STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205063	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clover Health Care	440 Minot Ave Auburn, ME 04210

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to create a homelike environment and promote each resident's dignity and respect on 1 of 4 units ([NAME]) for the evening meal for 1 of 5 days of survey (5/5/25). Findings: On 5/5/25 at 5:05 p.m., a surveyor observed in the [NAME] dining room, 6 residents seated at the dining room tables eating their dinner meal. These 6 residents had their meals served to them on trays and it was not homelike, dignified or respectful. On 5/5/25 at 5:10 p.m., in an observation and interview, the Regional Director of Operations confirmed that the meals should not have been served on trays and it was not homelike, dignified or respectful for the residents.

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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(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 - Some	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** 12. Resident #59 was admitted in April of 2022. A review of the entire electronic and paper medical record lacked evidence that the facility offered or provided the resident and/or resident representative with written information concerning the right to formulate an advanced directive. 13. Resident #83 was admitted in August of 2024. A review of the entire electronic and paper medical record lacked evidence that the facility offered or provided the resident and/or resident representative with written information concerning the right to formulate an advanced directive. Based on record review and interview, the facility failed to ensure that the resident and/or resident representative was provided with written information concerning the right to formulate an advanced directive for 13 of 14 residents reviewed (Residents #3, 6, 24, 29, 45, 47, 54, 59, 77, 81, 83, 88, 204, 206). Findings: 1. Resident #29 was admitted in February of 2021. A review of the entire electronic and paper medical record lacked evidence that the facility offered or provided the resident and/or resident representative with written information concerning the right to formulate an advanced directive. 2. Resident #204 was admitted in April of 2025. A review of the entire electronic and paper medical record lacked evidence that the facility offered or provided the resident and/or resident representative with written information concerning the right to formulate an advanced directive. 3. Resident #206 was admitted in May of 2025. A review of the entire electronic and paper medical record lacked evidence that the facility offered or provided the resident and/or resident representative with written information concerning the right to formulate an advanced directive. On [DATE] at 1:00 p.m., in an interview with a surveyor, the Clinical Reimbursement Manager confirmed there was no evidence in the clinical records of any discussion held with the residents or their designated representatives regarding advanced directives. On [DATE] at 1:50 p.m., in an interview with five surveyors, the Social Services Assistant confirmed the records did not contain evidence that residents or their representatives were asked to provide a copy of their advanced directives, or if they had none, were provided with information or assistance to formulate one. 4. Resident #3 was admitted to the facility in March of 2021. A review of the resident's electronic medical record and their paper medical record lacked evidence that the facility offered, reviewed, or provided written information concerning the right to formulate an advanced directive to the resident and/or resident representative. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Resident #24 was admitted to the facility in December of 2021. A review of the resident's electronic medical record and their paper medical record lacked evidence that the facility offered, reviewed, or provided written information concerning the right to formulate an advanced directive to the resident and/or resident representative. 6. Resident #47 was admitted to the facility in January of 2022. A review of the resident's electronic medical record and their paper medical record lacked evidence that the facility offered, reviewed, or provided written information concerning the right to formulate an advanced directive to the resident and/or resident representative. 7. Resident #88 was admitted to the facility in December of 2024. A review of the resident's electronic medical record and their paper medical record lacked evidence that the facility offered, reviewed, or provided written information concerning the right to formulate an advanced directive to the resident and/or resident representative. 10. Resident #45 was admitted to the facility in [DATE]. A review of the residents electronic medical record and their paper medical record lacked evidence that the facility offered, reviewed, or provided written information concerning the right to formulate an advanced directive to the resident and/or resident representative. 11. Resident #54 was admitted to the facility in [DATE]. A review of the residents electronic medical record and their paper medical record lacked evidence that the facility offered, reviewed, or provided written information concerning the right to formulate an advanced directive to the resident and/or resident representative. 8. Resident #77 was admitted in February 2025. A review of the entire electronic medical record and the paper medical record lacked evidence that the facility offered, reviewed, or provided written information concerning the right to formulate an advance directive to the resident and/or resident representative. 9. Resident #81 was admitted in [DATE]. A review of the entire electronic medical record and the paper medical record lacked evidence that the facility offered, reviewed, or provided written information concerning the right to formulate an advance directive to the resident and/or resident representative. On [DATE] at 1:42 p.m., during an interview in the presence of 5 surveyors, the Social Services Assistant stated she did not offer, review, or provide written information concerning advance directives to the above residents and/or resident representatives and stated she did not know what an advance directive includes other than cardiopulmonary resuscitation (CPR).

