STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(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 01/22/2024 through 01/26/2024, on-site visits were conducted at St. Mary's D'Youville Pavilion for the purpose of conducting the annual Long Term Care Survey Process and investigating complaints #ME00043822, #ME00044863, #ME00045616, #ME00045719, #ME00046031, #ME00046071, and facility reported incident #ME00045852. It was determined that St. Mary's D'youville Pavilion was not in substantial compliance with 42 CFR 483, Sub-part B Requirements for Long Term Care Facilities.	F 000		
F 578 SS=D	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.	F 578		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	01/26/2024

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F 578	Continued From page 1 (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 interviews and record review, the facility failed to ensure a resident's right to formulate an advance directive regarding cardiopulmonary resuscitation (CPR) or Code Status was accurate in the clinical record for 1 out of 7 sampled residents reviewed for advanced directives (Resident #108). Findings: Resident #108 was admitted to the facility on 9/23/22. On 1/24/24 at 10:51 a.m. during an interview with a Unit Secretary (US#1) a surveyor learned that Resident #108's Code Status was unknown. US#1 remembered that Resident #108 had requested "a while ago" to change their Code Status to "CPR" and [redacted] reportedly told a unit manager, but the chart indicated a Code Status of "No CPR".	F 578		

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	205053	A. BUILDING _____ B. WING _____	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 578	Continued From page 2	F 578		

On 1/24/24 at 11:00 a.m., a surveyor confirmed during an interview with the Unit Manager that Resident #108 makes his/her own decisions.

On 1/24/24 at 11:10 a.m., a surveyor interviewed Resident #108 in his/her room and learned Resident #108 wanted his/her Code Status to be "CPR" and he/she had already talked to staff about this.

On 1/24/24 at 11:14 a.m. both the surveyor and LPN#4 reviewed Resident #108's advance directive which indicated he/she was "No CPR". At this time the LPN #4 stated she/he was unaware of the request to change the code status to "CPR".

-The facility's policy, "Advanced Healthcare Directives, 1092", last reviewed 11/2018 under "If an Advanced Directive is revoked":
Licensed staff (RNs, LPNs, Social Workers) to whom revocation is communicated, must make the revocation part of the medical record.

Note "revoked" and the date revoked in the medical record; write a detailed statement of the revocation and attach it to the Advance Directive. Whenever possible the resident should sign the revocation statement.

If the Advanced Directive is revoked, the social worker staff will notify the physician of the resident/patient's revocation of the Advance Directive and will document this in the resident/patient's record.

On 1/25/24 at 1:00 p.m. during a follow up record review, Resident #108's clinical record indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

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F 578	Continued From page 3 on 1/24/24 at 3:31 p.m. LPN#4 had changed Resident #108's Code Status from "No CPR" to "CPR". The medical record lacked evidence of further supporting documentation as required by facility policy. On 1/25/24 at 1:06 p.m. a surveyor interviewed facility Administrator and Director of Nursing and confirmed that Resident #108's Code Status in the Clinical Record was inaccurate, and the facility did not follow it's own policy for changing of a Code Status.	F 578		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §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;	F 584		

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	205053	A. BUILDING _____ B. WING _____	01/26/2024

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F 584	Continued From page 4 §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 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 good repair and in a sanitary condition for 1 of 3 floors (3rd) and the laundry rooms for 1 of 1 environmental tour. (1/26/24) Findings: On 1/26/24 from 9: 20 a.m. to 10:10 a.m., an Environment tour was conducted with the Plant Operations Manager in which the following findings were observed: Laundry Rooms > The soiled laundry linen room had 1 wall fan that was dusty/dirty. The cement floor had chipped/missing paint and the non-skid floor tape was missing pieces/sections creating uncleanable surfaces. > The clean laundry linen room had 3 wall fans	F 584		

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	205053	A. BUILDING _____ B. WING _____	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

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F 584	Continued From page 5	F 584		

that were dusty/dirty. The cement floor had chipped/missing paint creating an uncleanable surface.
> The laundry room had 30 broken/missing floor tiles. The cement floor, behind and under the washing machines, had chipped/missing paint creating uncleanable surfaces.

3rd Floor East
> The wheelchair scale had ripped/missing non-skid surface tape creating an uncleanable surface.

3rd Floor West
> The two sit-to-stand patient lifts had missing/chipped paint and rusty areas in the foot base areas creating uncleanable surfaces.
> Resident room 334 - The baseboard heating unit was marred with black marks. The bathroom, which is shared by 4 residents, had an unmarked urinal hanging on the grab bar behind the toilet and the bathroom exhaust fan was dusty/dirty.
> Resident room 338 - The bathroom had 2 commode buckets sitting on the floor under the sink and a bed pan stored on the hand rail by the toilet.
> Resident room 348 - The bathroom exhaust vent was dusty/dirty.
> There were 2 hallway ceiling vents by Resident room 350 that were dusty/dirty.
> There was 1 hallway ceiling tile by Resident room 351 that had a large brown stain.
> Resident room 352 - The wall fan was dusty/dirty. There was debris in the shower light lens. The room walls and the bathroom doorframe were heavily marked/marred with blackish marks.

