STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205072	A. BUILDING _____ B. WING _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARSHWOOD CENTER	33 ROGER STREET LEWISTON, ME 04240

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F 000	INITIAL COMMENTS From 12/16/24 to 12/19/24, on-site visits were conducted at Marshwood Center to complete the annual Long Term Care Survey Process for Federal Recertification and investigating complaints #ME00048825, #ME00048952, and #ME00049910. It was determined that Marshwood Center is not in compliance with 42 CFR Part 483, Subpart B-Requirements for Long Term Care Facilities.	F 000	In filing this plan of correction, we seek to comply with the federal survey and certification requirements, however the filing of this plan of correction does not constitute an admission that the alleged deficiencies existed.	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on interviews, observations and record reviews, the facility failed to meet the reasonable needs of residents in the areas of beverage choices and bed size for 2 out of 16 residents screened for accomodation of needs (Resident #42 and Resident #356) Findings: 1. On 12/17/24 at 1:30 p.m., during a resident council meeting, Resident #42 complained that she cannot get Ginger Ale to drink unless the nurse calls the Kitchen and says that the resident is sick. On 12/18/24 at 11:50 a.m., a surveyor asked the staff on Carter Unit if they had ever been told that	F 558	The facility will continue to support the residents' right to reside and receive reasonable accommodation of resident needs and preferences unless the reasonable accommodation endangers resident safety. The Dietary Director and Regional Dietary Leaders have been instructed to include ginger ale as a routinely purchased item and, to make available as requested by and for residents. The bed request for Res # 356 has been accommodated	

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

Beth Barends, Administrator 1/8/2025

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 558	Continued From page 1 the residents could not have Ginger Ale unless the resident was ill? Medication Technician (MT) #1 and Certified Nursing Assistant (CNA) #1 stated that they have both been told that. "When we call to the Kitchen and ask, we have been told that residents cannot get Ginger Ale unless they are sick. On 12/18/24 11:45 a.m., a surveyor asked the Food Service Director if the residents can get Ginger Ale. He stated that if their diet allows them, they can have Ginger Ale. On 11/18/24 at 12:45 p.m., In an interview with Food Service Director and Director of Operations of Health Care Services the finding of lack of Ginger Ale being provided to the residents was confirmed with them. 2. On 12/16/24 at 10:00 a.m., a surveyor met with Resident #356 in their room. Resident #356 was admitted on 11/26/24 with a new Right Below the Knee amputation. Resident #356 stated that she/he fell out of bed the other day reaching for the call bell and hurt their left knee. Stated that the bed was too small and it was difficult to move around in the bed. The resident is 6 feet 2 inches. The surveyor observed that Resident #356's upper torso fills the width of the bed and with the head of the bed elevated their leg cannot be straightened. Resident #356 stated she/he had spoken with staff about the size of the bed. Record review of Resident #356's electronic medical record (EMR) revealed a fall out of bed on 12/11/24 due to reaching for the call bell. No mention was made regarding the size of the bed. An x-ray was obtained for left knee pain following the fall.	F 558	The Dietary and Nursing teams have been educated regarding residents' right to reasonable needs and preferences per regulation, as well as, timely communication of resident needs and preferences so that more timely responses can occur to these requests. A Resident Council meeting has been held to review this resident right to receive reasonable accommodation of resident needs and preferences, the facility's response to the alleged deficient practice, and methods for communicating needs and preferences. A random sample of 10 residents will be interviewed each month to ensure ongoing compliance with the facility's practice for meeting the requirement to meet residents' reasonable needs and preferences. Results from these interviews will be presented to and reviewed by the facility QAPI Committee at its monthly QAPI meeting x 3 months. Responsible: Dir of Nursing	1/28/2025

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F 558	Continued From page 2 On 12/17/24 at 12:40 p.m. a surveyor met with Resident #356 in their room and was told that they almost fell out of bed again this morning but managed to catch themselves on the overbed table. On 12/17/24 at 1:13 p.m.. a surveyor met with RN#1 regarding the size of Resident #356's bed. RN#1 stated they were unaware of any issues with the bed. On 12/17/24 at 1:30 p.m., a surveyor met with the Director of Nursing and was told that they were unaware the bed for Resident #356 was an issue. Stated that anyone can request a larger bed for a resident. Confirmed that a bed assessment was completed upon admission with no issues noted.	F 558		
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	F 578	The facility provides residents with written information regarding their right to participate in Health Care Decision Making and the right to formulate Advanced Directives. This information includes the facility's implementation practices. This information is provided upon admission and reviewed minimally, on a quarterly basis. The right to formulate an Advanced Directive has been reviewed with resident #70 and the resident's record has been updated to reflect this.	