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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** Based on observations and interviews, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable environment on 4 of 4 units (Belfast, [NAME], [NAME] and [NAME]) for 2 of 2 facility tours(5/5/25 and 5/9/25). Findings: 1. On 5/5/25 at 9:55 a.m., a surveyor and the Food Service Director observed the following in the Laundry room: > There were 2 black laundry carts with ripped duct tape on the inside of the carts creating uncleanable surfaces. > The floor had chipped/missing paint, on a wooden trap door, creating an uncleanable surface. On 5/5/25 at 9:55 a.m., in an interview, the Food Service Director confirmed the findings. On 5/9/25 from 8:15 a.m. to 9:15 a.m., a surveyor conducted an Environmental Tour with the Administrator, the Director of Plant Operations, the Assistant Director Plant Operations, the Housekeeping Supervisor and the Regional Director of Operations, in which the following findings were observed: 2. Belfast Unit: > The sit-to-stand patient lift had food debris and dirt in the foot base area. > Resident room [ROOM NUMBER] - The baseboard heater had chipped/missing paint creating an uncleanable surface. > Resident room [ROOM NUMBER]- The bathroom/shower ceiling light was missing a lens cover. > Resident room [ROOM NUMBER] - The room entrance door frame had chipped/missing paint creating an uncleanable surface. > Resident room [ROOM NUMBER]- Bathroom/shower ceiling light is missing lens cover. [NAME] Unit: > The wheelchair, scale in the whirlpool room, had a non-skid surface that was ripped/torn and created an uncleanable surface. > The inside entrance doors to the unit marred with black marks on the lower part of door. > Resident room [ROOM NUMBER]-2 - The wheelchair arm rests were worn and presented with an uncleanable surface. The right wheel was rubbing against the resident's seat causing the wheelchair to steer and roll to the right. > Resident room [ROOM NUMBER]- There were two ceiling tiles with brown stains on them. > Resident room [ROOM NUMBER]- There was an unbagged bedpan on shelf above toilet. > Resident room [ROOM NUMBER] - The heating unit had chipped/missing paint creating an uncleanable surface. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[NAME]: > A dining room table has 2 pieces of untreated wood, approximately 6 inches long, under 2 of the table legs. > A sit-to-stand lift had food debris and dirt in foot base area. > The exit doors hallway walls were marred with black marks and had chipped/missing paint exposing sheetrock. > The wall heater, in the center core, had metal that had come apart and was sticking out and not secured together. > Resident room [ROOM NUMBER] - The caulking around the base of the toilet was stained and dirty. > Resident room [ROOM NUMBER] - The wall by bed 2 was scuffed/marred with black marks. > Resident room [ROOM NUMBER] bathroom- The walls were scuffed/marred with black marks and had chipped/missing paint. > Resident room [ROOM NUMBER]- The walls were scuffed/marred with black marks. The ceiling light had debris in them. > Resident room [ROOM NUMBER] - There were multiple ceiling tiles with brown stains. > Resident room [ROOM NUMBER] - The was a cracked/broken ceiling tile above the toilet. There were two stained ceiling tiles above bed 1. > Resident room [ROOM NUMBER]-2 - The wall behind the bed had chipped/missing paint. > Resident room [ROOM NUMBER] - There was a dirty plunger on floor next to the toilet that was not bagged. There was a wash basin on the floor by the toilet. The bathroom walls had chipped/missing paint. There was a ceiling tile over the head of the bed with a large brown stain. The room heating unit had chipped/missing paint. > Resident room [ROOM NUMBER] - A ceiling tile in the bathroom was stained and dirty. [NAME] Unit > The exit 8 cement floor had chipped/missing paint creating an uncleanable surface. > The sitting area past the nurse's station had a small table with missing laminate on the top. > Resident room [ROOM NUMBER] - The room heater has chipped/missing paint. The room entrance door and door frame had chipped/missing paint and black marks on them. > > Resident room [ROOM NUMBER] - There was a dirty plunger on floor and unbagged. The wall by the bathroom entrance had chipped/missing paint and was marred with black marks. On 5/9/25 at 9:15 a.m., in an interview, the Administrator, the Director of Plant Operations, the Assistant Director Plant Operations, the Housekeeping Supervisor and the Regional Director of Operations, confirmed the findings.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on record review and interview, the facility failed to ensure a resident with a specialized mental health diagnosis, whose stay went beyond the expected 30 days, had been referred to the appropriate state-designated authority for Pre-admission Screening & Resident Review Level II (PASRR) evaluation and determination for 1 of 1 residents reviewed for PASRR (Resident #78) Finding: On 3/6/25, clinical record review indicated Resident #78 was admitted in March of 2025. Admitting diagnosis includes Post-Traumatic Stress Disorder. Review of Resident #78's PASRR, dated 3/7/25, indicated Resident #78 had a Convalescence Categorical exemption (a time-limited 30-day exemption). Further review the clinical record lacked evidence to indicate that the PASRR Level I was forwarded again to the State Mental Health Authority to determine if a PASRR Level II evaluation and determination was needed after the Residents stay changed from short-term to long-term. On 5/8/25 at 2:30 p.m., during an interview with the Area Manager of Clinical Reimbursement, the above was confirmed.

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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** Based on interview and record review, 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 care for 1 of 1 residents reviewed for baseline care plans (Resident #4). Finding: Resident #4 was recently admitted with diagnoses to include Repeated Falls, Difficulty in Walking, Muscle Weakness, and Need for Assistance in Personal Care. Review of admission Minimum Data Set (MDS), dated [DATE], revealed Resident #4 requires substantial/maximal assistance with Activities of Daily Living (ADLs). Review of Resident #4's care plan, initiated 4/2/25, lacked evidence that goals and interventions were put into place for ADLs. On 5/8/25 at 9:25 a.m. during an interview, Certified Nursing Assistant (CNA) #6 stated Resident #4 is sometimes incontinent but toilets in the bathroom and walks to the bathroom with his/her walker but needs help. On 5/8/25 at 12:30 p.m., the Director of Nursing (DON) reviewed Resident #4's care plan and confirmed it did not contain goals and interventions for the above concern.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, record review and interview, the facility failed to ensure that a care plan was developed in the area of smoking (Resident #45) and respiratory needs (Resident #78) for 2 of 28 sampled residents reviewed for comprehensive care plans. Findings: 1. Resident #45 was admitted to the facility in May of 2018. A review of the resident's Smoking Safety Screening completed on 11/21/24 indicates that he/she is safe to smoke with supervision. Further review of the resident's medical record lacks evidence of the need to smoke with supervision in his/her care plan. On 5/7/25 at 2:20 p.m., the above information was confirmed with the Facility Administrator. 2. Resident #78 was admitted to the facility in March of 2025. Review of the resident's physician orders indicates that he/she has been using his/her Continuous Positive Airway Pressure (CPAP) since 3/13/25. Further review of his/her medical record lacks evidence of a care plan for CPAP usage. On 5/7/25 at 2:00 p.m., the above information was confirmed with the Director of Nursing.