0n 1/26/24 at 10:10 a.m., in an interview, the

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	205053	A. BUILDING _____ B. WING _____	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

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F 584	Continued From page 6 Plant 0perations Manager confirmed the findings.	F 584		
F 637 SS=D	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 record review and interview, the facility failed to conduct a comprehensive Minimum Data Set 3.0 (MDS 3.0) assessment within 14 days after a resident experienced a significant change of condition and hospice services were initiated for 1 of 4 sampled residents receiving hospice services (R173). Finding: On review of R173's clinical record, a surveyor noted the resident received hospice services, initiated on 10/5/23. On further review, the surveyor noted the most recent comprehensive MDS 3.0 assessment was completed on 9/7/23 and no comprehensive MDS 3.0 assessment was completed within 14 days of the initiation of hospice services.	F 637		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

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F 637	Continued From page 7 On 1/26/24 at 12:45 p.m., the Director of Nursing confirmed a comprehensive assessment should have been completed within 14 days after the resident began hospice services..	F 637		
F 655 SS=D	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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

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F 655	Continued From page 8	F 655		

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 record review and interview, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours that included the instructions needed to provide minimum healthcare information necessary to properly care for 1 of 2 new admissions requiring Transmission Based Precautions (TBP). (Resident #160).

Finding:

Resident #160 was admitted to the facility on 11/21/23 with a primary diagnosis of: Sepsis (a serious condition in which the body responds improperly to an infection), acute kidney injury and recurrent Clostridioides Difficile (C-Diff) (a highly contagious bacterium that causes diarrhea and inflammation of the colon - which requires TBP, "contact precautions" while providing care, that is gloves and gown) requiring antibiotic use.

Resident #160's clinical record was reviewed and revealed; Physician order dated 11/21/23 for Fidaxomicin oral tablet 200 milligram (mg), give 200 mg by mouth two times a day for septicemia, this order was discontinued on 11/27/23 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

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F 655	Continued From page 9 another Physician order dated 11/27/23 for Fidaxomicin oral tablet 200 mg, give 200 mg by mouth two times a day for C-Diff until 11/30/2023 was initiated. Further review of the clinical record, revealed it lacked evidence of a baseline care plan that was completed within 48 hours to include the instructions necessary to properly care for Resident #160's immediate health and safety needs for the above concerns. The care plan for C-Diff was initiated on 1/23/24, 63 days after admission. On 1/26/23 at approx. 9:00 a.m., a surveyor discussed this finding with the Assistant Director of Nursing.	F 655		
F 656 SS=E	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 treatment under §483.10(c)(6).	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(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 656	Continued From page 10 (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, observations and interview, the facility failed to develop or implement the care plan interventions for the residents' current needs for 6 of 33 sampled residents/care plans reviewed (Resident #2, #20, #52, #101, #166 and #173) Findings: 1. Resident #2's clinical record was reviewed and revealed the resident has muscle weakness, unsteadiness on feet and has had falls. The	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

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F 656	Continued From page 11	F 656		

current care plan noted the following: "[Resident #2] requires floor mats when in bed on both sides of bed for fall safety. [Resident #2]will have no injuries if a fall occurs before the review date. Staff to pick up and place mats out of the way from wheelchair accessibility in room when out of bed and will lay them next to bed on both sides when in bed".

On 1/24/24 at 2:05 p.m., a surveyor observed Resident #2 in bed with no floor mats placed on the floor on both sides of the bed.

On 1/24/24 at 2:10 p.m., in an interview, Registered Nurse, RN. #3 confirmed that Resident #2 was in bed and the floor mats were not put on both sides of the bed.

2. Resident #20's clinical record was reviewed and revealed a diagnosis of Quadriplegia, tracheostomy and carrier of Methicillin Resistant Staphylococcus Aureus (MRSA) in his/her sputum. The care plan for "MRSA - colonization (respiratory)" revised on 10/11/21, instructs staff to wear "Mask /face shield to be worn during procedures with risk of splashes or droplet contamination of bodily fluids". In addition, the quarterly Minimum Data Set (MDS) dated 12/26/23 revealed Resident #20 had a Brief Interview for Mental Status (BIMS) of 15 of 15, indicating he/she is cognitively intact.

On 1/22/24 at 9:48 a.m., 2 surveyors observed Certified Nurses Aid (CNA) #7 and CNA #8 don PPE (gown, gloves and mask) and begin to enter room 401. At this time, surveyor interviewed CNA #7, who stated, Resident #20 has "MRSA" (Methicillin Resistant Staphylococcus Aureus) in his/her "trach/respiratory" and she is going into

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(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 656	Continued From page 12	F 656		

provide care for Resident #20, wash his/her body, apply cream etc. Surveyor questioned whether eye protection is used while providing care for Resident #20. CNA #7 stated, she doesn't wear eye protection because [Resident #20] has the trach covered with plastic and she would only wear eye protection if [he/she] was getting a nebulizer treatment. CNA #7 and CNA #8 entered the room and began providing care to Resident #20 without the use of eye protection.