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F 578	Continued From page 3 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. (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 reviews and interview, the facility failed to ensure that the resident and/or resident representative written information, concerning the right to accept or refuse medical or surgical treatment and/or formulate and advanced directive, was completed for 4 of 10 residents reviewed for advanced directives. (Residents #70, #90, #306, and #405) Findings: 1. Resident #70 was admitted to the facility on 9/2/24. Review of Resident #70's clinical record lacked evidence that the facility provided/obtained resident and/or resident representative written	F 578	Additionally, the record for Res #70 did contain a POLST order completed by resident #70 and the facility's MD on 9/6/2024. Res #90 has discharged home prior to the facility being able to offer the resident information regarding Advanced Directives. The record for Res #90 did contain a POLST order completed by resident #90 and the facility's MD on 11/25/2024. Res #306 has discharged home prior to the facility being able to offer the resident information regarding Advanced Directives.. The record for Res #306 did contain a POLST order completed by resident #306's spouse and the facility's MD on 12/12/2024. Res #405 has discharged home prior to the facility being able to offer the resident information regarding Advanced Directives. The record for Res #405 did contain a POLST order completed by resident #405 and the facility' s MD on 12/16/2024.	

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F 578	Continued From page 4 information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. 2. Resident #90 was admitted to the facility on 8/7/24. Review of Resident #90 's clinical record lacked evidence that the facility provided/obtained resident and/or resident representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. On 12/17/24 at 3:25 p.m., in an interview, the Licensed Social Worker confirmed the Resident's clinical records did not include evidence that the residents and/or representatives were asked or offered and refused assistance filling out an advanced directive. 3. Resident #306 was admitted to the facility on 12/6/24. Review of Resident #306's clinical record lacked evidence that the facility provided/obtained resident and/or resident representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. On 12/17/24 at 3:25p.m. The social worker stated that this resident did not have advance directive paperwork given to her because she was out on leave, and it was not done. 4. Resident #405 was admitted to the facility on 12/9/24. Review of Resident #405 clinical record lacked evidence of an advance directive being offered or completed.	F 578	An audit of all other current residents has been completed. For those residents without documentation in the record. Information regarding the right to formulate an Advanced Directive has been provided and a description of the facility's implementation policy has been provided. The records of newly admitting residents will be audited weekly to ensure ongoing compliance with the facility's practice to educate residents and provide written information regarding process for formulating Advanced Directives. Results from these audits will be reviewed at the facility's monthly QAPI x 3 months. Responsible: Dir of Nursing	1/28/2025
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		

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F 584	Continued From page 5 §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; §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	F 584	The facility promptly addressed the cited environmental concerns and will continue to address the alleged deficient practices as follows: Adams Unit Room 101- privacy curtain hooks have been secured and restored to proper repair. Edges to heating cover have been repaired. Bathroom walls are free of smudges/ marring. Room 102 - bathroom floor has been cleaned Room 103 - the caulking around the base of the toilet has been cleaned. The privacy curtain hooks have been secured and restored to proper repair. Room 104 - ceiling has been cleaned and holes have been filled Buchanan Unit Linen closet - Linens and debris on floor have been removed and floor cleaned Room 206 - privacy curtain hooks have been secured and restored to proper repair Room 207 - walker with nursing tape has been repaired Room 208 - privacy curtain hooks have been secured and restored to proper repair	

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F 584	Continued From page 6 sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable environment on 7 of 7 units (Adams, Buchanan, Carter, Eliot, Franklin, Gilbert and Hamilton) and the Activity Room for 1 of 1 facility tour. Findings: On 12/19/24 from 8:05 a.m. to 8:40 a.m., 2 surveyors conducted an Environmental Tour with the Maintenance Director, the Director of Nursing and the Administrator in which the following findings were observed: Adams Unit(100s) - Resident Room 101 - The privacy curtain was missing hooks and hanging down and in disrepair. The room heating unit had a cracked/broken top plastic grill with rough edges. The bathrooms walls were marred/marked with black marks. - Resident Room 102 - The bathroom floor was heavily soiled with dirt. - Resident Room 103 - The caulking around the base of the toilet was dirty. The privacy curtain was missing hooks and hanging down and in disrepair. - Resident Room 104 - The ceiling is dirty and has holes in it where a curtain track used to be. Buchanan Unit (200s) - The linen closet had linen and trash/debris on the floor. - Resident Room 206 - The privacy curtain was	F 584	Carter Unit Room 310 - missing ceiling tile has been replaced Room 311 - bed pan and urinals on bathroom floor were disposed of and the facility's pest control vendor serviced the room Activity Room Doors leading into Activities room have been cleaned of smudges / black marks Eliot Unit Linen closet - Linens and debris on floor have been removed and floor cleaned Room 502 - dried substance on floor has been cleaned Room 504 - privacy curtain hooks have been secured and restored to proper repair Room 506 - dried substance on floor has been cleaned Room 507 - bathroom ceiling tile was repaired; bathroom flooring tiles and caulking around the toilet was cleaned; sink has been cleaned. The room walls with dings and chips to paint have been repaired. Room 508 - thermostat cover has been replaced Sit-to-stand lift has been cleaned	

