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

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(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. 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 (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	(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. 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 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to adequately date and properly dispose of open biologicals according to manufacturer specifications in 1 of 2 medication storage rooms observed (August Unit).On 8/26/25 at 9:15 a.m. a surveyor observed the [NAME] Unit medication room with the Registered Nurse Manager. The refrigerator contained an opened and undated multidose vial of Tuberculin Purified Protein Derivative (TB) with the following manufacturer's instructions of, Once entered, vial should be discarded after 30 days. At this time, the Registered Nurse Manager confirmed the above and discarded the TB vial.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on record review and observation the facility failed to maintain an Infection Control Program designed to prevent the development and transmission of disease and infection related to hand hygiene during medication administration for 1 of 4 residents observed. Finding:The facilities Medication Administration- General Guidelines with an effective date of 5/1/18 states in section A.2, Handwashing and Hand Sanitization: The person administering medications adheres to good hand hygiene, which includes washing hands thoroughly and section 2.b states, Hand sanitization is done with an approved sanitizer. between hand washings, when returning to the medication cart or preparation area (assuming hands have not touched a resident or potentially contaminated surface.On 8/26/25 at 9:34 a.m. during observation of the medication administration pass on August unit, the Registered Nurse (RN) #1 was observed preparing medications for a resident when she stopped and picked up a piece of foil off the floor and then proceeded to prepare additional medications without performing hand hygiene.On 8/26/25 at 9:37 a.m. the surveyor discussed the lack of maintaining proper hand hygiene during medication preparation with RN#1.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on record review and interviews, the facility failed to ensure that the physician was notified of a wound culture and sensitivity (C&S) result when organisms were identified that were resistant to the antibiotic already ordered, for 1 of 1 residents reviewed for non-pressure related skin conditions (#52). A review of the facility's policies and procedures for Antibiotic Stewardship stated 1. The purpose of our Antibiotic Stewardship Program is to monitor the use of antibiotics in our residents. 12. When a culture and sensitivity (C&S) is ordered, lab results are received, and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified or discontinued. And, Antibiotic Stewardship - Orders for Antibiotics stated, 3. Appropriate indications for use of antibiotics include: a) Criteria met for clinical definition of active infection or suspected sepsis, and b) Pathogen susceptibility, based on culture and sensitivity to antimicrobial (or therapy begun while culture is pending). 6. When a culture and sensitivity (C&S) is ordered, lab results are received, and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified or discontinued. Review of Resident #52's clinical record revealed diagnoses that included chronic venous insufficiency with chronic wounds of both lower extremities. Resident #52 was followed weekly by the wound care specialist and received daily dressing changes to the lower extremities. The record contained a physician's order, dated 5/8/25, for Sulfamethoxazole/trimethoprim (Bactrim) suspension 200 mg/40 mg per 5 ml (milligrams per milliliter) - Give 10 ml by mouth twice daily for 10 days. A wound culture specimen was obtained on 5/5/25. A preliminary report on 5/7/25 stated Unable to evaluate culture for all pathogens due to overgrowth of Proteus. Final culture and sensitivity results, dated 5/10/25, noted 3 organisms present: Proteus mirabilis, Staphylococcus aureus, and Enterobacter cloacae complex. Proteus mirabilis was noted as resistant to the prescribed antibiotic. A nursing progress note, dated 5/8/25, stated 5/8/25 - Late Entry 5/7/2025: Wound Culture results received and this nurse advised nurse practitioner of results. She requested that I reach out to the wound nurse and let her know the results. Nurse Practitioner from (Wound Clinic) was advised and requested a copy of the results be sent to her so she could write antibiotic orders for the resident. A physician's note, dated 5/10/25 noted preliminary wound culture results from 5/7/25 were reviewed and to continue the prescribed antibiotic. On 5/14/25, the Wound Care Nurse Practitioner's note stated Wound cultures obtained were positive for Proteus mirabilis. (Resident #52) was placed on Bactrim DS (double strength) for 10 days. On 08/26/2025 at 12:20 p.m., in an interview with the Director of Nursing (DON), and the [NAME] President of Quality Improvement and Nursing Services, a surveyor discussed results of the wound culture indicating one of the organisms was resistant to Bactrim and the antibiotic was not changed based on the culture results. On 8/26/25 at 1:10 p.m., the Medical Director and DON met with 4 surveyors. The Medical Director reviewed the records with the surveyors and stated she had not been made aware of culture results indicating Proteus mirabilis was resistant to Bactrim, and based on those results, she would have switched the resident's antibiotic to a third generation cephalosporin. On 8/26/25 at 1:50 p.m., in an interview with a surveyor, the DON reviewed the facility's infection tracking, trending and monitoring logs. Resident #52's culture results had not been included. The DON confirmed the facility had failed to identify and report the results of the culture to ensure the use of the appropriate antibiotic as per its antibiotic stewardship program.