On 1/22/24 at 1:17 p.m., during an interview, Resident #20 was asked if staff wear eye protection during care, he/she stated, "mostly no, only when there COVID on the unit."

On 1/25/24 at 12:11 p.m., during an interview, the Director of Nursing confirmed the care plan was not followed for use of eye protection.

3. On 1/23/24 at approximately 11:00 a.m. a surveyor observed Resident #166 on a pressure reducing mattress. The clinical record for Resident #166 was reviewed. The admission Minimum data set (MDS) 3.0 dated 11/16/23, under section M1200 Skin and ulcer/injury treatments found "yes" was selected for Pressure Reducing device on bed. Review of Resident #166 care plan did not include a pressure reducing device on bed-under interventions.

On 1/26/24 24 at 11:41 a.m. during an interview with the rehab unit manager after discussing the missing interventions on the care plans reviewed, I learned he/she thought the MAR and TAR were part of the care plan meaning interventions on the MAR and TAR did not also need to be on the care plan. The MAR and TAR can not be used in lieu of a Care Plan to create the Comprehensive Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(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 656	Continued From page 13	F 656		

Plan.

4. On 1/24/24, during record review of Resident #52 physician orders, it was noted that he/she is receiving the psychotropic medication Quetiapine Fumarate since 11/26/22.

The Annual Assessment (MDS) - Version 3.0 dated 10/12/22, Section N indicated Resident #52's use of antipsychotics, in addition the CAA's indicated to proceed to care plan for Psychotropic Drug Use.

The medical record lacked evidence of a comprehensive care plan that addressed the use, goals and interventions for the use of Quetiapine Fumarate.

The surveyor confirmed this lack of care plan for Psychotropic Drug Use in an interview with the Assistant Director of Nursing, on 1/26/24 at 11:15 a.m.

5. On 1/25/24 at 2:40 p.m. during a clinical record review for Resident #101, a surveyor found under orders, "wear heel protectors when in bed" dated 10/25/23 and "turn patient every 2 hours" dated 10/25/23. These interventions were found in Resident #101's Medication Administration Record (MAR) and Treatment Administration Record (TAR) but not on the care plan.

On 1/26/24 24 at 11:41 a.m. during an interview with the rehab unit manager after discussing the missing interventions on the care plans reviewed, I learned he/she thought the MAR and TAR were part of the care plan meaning interventions on the MAR and TAR did not also need to be on the care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

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F 656	Continued From page 14 plan. The MAR and TAR can not be used in lieu of a Care Plan to create the Comprehensive Care Plan. 6. Residents #173's clinical record was reviewed and revealed hospice services were initiated on 10/5/23 for terminal diagnosis of Alzheimer's disease with late onset. On further review, Resident #173 passed away on 11/15/23, the medical record lacked evidence of a Hospice care plan being developed with goals and interventions for end of life care from the onset of hospice services on 10/5/23 through to end of life on 11/15/23. On 1/26/24 at 12:45 p.m., the Director of Nursing confirmed a comprehensive assessment should have been completed within 14 days after the resident began hospice services..	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

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F 657	Continued From page 15 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to revise a care plan to reflect the current needs for 3 of 33 sampled residents/care plans reviewed (#104, #135 and #144) Findings: 1. A review of Resident #104's clinical record revealed that Hospice was initiated on 9/2/23 for terminal diagnosis of Parkinson's Disease. A Significant Change in Status Minimum Data Set (MDS) 3.0 assessment was completed on 9/4/23 with the Interdisciplinary Team (IDT) meeting held on 9/22/23 and the most recent Quarterly MDS completed on 12/5/23 with the IDT meeting held on 12/8/23. The most recent care plan revision was completed on 12/12/23. As of 1/26/24 Resident #104's care plan lacked evidence of a revision to reflect Hospice services after both MDS assessments and IDT meetings. On 1/26/24 at 11:24 a.m., during an interview with Assistant Director of Nursing, the above was confirmed.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

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F 657	Continued From page 16	F 657		

2. A review of Resident #135's clinical record revealed a progress note dated, 1/9/24 at 12:24. Progress note states "resident had a verbal outburst and was yelling out this a.m. for help, and made reference to killing [himself/herself], as [he/she] sat on the side of [his/her] bed, attempting to rise up to a standing position. This writer entered the room and offered assistance with getting out of bed. [He/She] accepted and stated, I need to get up. This writer acknowledged [his/her] feelings and offered assistance, with ADL's."

Another progress note dated, 1/11/24 at 12:20 states "Resident had a verbal outburst and a crying spell as [he/she] was leaving the dining room, upset that no other residents would talk to [him/her]. [He/She] expressed a feeling of worthlessness, and anxiety, and stated if [he/she] could get out of here and drive away, [he/she] would never come back again. [He/Sh]e also made reference to not wanting to live like this. Other phrases [he/she] used to express [his/her] feelings were, I guess my life is over, and I've never been treated like this before and just want to die."

On 1/12/24 Zoloft (antidepressant) was increased from 50 milligrams (mg.) once a day to 100 mg. once a day. Seroquel (antipsychotic) was increased from Seroquel 25 mg. once a day to 25 mg. three times a day.

