STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205187	A. BUILDING _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIPER SHORES	15 PIPER ROAD SCARBOROUGH, ME 04074

(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 July 10, 2023 to July 12, 2023, on-site visits were conducted at Piper Shores to complete the annual Long Term Care Survey Process for Federal Recertification and investigating complaint #ME00043714. It was determined that Piper Shores is not in compliance with 42 CFR Part 483, Subpart B-Requirements for Long Term Care Facilities.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen	F 550		

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

Administrator 8-4-23

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.

Piper Shores Skilled Nursing Facility
Plan of Correction
Provider Number 205187
Survey Date 07/12/23

F 550- Resident Rights/Exercise of Rights

1. The Environmental Services staff person who placed a clothing protector on the resident was in-serviced on 7/10/23.

2. The deficient practice has the potential to affect residents who need assistance with meals.

3. Staff will be in-serviced on resident choice and dignity. The Director of Nursing and Charge Nurses will observe staff interactions during meal service periodically. Written documentation of discrepancies will be submitted to the DON.

4. Corrective action results will be monitored and corrected by the DON and the Administrator. Audit results will be reported to the QA Committee for at least 120 days.

F 550 Correction Date: August 26, 2023

F558 – Reasonable Accommodations Needs/Preferences

1. Resident #22's call bell was placed within reach on 7/10/23 at time of discovery.

2. The deficient practice has the potential to affect residents who rely on the call bell for assistance.

3. At time of discovery, a Resident call bell audit was conducted by the Staff Development RN and DON verifying other call bells were within resident reach of potentially affected Residents on 7/10/23. Nursing staff will be in-serviced on call bell placement and accessibility.

4. Charge nurses will perform call bell audits periodically, correct, and report discrepancies. Discrepancies will be reviewed by DON or designee. Results will be reported to the QA committee for at least 120 days.

F 558 Correction Date: August 26, 2023

F 582 - Medicaid/Medicare Coverage/Liability Notice

1. The facility cannot retroactively correct the deficient practice for residents 39, 201 and 202.

2. The deficient practice has the potential to affect residents who are Medicare Beneficiaries.

3. The facility policy will be updated and staff will be in-serviced. Social Worker/Admissions Coordinator will issue the SNFABN prior to the resident's last covered day when Medicare Part A coverage for skilled services ends.

4. Corrective action results will be monitored by the DON in the Utilization Review Committee and the reported to the QA Committee for at least 120 days.

F 582 Correction Date: August 26, 2023

F 623 – Notice Requirements before Transfer/Discharge

1. The facility cannot retroactively correct the deficient practice for resident #11.

2. The deficient practice has the potential to affect residents who are transferred or discharged from the facility.

3. The facility policy will be updated and staff will be in-serviced. The Charge Nurse will notify the resident and the resident's representative in writing, before transfer or discharge, and send a copy of the notice to the Office of the State Long-Term Care Ombudsman.

4. Corrective action results will be monitored by the DON in Utilization Review Committee and reported to the QA Committee for 120 days.

F 623 Correction Date: August 26, 2023

F 625 – Notice of Bedhold Policy Before/Upon Transfer

1. The facility cannot retroactively correct the deficient practice for resident #11.

2. The deficient practice has the potential to affect residents who are transferred to a hospital or go out on a therapeutic leave.

3. The policy will be revised and staff will be in-serviced. The Social Worker/Admissions Coordinator will issue a bedhold policy/notice to the resident and/or legal representative at the time of a resident transfer or therapeutic leave.

4. Corrective action results will be monitored by the DON in Utilization Review Committee and reported to the QA Committee for at least 120 days.

F 625 Correction Date: August 26, 2023

F656 – Comprehensive Care Plans

1. The gait belt was removed from Resident #39's room on 7/11/23 at time of discovery.

2. The deficient practice has the potential to affect residents whose individual interventions require gait belt storage outside resident rooms. The Clinical Assessment Manager conducted an Audit on 7/11/23 for CNA accuracy of care plan compliance identifying no other affected Residents.

3. Nursing staff will be in-serviced on care plan updates and systems to identify care plan interventions.

4. Charge nurses will observe compliance with individualized interventions periodically, correct, and report discrepancies. The Clinical Assessment Manager will periodically audit compliance with care plans. Identified discrepancies and compliance audits will be reviewed by the DON and reported to QA committee for at least 120 days.

F 656 Correction Date: August 26, 2023

F756 – Drug Regimen Review

1. Resident #24's Consultant Pharmacist recommendations of 5/3/23 were addressed by Medical Provider on 7/12/23.

2. The deficient practice has the potential to affect Residents who receive Consultant Pharmacist MRR recommendations. The Clinical Assessments Manager reviewed Consultant Pharmacist recommendations from 5/1/23 to 5/3/23 validating recommendations were addressed by Medical Providers and no other residents had been affected.

3. Consultant Pharmacist MRR recommendation-tracking system will be developed to assure Medical Providers review and address Pharmacist recommendations. The DON or designee will log Pharmacist MRR recommendations on receipt from the Pharmacist and track Medical Provider response.

4. DON or Designee will audit compliance with Consultant Pharmacist MRR tracking and report to QA committee for at least 120 days.

F 756 Correction Date: August 26, 2023

F880 – Infection Control

1. **Hand Hygiene**-CNAs assigned were educated on PPE (glove) use and associated hand hygiene by Staff Development RN on 7/11/23.

2. **Water Management Policy**-On 7/11/23 testing for Legionella was scheduled for 7/13/23. The test was performed on 7/13/23.

3. **Hand Hygiene**-The deficient practice has the potential to affect residents who require assistance with perineal care.

4. **Water Management Policy**-The deficient practice has the potential to affect other residents.

5. **Hand Hygiene**- Staff Development/Infection Control RN will in-service staff on PPE/Hand Hygiene.

6. **Water Management Policy**-Microbial sampling to validate testing for Legionella was completed on 7/13/23. The results were received on 7/28/23. The test results were negative and Legionella was not detected. The next quarterly test is scheduled on 10/11/23.

7. **Hand Hygiene**- Charge nurse will conduct PPE (glove) use and hand hygiene audits by observation, correct and report discrepancies to Staff Development/Infection Control RN. The DON or designee will review and report the results of the audit to the QA committee for 120 days.

8. **Water Management Policy**- Testing results will be monitored by the Administrator and reported to the QA committee for at least 120 days.

F 880 Correction Date: August 26, 2023