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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48648 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 [DATE]. On [DATE] 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 she reportedly told a unit manager, but the chart indicated a Code Status of No CPR. On [DATE] at 11:00 a.m., a surveyor confirmed during an interview with the Unit Manager that Resident #108 makes his/her own decisions. On [DATE] 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 [DATE] 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 ,d+[DATE] 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. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 [DATE] at 1:00 p.m. during a follow up record review, Resident #108's clinical record indicated on [DATE] 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 [DATE] 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.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37440 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 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 [ROOM NUMBER] - 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 [ROOM NUMBER] - 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 [ROOM NUMBER] - The bathroom exhaust vent was dusty/dirty. > There were 2 hallway ceiling vents by Resident room [ROOM NUMBER] that were dusty/dirty. > There was 1 hallway ceiling tile by Resident room [ROOM NUMBER] that had a large brown stain. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	> Resident room [ROOM NUMBER] - 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 Plant 0perations Manager confirmed the findings.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 37648 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. 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

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37648 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 [DATE] 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 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.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37648 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 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 [DATE] 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 [ROOM NUMBER]. 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. 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. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 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 37440 33639 48648 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	33640

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F 0657 Level of Harm - Minimal harm or potential for actual 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. 37648 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. 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 (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. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 33640

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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. 37648 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 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 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. 37440

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 37648 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, 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

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 33639 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 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.

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	205053	A. Building B. Wing	01/26/2024

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37440 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 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 [NAME] 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 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. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	> 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 [NAME] 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 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: 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: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, 4 East refrigerator, 4 East freezer, 4 East patient refrigerator, 4 East patient freezer, 4 [NAME] deli refrigerator, 4 [NAME] refrigerator, 4 [NAME] freezer, 3 East deli refrigerator, 3 East refrigerator, 3 East freezer, 3 [NAME] patient freezer, 3 [NAME] patient refrigerator, 2 [NAME] deli refrigerator, 2 [NAME] refrigerator, 2 [NAME] freezer, 2 [NAME] patient refrigerator, 2 [NAME] patient freezer, November 2023 11/11/23- opening check- 4 [NAME] patient freezer(also closing check), 4 [NAME] patient refrigerator, 4 [NAME] freezer, 4 [NAME] Refrigerator, 4 [NAME] Deli Refrigerator, 4 East patient freezer, 4 East patient refrigerator, 4 East freezer, 4 East refrigerator, 4 East deli refrigerator, 3 [NAME] patient freezer, 3 [NAME] patient refrigerator, 3 [NAME] freezer, 3 [NAME] refrigerator, 3 [NAME] Deli Refrigerator, 3 East freezer, 3 East refrigerator, 3 East deli refrigerator, 2 [NAME] patient freezer, 2 [NAME] patient refrigerator, 2 [NAME] freezer, 2 [NAME] refrigerator, 2 [NAME] deli refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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) (continued on next page)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, 4 East refrigerator, 4 East freezer, 4 East patient refrigerator, 4 East patient freezer, 4 [NAME] deli refrigerator, 4 [NAME] refrigerator, 4 [NAME] freezer, 3 East deli refrigerator, 3 East refrigerator, 3 East freezer, 3 [NAME] patient freezer, 3 [NAME] patient refrigerator, 2 [NAME] deli refrigerator, 2 [NAME] refrigerator, 2 [NAME] freezer, 2 [NAME] patient refrigerator, 2 [NAME] patient freezer, November 2023 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/11/23- opening check- 4 [NAME] patient freezer(also closing check), 4 [NAME] patient refrigerator, 4 [NAME] freezer, 4 [NAME] Refrigerator, 4 [NAME] Deli Refrigerator, 4 East patient freezer, 4 East patient refrigerator, 4 East freezer, 4 East refrigerator, 4 East deli refrigerator, 3 [NAME] patient freezer, 3 [NAME] patient refrigerator, 3 [NAME] freezer, 3 [NAME] refrigerator, 3 [NAME] Deli Refrigerator, 3 East freezer, 3 East refrigerator, 3 East deli refrigerator, 2 [NAME] patient freezer, 2 [NAME] patient refrigerator, 2 [NAME] freezer, 2 [NAME] refrigerator, 2 [NAME] 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 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.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 37648 Based on record review, observations and interviews, the facility's Quality Assurance Committee failed to ensure that the Plan of Correction (POC) for an identified deficiency from the annual Long Term Care Recertification Survey, dated 1/26/24, was effective. The Federal citation F584 and F812 was cited again during the re-visit to the annual Long Term Care Recertification Survey, dated 3/21/24. Findings: During the annual Long Term Care survey, dated 1/26/24, a deficiency was cited at F584 for the facilities failure to adequately provide housekeeping and maintenance services necessary to maintain the building in good repair and in a sanitary condition and at F812 for the facilities failure to ensure foods were dated and/or labeled in a freezer and refrigerator. The facility's POC, dated 2/12/24, indicated that the facility would ensure that the resident rooms/bathrooms would be in a sanitary condition by clean ceiling fans weekly and all rooms/bathrooms in the facility will have bed pans/commodes stored appropriately, and the facility would ensure kitchen staff would date and label items in the refrigerator and freezer, with the POC completion date of 3/11/24. During the re-visit survey on 3/21/24, a brief interview was conducted with the Quality Assurance Performance Improvement (QAPI) Manger who stated the POC was reviewed in the monthly QAPI meeting held on 2/28/24 and provided the surveyor with the 2/28/24 QAPI agenda indicating the Statement of Deficiencies and POC was reviewed with the team. On 3/12/24 during a tour of 3rd Floor [NAME] unit with the Director of Nursing and QAPI Manager, resident bathrooms 334, 338, 344, 348, 350 and 352 were found to have ongoing concerns regarding storage of bed pans/commode buckets and exhaust fans dusty/dirty. In addition, several of these rooms had unlabeled person items and medicated powder stored around the sink. It was determined the same tag F584 would be recited. On 3/21/24 a kitchen tour was conducted with the Director of Culinary Services and the QAPI Manger in which freezer #3 and refrigerator/cooler #2 contained food items that were unlabeled and undated. It was determined the same tag F812 would be recited. On 3/21/24 at 1:40 p.m., the above ongoing concerns with discussed with the Director of Nursing and the Assistant Director of Nursing.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37440 37648 Based on observations, interviews, record review 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 [DATE] 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 [ROOM NUMBER] and 407. room [ROOM NUMBER] had with a free standing Personal Protective Equipment (PPE) bag indicating B bed was on Precautions, instructions stating As a caregiver when entering 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 [ROOM NUMBER]. 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 [ROOM NUMBER]'s free standing PPE bag indicating caregivers are now to wear goggles, in addition to the gloves, mask and gown when entering the room. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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 [ROOM NUMBER] 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 [ROOM NUMBER] 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 [ROOM NUMBER], 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 [ROOM NUMBER], 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 [ROOM NUMBER]. RN stated [Resident #148] had a [NAME] (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 with the RN Manager on 4 [NAME] unit. Surveyor asked why there wasn't a TBP cart for room [ROOM NUMBER] 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. (continued on next page)

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

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident #148's clinical record indicated he/she was readmitted to the facility on [DATE] 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.