The care plan was initiated on 11/16/23 with a target date of 2/25/24. As of 1/24/24 the care plan lacked evidence of a revision to reflect suicidal ideation.

In a meeting with the Licensed Social Worker

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(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 657	Continued From page 17 (LSW) at approximately 8:49 a.m. on 1/24/24 he/she was unaware of the above issue and planned to institute required protocol. On 1/24/24 at approximately 9:45 a.m. during an interview with the Nurse Manager on the Memory Unit, the above was confirmed. 3. A review of Resident #144's clinical record revealed a physician order dated 9/13/23 for Sertraline HCl (antidepressant) Tablet 50 milligrams (MG) Give 1 tablet by mouth one time a day for Depression. The most recent care plan revision was completed on 12/12/23. As of 1/23/24 Resident #144's care plan lacked evidence of a revision to reflect the use of an antidepressant medication. On 1/23/24 at 4:06 p.m., during an interview with two of the facilities MDS coordinators, the above was confirmed.	F 657		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to follow a physician order for obtaining daily weights for 1 of 8 sampled residents for rehospitalization (#114) and failed to	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(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 684	Continued From page 18	F 684		

follow physician orders for making a referral to a specialist for 1 of 5 residents reviewed for unnecessary medications. (#144)

Finding:

1. On 1/24/24, Resident #114's clinical record was reviewed and contained a physician order dated 10/12/23, for "Daily weight in the morning for edema". Review of Resident #114's weights from 10/13/23 to 1/21/24 revealed that weights were not completed on 10/17/23-10/19/23, 10/21/23, 10/22/23, 10/24/23, 10/25/23, 10/31/23, 11/1/23, 11/5/23, 11/7/23, 11/9/23-11/15/23, 11/18/23-11/20/23, 11/23/23-11/29/23, 12/1/23-12/9/23, 12/11/23-12/16/23, 12/18/23-12/25/23, 12/27/23, 12/28/23, 12/31/23, 1/1/24-1/3/24, 1/6/24, 1/9/24-1/13/24, 1/15/24, 1/17/24, 1/19/24, 1/20/24, 1/22/24 and 1/23/24.

On 1/24/24 at 10:05 a.m., during an interview with the Assistant Director of Nursing, she confirmed that Resident #114's weights had not been taken daily between 10/13/23 to 1/21/24 as the current physician's order stated.

2. On 1/23/24, Resident #144's clinical record was reviewed and contained a physician order dated 9/13/23, for a "Psych evaluation for depression". A nurses note dated 9/20/23 stated, "We are working on [Dr.] referral - per office need a recent note from provider to fax to them to justify referral for depression. All recent notes do not address depression". The surveyor was unable to find evidence that this appointment was made.

On 1/24/24 at 8:21 a.m., during an interview with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

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F 684	Continued From page 19 a Registered Nurse Minimum Data Set Coordinator she confirmed a provider order on 9/13/23 for psych eval but was unable to find the psych eval was completed stating, she had let [Registered Nurse] (RN) Manager of 4 East know and it will happen today. On 1/24/24 at 11:00 a.m., during an interview, the RN Manager of 4 East unit stated, "My nurse, [RN #2] made an SBAR (Situation, Background, Assessment, and Recommendation, means of communication with provider) in September and nothing happened, no response from the doctor" and "I spoke with the Doctor today because [he/she] looks the best [he/she] ever looks". She then showed surveyor an order dated 1/24/24 to discontinue the Psych evaluation.	F 684		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(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 756	Continued From page 20	F 756		

attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure the pharmacist provided services to identify that a physician's order for the psychiatric evaluation was completed for 1 of 5 residents reviewed for unnecessary medications (Resident #144).

Finding:

On 1/23/24 during review of Resident #144's clinical record, a Physicians order dated 9/13/23 to start Sertraline (Antidepressant) 50 milligrams daily for depression and for a "Psych evaluation for depression". As of 1/23/24 the medical record lacked evidence of a psychiatric evaluation.

The Pharmacist reviewed Resident #144's medication regimen on 9/29/23, 10/29/23,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

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F 756	Continued From page 21 11/29/23 and 12/26/23. There was no evidence in Resident #144's clinical record that the Pharmacist identified the lack of a Psychiatric evaluation for depression with use of Sertraline. On 1/24/24 at 11:00 a.m., the above was confirmed with the Registered Nurse Manager on 4 East unit	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(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 758	Continued From page 22	F 758		

psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to show evidence of an attempt of a gradual dose reduction (GDR) and lacked documentation to justify the continued use of an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications (#52).

Finding:

Resident #52's Physician Order Sheet signed by the physician on 11/18/23 indicated Resident #52 had been receiving the antipsychotic medication Quetiapine 25 milligrams (mg) one tablet every morning and Quetiapine 50 mg two times daily, since 11/26/22.

