person performing Audit: Alexa Plaisted, RN

Overstock: **Too soon to order:** **Reordered this week:**