STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205105	A. BUILDING _____ B. WING _____	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTGATE CENTER FOR REHAB & ALZHEIMERS CARE	750 UNION ST BANGOR, ME 04401

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F 000	INITIAL COMMENTS From 1/29/24 through 1/31/24, on-site visits were conducted at Westgate Center for Rehabilitation and Alzheimer's Care for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification and to investigate complaints #ME00044828 and #ME00044838. It was determined that Westgate Center for Rehabilitation and Alzheimer's Care is not in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence.	F 636		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ashley Nichols LCSW, LNHA	Administrator	2-22-24

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 636	Continued From page 1 (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to complete an Annual Comprehensive Minimum Data Set (MDS) 3.0 with Care Area	F 636		

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F 636	Continued From page 2 Assessment (CAA) in a timely manner for 2 of 14 sampled residents (Resident [R] 7, Resident [R] 6). Findings: 1. On 1/31/24, a review of R7's clinical record was reviewed. R7's Annual MDS with CAA had an Assessment Reference Date (ARD) of 9/3/23 and was due to be completed by 9/17/23, which is the ARD plus 14 calendar days. R7's Annual MDS was completed on 9/18/23, 1 day late. On 1/31/24 at 8:25 a.m., during an interview with a surveyor, the MDS Coordinator, stated she has been behind on finishing the MDS's in a timely manner. 2. On 1/31/24, a review of R6's clinical record was reviewed. R6's Annual MDS with CAA had an ARD of 1/12/24, and was due to be completed by 1/26/24, which is the ARD plus 14 calendar days. R6's Annual MDS was completed on 1/30/24, 4 days late. On 1/31/24 at 8:25 a.m., during an interview with the MDS Coordinator, two surveyors confirmed this finding when she stated she has been behind on finishing the MDS's in a timely manner.	F 636		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the	F 637		

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F 637	Continued From page 3 resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to complete a Comprehensive Minimum Data Set (MDS) 3.0 with Care Area Assessment (CAA) for a significant change in status, in a timely manner for 1 of 14 sampled residents (Resident #9[R9]). Finding: On 1/31/24, R9's clinical record was reviewed. R9's significant change in status MDS with CAA had an Assessment Reference Date (ARD) of 12/05/23, which was due to be completed by 12/19/23 (which is the ARD plus 14 calendar days). R9's MDS with CAA was completed on 12/25/23, 6 days late. On 1/31/24 at 8:25 a.m., during an interview with the MDS Coordinator, two surveyors confirmed this finding when she stated she has been behind on finishing the MDS's in a timely manner.	F 637		
F 638 SS=E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the	F 638		

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F 638	Continued From page 4 quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record reviews and interview, the facility failed to complete a Quarterly Minimum Data Set (MDS) 3.0 in a timely manner for 7 of 14 sampled residents (Resident [R] R3, R5, R8, R35, R7, R23, R10). Findings: 1. On 1/30/24, R3's clinical record was reviewed. R3's Quarterly MDS had an Assessment Reference Date (ARD) of 10/24/23 and was due to be completed by 11/7/23, which is the ARD plus 14 calendar days. R3's Quarterly MDS was completed on 11/27/23, 10 days late. 2. On 1/30/24, R5's clinical record was reviewed. R5's Quarterly MDS had an Assessment Reference Date (ARD) of 12/1/23 and was due to be completed by 12/15/23, which is the ARD plus 14 calendar days. R5's Quarterly MDS was completed on 12/25/23, 10 days late. 3. On 1/30/24, R8's clinical record was reviewed. R8's Quarterly MDS had an Assessment Reference Date (ARD) of 8/25/23 and was due to be completed by 9/8/23, which is the ARD plus 14 calendar days. R8's Quarterly MDS was completed on 9/13/23, 5 days late. 4. On 1/30/24, R35's clinical record was reviewed. R35's Quarterly MDS had an Assessment Reference Date (ARD) of 11/22/23	F 638		