Between 11/26/22 and 1/25/24, there was no documentation in the clinical record that a GDR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(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 758	Continued From page 23 was attempted or that a GDR was clinically contraindicated for Resident #52. The surveyor discussed this finding in an interview with the Assistant Director of Nursing on 1/26/24 11:15 a.m.	F 758		
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 interviews, the facility failed to ensure the kitchen was maintained in a clean manner on 1 of 1 days of survey (1/22/24) for ceiling vents, ceiling tiles, and an auto bag machine; failed to ensure the male kitchen staff were wearing facial hair protection, failed to ensure wet sacking of glasses, and failed to ensure foods were dated and/or labeled in	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(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 812	Continued From page 24	F 812		

freezers and refrigerators. Further, the facility failed to monitor temperatures of the dish washing machine and the refrigerators and freezers. In addition, the facility failed to ensure that proper hand sanitizing and proper food handling, during lunch service, was followed for 1 of 2 lunch observations (1/22/24) on the 3rd floor West Unit.

Findings:

Refrigeration Temperature Log(documented at the bottom of the Refrigeration Temperature Log)- This log will be maintained for each refrigerator and freezer(both walk in and reach in units) in the facility. Employee will record the time, air temperature and their initials (preferably upon arrival) once in the morning and once(preferably just before leaving the facility). The food service supervisor for each facility will verify that food service employees have taken their required temperatures by visually monitoring food service employees and reviewing, initially, and dating a sample of logs each month. Record retention requirement one year. If corrective action is required on any day, circle the date in the first column and explain the action taken. Refrigerator should be below 41° Fahrenheit.

The facility policy "Standards, Food Temperature Controls" las revised 10/2023 noted: temperatures of refrigerators and freezers for all patient and resident service are taken and recorded. Dish machine and pot machine temperatures are taken and recorded.

The facility policy "Pantry Storage and Refrigeration" dated as last reviewed on January 2020 noted: Procedure: All perishable food items

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(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 812	Continued From page 25	F 812		

are covered and labeled with the following, as appropriate; Date delivered, date open, and discard date. All stored items must meet the criteria for storage(covered, labeled, and dated).

On 1/22/24 from 9:30 a.m. to 10:30 a.m., during the initial tour of the kitchen with the Food Service Director, the following was observed:
> 4 male kitchen staff observed having facial hair were not wearing facial hair protection.
> There were 5 ceiling vents, above clean dish storage shelves, that were dusty/dirty and rusty.
> There were 30 - eight ounce plastic glasses, on two trays, that were observed to be wet stacked.
> The auto bag machine had chipped/missing paint and was rusty creating an uncleanable surface.
> The dish room had 2 ceiling tiles with brownish stains on them and 4 ceiling vents that were dusty/dirty.
> Refrigerator/Cooler #3 had 3 packages of sub rolls and 3 packages of biscuits that were unlabeled and undated. Additionally, the biscuits had large amounts of ice crystals built up inside the packages.
> Freezer #3 had a previously opened bad of french fries that were unsealed, unlabeled and undated.

On 1/22/24 at 10:30 a.m., in an interview, the Food Service Director confirmed the findings.

2. On 1/22/24 from 11:32 a.m. to 12:05 p.m., a surveyor observed lunch service on the 3rd floor West dining room. A surveyor observed the dietary aide/server did not have a hair restraint on while handling and serving food. A surveyor also observed the dietary aide/server had gloved

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(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 812	Continued From page 26	F 812		

hands and touched a cleaning towel then opened cupboards and removed dishes, then used utensils to serve/plate foods, then he reached into a bag of rolls with his gloved hands and got a roll out and put in on a plate of food. With the same gloved hands, a surveyor observed the dietary aid get a biscuit out of a pan and then use the microwave with same gloved hand. He got rolls out of a bag with the same gloved hands multiple times to serve/plate. He then got two pieces of bread out of bag with same gloved hands, then grabbed meat patties out of freezer with same gloved hands. He held the bread with gloved hands while spreading peanut butter and got a muffin out of bag with same gloved hand and held while cutting. He touched a cheese slice with same gloved hands and then used the phone again with same gloved hands. He never changed gloves or washed and sanitized his hands through the entire meal service.

0n 1/22/24 at 11:59 a.m., in an interview, the dietary aide/server confirmed that his procedure of serving was not preventing possible cross contamination of foods.
0n 1/22/24 at 12:55 p.m., in an interview, a surveyor discussed the finding with the Food Service Director.

3. 0n 1/23/24 at 8:45 a.m., a surveyor reviewed documentation the facility provided for dish machine and refrigerator/freezer temperatures and noted he following:
> The main kitchen dish machine wash and rinse temperatures were not monitored and documented on the following dates:
Dish Machine Temperature Logs:
0ctober 2023:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 812	Continued From page 27 Main Kitchen - 10/3/23(supper check), 10/16/23(breakfast check), 10/30/23(supper check) Pot Room Dish Machine - 10/23/23 November 2023: 11/8/23(supper check), 11/19/23(breakfast and lunch checks) December 2023: Main Kitchen: 12/15/23(lunch check) and 12/22/23(breakfast check) Pot Room Dish Machine - 12/22/23(breakfast check) and no documentation from 12/1/23 to 12/31/23(supper check) January 2024: Main Kitchen: 1/1/24(supper check) 1/4/24(lunch check) Pot Room Dish Machine - no documentation from 12/1/23 to 12/31/23(supper check) The main kitchen dish machine wash and rinse temperatures were documented below 180 degrees Fahrenheit on the following dates: November 2023: Main Kitchen: 11/1/23 - 11/14/23(breakfast check and lunch check) 11/1/23 - 11/7/23 and 11/9/23 - 11/14/23(supper check) Pot Room Dish Machine: 11/5/23 and 11/8/23 > The facility failed to monitor and document the refrigerator and freezer temperatures on the following dates: December 2023 11/22/23- opening check- 4 East deli refrigerator,	F 812		