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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. 2. Resident #3's clinical record contained a Quarterly MDS Assessment, dated 2/6/25. Further review of Resident #3's record revealed that the last IDT meeting were held on 3/12/2025 and lacked evidence that an IDT meeting was held within 7 days following the latest MDS assessment. 3. Resident #19's clinical record contained a Quarterly MDS Assessment, dated 4/14/25. Further review of Resident #19's record revealed that the last IDT meeting were held on 5/6/2025 and lacked evidence that an IDT meeting was held within 7 days following the latest MDS assessment. 4. Resident #24's clinical record contained a Quarterly MDS Assessment, dated 3/22/25. Further review of Resident #24's record revealed that the last IDT meeting were held on 4/17/2025 and lacked evidence that an IDT meeting was held within 7 days following the latest MDS assessment. 5. Resident #47's clinical record contained a Quarterly MDS Assessment, dated 3/16/25. Further review of Resident #47's record revealed that the last IDT meeting were held on 1/31/25 and lacked evidence that an IDT meeting was held within 7 days following the latest MDS assessment. 6. Resident #88's clinical record contained a Quarterly MDS Assessment, dated 4/2/25. Further review of Resident #88's record lacked evidence that an IDT meeting was held within 7 days following the latest MDS assessment. On 5/07/25 at 12:31 p.m., in an interview, the Social Service Assistant confirmed that the residents did not have their IDT meetings within 7 days of MDS completion date. On 5/07/25 12:40 p.m., the surveyor discussed the findings with the Area Manager of Clinical Reimbursement. Based on interviews and record review, 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 and/or his/her representative after each Minimum Data Set (MDS) assessment for 5 of 7 residents reviewed for care planning (Residents #3, 19, #24, #47, and #22). Findings: 1. Review of Resident #22's clinical record revealed MDS Quarterly Assessments were completed on 10/7/24, 1/5/25, and 3/31/25. Further review of Resident #22's record revealed that IDT meetings were held on 10/25/24, 1/30/25, and 4/22/25 and lacked evidence that an interdisciplinary team (IDT) meeting was held within 7 days following the assessments.

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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. Based on clinical record review and interview, the facility failed to ensure physician orders were followed for urine collection for urinalysis/culture a week prior to surgery for 1 of 1 sampled residents (Resident #24). Additionally, the facility failed to adequately assess and monitor a resident after an unwitnessed fall for 1 of 2 residents reviewed for falls (Resident #77). Findings: 1. Resident #24 was admitted to the facility in December of 2024 with diagnosis to include medically complex conditions, Multiple Sclerosis and the use of an indwelling urinary catheter. A Nurse Note dated 4/17/2025 7:30 a.m. stated: Resident due for catheter change to obtain clean catch urine in preparation for Botox treatment that resident has requested. Changes without difficulty using new #18 French with 10 ml (milliliter) balloon and received immediate return of straw-colored urine that is slightly hazy. Set up specimen in refrigeration for pick up. On 5/5/25, a surveyor reviewed Resident 24's clinical record. On 4/17/25, orders were received by the facility from a Family Nurse Practitioner (FNP) at a urology center in a hospital noting; Please have patient perform a clean catch urine collection for urinalysis (UA)/culture a week prior to surgery on 5/9/25. A Nurse Note dated 5/8/2025 2:50 p.m. stated: Called Nordx, urine was received on May 4th but was not accompanied by an order. Reported that charge nurse received call from lab on 5/5 at 8:58 a.m. and confirmed no order, due to instability of specimen past 24 hours, the urine in not usable for a UA. Urology appointment will be May 23rd at 9:30 a.m. On 5/9/25 at 9:25 a.m., in an interview, a Licensed Practical Nurse (LPN) stated, We had received instructions from the FNP at the Urology Center at the hospital to please have the patient perform a clean catch urine collection for urinalysis/culture a week prior to surgery on 5/9/25. The specimen was collected on 5/2/25 and sent to the lab on 5/3/25. The facility called the lab on 5/8/25 and the facility was told by the lab that the urine was received on May 4th but was not accompanied by an order. The lab reported that a charge nurse received a call from the lab on 5/5/255 at 8:58 (a.m.) and confirmed no order and due to instability of the specimen for the past 24 hours, the urine was not usable for a UA. The Urology appointment will be re-scheduled for May 23rd at 9:30 (a.m.). It was not true that there was no order. What happened was that the nurse at our facility did not fill out the paperwork that accompanied the specimen so the lab could not perform the analysis/culture. At this time, the LPN confirmed the FNP's preoperative orders were not carried out resulting in the cancellation of the resident's surgery on 5/9/25. On 5/9/25 at 9:40 a.m., in an interview, the surveyor discussed the finding with the Administrator, the Assistant Director of Nursing/Infection Preventionist(ADON/IP), the Area Director of Clinical Operation and Regional Director of Reimbursement. On 5/09/25 at 11:15 a.m., in an interview, the ADON/IP and the Area Director of Clinical Operation confirmed that the facility did not fill the lab paperwork out correctly and they cannot locate the lab paperwork and that is why the resident's surgery was cancelled for 5/9/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of facility policy, Neurological Review-Skilled, revised 7/8/21, states, .Following an unwitnessed fall .neurological parameters to be completed every 15 minutes x2, every 30 minutes x2, every 1 hours x2, and every 4 hours x2 or as per specific physician order .When assessing neurological status, vital signs must be included .Any changes .will be reported to the physician immediately . Resident #77 was recently admitted with diagnoses to include dementia and difficulty in walking. Review of Resident #77's clinical record revealed he/she sustained an unwitnessed fall on 4/12/25 and 4/19/25. A nursing progress note, dated 4/12/25 states, CNA [Certified Nursing Assistant] called this nurse to room res [resident] was sitting on the right side of bed in the floor with back against the bed .res stated she was trying to get up to get to the rest room . A nursing progress note, dated 4/19/25, states, Fall: CNA notified this writer that the resident is on the floor. This writer found the resident on the floor in the hallway . Further review of the electronic medical record (EMR) and paper chart lacked evidence of neurological monitoring and vital sign monitoring. On 5/8/25 at 9:47 a.m., during an interview, Licensed Practical Nurse (LPN) #1 stated when a resident has an unwitnessed fall, neurological checks and vital signs are started. On 5/8/25 at 10:45 a.m., during an interview, the Director of Nursing (DON) stated after a resident falls, the nurse documents in Risk Management in the EMR, and neurological checks are documented in the resident's paper chart or a progress note. On 5/8/25 at 12:30 p.m. during a follow up interview, the DON stated the Area Director for Clinical Operations informed her that a neurological checklist was implemented in the EMR. At this time, the DON reviewed Resident #77's entire clinical record and confirmed it lacked evidence that neurological monitoring was completed and documented for the above unwitnessed falls.