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F 584	Continued From page 7 missing hooks and hanging down and in disrepair. - Resident Room 207 - The walker had white nursing tape on the cross brace holding an arm rest attachment secure. - Resident Room 208 - The privacy curtain was missing hooks and hanging down and in disrepair. Carter Unit(300s) - Resident Room 310 - The closet had a ceiling tile missing. - Resident Room 311 - There was a bed pan and a urinal stored behind the toilet with the bed pan tucked in between toilet and wall. There were fruit flies observed in the room. Activity Room- The activity room doors had chipped/missing paint and black marks on them. Eliot Unit(500s) - The linen closet had linen and trash/debris on the floor. - Resident Room 502 - There was a dried brown substance next to the head of the bed #1. - Resident Room 504 - The privacy curtain was missing hooks and hanging down and in disrepair. - Resident Room 506 - There was a large amount of a dried pink substances on the floor to the left of bed #1. - Resident Room 507 - The bathroom had a broken ceiling tile sitting on the back of the toilet. The caulking around the base of the toilet was dirty. The bathroom floor tiles, around the toilet, have a light brownish substance coming up between the seams and the floor is dirty. The sink is dirty. The room walls had chipped/missing paint exposing sheetrock. - Resident Room 508 - The wall thermostat was	F 584	Franklin Unit Linen closet - Linens and debris on floor have been removed and floor cleaned Dining room window - seal to 1 window pane has caused fogging; a vendor search for the replacement window pane has been initiated Table fan - was removed from the dining room Gilbert Unit Linen closet - Linens and debris on floor have been removed and floor cleaned Room 704 - Room was deep-cleaned; ongoing education with residents regarding their personal hygiene and need for cooperation to deep clean their room regularly will continue. Deep cleans will be scheduled each 2 weeks Room 708 - ceiling next to air vent has been cleaned Hamilton Unit Dining room ceiling tiles around ceiling air unit - have been cleaned Linen closet - Linens and debris on floor have been removed and floor cleaned Shower room - dirt debris in the caulked tiles have been replaced Room 803 - privacy curtain hooks have been secured and restored to proper repair	

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F 584	Continued From page 8 missing the cover exposing the wires. The sit-to-stand patient lift, in the hallway, had food and debris in the foot base area and dried liquid residue on the back of the kneepads. Franklin Unit(600s) - The linen closet had linen and trash/debris on the floor. - The dining room window is fogged and hard to see out. - The table fan on the windowsill was dusty/dirty. Gilbert Unit (700s) - The linen closet had linen and trash/debris on the floor. - Resident Room 704 - The room had a very strong odor of urine that extended down the hall past two other rooms even with the room door closed. - Resident Room 708 - The ceiling, directly next to the room air vent, was soiled with dust/dirt. Hamilton(800s) - Two ceiling tiles around the dining room ceiling air conditioning unit were dusty/dirty. - The storage room had linen and trash/debris on the floor. - The shower room walls had caulking, in the grout areas between the tiles, around the base of the room that had a black substance on it. - Resident Room 803 - The privacy curtain was missing hooks and hanging down and in disrepair. - Resident Room 806 - The privacy curtain was missing hooks and hanging down and in disrepair. The bathroom ceiling light had debris in it. On 12/19/24 at 8:40 a.m., in an interview, the	F 584	Room 806 - privacy curtain hooks have been secured and restored to proper repair; bathroom ceiling light has been cleaned All other resident rooms and resident living areas have been audited for same or similar environmental concerns and corrections have been made. The facility Administrator/ designee, Maintenance staff and Housekeeping staff will conduct weekly rounds of the facility common areas and a rotating selection of resident rooms weekly x 4 weeks and monthly x 3 months thereafter. Work orders will be submitted for needed cleaning and repairs. Follow up inspections to ensure the completion of the work orders will be completed to ensure environmental issues have been fully addressed. The outcome of these audits will be submitted to the facility's QAPI Committee at its monthly meeting x 6 months. Responsible: Administrator	1/28/2025