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F 812	Continued From page 28 4 East refrigerator, 4 East freezer, 4 East patient refrigerator, 4 East patient freezer, 4 West deli refrigerator, 4 West refrigerator, 4 West freezer, 3 East deli refrigerator, 3 East refrigerator, 3 East freezer, 3 West patient freezer, 3 West patient refrigerator, 2 West deli refrigerator, 2 West refrigerator, 2 West freezer, 2 West patient refrigerator, 2 West patient freezer, November 2023 11/11/23- opening check- 4 West patient freezer(also closing check), 4 West patient refrigerator, 4 West freezer, 4 West Refrigerator, 4 West Deli Refrigerator, 4 East patient freezer, 4 East patient refrigerator, 4 East freezer, 4 East refrigerator, 4 East deli refrigerator, 3 West patient freezer, 3 West patient refrigerator, 3 West freezer, 3 West refrigerator, 3 West Deli Refrigerator, 3 East freezer, 3 East refrigerator, 3 East deli refrigerator, 2 West patient freezer, 2 West patient refrigerator, 2 West freezer, 2 West refrigerator, 2 West deli refrigerator. Meat prep freezer- opening check- 11/3/23 and 11/5/23. Blast Chiller- opening check- 11/3/23 and 11/5/23. Closing check on 11/9/23, 11/11/23, 11/12/23, 11/16/23/11/23/23, 11/25/23, 11/26/23 and 11/30/23. October 2023 Food Bank Refrigerator- opening check- on 10/7/23, 10/8/23, 10/21/23 and 10/22/23. closing check on 10/25/23 and 10/29/23. Food Bank Freezer- opening check- on 10/7/23, 10/8/23, 10/21/23 and 10/22/23. closing check on 10/25/23 and 10/29/23. Bake Shop Refrigerator- opening check- on 10/7/23, 10/8/23, 10/21/23 and 10/22/23. closing check on 10/25/23 and 10/29/23.	F 812		

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F 812	Continued From page 29	F 812		

Bake Shop Freezer- opening check- on 10/7/23, 10/8/23, 10/21/23 and 10/22/23. closing check on 10/25/23 and 10/29/23.
Pizza Refrigerator- opening check- on 10/7/23, 10/8/23, 10/21/23 and 10/22/23. closing check on 10/25/23 and 10/29/23.
Blast Chiller- opening check- on 10/7/23, 10/8/23, 10/21/23 and 10/22/23. closing check on 10/1/23, 10/5/23, 10/12/23, 10/19/23, 10/25/23 and 10/26/23.
Produce Refrigerator- opening check- on 10/7/23, 10/8/23, 10/21/23 and 10/22/23. closing check on 10/25/23 and 10/29/23.
Meat Prep Refrigerator- opening check- on 10/7/23, 10/8/23, 10/21/23 and 10/22/23. closing check on 10/25/23 and 10/29/23.
Meat Prep Freezer- opening check- on 10/7/23, 10/8/23, 10/21/23 and 10/22/23. closing check on 10/25/23 and 10/29/23.

> The main kitchen dish machine wash and rinse temperatures were not monitored and documented on the following dates:
Dish Machine Temperature Logs:
0ctober 2023:
Main Kitchen - 10/3/23(supper check), 10/16/23(breakfast check), 10/30/23(supper check)
Pot Room Dish Machine - 10/23/23

November 2023:
11/8/23(supper check), 11/19/23(breakfast and lunch checks)

December 2023:
Main Kitchen: 12/15/23(lunch check) and 12/22/23(breakfast check)
Pot Room Dish Machine - 12/22/23(breakfast check) and no documentation from 12/1/23 to

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F 812	Continued From page 30 12/31/23(supper check) January 2024: Main Kitchen: 1/1/24(supper check) 1/4/24(lunch check) Pot Room Dish Machine - no documentation from 12/1/23 to 12/31/23(supper check) The main kitchen dish machine wash and rinse temperatures were documented below 180 degrees Fahrenheit on the following dates: November 2023: Main Kitchen: 11/1/23 - 11/14/23(breakfast check and lunch check) 11/1/23 - 11/7/23 and 11/9/23 - 11/14/23(supper check) Pot Room Dish Machine: 11/5/23 and 11/8/23 > The facility failed to monitor and document the refrigerator and freezer temperatures on the following dates: December 2023 11/22/23- opening check- 4 East deli refrigerator, 4 East refrigerator, 4 East freezer, 4 East patient refrigerator, 4 East patient freezer, 4 West deli refrigerator, 4 West refrigerator, 4 West freezer, 3 East deli refrigerator, 3 East refrigerator, 3 East freezer, 3 West patient freezer, 3 West patient refrigerator, 2 West deli refrigerator, 2 West refrigerator, 2 West freezer, 2 West patient refrigerator, 2 West patient freezer, November 2023 11/11/23- opening check- 4 West patient freezer(also closing check), 4 West patient refrigerator, 4 West freezer, 4 West Refrigerator, 4 West Deli Refrigerator, 4 East patient freezer, 4	F 812		