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on water temperature observations, water temperature log reviews, interviews, and review of facility's Water Temps[temperatures] policy the facility failed to identify hazards in a resident's environment and implement interventions to prevent potential accidents/injuries by ensuring that hot water temperatures, accessible to residents did not exceed 120 degrees Fahrenheit on 3 of 4 units ([NAME], [NAME] and [NAME]) for 1 of 5 days of survey (5/5/25). The failure of the facility to ensure that hot water temperatures accessible to residents did not exceed 120 degrees Fahrenheit created the potential for residents to be scalded/burned by the domestic hot water. This created an Immediate Jeopardy (IJ) situation for residents. In addition, the facility failed to provide supervision, a protective apron, and ensure safety for 1 of 1 residents reviewed for smoking (Resident #45). Findings: 1. On 5/5/25 at 10:50 a.m., a surveyor identfied that hot water in Resident room [ROOM NUMBER] was too hot to the touch, and additional hot water temperatures of other resident rooms on all units were taken: [NAME] Unit: At 10:52 a.m., the hot water temperature in Resident room [ROOM NUMBER]'s sink was 129.5 degrees Fahrenheit(F). At 10:55 a.m., the hot water temperature in Resident room [ROOM NUMBER]'s sink was 131.1 degrees (F). At 10:57 a.m., the hot water temperature in Resident room [ROOM NUMBER]'s sink was 123.9 degrees (F). At 10:59 a.m., the hot water temperature in Resident room [ROOM NUMBER]'s sink was 125.9 degrees (F). [NAME] Unit: At 11:15 a.m., the hot water temperature in Resident room [ROOM NUMBER]'s sink was 121.9 degrees (F). At 11:22 a.m., the hot water temperature in Resident room [ROOM NUMBER]'s sink was 127.0 degrees (F). At 11:33 a.m., the hot water temperature in Resident room [ROOM NUMBER]'s sink was 123.9 degrees (F). [NAME] Unit: At 11:05 a.m., the hot water temperature in Resident room [ROOM NUMBER]'s sink was 122.5 degrees (F). At 11:08 a.m., the hot water temperature in Resident room [ROOM NUMBER]'s sink was 123.1 degrees (F). At 11:10 a.m., the hot water temperature in Resident room [ROOM NUMBER]'s sink was 122.1 degrees (F). [NAME] Unit: On 5/5/25, a surveyor took hot water temperatures on the units again and found the following: At 3:42 p.m., the hot water temperature in Resident room [ROOM NUMBER]'s sink was 127.2 degrees (F). At 3:46 p.m., the hot water temperature in Resident room [ROOM NUMBER]'s sink was 128.4 degrees (F). At 3:49 p.m., the hot water temperature in Resident room [ROOM NUMBER]'s sink was 121.2 degrees (F). Gallway Unit: At 3:34 p.m., the hot water temperature in Resident room [ROOM NUMBER]'s sink was 121.2 degrees (F) (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	All three of the above named units have residents who are able to ambulate and could potentially assess sinks with the noted hot water temperatures without staff assistance. On 5/5/25 at 11:33 a.m. in an interview with a surveyor, CNA6 said, regarding water temperatures, burnt me this a.m. (morning), the surveyor asked, you burned yourself?, CNA6 said, No, but I was like, it's too hot. She stated it's usually hotter early in the morning after breakfast time. She did not make anyone aware of the hot temperatures. On 5/5/25 at 11:40 a.m., in an interview with the Administrator, the surveyor asked if there were any hot water issues in the facility. The Administrator stated that there were no issues she knew about. The surveyor informed the Administrator of the hot water temperatures taken by the surveyors in the resident rooms above 120 degrees. The Administrator stated that she was not aware of the hot water being above 120 degrees F. At this time, the Administrator confirmed the findings and stated a call would be made to get a mechanical contractor into the facility to fix the problem. On 5/5/25 at 1:00 p.m., in an interview, the Director of Plant Operations stated that he had only been at the facility for a month and that he has never calibrated his digital thermometer or documented any resident room hot water temperatures. The surveyor requested and received the last documented hot water temperatures for resident rooms/areas and the documentation showed December 2024 as the last time hot water temperatures were monitored and documented. He stated that he has taken temperatures approximately once a week in the last month but does not document them. He stated that there is a mixing valve and he does not adjust it. He gave the surveyors a form from Direct Supply that states what the hot water temperatures are supposed to be and to monitor them and log them. At this time, the Director of Plant Operations confirmed that the facility is not monitoring, documenting them and adjusting the resident area hot water to ensure they stay below 120 degrees F. On 5/5/25 at 2:20 p.m., a mechanical services company arrived at the facility. The contractor worked on the facility hot water system and told the facility the hot water mixing valve was set too high, they adjusted the temperature and was corrected. The mechanical services company stated they had taken hot water temperatures throughout the facility and all were below 120 degrees F. The work was signed off and accepted by the facility. On 5/5/25 at 4:20 p.m., two surveyors met with the Regional Director of Operations and the Administrator to confirm that the [NAME] and [NAME] units still had resident areas that were above 120 degrees Fahrenheit and still an accident hazard concern. The Administrator confirmed the findings and stated that the mechanical services company would come back to fix it. On 5/5/25 at 4:50 p.m., in an interview, the Director of Plant Operations stated and confirmed that he had not taken hot water temperatures after he was told by the mechanical services company the hot water had been fixed and adjusted below 120 degrees F. On 5/5/25 at approximately 5:38 p.m., the mechanical services company returned to the facility and found that the hot water mixing valve was broken and causing huge fluctuations in the hot water temperatures to the resident areas. The mechanical services company completed additional work on the hot water system and additional testing of water temperatures found them to be in acceptable ranges (below 120 degrees F). