STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20210804	A. BUILDING: _____ B. WING _____	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE HEALTH & REHAB CANTON	26 PLEASANT ST CANTON, ME 04221

(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) COMPLETE DATE
P 000	Initial Comments On 7/29/24 and 7/30/24, onsite visits were made at Pinnacle Health and Rehabilitation Residential Care, Canton, for the purpose of completing the state re-licensure survey, and complaint investigation #ME00047232. It was determined that Pinnacle Health and Rehabilitation Residential Care, Canton, was not in substantial compliace with 10/144, Chapter 113-Regulations Governing the Licensing and Functioning of Assisted Housing Programs-Level IV, Private Non-Medical Institutions.	P 000		
P 318	7.1.7 Medications and Treatments Orders for medications and treatments shall be in writing, signed and dated by a duly authorized licensed practitioner and shall be in effect for the time specified by the duly authorized licensed practitioner, but in no case to exceed twelve (12) months, unless there is a written reorder. Orders for psychotropic medications shall be reissued every three (3) months, unless otherwise indicated by the duly authorized licensed practitioner. Standing orders for individual residents are acceptable when signed and dated by the duly authorized licensed practitioner. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the authorized licensed practitioner reviewed and approved orders for 1 of 6 residents (#5) after return from another facility. Findings: A review of Resident #5's clinical record noted a hospital discharge summary, dated 6/27/24, in	P 318		

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P 318	Continued From page 1	P 318		

which changes were made as follows:

>Diltiazem ER (extended release), used to treat atrial fibrillation, was decreased to 120 mg (milligrams) by mouth once daily.
>Warfarin, used as an anticoagulant to treat atrial fibrillation, was changed to 2.5 mg by mouth once daily.

Upon review of the licensed practitioner's orders, the surveyor noted an order to check the INR (international normalized ratio, used to monitor for the therapeutic drug level of Warfarin) on 7/12/24. The surveyor was not able to locate a current order with the dose for Warfarin. In addition, the surveyor was not able to locate a current order for Diltiazem ER. A review of the July Medication and Treatment Administration Records noted the last date Resident #5 received Warfarin was on 7/11/24. The last dose of Diltiazem ER was received on 7/27/24.

On 7/30/24 at approximately 3:30 p.m., the surveyor discussed the findings with the Residential Care Director (RCD). The surveyor noted the record lacked evidence that the licensed practitioner had reviewed and approved the discharge summary with new orders upon return to the facility.

On 7/30/24 at 4:30 p.m., the RCD confirmed that Resident #5's Diltiazem ER had been dropped from the facility's electronic orders as the original prescription from the discharging hospital was written for a 30 day supply.

In addition, The RCD confirmed the Warfarin had not been reordered on 7/12/24 when the next INR was ordered, and that the provider's intent had been to switch to Eliquis (another anticoagulant).

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P 318	Continued From page 2 The RCD provided a copy of the electronic order, dated 7/30/24, from the nurse practitioner which stated "It appears coumadin (Warfarin) was discontinued but Eliquis was not started. Patient's most recent INR is 1.2, reviewed today. Will start Eliquis 5 mg twice daily." On 7/30/24 at 4:30 p.m., the findings were discussed at the exit interview with the Administrator, current RCD, and former RCD.	P 318		
P 627	16.6.1 Sanitation/physical plant requirements The facility and surrounding premises shall show evidence of routine maintenance and housekeeping and repair of wear and tear shall be made in a timely fashion. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to maintain the facility in a clean and sanitary manner, and repair wear and tear for 1 of 3 resident living areas (Maplewood), on 2 of 2 days of survey. Findings: On 7/29/24, from 10:00 a.m. to 10:40 a.m., a surveyor confirmed the following with the Certified Residential Medication Aide (CRMA) on duty for the Maplewood Unit: >The main floor in the common areas of the living and dining rooms were observed to be excessively worn. An area under one rocker recliner had worn through the flooring, creating an uncleanable surface. >The floor in room 303 appeared worn, the walls and wood trim demonstrated wear and tear in	P 627		

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regard to paint.
>In the kitchen area, vinyl flooring was lifted up underneath the cabinets near the sink.
>The floor in the medication room was worn through, creating an uncleanable surface.
>The hallway outside of room 305 was worn with torn and lifting areas of vinyl, creating an uncleanable surface.
>Stairs leading up to room 306 wear observed with dirt and debris.
>Room 308, upstairs, was noted with one empty bed. Next to this bed the vinyl flooring was observed to be torn and lifting, creating an uncleanable surface. The second bed was observed with trash, debris, and dirty clothing all around on the floor. There was a strong odor of urine. Next to the wall was a commode with a brown substance on the frame underneath the front of the seat. The CRMA confirmed the substance was rust.

On 7/30/24 at 10:00 a.m., the surveyor observed the Maplewood Unit with the CRMA on duty for the day.
>In addition to the previous findings, the surveyor confirmed the rusty commode in room 308 remained.
>Multiple cobwebs and live spiders were observed in the ceiling area of room 308.
>Debris, trash and dirty clothes remained on the floor around the second bed in room 308.

On 7/30/24 at approximately 10:30 a.m., the Administrator toured the Maplewood unit with the surveyor. The above findings were confirmed. It was noted that the rusty commode in room 308 had been removed.