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record reviews and observations the facility failed to review and revise the care plan by an interdisciplinary team (IDT), that included, to the extent possible, participation of the resident after each Minimum Data Set (MDS) 3.0 assessment for 2 of 18 residents (Resident #34 and #32), and failed to ensure a care plan was updated to reflect the current needs in the areas of falls and self-care deficit (Resident #43), and communication (Resident #6) for 4 of 18 residents whose care plans were reviewed.Findings: 1. On 8/25/25 at 9:53 a.m., during an interview, Resident #34 stated, Not that I know of when asked if he/she is invited and/or participates in his/her plan of care. Residents #34's medical record lacked evidence that a care plan meeting was held by the interdisciplinary team (IDT) after the Quarterly MDS dated [DATE]. On 8/26/25 at 1:31 p.m., during an interview, the Licensed Social Worker (LSW) stated Resident #34 has a Guardian and they couldn't get timing down for that IDT meeting but she had attempted to get corresponding dates that would work. On 8/26/25 at 1:36 p.m., during an interview, the LSW provided an email between her and the Guardian dated 6/11/25 and 6/12/25 attempting to plan a date for the IDT meeting. No further attempts were made to ensure Resident #34 had an IDT meeting. The LSW stated we both forgot, it just slipped us. 2. On 8/25/25 at 10:02 a.m., during an interview, Resident #32 stated, They don't tell us, when asked if he/she is invited and/or participates in his/her plan of care. Residents #32's medical record lacked evidence that a IDT meeting held on 8/21/25 included, to the extent possible, participation of Resident #32 to review and revise the care plan. On 8/26/25 at 1:31 p.m., LSW stated the IDT was held on 8/21/25 but resident was still eating so they had the meeting without him/her and the unit manager followed up with the resident after. 3. On 8/25/25 at 11:05 a.m., and at 1:28 p.m., on 8/26/2025 at 10:35 a.m., and at 2:52 p.m., and on 8/27/25 at 11:14 a.m., observation of Resident #43 in the recliner chair, with the call bell lying on the bed or wrapped around the bedside rail across the room and out of reach of the resident. On 8/25/25 at 1:36 p.m., during a resident representative interview, Resident #43's Power of Attorney stated, [he/she] really can't push the call bell, it's a useless object, [he/she] really can't put it together and [he/she] wasn't ever able to use the button around [his/her] neck at home either. Review of Resident #43's care plan updated on 7/22/25 states under the problem At Risk for falls related to weakness, impaired cognition with interventions of Place call bell/light within easy reach.Remind [Resident] to call for assistance before getting up to walk. Respond promptly to calls for assist to the toilet. Under the problem Self Care Deficit related to impaired cognition/communication, general debility secondary to dementia, inability to perform ADL tasks independently and BIMS score of 3 with interventions of Call bell within reach at all times. (continued on next page)

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	On 8/27/2025 at 11:16 a.m., both the Registered Nurse (RN#2) and the surveyor observed Resident #43 in the recliner with the call bell across the room on the side rail of the bed. The surveyor discussed the lack of access to the call bell and the care plan that is in place for this resident to have access to the call bell at all times. The RN#2 stated, I think [he/she] probably doesn't know what that is and confirmed the care plan does not reflect the current status of the resident relating to the use of a call bell. 4. Review of Resident #6's Minimum Data Set (MDS) Version 3.0 on 8/26/25 indicated the resident has unclear speech, sometimes makes self-understood, sometimes understands verbal content, sometimes can express ideas/wants. Review of the resident's care plan, last updated on 8/18/25, that addressed the concern of communication states the resident communicates mostly by reading/writing, pointing, picture paper, nod and shakes head. On 8/25/25 at 10:44 a.m. a surveyor attempted to interview Resident #6. The resident was able to respond to yes and no questions but unable to communicate his/her needs or wants to the surveyor. On 8/25/25 at 10:50 a.m. during an interview, Certified Nursing Assistant (CNA)#1 who was assigned to resident#6, stated that communication, is a work in progress and was not aware of any other ways to communicate with this resident. On 8/26/25 at 1:15 p.m. the surveyor met with the Registered Nurse (RN) Manager for the July unit and asked how the resident communicates and how staff communicates with Resident #6. The RN stated, he/she points, says yes/no, staff write stuff down, and stated that he/she wanted her remote earlier and that the resident communicated this by pointing and making a noise to get the staff's attention. When the surveyor asked if the resident could write she stated, no, [he/she] can't write. At this time, the surveyor discussed the residents care plan indicates he/she can write as a form of communication. The RN offered to demonstrate how she communicates with the resident. The resident was able to say yes/no, make facial expressions to express likes/dislikes, and was able to point to the call bell when asked how he/she lets staff know he/she needs something. When the RN asked Resident #6 if he/she can write he/she stated, no, but was given paper and pen. The resident was unable to write any sensical words on the paper. On 8/26/25 at 1:22 p.m. the RN manager confirmed Resident #6 could not communicate by writing and the care plan did not reflect the current status in that area of communication.

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F 0868 Level of Harm - Potential for minimal harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and review of the facility's Quality Assurance and Performance Improvement (QAPI) program, the facility failed to present evidence that the required members attended 3 of 4 quarters provided (January 2025, April 2025, and July 2025).On 8/27/25, a surveyor reviewed attendance sheets for the QAPI quarterly meetings. A review of the January 2025 QAPI attendance sheet lacked evidence that the Medical Director attended the meeting. The April 2025 QAPI attendance sheet lacked evidence that the Infection Preventionist attended the meeting. The July 2025 QAPI attendance sheet lacked evidence that the Director of Nursing attended the meeting. On 8/27/25 at 3:30 p.m., in a discussion with a surveyor, the Administrator confirmed the finding.