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility's Water Temps[temperatures] policy was reviewed. The policy indicated the following: Test water temperatures: 1. Ensure patient room water temperatures are 120 degrees Fahrenheit (or as specified by state requirements). 3. Check resident rooms at the end of each wing on a rotating basis. Record results in the water temperature log: 1. Note any discrepancies. 2. Adjust water heater settings as required. 3. Retest as necessary The immediate jeopardy began on 5/5/25 when the facility failed to identify hazards in a resident environment and implement interventions to prevent injury including the risk of scalding and burning. The Administrator was notified of the immediate jeopardy at 2:45 p.m. on 5/5/25. Please See F-000 Initial Comments related to the IJ removal plan. 2. On 5/5/25 at 10:21 a.m., a surveyor observed an unsecured container of PDI Sani-Cloth Bleach Germicidal Disposable Wipes in resident room [ROOM NUMBER]. At this time, after surveyor intervention, the Facility Administrator removed the chemical from the room, confirming the chemicals should not be available for resident use. The Safety Data Sheet for PDI Sani-Cloth Bleach Germicidal Disposable Wipes states in Section 4: First Aid Measures Eye: Rinse thoroughly with water. Get medical attention if irritation occurs and persists . Skin: No first aid should be required. Wash skin with water. Get medical attention if irritation develops or persists . Inhalation: Not a normal route of exposure. If symptoms develop move victim to fresh air. Get medical attention if symptoms develop . Ingestion: Ingestion is unlikely for solid products. No first aid is required for small amounts transferred from hands to mouth. On 5/5/25 at 10:21, the above information was discussed with the Facility Administrator. 3. Record review of Resident #45's clinical record showed smoking assessments were completed on 11/21/24 and 3/6/25 and indicated he/she requires supervision when smoking. On 5/7/25 at 2:10 p.m., during an interview with a surveyor, Certified Nursing Assistant- Medication Technician #1 (CNA-M) who stated Resident #45 usually goes out on his/her own to smoke. On 5/7/25 at 2:14 p.m., during an interview, Licensed Practical Nurse #1 (LPN) stated that Resident #45 smokes a couple times a day and he/she typically goes out on his/her own, but the LPN will occasionally go out with the resident as he/she has a hard time getting back to the facility entrance on his/her own. On 5/7/25 at 2:52 p.m., during an interview a surveyor, Resident #45 stated they typically smoke in the morning, and he/she will go outside on his/her own. On 5/7/25 at 12:07 p.m., during an interview with the Area Manager of Clinical Reimbursement the above information was discussed. On 5/8/25 at 9:26 a.m. a surveyor observed Resident #45 outside, at the end of [NAME] unit, sitting in wheelchair, smoking. He/she had on a t-shirt. LPN3 is observed standing near Resident #45. Resident #45 was not wearing a protective apron for safety. Resident #45s assessment for safety stated he/she needs a smoking apron, needs supervision with smoking. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 5/8/25 at 9:35 a.m. in an interview with a surveyor, LPN3 stated she took Resident #45 outside to smoke this morning, she stated that she did not encourage him/her to wear a protective apron while he/she was smoking and was not aware that he/she was assessed to need a protective apron while smoking for safety. The surveyor confirmed the accident hazard at this time.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, record reviews, and interviews, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to respiratory care for 2 of 2 residents reviewed for respiratory care. (Resident #23 and #78) Findings: 1. On 5/5/25 at 9:03 a.m., 5/6/25 at 2:10 p.m., and on 5/7/25 at 12:45 p.m., a surveyor observed Resident #23's unbagged nebulizer mask and tubing on the bedside table. Review of Resident #23's clinical record indicated a physician order for Albuterol Sulfate Inhalation Nebulization Solution (2.5 MG/3ML) 0.083%, with instructions to give 1 dose three times a day for cough, which was discontinued on 4/23/25. Further review shows an active physician order for Albuterol Sulfate Inhalation Nebulization Solution (2.5 MG/3ML) 0.083%, with instructions to give 1 dose every 4 hours as needed for cough. Review of the medication administration record/treatment administration record indicated that his/her last time using the nebulizer was on 4/23/35. On 5/8/25 at 2:25 p.m., during an interview with the Facility Administrator the above information was confirmed. 2. Review of Resident #78's clinical record reveals a physician order indicating that he/she has been using his/her Continuous Positive Airway Pressure (CPAP) machine since 3/13/25. Further review of his/her medical record lacked evidence of it being cleaned or maintained. On 5/8/25 at 12:00 p.m., during an interview with the Area Manager of Clinical Reimbursement, who discusses that they are unable to find documentation of the last time his/her CPAP was cleaned but are going to initiate an order and get it cleaned today 5/8/25.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews, and facility policy, the facility failed to ensure that a resident who requires dialysis receives such services, consistent with the professional standards of practice in the areas of monitoring a dialysis fistula and assessing and monitoring a resident before and after dialysis treatments for 1 of 1 resident receiving dialysis (#21). Finding: Review of facility policy, Dialysis-Access Site Management-Skilled, revised 6/30/22, states, The staff must assess and note placement of the resident's access site on their eMAR [electronic Medication Administration Record] or eTAR [electronic Treatment Administration Record] and care plan .Licensed staff is to note every shift for any sign/symptom of infection .at the access site and document findings .Every shift on the access arm licensed staff will note color and temperature of fingers, and presence of radial pulse .If an AV fistula or graft is present, the licensed staff will palpate the site to feel the 'thrill' or use a stethoscope to hear the . 