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F 584	Continued From page 9 Maintenance Director, the Director of Nursing and the Administrator confirmed the findings.	F 584		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section-	F 645	A new PASRR 1 has been submitted for Resident #91. An audit of all current residents' records to ensure a new PASRR Level I has been submitted for any resident that continued to stay in the facility as a long term resident beyond the initial 30 days. A new PASRR Level I has been submitted for any residents identified in this audit. Ongoing compliance will be ensured through monthly audits of PASRRs for newly admitting residents and those residents staying long-term following their initial 30 days of skilled care service. Audit findings will be presented to the QAPI Committee at the facility's monthly QAPI meeting x 3 months. Responsible: Administrator	1/28/2025

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F 645	Continued From page 10	F 645		

(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure that 1 of 2 residents reviewed with a specialized mental health diagnosis, whose stay went beyond the expected 30 days, had been referred to the appropriate state-designated authority for Pre-Admission Screening & Resident

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F 645	Continued From page 11 Review Level II (PASRR) evaluation and determination (Residents #91). Finding: Resident #91 was admitted to the facility on 8/7/24 with diagnosis of Major Depressive Disorder and Suicidal Ideations. Resident #91's clinical record contained a PASRR Level I determination letter dated 8/27/24 that stated further PASRR evaluation was not required due to a Time Limited Waiver of 30 days. Resident #91 had a suspected or confirmed PASRR Condition: Mental Health Disability. Resident #91 was not discharged after a short stay and was assessed to be Nursing Facility level of care and continued to reside in the facility. The clinical record lacked evidence to indicate that the PASRR Level I was forwarded again to the State Mental Health Authority to determine if a PASRR Level II evaluation and determination was needed after the Residents stay changed from short-term to long-term. On 12/17/24 at 2:15 p.m., in an interview, the Licensed Social Worker confirmed that Resident #91 has been at the facility for longer than 30 days and the facility did not submit a new PASRR Level I to the State Mental Health Authority to determine if a PASRR Level II evaluation and determination was needed.	F 645		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary,	F 685	Resident #63 has received new glasses and expresses satisfaction with her ability to see her TV with the glasses.	

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F 685	Continued From page 12 assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on facility policy, interviews, and record review the facility failed to complete an personal property list, identify, and assist resident to get new eye glasses when they were lost for 1 of 41 resident reviewed during survey. Findings: Review of the facility policy titled "Personal Property: Patient's" revised on 8/15/23 states that "personnel will identify and record the patient/patient's belongings upon admission to a center"..... "Any loss or breakage of a patient's personal item will be documented on the property loss form be the person receiving the report, and then referred to the Administrator"..... "Administrator or designee will investigate the lost item". On 12/16/24 at 11:06 a.m., during an interview with Resident #63, stated his/her glasses have been missing for several months. Review of quarterly Minimum Data Set (MDS) dated 9/14/24 revealed Resident #63 had a Brief Interview for Mental Status (BIMS) of 15 of 15, indicating he/she s cognitively intact.	F 685	The personal property inventory listings for all current residents have been audited to ensure devices to maintain hearing and vision are recorded on the inventory listing. An assessment to determine facility support in securing and safeguarding these items when not in use, will be completed. Any needed support will be incorporated into the resident's care plan, if needed. Nursing staff have been educated regarding the Personal Property Policy, recording the resident's personal property on an inventory list, and how to report misplaced items. Assisting residents to safeguard their personal property, especially eyeglasses and hearing aids, will be a focus of this education. The Personal Property inventory process and reporting of misplaced items will be reviewed with residents at a Resident Council meeting.	

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F 685	Continued From page 13 Reviwe of quarterly Minimum Data Set (MDS) dated 12/13/23, Section B1200 was checked yes, that Resident #63 wears glasses. Review of nursing documentation on 4/7/23 shows Resident #63 wears glasses. Review of care plan meeting notes, dated 6/18/24, shows that Resident #63 enjoys watching T.V. On 12/17/24 at 2:00 p.m., during an interview Resident 63 states that she is unable to see the T.V. without his/her glasses. On 12/17/24 at 2:10 p.m., during an interview with CNA #2, who stated that she saw Resident #63 wearing glasses a few months ago. On 12/17/24 at 2:20 p.m., during an interview with the Registered Nurse Manager of the second floor, stated that when residents are admitted to the facility an inventory sheet has to be completed. She also discusses that if a resident advises staff of a missing item an incident report is to be filled out. On 12/17/24 at 2:13 p.m., during an interview with the Director of Nursing, it was confirmed that no inventory sheet , incident report was filled out for Resident #63. In addition, the facility did not assist Resident #63 with obtaining new glassess after they were lost.	F 685	Audits for a random sample of 10 residents will be completed each month to ensure a personal property inventory is completed. Any of the sampled residents with hearing or vision devices will be interviewed to ensure ongoing availability of these devices. Results from these audits will be presented to the facility's QAPI Committee at the monthly QAPI meeting x 3 months. Responsible: Dir of Nursing	1/28/2025
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a	F 688	The care plans for Resident #500 and #45 have been updated.	