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F 812	Continued From page 31	F 812		

East patient refrigerator, 4 East freezer, 4 East refrigerator, 4 East deli refrigerator, 3 West patient freezer, 3 West patient refrigerator, 3 West freezer, 3 West refrigerator, 3 West Deli Refrigerator, 3 East freezer, 3 East refrigerator, 3 East deli refrigerator, 2 West patient freezer, 2 West patient refrigerator, 2 West freezer, 2 West refrigerator, 2 West deli refrigerator.
Meat prep freezer- opening check- 11/3/23 and 11/5/23.
Blast Chiller- opening check- 11/3/23 and 11/5/23.
Closing check on 11/9/23, 11/11/23, 11/12/23, 11/16/23/11/23/23, 11/25/23, 11/26/23 and 11/30/23.

October 2023
Food Bank Refrigerator- opening check- on 10/7/23, 10/8/23, 10/21/23 and 10/22/23. closing check on 10/25/23 and 10/29/23.
Food Bank Freezer- opening check- on 10/7/23, 10/8/23, 10/21/23 and 10/22/23. closing check on 10/25/23 and 10/29/23.
Bake Shop Refrigerator- opening check- on 10/7/23, 10/8/23, 10/21/23 and 10/22/23. closing check on 10/25/23 and 10/29/23.
Bake Shop Freezer- opening check- on 10/7/23, 10/8/23, 10/21/23 and 10/22/23. closing check on 10/25/23 and 10/29/23.
Pizza Refrigerator- opening check- on 10/7/23, 10/8/23, 10/21/23 and 10/22/23. closing check on 10/25/23 and 10/29/23.
Blast Chiller- opening check- on 10/7/23, 10/8/23, 10/21/23 and 10/22/23. closing check on 10/1/23, 10/5/23, 10/12/23, 10/19/23, 10/25/23 and 10/26/23.
Produce Refrigerator- opening check- on 10/7/23, 10/8/23, 10/21/23 and 10/22/23. closing check on 10/25/23 and 10/29/23.
Meat Prep Refrigerator- opening check- on

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F 812	Continued From page 32 10/7/23, 10/8/23, 10/21/23 and 10/22/23. closing check on 10/25/23 and 10/29/23. Meat Prep Freezer- opening check- on 10/7/23, 10/8/23, 10/21/23 and 10/22/23. closing check on 10/25/23 and 10/29/23. 0n 1/23/24 at 9:00 a.m., in an interview, the Food Service Director confirmed the findings.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		

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F 880	Continued From page 33	F 880		

possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews, record review

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F 880	Continued From page 34	F 880		

and facility policy, the facility failed to maintain and implement an infection control program to help prevent the development and transmission of disease and infection related to Methicillin Resistant Staphylococcus Aureus (MRSA- a Multidrug-Resistant Organism) colonized in sputum and urine for a 2 of 2 sampled residents (Resident #20 and #148) diagnosed MRSA for 1 of 5 days of survey (1/22/24). This has the potential to affect all 39 residents on the 4 East unit.

Findings:

1. Resident #20's clinical record was reviewed and revealed a diagnosis of Quadriplegia, tracheostomy, a carrier of MRSA in his/her sputum and chronic respiratory failure with Oxygen supplement. Physician order dated 7/23/23 for Tobramycin (antibiotic) inhalation nebulization solution, 3ml (milliliters) inhale orally via nebulizer two times a day 28 days on and 28 days off for respiratory MRSA. The care plan for "MRSA - colonization (respiratory)" revised on 10/11/21, instructs staff to wear "Mask /face shield to be worn during procedures with risk of splashes or droplet contamination of bodily fluids". In addition, the quarterly Minimum Data Set (MDS) dated 12/26/23 revealed Resident #20 had a Brief Interview for Mental Status (BIMS) of 15 of 15, indicating he/she is cognitively intact.

On 1/22/24 at approx. 9:30 a.m., 2 surveyors observed 4 East unit having 2 rooms with Transmission Based Precautions (TBP) in place; room 401 and 407. Room 401 had with a free standing Personal Protective Equipment (PPE) bag indicating B bed was on Precautions, instructions stating "As a caregiver when entering

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 35	F 880		

this room, please wear the following: Gloves, Gown, Mask" were checked off.

On 1/22/24 at 9:48 a.m., 2 surveyors observed Certified Nurses Aid (CNA) #7 and CNA #8 don PPE (gown, gloves and mask) and begin to enter room 401. At this time, surveyor interviewed CNA #7, who stated, Resident #20 has "MRSA" (Methicillin Resistant Staphylococcus Aureus) in his/her "trach/respiratory" and she is going into provide care for Resident #20, wash his/her body, apply cream etc. Surveyor questioned whether eye protection is used while providing care for Resident #20. CNA #7 stated, she doesn't wear eye protection because [Resident #20] has the trach covered with plastic and she would only wear eye protection if [he/she] was getting a nebulizer treatment. CNA #7 and CNA #8 entered the room and began providing care to Resident #20 without the use of eye protection. At this time, Surveyor entered the room and observed Resident #20 to have a tracheostomy mask with visible yellow sputum noted in the mask.