'bruit' of blood flow through the access. Document all findings in the Progress notes . or Dialysis form . Review of facility policy, Dialysis-Communication, Documentation, Management-Skilled, revised 8/5/24, states, Management of the resident receiving hemodialysis will include assessment of the resident's condition and monitoring for complications before and after dialysis treatments .Prior to sending the resident to treatment the staff will complete the 'Pre-Dialysis' . form, print and send with the resident . On the resident's return from their dialysis treatment, the staff nurse will complete the 'Post Dialysis' portion of the dialysis form . Resident #21 was recently admitted with diagnoses to include End-Stage Renal Disease (ESRD), dependence on Hemodialysis, and arteriovenous (AV) fistula of right arm. Review of admission Minimum Data Set (MDS), dated [DATE], revealed Resident #21 had a Brief Interview for Mental Status (BIMS) of 15 out of 15, indicating he/she is cognitively intact. Review of Resident #21's care plan, last revised on 4/26/25, revealed, Focus .needs dialysis r/t chronic renal disease . Resident receives dialysis M-W-F [Monday, Wednesday, Friday] .Monitor for Thrill and Bruit each shift. Notify physician/dialysis if absent or significant change .Monitor/document/report PRN [as needed] any s/sx [signs/symptoms] of infection to access site . Review of Resident #21's March 2025 and April 2025 MAR/TAR lacked evidence of monitoring his/her dialysis access site. Further review of Resident #21's clinical record lacked evidence of assessment of the access arm, monitoring for complications before and after dialysis, and completion of the Pre- and Post-Dialysis Review. On 5/6/25 at 11:22 a.m., during an interview, Resident #21 stated he/she has been receiving dialysis for 8 years via his/her right upper arm fistula and that the nurses here do not check his/her fistula and do not usually check on him/her after he/she returns from dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/8/25 at 9:50 a.m., during an interview, Licensed Practical Nurse (LPN) #1, stated when a resident returns from dialysis, they get a meal and their regular medications and the nurse does not do an assessment or vital signs unless medications require vital signs. On 5/8/25 at 10:45 a.m., during an interview, the Director of Nursing (DON) stated the nurse does not assess or monitor the resident after dialysis. At this time, the DON reviewed the above policies and stated nursing has not been doing the pre-dialysis assessment or the post-dialysis assessment and reviewed Resident #21's entire clinical record and confirmed that the clinical record lacked evidence that the fistula and access arm was being monitored and lacked evidence that a Pre- and Post- Dialysis assessment is being done.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on performance evaluation reviews and interview, the facility failed to complete annual performance evaluations at least every 12 months for 5 of 5 sampled employees (Certified Nursing Assistant #1 [CNA1], CNA2, CNA3, CNA4, CNA5). Findings: 1. CNA1 was hired on 12/1/2023. The facility was unable to provide evidence of a completed annual performance evaluation for 2024. 2. CNA2 was hired on 12/1/2023. The facility was unable to provide evidence of a completed annual performance evaluation for 2024. 3. CNA3 was hired on 12/1/2023. The facility was unable to provide evidence of a completed annual performance evaluation for 2024. 4. CNA4 was hired on 12/1/2023. The facility was unable to provide evidence of a completed annual performance evaluation for 2024. 5. CNA5 was hired on 12/1/2023. The facility was unable to provide evidence of a completed annual performance evaluation for 2024. On 5/9/2025 at 12:24 p.m., in an interview with the surveyor, the Administrator and Regional Director of Operations stated that when the previous administration sold the company, all employee records were taken. All employees became new with the company on 12/1/2023. All employees were due to have performance reviews completed in January to April, 2025, for 2024. The surveyor confirmed none had been completed at this time.

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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** 2. On 5/9/25 at 11:30 a.m., in an observation and interview with the Director of Nursing (DON), a surveyor and the DON observed, on the [NAME] Unit, in the medication storage room, significant ice buildup in the dormitory style refrigerator (small combination refrigerator/freezer unit that is outfitted with one exterior door) which is inappropriate for storing medications due to temperature fluctuations. The refrigerator contained several medications. Based on observations, interviews and review of facility Resident Self-Administration of Medication - Skilled policy/procedure, the facility failed to ensure medications were stored properly and that the facility failed to obtain physician orders and complete a safety assessment for a medication observed located at a resident's bedside, for 1 of 1 sampled resident (Resident #24). The facility failed to ensure medications were stored properly in a refrigerator for 1 of 3 medication storage refrigerators ([NAME] Unit). Findings: The facility's Resident Self-Administration of Medication - Skilled policy/procedure, reviewed 4/9/24, noted: Policy: If a resident requests to self-administer their medications, it is the responsibility of the community to determine that it is safe for the resident to do so before the resident may exercise that right. Procedure: 2. The Self-Administration Review . shall be completed in the EHR[Electronic Health Record] by a licensed nurse. 3. The licensed nurse will notify the resident's physician of the resident request and the results of the Self-Administration Review. 4. An order must be obtained from the physician either granting or denying the resident request 5. If the physician allows the resident to self-administer, the order must include which medications that the resident may administer. 6. The community must provide the resident a receptacle that can store all the medications that will be self-administered. 7. The receptacle must have a lock with only the resident having possession of the key, combination, etc. 1. On 5/6/25 at 10:20 a.m., a surveyor observed in Resident 24's room, a bottle of extra strength Tylenol capsules, 500 milligrams (mg), sitting on the resident's bedside table. Resident 24 stated that he/she keeps the medication in his/her room and takes it when he/she needs it. On 5/6/25 at 10:25 a.m., in an interview, a Licensed Practical Nurse (LPN) confirmed that the resident had the Tylenol medication on his/her bedside table by his/her bed and that there was no doctor's order to self-administer medications and that the facility did not have a safety assessment completed by an interdisciplinary team (IDT) for the resident to self-administer medications. The LPN removed the medication from the resident's room. On 5/7/25, a review of Resident 24's medical record lacked evidence that a safety assessment to self-administer medications was completed by an IDT team, or evidence of a doctor's order to self-administer medications.