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F 688	Continued From page 14 resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on Interviews and record reviews, the facility failed to prevent a decrease in the Range of Motion (ROM) and/or mobility for 2 of 11 residents screened for maintenance of physical abilities following discharge from physical/occupational therapies. (Resident #45 and Resident #500) Findings: 1. On 12/18/24 at 10:13 a.m. a surveyor reviewed a binder provided by therapy services with Restorative Nursing Program Goals Sheets for residents discharged from Physical and/or Occupational therapy. This binder contains the after therapy plans recommended to maintain the physical abilities the resident achieved during therapy. A surveyor located a plan for Resident #500 in this binder, dated 7/9/24, that stated: "Ambulate	F 688	An audit was conducted on all residents with functional maintenance programs and care plans updated as needed. Nursing staff have been re-educated on where to find and document functional maintenance plans. Audits will be completed weekly x 3 weeks and monthly for 3 months. The outcome of these audits will be presented and reviewed with the QAPI Committee at the facility's monthly QAPI meetings. Responsible: Dir of Nursing	1/28/2025

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with walker, gait belt and wheelchair follow 1-2 times a day as patient allows. Have patient do lower extremity home exercise program once a day as patient allows (program in patient room)."

Record review of Resident #500's care plan failed to find the above program as an intervention.

Facility was unable to provide any documentation that the above program was followed or the reason for not following.

Record review of Electronic Medical Record (EMR) indicated that Resident #500 experienced falls on 8/28/24 and 9/2/24 and was once again referred to Physical therapy on 9/3/24.

2. On 12/18/24 at 10:30 a.m., a surveyor interviewed Resident #45 and learned she/he does not get to walk every day or perform exercises since ending therapy last summer. "I'm noticing that I'm more weaker."

Resident #45 Restorative plan dated 6/5/24 states "Ambulate with CNAs or Restorative CNA daily with walker and gait belt. Encourage patient to perform lower extremity home exercise program"

Record review of Resident #45 care plan failed to show the restorative plan as an intervention.

Facility was unable to provide documentation that the above program was followed or the reason for not following.

On 12/18/24 at 10:39 a.m., a surveyor interviewed Certified Nursing Assistant (CNA) #4 and learned that while she/he was trained to be a

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F 688	Continued From page 16 restorative aide (RA) in addition to a CNA, it was rare she/he was able to perform the RA role. I usually have a CNA assignment and can't do the restorative plans. Confirmed that therapy went over the restorative plans with him/her as shown by his/her signature on the plans. On 12/18/24 at 11:48 a.m., a surveyor interviewed CNA#3 and learned she/he does not have time to assist residents with exercise programs or range of motion beyond getting dressed and undressed. She/he was unaware of any exercise programs for residents. Residents are lucky to get a walk to the bathroom in the morning. CNA#3 was working with Resident #45 today and was unaware of an exercise or ambulation plan. On 12/18/24 at 12:35 p.m., a surveyor interviewed a Unit Manager and learned the recommendations are not added to the care plan because there is no restorative nursing program due to lack of staffing. Confirmed that ambulation and range of motion were important nursing tasks to prevent falls, contractures, loss of range of motion, pressure ulcers, circulation and breathing difficulties. A surveyor reviewed the Facility Assessment for the facility and found under A.1. Function - Care Requirements "Facility provides .... Mobility/fall prevention: Transfers, ambulation, restorative nursing, contracture prevention/care; supporting resident independence in doing as much of these activities by himself/herself." On 12/18/24 at 2:24 p.m. a surveyor reviewed the above with the Administrator.	F 688		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices	F 689		

