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	205137	A. BUILDING _____ B. WING _____	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEDGEWOOD MANOR	200 ROUTE 115 WINDHAM, ME 04062

(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 2/24/2025 through 2/26/2025, on-site visits were conducted at Ledgewood Manor for the purpose of conducting the annual Long Term Care Survey Process and investigating complaint #ME00050020. It was determined that Ledgewood Manor was not in substantial compliance with 42 CFR 483, Sub-part B Requirements for Long Term Care Facilities.	F 000		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.	F 578		

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

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F 578	Continued From page 1 (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the resident and/or resident representative was provided with written information concerning the right to formulate an advanced directive for 2 of 5 residents (Residents #24, #38), and failed to ensure a physician's order included the resident's preference for resuscitation (Resident #17). Findings: 1. Resident #24 was admitted in August of 2023. A review of the entire electronic medical record lacked evidence that the facility offered or provided the resident and/or resident representative with written information concerning the right to formulate an advanced directive. 2. Resident #38 was admitted in September of 2024. A review of the entire electronic medical record lacked evidence that the facility offered or provided the resident and/or resident representative with written information concerning the right to formulate an advanced directive.	F 578		

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F 578	Continued From page 2 3. Resident # 17 was admitted in December of 2024. A review of the electronic medical record revealed that provider orders did not designate the resident's preferred "code status," meaning to resuscitate or do not resuscitate. On 2/25/25 at 12:30 p.m., in an interview with a surveyor, the Business Office Manager stated the facility's admission process includes requesting copies of an advanced directive but staff do not document if a resident is offered the opportunity to form an advanced directive or if the resident declines the offer, and stated it has not been routine practice to offer or provide assistance with formulating advanced directives. The Business Office Manager reviewed the records and confirmed that there was no advanced directive in the records of Residents #24 and #38. On 2/25/25, at approximately 3:30 p.m., the Business Office Manager reviewed Resident #17's record and confirmed the provider did not write an order indicating Resident #17's code status was to be designated as "do not resuscitate."	F 578		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The	F 623		

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facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;

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F 623	Continued From page 4 (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is	F 623		

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the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k).
This REQUIREMENT is not met as evidenced by:
Based on record reviews and interviews, the facility failed to issue a written transfer/discharge notice to a resident or their legal representative for a facility-initiated transfer/discharge for 3 out 3 of of sampled residents transferred/discharged to an acute care facility.(#6, #21 & #40)

Findings:

1. Documentation in Resident 6's clinical record indicated that he/she was transferred to an acute hospital in early February of 2025 and subsequently admitted. The clinical record lacked evidence that the facility issued a written transfer/discharge notice to the resident and/or legal representative.

2. Documentation in Resident 21's clinical record indicated that he/she was transferred to an acute hospital in early December of 2024. The clinical record lacked evidence that the facility issued a written transfer/discharge notice to the resident and/or legal representative.

On 2/26/25 at 11:15 a.m., in an interview with a surveyor, the Director of Nursing (DON) confirmed that she was unable to locate evidence that the facility issued a written transfer/discharge notice to the resident, a family member, or a legal

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F 623	Continued From page 6 representative upon transfer to an acute care facility for Resident #6 and Resident #21. 3. Documentation in Resident 40's clinical record indicated that he/she was transferred to an acute hospital in early January of 2025 and subsequently admitted. The clinical record lacked evidence that the facility issued a written transfer/discharge notice to the resident and/or legal representative. On 2/26/25 at 8:54 a.m., During an interview the Facility Administrator confirmed that the clinical record lacked evidence that a transfer/discharge notice was provided in writing to the Resident and/or Resident Representative.	F 623		
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1)	F 625		

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of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and interviews, the facility failed to issue a written bed hold notice to a resident, known family member or legal representative for 3 of 3 sampled residents who had been transferred to an acute care facility (#6, #21, & #40).

Findings:

Documentation in Resident #6's clinical record indicated that he/she transferred to an acute care hospital in early February of 2025 and subsequently admitted. The clinical record lacked evidence that the facility issued a written bed hold notice to the resident, a family member, or legal representative upon transfer.

Documentation in Resident #21's clinical record indicated that he/she transferred to an acute care hospital in early December of 2024. The clinical record lacked evidence that the facility issued a written bed hold notice to the resident, a family member, or legal representative upon transfer.