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and review of the facility's Dish Machine Temperature Monitoring policy/procedure, the facility's Refrigerator and Freezer Monitoring Standard policy/procedure and the facility's Food Preparation -Food Storage policy/procedure, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for the ice machine, ceiling tiles, ceiling vents, fans, walls and floors; failed to ensure kitchen staff with facial hair wore facial protection; failed to ensure foods were dated in the reach in refrigerator; and failed to ensure the ice machine was properly installed to prevent backflow as required by the Maine State Plumbing Code requirements to prevent food contamination for 1 of 1 kitchen tour. (4/28/25) Findings: The facility's Dish Machine Temperature Monitoring policy/procedure last reviewed 8/23/2018 noted: Policy: Dish machine should be monitored at each meal to ensure proper washing, rinsing and sanitizing. Procedure: 2. At each meal the temperature of the wash and rinse cycle are to be recorded on the dish machine temperature log for the high temperature machine. 5. Any variation from acceptable temperature or sanitizing range will be reported to the supervisor for corrective action. The facility's Food Preparation -Food Storage policy/procedure last reviewed 8/20/2018 noted: Policy: food items should be stored following good sanitary practices and local codes and manufacturers specifications. Procedure: 1. All products should be dated upon receipt and upon use when the entire amount of the product is not prepared. Where required by state regulations, use by dates are put on the products. Leftovers should be dated according to the leftovers policy. 2. Tightly wrap, label, and date all food items. The facility's Refrigerator and Freezer Monitoring Standard policy/procedure last reviewed 8/30/2018 noted: Standard: refrigerators and freezers should be monitored twice daily and temperatures recorded on temperature logs. All refrigerators and common areas should be monitored. Procedure: 3. Temperatures are to be recorded once in the morning and once in the evening by writing the temperature on the temperature log. 4. Whenever the temperatures are out of range or nearing out of range, the department head and property manager will be notified to take corrective action. Any malfunctions need to be communicated to the supervisor immediately. This direct connection of wastewater and potable water was in violation of the 10-114 State of Maine Rules Chapter 226, definition Section A, which defines an Air-Gap Separation - A physical separation between the free-flowing discharge end of a potable water supply pipeline and an open or non-pressure receiving vessel. An air-gap separation shall be at least twice the diameter of the supply pipe measured vertically above the overflow rim of the vessel - in no case less than one-inch (2.54 cm) and the Code of Federal Regulation, Title 21, Part 1250, Section 1250, 30 (d) states all plumbing shall be so designed, installed, and maintained as to prevent contamination of the water supply, food, and food utensils. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/5/25 from 9:15 a.m. to 9:55 a.m., an initial kitchen tour was completed with the Food Service Director in which the following findings were observed: -There were two kitchen workers with facial hair that were observed not wearing facial hair protectors. -There were six ceiling tiles throughout the kitchen with brown stains on them. -The fan sitting on a wall in the dish room was dusty/dirty. -There were seven ceiling vents that were dusty/dirty and two of the seven had excessive amounts of rust on them as well. -There were 16 ceiling tiles, around ceiling vents, that had large amounts of dust build up on them. -The wall over the reach-in freezer and reach-in refrigerator was heavily soiled with dust. -The dry storage room floor had chipped/missing paint. Additionally, there was trash and debris on the floor around the entire room and under shelving. -The reach-in refrigerator had a 16-ounce package of whipped topping with no thaw date. Manufacturer's instructions on the package state that it is only good for 14 days after thawing. -The ice machine was observed to not have an air gap. On 5/5/25 at 9:55 a.m., in an interview, the Food Service Director confirmed the findings. On 5/6/25 at 2:40 p.m., a surveyor reviewed the kitchen dish washer and refrigerator/freezer temp logs and found missing and/or low temps for dish washer rinse sanitizing monitoring/documenting temps and missing monitoring/documentation for refrigerator/freezer. For January, February, March, April and May 2025. Dish Washer Temperature dates missing and/or low for 2025: January: Missing - 4, 5, 11, 12, 18, 19, 20, 25, 26, and 28. Rinse under 180 degrees Fahrenheit(F.) - 1-31 February: Missing - 1, 2, 8-10, 15, 16, 21-23, and 28. Rinse under 180 degrees F. - 1-31 March: Missing - 1, 2, 7-9, 15, 16, 22, 23, 29 and 30. Rinse under 180 degrees F. - 1-31 April: Missing - 4-9, 18, 19, 25, 26, 29 and 30. Rinse under 180 degrees F. - 1-30 Refrigerator/Freezer Temperature dates missing for 2025: January: Kitchen refrigerator - No documentation Milk refrigerator - 4, 5, 11, 12, 17-20, 24-26, 28 and 31. Prep refrigerator - 8, 12, 16, 19, 20, 21, 23, 26 and 27. Always available refrigerator - 9, 10, 12, 15, 19 20, 21-23, 25 and 26. Kitchen Freezer - No documentation. Unit Refrigerator/Freezer Belfast - No documentation. [NAME] -. No documentation. [NAME] - No documentation. [NAME] - No documentation. February: Kitchen refrigerator - 1, 2, 4, 6-10, 13-16, 21-23, and 28. Milk refrigerator - 1, 6, 9, 10, 13, and 20. Prep refrigerator - 1, 6, 9, 10, 13, and 20. Always available refrigerator - No documentation. Kitchen Freezer - 6, 8, 9, 13, 17, and 20. Unit Refrigerator/Freezer Belfast - 1-4, 8-10, 14-16, 18, 21-23, and 28. [NAME] - 1-3, 6, 8-10, 14-16, 21-24, and 28. [NAME] - 1-3, 8-10, 14-16, 21-24, and 28. [NAME] - 1-3, 4, 7-9, 14-16, 21-23, and 28. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205063	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clover Health Care	440 Minot Ave Auburn, ME 04210