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F 689	Continued From page 17 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 being properly secured for 3 of 3 observations for 2 of 4 days of survey (12/16/24 and 12/18/24). Findings: The Safety Data Sheet for Clorox Healthcare Bleach Germicidal Wipes noted the following: 4. First Aid Measures Eye contact: Rinse thoroughly with water as necessary. If symptoms persist, call a physician. Skin contact: Wash with soap and water. If skin irritation persist, call a physician. Inhalation: Remove to fresh air. If breathing is difficult, trained personnel should give oxygen. If symptoms persist, call a physician. Ingestion: Drink one to two glasses of water. Get medical attention if symptoms occur. The Safety Data Sheet for Pure Bright Germicidal Ultra Bleach noted the following: 4. First Aid Measures Eye contact: Immediately flush with plenty of water. After initial flushing, remove any contact	F 689	The chemical cleaning supplies identified during the survey dates were immediately removed from resident access and returned to locked storage space. Staff present at the time were educated on the safety risk to residents at that time. All resident areas throughout the facility have been audited and no additional improperly stored chemicals have been identified. All facility staff are re-educated on the need and importance to store chemicals and cleaning supplies in a locked storage area. Weekly audits of resident care areas, including shower rooms, will be conducted to ensure chemicals / cleaning supplies are stored in a secured area that is not available to residents. These audits will occur x 3 weeks and monthly thereafter x 3 months. The results of these safety audits will be presented to the facility's QAPI Committee at its monthly QAPI meeting x 3 months. Responsible: Dir of Nursing	1/28/2025

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F 689	Continued From page 18	F 689		

lenses and continue flushing for at least 15 minutes.
Skin contact: Wash skin with soap and water. If symptoms persist, call a physician.
Inhalation: Remove to fresh air.
Ingestion: Do not induce vomiting. Clean mouth with water and drink afterwards plenty of water. If symptoms persist, call a physician.

1. On 12/16/24 at 10:25 a.m., a surveyor observed an unsecured 1 pound 10 ounce container of Bleach Germicidal Wipes stored on top of a soiled utility cart in the unlocked shower room.
On 12/16/24 at 10:30 a.m., in an interview, Angela Kelleher, LPN #1 confirmed the finding and stated that there were confused and compromised residents that can move around the unit and access this room even in their wheelchairs.
On 12/16/24 at 11:18 a.m., a surveyor discussed the finding with the Director of Nursing.

2. On 12/16/24 at11:59 a.m., a surveyor observed in the Buchanan unit the shower room, three(3) unsecured 1 pound 10 ounce containers of Bleach Germicidal Wipes in the unlocked shower room.
On 12/16/24 at 12:02 p.m., in an interview, the Director of Nursing confirmed the chemicals were being stored in the unsecured and unlocked Buchanan shower room. She removed the chemicals and confirmed that there were confused and compromised residents that can move around the unit and access this room even in their wheelchairs.

3. On 12/18/24 at 10:50 a.m., a surveyor observed in the Gilbert unit shower room a 12

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F 689	Continued From page 19 ounce spray bottle marked "Bleach and Water". The bottle had no labeling and the ratio of bleach to water was unknown. On 12/18/24 at 11:00 a.m., in an interview, the Administrator confirmed that the bleach/water spray bottle was not labeled appropriately and it should have been secured and stored behind a locked door. She additionally confirmed that the unit had residents that can get around and that are confused, have dementia and are compromised.	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 facility policy, observations, and interviews, the facility failed to maintain a sanitary environment to help prevent the development and transmission of disease and infection related to respiratory care for 2 of 2 residents reviewed for respiratory care (Resident 98 and 405). Findings: Review of facility procedure titled "Oxygen: Nasal Cannula" last revised on 8/7/23 states "Date and store cannula in a treatment bag when not in	F 695	The nebulizer and oxygen tubing/ cannulas for Resident #96 and #405 were immediately replaced with clean tubing/ cannulas and stored properly in treatment bags. Nursing staff have been re-educated on the facility's Oxygen, Nasal Cannula procedure. Ongoing compliance will be ensured through weekly audits of cannula / tubing storage for residents with oxygen and / or nebulizer orders. These audits will be weekly x 3 weeks then monthly thereafter. Results from the audits will be presented to the facility's QAPI Committee at its monthly meeting for 3 months. Responsible: Dir of Nursing	1/28/2025

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F 695	Continued From page 20 use". On 12/16/24 at 1:09 p.m. and on 12/17/24 at 7:48 a.m., observation of Resident 98's nebulizer tubing stored on bedside table. On 12/16/24 at 2:36 p.m. and on 12/17/24 at 7:44 a.m., observation of Resisent 405's oxygen tubing stored under the oxygen concentrator handle. 12/17/24 3:42 p.m., during an interview with the Director of Nursing, the above information was confirmed.	F 695		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.	F 725	The facility will continue to schedule direct care nursing staff to meet the care needs of the residents. This includes meeting the minimum nursing staffing ratios each day of the week as defined by the State of Maine: 1 staff:5 residents on day shift; 1 staff: 10 residents on evening shift; 1 staff: 15 residents on night shift. In the event that staff call out sick, including during weekend shifts, on-call nursing staff will be available to cover those shifts in order to meet the needs of the facility residents.	