On 2/26/25 at 11:15 a.m., in an interview with a surveyor, the Director of Nursing (DON) confirmed that she was unable to locate evidence that the facility issued a written bed hold notice to

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F 625	Continued From page 8 the resident, a family member, or a legal representative upon transfer to an acute care facility for Resident #6 and Resident #21. 3. Documentation in Resident #40's clinical record indicated that he/she transferred to an acute care hospital in early January of 2025 and subsequently admitted. The clinical record lacked evidence that the facility issued a written bed hold notice to the resident, a family member, or legal representative upon transfer. On 2/26/25 at 8:54 a.m., During an interview the Facility Administrator confirmed that the clinical record lacked evidence that a written bed hold notice was provided in writing to Resident and/or Resident Representative.	F 625		
F 637 SS=B	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 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 interview and record review, the facility failed to conduct a comprehensive Minimum Data Set 3.0 (MDS 3.0) assessment within 14 calendar	F 637		

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days after a resident experienced a significant change of condition and hospice services were initiated for 3 of 16 sampled residents (Resident #23, Resident #29, and Resident #31).

Finding:
The Resident Assessment Instrument (RAI) Version 3.0 Manual, Chapter 2, page 2-23 reads that "a Significant Change in Status Assessment (SCSA) is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The Assessment Reference date (ARD) must be within 14 calendar days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). A SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place."

Resident #23's clinical record contained documentation that indicated the resident was admitted into Hospice care in mid December of 2024. An SCSA was not completed.

Resident #29's clinical record contained documentation that indicated the resident was admitted into Hospice care in mid July of 2024. An SCSA was not completed.

Resident #31's clinical record contained documentation that indicated the resident was admitted into Hospice care in mid October of 2024. An SCSA was not completed.

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F 637	Continued From page 10 On 2/25/25 at 9:45 a.m., during an interview with the Director of Nursing, the surveyor confirmed the SCSA was not completed for the residents listed.	F 637		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the	F 655		

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resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on interviews and record review, the facility failed to complete a baseline care plan, as required, within 48 hours of admission to the facility for 5 of 16 residents sampled. (Resident #38, Resident #39, Resident #242, Resident #243 and Resident #244).

Finding:
Resident #38 was admitted to the facility in mid September of 2024. The care plan for Resident #38, located in the Electronic Medical Record (EMR), was initiated on 10/2/24.

Resident #39 was admitted to the facility in early December of 2024. The care plan for Resident #39, located in the EMR, was initiated on 12/11/24.

Resident #243 was admitted to the facility in mid February of 2025. The care plan for Resident #243 located in the EMR, was initiated on 2/20/25.

Resident #242 was admitted to the facility in mid February of 2025. The care plan for Resident #242, located in the EMR, was initiated on

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F 655	Continued From page 12 2/24/25. Resident #244 was admitted to the facility in mid February of 2025. On 2/25/25 a surveyor was unable to locate a care plan in the EMR for Resident #244. On 2/25/25 at 12:50 p.m. a surveyor met with the charge nurse about Resident #249's missing care plan. The charge nurse confirmed that a baseline care plan should be in the resident's EMR and completed within 48 hours. She/he was also unable to locate a care plan for Resident #249. On 2/26/25 at 9:50 a.m. a surveyor met with the Director of Nursing to discuss the above findings.	F 655		
F 656 SS=D	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	F 656		

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F 656	Continued From page 13 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 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 develop a comprehensive care plan that addressed the use of psychotropic drug use and nutrition for 1 of 5 residents reviewed for unnecessary medications. (#21). Finding: Resident #21's February 2025 Medication Administration Record (MAR) indicated that the resident had received the antidepressants Fluoxetine 40 milligrams (mg) once daily since	F 656		

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F 656	Continued From page 14 10/8/24 and Trazodone 100 mg once daily at bedtime since 5/8/24. Resident #21's Minimum Data Set (MDS) 3.0 Annual Assessment dated 10/9/24, under Care Area Assessment Summary, noted Resident #21 would be care planned for Psychotropic Drug use and Nutrition. As of 2/26/25, Resident #21's medical record lacked evidence of a comprehensive care plan in the area of psychotropic drug use and Nutrition. The surveyor confirmed this lack of care plan for psychotropic drug use and in the care area of nutrition in an interview with the Director of Nursing, on 2/26/25 at 11:15 a.m.	F 656		
F 689 SS=E	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 observations, interviews, and a review of Safety Data Sheets (SDS), the facility failed to ensure that the resident's environment was free of accident hazards relating to the storage of chemicals and over-the-counter medications for 1 of 3 survey days. (2/24/25) Findings:	F 689		

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On 2/24/25 at 9:08 a.m. a surveyor observed a storage room door propped open, cupboards in the room were unlocked and contained the facility's of supply of over-the-counter medications. The administrator was immediately made aware.

On 2/24/25 at 9:14 a.m. a surveyor observed a whirlpool #1 room with a door propped open that had a closet door inside with a key in the door. The closet contained a supply of G2-2100 bottles used for surface cleaning and Simoniz hospital disinfecting deodorant. CNA #1 was immediately made aware.

