STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205012	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summer Commons	21 June Street Sanford, ME 04073

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to assess and monitor a resident after a fall and failed to follow their own Fall management and Neurological evaluation policies and procedures by obtaining neurological assessments for residents who had unwitnessed falls for 3 of 6 residents reviewed for falls. (Resident #9, #23, #71) The facilities Falls Management Policy last updated 2/2025 states under procedure; A fall incident report will be completed after a resident has had a fall, whether it is witnessed or not. Complete Post Fall Observation Tool, following a fall, to identify if the cause of the fall is related to mental status changes, physical limitations or environment factors. A neurological assessment tool will be initiated for falls where there is a known head bump. A neurological assessment will also be initiated for an unwitnessed fall in a resident who has a BIMS (Brief Interview for Mental Status) score of 12 or lower. The facilities Neurological Assessment Policy updated on 1/9/2025 states under procedure; Neurological assessment following resident head injury will be completed for all residents sustaining head trauma or suspected head trauma. In EMR (Electronic Medical Record): Neuro Checks will be conducted - every 15 min x4, every 30 min x4, every 1 hr. x4, every 4 hr. x2 and every 8 hr. x1. Frequency of neuro checks after 24 hours is determined by resident's observed signs and symptoms of neurological compromise. 1. Review of Resident #9’s quarterly Minimum Data Set (MDS) dated [DATE] revealed he/she had a Brief Interview for Mental Status (BIMS) of 5 of 15 indicating he/she was not cognitively intact. On 7/31/25 Resident #9 had an unwitnessed fall and was found lying on the floor. The nurses note dated 7/31/25 at 12:57 p.m., stated, “This writer was sitting at the nurses station when I heard housekeeping telling resident to hold on help was coming, this writer along with 2 CNAs (Certified Nursing Aids) looked around the corner and saw resident laying on the floor in front of [his/her] wheelchair near the visitor restroom. SLP (Speech therapists) states she saw resident attempting to reposition in wheelchair right before the fall. No observable injuries noted, no c/o pain. No indication resident hit head. Resident hoyered off the floor. VM (voice mail) left for POA (Power of Attorney), Copy of incident report in SBAR (Situation Background Assessment and Recommendations) book for provider.” Further review of the medical record lacked evidence of a post fall observation and the neurological assessments being completed after this fall. (continued on next page)

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.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/9/25 Resident #9 had another unwitnessed fall and was found lying on the floor. The nurses note dated 8/9/25 at 8:02 a.m., stated, “Unwitnessed fall, resident found in bathroom lying on [his/her] right side, Resident is alert and pleasantly confused. [He/she] said, I am in my bedroom, resident also said [he/she] hurt [his/her] forehead on floor. Resident was checked for injury, VSS (Vital signs stable), NVSS (neurological vital signs stable), rom (range of motion) x 4 to baseline. Safety checks throughout shift in place. Notified [resident representative]. Resident stated [he/she] was a little sore from fall. Tylenol given and taken for pain with good effect., will continue to monitor.” Further review of the “Neurological Check Flow Sheet” after this fall has only 5 of the 15 neurological assessments completed. On 8/25/25 at 2:31 p.m., during an interview, the Registered Nurse Manager of the July Unit confirmed the above stating the post fall observation and neurological assessments should be completed after an unwitnessed fall if the resident reports he/she hit their head and if the residents BIMS is below 12 then the neurological assessments should be completed regardless for any unwitnessed falls. 2. Review of Resident #23’s quarterly Minimum Data Set (MDS) dated [DATE] revealed he/she had a Brief Interview for Mental Status (BIMS) of 11 of 15 indicating he/she was moderately cognitively impaired. On 08/25/2025 at 10:53 a.m., in an interview with a surveyor, Resident #23 stated he/she had experienced “a bad fall,” but could not remember the details. A review of Resident #23’s clinical record revealed a progress note, dated 8/24/25, which stated “Writer entered room to find patient sitting on the floor. Writer asked patient what happened and he/she stated he/she was on his/her way from the bathroom and his/her feet got twisted up and he/she fell. Writer asked why his/her walker was over by the bathroom and patient stated he/she wasn't using it at the time. He/she states he/she does not remember hitting his/her head. Writer performed complete assessment of patient to find no injuries. (Pupils equal in roundness and reactive to light and accommodation) PERRLA intact, no signs or symptoms of trauma. Vital signs stable. Patient denies pain. Patient stated he/she did not need or want to go to the hospital. Writer called and left message with patient’s son. Notified provider. ” A Neurological Check Flowsheet, dated 8/24/25, revealed only 3 of 15 neurological assessments had been completed. On 8/27/25 at 9:50 a.m., in a discussion with a surveyor, the Director of Nursing confirmed staff had not followed the facility’s policy after Resident #23’s fall on 8/24/25, as only 3 neurological assessments had been completed. 3. Review of Resident #71’s quarterly Minimum Data Set (MDS) dated [DATE], revealed he/she had a Brief Interview for Mental Status (BIMS) of 3 of 15 indicating severe cognitive impairment. On 9/16/24 at 10:15 a.m., there is documentation of an unwitnessed fall for Resident #71. There is an incident report stating that the Nurse Practitioner (NP) was in the facility at the time and evaluated the resident and had him/her sent to the Emergency Department (ED) for further evaluation and treatment. On 9/16/24 at 6:30 p.m., there is documentation of Resident #71 having an unwitnessed fall. The record lacks documentation of any further post fall evaluation or neurological assessments being done. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/16/24 at 7:30 p.m., there is documentation of another unwitnessed fall for Resident #71. Documentation of neurological assessments started at 7:30 p.m. and continued into the eighth hour after the fall. All other components of the neurological assessment were unremarkable. On 9/17/24 at 3:00 p.m., there is documentation of an unwitnessed fall for Resident #71. Due to extensive injuries, Resident #71 was sent to the local Emergency Department via Emergency Medical Services and then transferred to Maine Medical Center for further evaluation and treatment. On 8/26/25, in an interview with a surveyor, the Director of Nursing (DON) provided documentation for Resident #71's three falls on 9/16/24, and one fall on 9/17/24. The DON confirmed that there were no notes for monitoring Resident #71 with post fall documentation, and there were no neurological assessments documented for the second fall on 9/16/24. On 8/27/25 at approximately 9:00 a.m. in an interview with a surveyor, the July Unit Manager, reviewed the documentation for Resident #71 and confirmed that They should have done neuro checks after the second fall and did not. I was not here at the time, I had already left for the day.