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F 638	Continued From page 5 and was due to be completed by 12/6/23, which is the ARD plus 14 calendar days. R35's Quarterly MDS was completed on 12/21/23, 15 days late. 5. On 1/31/24, a review of R7's clinical record was reviewed. R7's Quarterly MDS had an ARD of 12/4/23 and was due to be completed by 12/18/23, which is the ARD plus 14 calendar days. R7's Quarterly MDS was completed on 12/25/23, 7 days late. 6. On 1/31/24, a review of R23's clinical record was reviewed. R23's Quarterly MDS had an ARD of 10/27/23 and was due to be completed by 11/10/23, which is the ARD plus 14 calendar days. R23's Quarterly MDS was completed on 11/12/23, 2 days late. R23 had another Quarterly MDS with an ARD date of 11/20/23 and was due to be completed by 12/4/23, which is the ARD plus 14 calendar days. R23's Quarterly MDS was completed on 12/2123, 17 days late. 7. On 1/30/24, R10's clinical record was reviewed. R10's Quarterly MDS had an Assessment Reference Date (ARD) of 10/17/23 and was due to be completed by 10/31/23, which is the ARD plus 14 calendar days. R10's Quarterly MDS was completed on 11/13/23, 13 days late. On 1/31/24 at 8:25 a.m., during an interview with the MDS Coordinator, two surveyors confirmed this finding when she stated she has been behind	F 638		

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F 638	Continued From page 6 on finishing the MDS's in a timely manner.	F 638		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to ensure that plumbing fixtures were properly installed to prevent backflow as required by the Maine State Plumbing Code on 1 of 3 survey days (1/29/24). In addition, the facility failed to ensure products in the reach-in refrigerator located in the kitchen were labeled on 2 of 3 days of survey (1/29/24, 1/30/24). Findings: 1. On 1/29/24, at 11:00 a.m., three surveyors observed there was an improper air gap provided	F 812		

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F 812	Continued From page 7 on the drain lines of the ice machine located in the hallway leading to the kitchen. This direct connection of wastewater and potable water was in violation of the 10-114 State of Maine Rules Chapter 226, definition Section A, which defines an Air-Gap Separation - A physical separation between the free-flowing discharge end of a potable water supply pipeline and an open or non-pressure receiving vessel. An air-gap separation shall be at least twice the diameter of the supply pipe measured vertically above the overflow rim of the vessel - in no case less than one inch (2.54 cm). On 1/29/24 at 11:10 a.m., a surveyor confirmed this finding with the Food Service Director (FSD). 2. On 1/29/24 at 11:13 a.m., during the initial kitchen tour, a surveyor observed 2 trays of individual cups of a yellow/orange substance that were not labeled in the reach in refrigerator. The surveyor asked the FSD what was in the individual cups, the FSD identified the substance to be sugar free pudding used for medication passes. 3. On 1/30/24 at 11:25 a.m., during a second tour of the kitchen, the surveyor observed 2 trays of individual cups of a yellow/orange substance that were not labeled in the reach in refrigerator. The surveyor confirmed with the FSD at this time that the trays were not labeled.	F 812		
F 814 SS=D	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	F 814		

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F 814	Continued From page 8 by: Based on observations and interview, the facility failed to ensure garbage was properly disposed of and contained to prevent the harborage and feeding of pests for 1 of 3 days of survey (1/31/24). Finding: On 1/31/24 at approximately 12:12 p.m., two surveyors observed the dumpster filled with garbage bags not allowing the covers to be closed. During this observation the two surveyors observed a full black garbage bag that was under the dumpster that was spilling some of the contents on the ground on the right side of the dumpster, behind the dumpster were two bags filled with garbage. On 1/31/24 at 12:14 p.m., the two surveyors confirmed with the Maintenance Supervisor, Food Service Director, Director of Nursing, Assistant Director of Nursing, and the Regional Director of clinical operations that the dumpster was full not allowing the covers to be closed and the garbage bags that were under and behind the dumpster.	F 814		