On 2/25/25 at 10:00 a.m. a surveyor observed Whirlpool #2 room with a door propped open and found a bottle of G2-2100 on a shelf unsecured next to the sink. A closet door inside Whirlpool #2 was observed with a key in the lock. The closet contained a supply of G2-2100 and Simoniz hospital disinfecting deodorant. CNA #2 was immediately made aware. She/he stated that shouldn't be there and locked the door and removed the key.

On 2/24/25 at 9:00 a.m. a surveyor observed Resident #11 wandering in and out of accessible areas. MDS review of Resident #11 revealed a diagnosis of Dementia with a Brief Interview for Mental Status (BIMS) score of 0 indicting severe cognitive impairment.

A review of the SDS for GC-2100 with a revision date of 3/24/27 showed a GHS US classification -Serious eye damage/eye irritation Category 2B

A review of the SDS for Simoniz hospital disinfectant deoderant with a revision date of

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F 689	Continued From page 16 3/3/2015 showed a classification for eye irritant as Category 2A. Hazardous ingredients include Propane/n-Butane and ethyl Alcohol. On 2/24/25 at 3:12 p.m. the Director of Nursing was made aware of the above findings.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record and policy review, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to respiratory care for 1 of 2 residents (Resident's #24). Finding: On 2/24/25 at 11:18 a.m., a surveyor observed a nebulizer machine on a stand next to Resident #24's bed. The face mask and attached tubing was noted to be dated "10/27," and was placed exposed on a shelf of the stand. On 2/24/25 at 11:28 a.m., a surveyor asked the treatment nurse how staff care for nebulizer equipment. The nurse stated tubing is changed	F 695		

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F 695	Continued From page 17 weekly and other items are washed every night. The nurse stated "I don't have anyone with a nebulizer right now." At this time, the surveyor showed the nurse Resident #24's nebulizer machine and face mask with tubing dated 10/27. The nurse stated he/she did not know why that was there and should have been removed as there is no order for a nebulizer. The nurse then removed the equipment. A review of Resident #24's provider orders noted an active order, dated 10/22/24, for "DuoNeb Solution (Ipratropium-Albuterol) 0.5-2.5 mg/3 ml (milligrams per milliliter) - 3 ml inhale orally every 4 hours as needed for shortness of breath, wheezing related to chronic respiratory failure with hypoxia; panlobular emphysema." On 2/24/25 at 4:00 p.m., a surveyor discussed the finding with the Director of Nursing who confirmed Resident #24 had an active order for nebulizer treatments and that the tubing should be changed weekly. The facility's policy, "Equipment Change Out," revised 10/4/24, stated "Small volume nebulizers will be dated and changed out weekly."	F 695		
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.	F 755		

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F 755	Continued From page 18 §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. §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 facility policy and clinical 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 policy, "Controlled Drug	F 755		

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F 755	Continued From page 19 Policy and Procedure," dated 10/4/24, stated "Controlled drugs, as determined by the facility, are counted every shift by the nurse/med tech reporting on duty with the nurse/med tech reporting off-duty. The inventory of the controlled drugs must be recorded on the narcotic records and signed for accuracy of count." On 2/24/25 at 11:45 a.m., 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 administer medications going off duty failed to sign the Shift Count page of the Controlled Substances Book that indicated the controlled substances count was completed on multiple days. Multiple days on both units were missing staff signatures for verification and completion of the controlled medication count on the following dates: 9/28/24, 11/28/24, 12/19/24, 1/21/25, 1/23/25, 2/3/25, 2/15/25, 2/23/25, and 2/24/25. On 2/24/25 at 4:00 p.m., the surveyor confirmed the findings with the Director of Nursing and the Administrator.	F 755		
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	F 812		

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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, interviews and record review, the facility failed to ensure the facility was maintained in a clean and sanitary manner for the kitchen counter, fans, ceiling vents and floors. In addition, the facility failed to ensure the kitchen ice machine and food preparation sink were plumbed in accordance with code requirements to prevent food contamination. Further, the facility lacked evidence that the sanitizing bucket and sanitizing sink solutions, dishwashing temperatures were documented and within the appropriate range for 3 of 3 days of survey.

Findings:

Initial Kitchen Tour:

1. On 2/24/25 from 9:23 a.m. to 9:45 a.m. a surveyor completed a tour of the kitchen with the Food Service Director [FSD] in which the following findings were observed:

-The countertop near the food preperation sink had several gauged areas on the surface creating

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an uncleanable surface.
-Two floor fans in the dish room had chipped paint on the front grille and base of fan.
-The ceiling vent in the dishwashing room had dust/debris.
-The floor in the dishwashing room was soiled and had missing pieces of tile.
-The ceiling and walls in the dishwashing room were stained and had areas of chipped loose paint creating an uncleanable surface.