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F 725	Continued From page 21 §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure sufficient direct care staff were scheduled and on duty to meet the needs of residents that reside in the facility. This has the potential to affect all residents needing assistance with Activities of Daily Living (ADL's). Findings: Review of Payroll Based Journal staffing report revealed the facility triggered for "Excessively Low Weekend Staffing" during the fourth quarter 4 (July 1, 2024 through September 30, 2024). On 12/19/24 at approx. 11:00 a.m., review of weekend staffing from July 1, 2024 through September 30, 2024, both the Director of Nursing and the Scheduler/Payroll/Human Resource personal confirmed the facility did not have enough staff to meet resident needs on the weekends.	F 725	The staffing sheets will be audited daily to validate sufficient direct care staff are scheduled to meet the needs of the residents and to meet the state's minimum nursing staff-to-resident ratios. Results of these audits will be presented to the facility's QAPI Committee on a monthly basis x 3 months. Responsible: Dir of Nursing	1/28/2025
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by	F 726	The facility has scheduled an onsite BLS / CPR refresher course for the licensed staff. All of the identified licensed staff: LPN #2, RN#2, RN#3, RN#4, RN#5, RN#6, RN#7, and RN#8 at the facility will renew their certification.	

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F 726	Continued From page 22 resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that 8 out of 25 licensed staff had current certification in Healthcare Basic Life Support (BLS) as required by facility. Licensed Practical Nurse (LPN) #2, Registered Nurse (RN) #2, RN#3, RN#4, RN#5, RN#6, RN #7 and RN#8. Findings: A surveyor reviewed the Job Descriptions for Registered Nurses and Licensed Practical Nurses at the facility and found under Specific Educational/Vocational Requirements: "Maintains	F 726	The facility has ensured staffing includes a BLS / CPR certified staff on each shift. To ensure ongoing compliance, monthly audits of licensed nursing staff's BLS / CPR certifications will be completed. Prospectively, licensed nurses will be alerted at least 2 months in advance of their upcoming BLS / CPR expiration so they have adequate notice to renew their BLS/ CPR certification. Audit results will be presented monthly to the facility's QAPI Committee at its monthly QAPI meeting x 3 months. Responsible: Dir of Nursing	1/28/2025

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F 726	Continued From page 23 current BLS/CPR certification" A surveyor reviewed the documentation provided by the facility for the 25 licensed staff currently employed and found 8 staff without documentation of a current BLS/CPR certification. LPN #2, RN #2, RN#3, RN#4, RN#5, RN #6, RN#7 and RN #8. On 12/19/24 at 1:13 p.m. a surveyor met with the Director of Nursing and discussed the above findings.	F 726		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to	F 732	Education regarding the regulatory requirement of CFR 483.35 (g)(1)-(4) for posting and document retention of the daily Nurse Staffing Information has been provided to the facility's Scheduler and to Nurse Leaders. The facility posting of the Nursing Staffing Information is being posted daily at the beginning of each shift and includes the resident census. A system for retaining the required documentation x 18 months has been established. Audits will be conducted randomly 3x per week x3 weeks and weekly thereafter x 3 months. Audit findings will be reported to the facility's QAPI Committee at its monthly QAPI meeting x 3 months. Responsible: Dir of Nursing	1/28/2025

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F 732	Continued From page 24	F 732		

residents and visitors.

§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview, the facility failed to post nurse staffing information on a daily basis including: the resident census per shift for 3 of 4 survey days. In addition, the facility failed to maintain records of the posted daily nurse staffing data for a minimum of 18 months.

Findings:

On 12/16/24, 12/17/24 and 12/18/24, a surveyor observed the nurse staffing information posted in the main entrance, the posting lacked the resident census.

On 12/18/24 at 7:58 a.m., during an interview, the Scheduler/Payroll/HR personal, confirmed the lack of the resident census on the posted nurse staffing. During this interview, she confirmed the facility does not maintaining records of the daily posted staffing sheets and was unaware that she needed to keep them for minimum of 18 months.