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	March: Kitchen refrigerator - No documentation. Milk refrigerator - 1, 2, 7-9, 14-16, 21-24, 29 and 30. Prep refrigerator - No documentation. Always available refrigerator - No documentation. Kitchen Freezer - No documentation. Unit Refrigerator/Freezer Belfast - 1, 8, 21, 22, 24, and 28-30. [NAME] - 1, 7, 8, 14, 15, 21-23, 25, 28 and 29. [NAME] - No documentation. [NAME] - No documentation. April: Kitchen refrigerator - No documentation Kitchen Freezer - 20, and 26-31. Milk refrigerator - No documentation. Snack refrigerator - 4-12, 19, 25, 26, 29, and 30. Always available refrigerator - 29 and 30. Unit Refrigerator/Freezer Belfast - 18, 19, 25-28, and 30. [NAME] - 25-29. [NAME] - No documentation. [NAME] - No documentation. On 5/6/25 at 3:00 p.m., the FSD confirmed the findings of missing dates for monitoring of temperatures for the dish washer and refrigerators/freezers. The FSD also confirmed Rinse Temperatures of breakfast dishes for January, February, March, April 2025 were too low to sanitize adequately. There was no widespread outbreak of illness during those months.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation and interview, the facility failed to maintain a garbage storage area and in a sanitary condition to prevent the harborage and feeding of pests for one trash dumpster and for an area outside the back kitchen door for 1 of 5 days of survey (5/5/25). Findings: On 5/5/25 at 9:15 a.m., a surveyor and the Food Service Director(FSD) observed food and trash to be on the ground outside the back kitchen door and observed one of two dumpsters with a right-side slide door open exposing trash. Additionally, there was trash on the ground around the open dumpster. On 5/5/25 at 9:15 a.m., in an interview, the FSD confirmed the findings.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, the facility failed to ensure that clinical records were complete and contained accurate information for 1 of 3 residents reviewed for activities of daily living care. (Resident #67) Findings: Review of Resident #67's medical record lacked evidence of completed documentation for: -Missing documentation of ADL Bathing/Showering for day shift on 4/4/25, 4/8/25, and 4/10/25. Missing documentation for night shift on 4/2/25, 4/10/25, 4/12/25, 4/14/25, 4/19/25, and 4/30/25. -Missing documentation of B&B-Elimination, Urinary for day shift on 4/4/25, 4/10/25, 4/16/25, and 4/25/25. Missing documentation for night shift on 4/2/25, 4/10/25, 4/12/25, 4/14/25, 4/19/25, and 4/30/25. -Missing documentation of Oral Hygiene for day shift on 4/4/25, 4/8/25, 4/10/25, 4/16/25, and 4/25/25. Missing documentation for night shift on 4/2/25, 4/10/25, 4/12/25, 4/14/25, 4/19/25, and 4/30/25. -Missing documentation of Toileting Hygiene for day shift on 4/4/25, 4/8/25, 4/10/25, 4/16/25, and 4/25/25. Missing documentation for night shift on 4/2/25, 4/10/25, 4/12/25, 4/14/25, 4/19/25, and 4/30/25. -Missing documentation of B&B Scheduled Toileting Program for day shift on 4/16/25, 4/23/25, and 4/26/25. Missing documentation for night shift on 4/20/25, 4/23/25, 4/24/25, 4/25/25, 4/26/25, and 4/29/25. -Missing documentation of Elimination, Bowel for day shift on 4/10/25, 4/16/25, 4/23/25, and 4/25/25. Missing documentation for night shift on 4/10/25, 4/12/25, 4/14/25, 4/19/25 and 4/30/25. -Missing documentation for Eating for day shift on 4/2/25, 4/10/25, 4/16/25, 4/23/25, 4/25/25, 4/26/25, and 5/5/25. On 5/7/25 at 9:00 a.m., the above information was discussed with the Facility Administrator.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on record review and interview, the facility's Quality Assurance Committee failed to ensure that the Plan of Correction for identified deficiencies from the Annual Long Term Care Survey Process for Federal Recertification, dated 5/9/25, were effective. The Federal citations F684 and F812 were cited again during the re-visit for the Annual Long Term Care Recertification Survey, completed 6/30/25. Finding: During the follow-up survey on 6/30/25, it was determined that F684 and F812 would be re-cited for the same reasons: F684 for failure to adequately assess and monitor a resident after an unwitnessed fall and F812 for failure to ensure the kitchen was maintained in a clean and sanitary manner and ensure foods were labeled and dated. (see F684 and F812) On 6/30/25 at 4:55 p.m., the above was discussed during the exit conference with the Executive Director and interim Director of Nursing.

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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 observation, and interview, the facility failed to maintain an Infection Control Program designed to help prevent the development and spread of infection related to Enhanced Barrier Precautions (EBP) for 1 of 1 sampled resident reviewed for intravenous medication administration (Resident #206). Finding: A review of the sign posted on resident #206's room indicated the following: Before entering the resident's room, a sign posted outside resident #206's room indicated that the Resident was on EBP. The sign indicated that staff were required to wear personal protective equipment (PPE), a gown, gloves and a face mask/eye protection when providing care. On 5/6/25 at 1:54 p.m. a surveyor observed an intravenous medication administration for Resident #206 with the Registered Nurse #1 (RN1), Belfast Unit. The RN1, Belfast Unit was wearing PPE's. The resident requested pillows placed under his/her right foot and leg. The RN1, Belfast Unit placed a pillow under his/her foot, and then removed her PPE to leave the room for a clean pillow case for a second pillow for R206's right thigh. When she returned, she put a new pillow case on the pillow and proceeded to place the pillow under R206's right thigh, lifting the thigh with both of her hands. The treatment nurse was not wearing a gown, gloves or mask when providing high contact care to R206. On 5/6/25 at approximately 2:15 p.m. in an interview, a surveyor confirmed with the RN1, Belfast Unit that he/she handled R206's upper right leg, and positioned the leg without wearing proper PPE. She did not have a gown, gloves, or face mask on while providing high contact care to R206 with whom is on EBP.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. Based on record reviews and interview, the facility failed to ensure staff received mandatory training on it's Quality Assurance and Performance Improvement Program (QAPI), which included the staff's role and communication with the program, for 5 of 5 employee files reviewed (Certified Nurse Assistant #1 [CNA1], CNA2, CNA3, CNA4, CNA5). Findings: Review of the facility's Quality Assurance/Assessment and Performance Improvement Plan policy, undated, stated Education: All staff, including contracted staff are educated on the principles of QAPI. QAPI is included in the orientation of new employees and in the annual education that all staff are required to attend. Staff will be trained in using QAPI principles, identifying areas for improvement, and how they can be involved in the QAPI process including participation on a PIP (performance improvement project) team. The QAPI program is sustained during transitions in leadership and staffing through all-staff education and involvement in the QAPI process. A review of employee education files lacked evidence that CNA1, CNA2, CNA3, CNA4, and CNA5, received mandatory training regarding the facility's QAPI program. On 5/9/24 at 11:30 a.m., in an interview with a surveyor, the Administrator and the Regional Director of Operations confirmed the finding.