The kitchen ice machine and the food preparation sink were not plumbed in accordance with the code requirement and did not have the required proper air gaps.

"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) and the Code of Federal Regulation, Title 21, Part 1250, Section 1250, 30 (d) states "all plumbing shall be so designed, installed, and maintained as to prevent contamination of the water supply, food, and food utensils."

On 2/25/25 a.m. during an interview with the FSD. She indicated that the dishwashing final rinse temperature is not always accurate on the temperature gauge and that the facility is currently waiting for a part to repair the dishwasher. A surveyor asked if there was an

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alternate method of checking the final rinse temperature. The FSD confirmed that the staff had no alternative method of checking the final rinse temperature while using the dishwashing machine.

Record review of the facilities monthly "Dish Machine Temperatures" log for October, November 2024 and February 2025 revealed that the staff recorded using the High-Temp dish washer at temperatures below the recommended range (Wash 150°F-165° F, Rinse 180° F) on various shifts and on five days including but not limited to:

On the morning shift of 10/14/24 the rinse was recorded at 178° F; on the evening shift of 10/16/24, the rinse was recorded as 179° F; on the evening shift of 11/25/24, the rinse was recorded at 179° F; on the evening shift of 11/27/24, the rinse was recorded at 178° F; on the evening shift of 2/25/25, the rinse was recorded at 179° F.

A review of the monthly "Dish Machine Temperatures" log for November 2024 and January 2025, revealed that the staff did not record dish machine temperatures for the Wash and Rinse cycles on various shifts on three days including but not limited to: Evening shift on 11/29/24 and 11/30/24; and Evening shift on 1/31/25.
A review of the Dish Machine Temperature/Sanitizer Records Policy & Procedure indicates Dish machine temperatures and/or sanitizer strengths (as indicated) shall be monitored prior to each meal and recorded to prevent foodborne illness by ensuring all food contact surfaces are properly cleaned and

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sanitized. Special attention is required to determine if a high temperature or low temperature dish machine is being used. 1. The Dietary Manager shall train all dietary employees regarding the type of dish machine (high temperature/low temperature) and sanitation methods specific to the type being used. 2. Dish machines use either heat or chemical sanitation methods. The following are specifications according to the US Department of Health and Human Services , 7. If there is concern about the sanitizing quality due to inadequate wash or rinse temperature, inadequate sanitizer strength, or inappropriate flow pressure that cannot be resolved by the dietary employee, the ware washing shall be stopped and reported to the Dietary Manager or a designee for corrective action. 9. The Dietary Manager shall be responsible for assuring that the record of dish machine temperatures is maintained at all times.
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The facilities Sanitizer Bucket Strength Record Policy and Procedure revised 5/2011 indicates When sanitizing buckets are utilized as a system to sanitize food contact surfaces, the strength of the sanitizer in the buckets shall be monitored. Procedure: 1. The Dietary Manager shall train all dietary employees regarding the use of sanitizer test strips, acceptable sanitizer concentration, and the required procedure for documenting sanitizer strength in the sanitizer bucket(s). 3. Sanitizer strength in sanitizing bucket(s) shall be monitored following each meal and recorded by the dietary staff. The Sanitizer Bucket Strength Log may be utilized as a reference as needed. 5. The Dietary Manager or designee shall be responsible for posting the log in the Dietary Department to record sanitizer strength in sanitizer bucket(s). 6. The Dietary Manager shall

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F 812	Continued From page 24 be responsible for assuring that the record of sanitizer bucket(s) is maintained at all times. The Sanitization Buckets in the Kitchen: The facility lacked evidence that the sanitizer checks for appropriate parts per million (ppm) were monitored and documented for the following dates and times: 11/16/24 6 a.m., 9 a.m., 11 a.m., and 1 p.m., 11/20/24 and 11/21/24 3 p.m., 6 p.m., 11/23/24 and 11/24/24 6 a.m., 9, a.m., 11 a.m., 1 p.m., 3 p.m., 6 p.m., 11/25/24, 11/26/24 and 11/27/24 3 p.m., 6 p.m., 1/28/25 3 p.m., 6 p.m., 2/8/25 11 a.m. On 2/26/25 at 10:38 a.m. during an interview with a surveyor, the FSD stated that the facility started using paper and plastic during the evening meal on 2/25/25 and that the dishwasher is not currently being used. On 2/26/25 at 12:37 p.m., a surveyor discussed the above findings with the Administrator and the Director of Nursing.	F 812		