On 1/22/24 at 9:55 a.m., During an interview with the Registered Nurse (RN) Manager of 4 East unit, surveyor questioned the lack of eye protection while providing care for resident #20, if there is a diagnosis of respiratory MRSA. RN Manager stated she would get back to the surveyor shortly. At 10:16 a.m., RN Manager reapproached the surveyor and stated, "[Resident #20] is colonized", "has been colonized for about 6 years" and the TBP are up because "[resident #20] does get a mist (nebulizer) by the nurse". At this time, the surveyor observed Room 401's free standing PPE bag indicating caregivers are now to wear goggles, in addition to the gloves, mask and gown when entering the room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 36 On 1/22/24 at 1:17 p.m., during an interview, Resident #20 was asked if staff wear eye protection while providing care, he/she stated, "mostly no, only when there COVID on the unit." Surveyor asked about the diagnosis of respiratory MRSA, he/she stated, "I did, they haven't tested me in a year and half. I would think it would be colonized by now." At this time resident #20 stated he receives an Antibiotic nebulizer every other month for 28 days and regular nebulizers 3x day. On 1/23/24 approx. 10:15 a.m., observation of 2 CNA's transferring Resident #20 from the shower chair to the bed for tracheostomy care, both wearing PPE including eye protection. On 1/25/24 at 12:11 p.m., during an interview with Assistant Director of Nursing (ADON), surveyor discussed the lack of eye protection use and the TBP PPE stand without instructions for eye protection during the observations on 1/22/24. The ADON stated "it's colonized". Both the Surveyor and ADON reviewed the Infection Prevention and Control Plan revised 1/2024, Under section Precautions: stating, "Transmission-based Precautions. The Centers for Disease Control and Prevention Guidelines for Transmission-based Precautions will be follow. Transmission-based Precautions are designed for residents known or suspected to be infected or colonized with highly transmissible or epidemiologically important pathogens for which additional precautions beyond Standard Precautions are needed to interrupt transmission within the facility. Transmission-based Precautions will be followed by all employees per policy.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 37	F 880		

2. On 1/22/24 at approx. 9:30 a.m., 2 surveyors observed 4 East unit having 2 rooms with Transmission Based Precaution (TBP) in place; room 401 with free standing bag indicating B bed and 407 with cart outside door for A Bed, this was again observed later in the day at 3:30 p.m. On 1/23/24 at 7:34 a.m., a surveyor entered 4 East unit and observed a 3rd room now on TBP, room 412 with a cart outside of the door and a sign to see nurse before entering on the door frame.

On 1/23/24 at 7:39 a.m., during a brief interview with the Certified Medication Technician (CNA-M #5), she stated room 412, bed one (resident #148) has MRSA (Methicillin Resistant Staphylococcus Aureus), not sure where but knows it's not respiratory.

On 1/23/24 at 7:43 a.m., during a brief interview with Certified Nursing Assistant (CNA #6) stated room 412, bed one (resident #148) has "MRSA urine I believe, it's new last couple of weeks."

On 1/23/23 at approx. 7:45 a.m., during an interview with the RN Manager on 4 East, surveyor asked why TBP were now in place for room 412. RN stated [Resident #148] had a Caddy (on the door), the roommate has an electric wheelchair, hits it and it fell off. She then stated, she had noticed it yesterday afternoon and placed the cart by the door. At this time, the Surveyor informed the RN that there was no TBP in place yesterday (1/22/23), either by cart or caddy from approx. 9:30 a.m. to 3:30 p.m. RN then stated, "I know there was one, it must have fallen down".

On 1/23/24 at 8:06 a.m., during a brief interview

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205053	A. BUILDING _____ B. WING _____	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S D'YOUVILLE PAVILION	102 CAMPUS AVE LEWISTON, ME 04240

(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 880	Continued From page 38 with the RN Manager on 4 West unit. Surveyor asked why there wasn't a TBP cart for room 412 yesterday. RN Stated, "That's probably true, only in [his/her] urine, VRE (Vancomycin-resistant Enterococcus) I believe. I think [heshe] brought it back from the hospital last or week before." Surveyor then asked why a TBP cart was now in place, RN stated "I'm not sure". Review of resident #148's clinical record indicated he/she was readmitted to the facility on 12/27/23 with the hospital discharge diagnosis of, "Developed positive MRSA in urine" and a provider order dated 12/29/23 for, "contact precaution MRSA urine." On 1/25/24 at 12:11 p.m., during an interview with Assistant Director of Nursing, the surveyor discussed the above concerns of, on 1/22/24 from approx. 9:30 a.m. to 3:30 p.m. 2 surveyors observed Resident #148 without TBP in place, with MRSA urine.	F 880		