On 12/18/24 at 8:10 a.m., the above was

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F 732	Continued From page 25 confirmed with the Registered Nurse Market Clinical Advisor.	F 732		
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 interview, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for the floor, the walk-in freezer, a sink, a food mixer, ceiling tiles, a food disposal unit, a blender and a convection oven; failed to ensure food in the dry storage room was closed and secured shut; and failed to ensure that the kitchen ice machine was plumbed in accordance with code requirements to prevent food contamination for 1 of 1 kitchen tour for 1 of 1 day of survey (12/16/24).	F 812	The following corrections have been made following the initial kitchen tour on 12/16/2024: The kitchen floor has been cleaned of food and paper / plastic trash, including under equipment and shelving The leak in the corner of the dish room spray sink has been repaired The food mixer arm and base will be repaired to a cleanable surface The 5 ceiling tiles above the food prep have been cleaned The broken ceiling tile next to the ceiling air conditioner near the walk-in freezer has been replaced The food disposal unit outside surface has been cleaned of any dried food or liquid residues The outside surface of the blender has been cleaned of any dried food or liquid residue The outside surface of the convection oven has been cleaned of food / liquid debris Sugar is properly stored in sealed containers once opened in the dry storage room The large box of sandwich buns noted to have ice build up in the walk-in freezer, were disposed	

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F 812	Continued From page 26 Findings: "This direct connection of waste water 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 12/16/24 from 9:10 a.m. to 9:45 a.m., 2 Surveyors did an Initial Kitchen Tour with the Food Service Director, the Director of Operations, and the District Manager in which the following findings were observed: - There was food, paper/ plastic trash on the entire floor and under the equipment and shelving. - The dish room spray sink was leaking liquid into a bucket sitting under the corner of the sink. - The food mixer had chipped/missing paint on the mix arm and base. - There were 5 ceiling tiles, above a food preparation area, that had dried liquid spatter on them. - There was a broken ceiling tile next to the ceiling air conditioner near the walk-in freezer. - The food disposal unit outside surface was covered with dried food particles and dried liquid residue. - The blender had dried food particles and dried	F 812	The physical separation of free-flowing drainage of the ice machine in relation to the potable water supply piping has been corrected. Dietary staff will be educated regarding the cited deficiencies, the kitchen's cleaning log that instructs staff for tasks to be completed, identifying maintenance issues and how to communicate and escalate any broken or damaged equipment including lights, vents and ceiling tiles or other maintenance needs in the kitchen. Weekly audits of the kitchen for cleanliness, maintenance and sanitation will be conducted x 3 weeks and monthly for 3 months thereafter. Audit findings will be reported to the facility's QAPI Committee at its monthly meeting x 3 months. Responsible: Dietary Director	1/28/2025

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F 812	Continued From page 27 liquid residue on the outside surface of the unit. - The convection oven had dried food particles and dried liquid residue on the outside surface of the unit. - The dry storage room had a 50 pound bag of previously open sugar, which was not secured shut and was sitting in an opened bin. - The walk-in freezer had a large box of sandwich buns that had a large ice build-up on the opened box. - The ice machine was not plumbed in accordance with code requirements to prevent food contamination. On 12/16/24 at 9:45 a.m., in an interview with 2 surveyors, the Food Service Director, the Director of Operations, the District Manager confirmed the findings.	F 812		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its	F 868	The facility has and continues to conduct monthly QAPI meetings which exceeds the, at least quarterly, meeting requirement. While the IPC RN was not in attendance at the July 2024 and Oct 2024 meeting, she did contribute her reports to the QAPI Committee and the DON, who is also certified as an IPC nurse, did attend the July 2024 and Oct 2024 meetings.	

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F 868	Continued From page 28 activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on review of the Quality Assessment and Assurance (QAA) attendance sheets and interview, the facility failed to ensure that an Infection Preventionist attended 2 of 4 quarterly QAA meetings. Finding: A review of the quarterly QAA meeting attendance sheets indicated that an Infection Preventionist did not attend the 7/25/24 and 10/31/24 quarterly QAA meetings. On 12/18/24 at approximately 9:00 a.m., in an interview with the surveyor, the Administrator stated, she does not know why the Infection Preventionist (I/P) was not at the July meeting, but she left the facility in mid-October, so she was not at the October meeting. Since that time there	F 868	A newly hired RN is obtaining the CMS IPC certification and will fulfill the IPC role. The IPC RN will attend the facility's monthly QAPI meetings. The facility QAPI Committee will review the regulatory requirements of the QAPI Committee and its member composition. The attendance sheet for QAPI meetings will be adjusted to identify the minimum required member participation to ensure ongoing compliance. If a required QAPI Committee member is unexpectedly not available at the scheduled meeting, the meeting will be rescheduled to include all required participants. Attendance will be reviewed monthly at the monthly QAPI Committee meetings x4 months Responsible: Administrator	1/28/2025

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F 868	Continued From page 29 has not been anyone in that role. A new I/P has been hired. She was just here on Monday to finalize her position. The above was confirmed with the Marketing Clinical Advisor on 12/18/24 at 2:00p.m.	F 868		