STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205115	A. BUILDING _____ B. WING _____	C 10/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEXTER HEALTH CARE	**64 PARK STREET DEXTER, ME 04930**

(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 10/17/23, an unannounced on-site visit was conducted at Dexter Health Care for the purpose of investigating a facility reported incident #ME00045127. It was determined that Dexter Health Care was in past non-compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
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 interviews, review of the facility incident report, and investigation, the facility failed to ensure the entrance door locked/alarmed when a resident that wore an ankle secure care transmitter and had been identified as an elopement risk was able to leave the building unnoticed for 1 of 1 facility reported incidents reviewed (10/2/23). A nearby neighbor who lived 0.2 miles away called the facility to let staff know that Resident #1 was at their residence. Finding: Review of the facility's incident report sent to the State Agency, dated 10/2/23, indicated that [Resident #1] was wearing a secure care bracelet but was able to exit the facility unwitnessed. A	F 689	Past noncompliance: no plan of correction required.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 1	F 689		

near by neighbor called the facility to alert them that they had a resident at their property. On 10/5/23, the facility completed their investigation and sent it to the State Agency. This investigation indicated that after reviewing the facility cameras, it was found Resident #1 exited the front door at 5:34 p.m. The neighbor called the facility at 5:50 p.m.; staff immediately went to get Resident #1 from the neighbors residence and Resident #1 was assessed and found with no injuries. The front door was tested and was found to work/alarm correctly 3 out of 4 times but would not lock all of the time when the secure care bracelet transmitter was passed through the door.

On 10/17/23 at 9:40 a.m., during an interview with a surveyor, the Maintenance Director stated that he just tested all of the door alarms that day and they worked properly. He stated that he put it in the lock mode continually until the problem was diagnosed and fixed. The dining room door which tested OK was throwing off a signal (which interfered with the front door causing it to malfunction some of the time).

On 10/17/23 at 3:59 p.m., during an interview with a surveyor, Licensed Practical Nurse (LPN) #1 stated that she didn't know Resident #1 had left until she received the phone call from the neighbor. There were two Certified Nursing Assistants (CNA) that took off to go get him/her and that she did not hear a door alarm.

On 10/17/23 at 4:21 p.m., during an interview with a surveyor, LPN #2 stated, "it was brought to our attention that the resident was outside. Two aides and myself went and got Resident #1 from down the street. He/she made a right after the driveway.....I was nervous because of the hill.

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F 689	Continued From page 2 Resident #1 was still in his/her wheelchair. I assessed Resident #1, no apparent injuries....We did not hear any alarms at all. [redacted] did have a wanderguard on." As a result of this isolated incident, the following corrective actions were initiated: - On 10/2/23 at 5:50 p.m., the facility received a phone call from a residence on Park St that Resident #1 was at their location. The Charge Nurse immediately sent 2 CNAs to get Resident #1. Upon return to the facility, Resident #1 was checked for injuries by LPN #2. In addition, the front door was now locked and only could be opened by entering a code or being let in by facility staff until the faulty front door was fixed. - On 10/3/23, Maine Fire was called to check out the front door. The faulty control box was placed on order by Maine Fire. - On 10/4/23, Maine Fire replaced the faulty control box. The front door was now unlocked from 6 a.m. to 2:30 p.m. and after 2:30 p.m., (second and third shift when there is left staff in the front lobby area), the door is locked and visitors must be let in the facility by staff or entrance can only be gained by entering a code. -On 10/5/23, a facility wide in-service was conducted in regards to the Front Door-Secure Care alarm system. -The facility continues to check the 7 doors that have the Resident Monitoring System (secure care) lock on them weekly in addition to weekly checks on the secure care bracelets that the residents wear.	F 689		