STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205070	A. Building B. Wing	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Point Center	67 Pine Point Rd Scarborough, ME 04074

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to clarify hospital discharge orders and provide a brand name medication for a resident for 1 of 3 residents reviewed for medications. Findings:During a medical record review, Resident #3's hospital Discharge summary, dated [DATE], Medications to continue, levothyroxine 112 mcg(microgram) tabs- take 112 mcg by mouth. Commonly known as: Synthroid, PATIENT TAKES BRAND NAME. Discharge Summary also included TSH level was 1.48 (5/9/23) (last known level).Medication Administration Record (MAR) for January, indicated Levothyroxine Sodium tab, 112 mcg. Start Date 1/21/26. End date 1/31/26.On 5/27/26 at 12:16 p.m., during an interview with the family, stated, Our family communicated repeatedly since admission that [Resident #3] cannot tolerate generic levothyroxine. Family indicated that the resident's husband has delivered brand-name Synthroid directly from home to the facility for this reason.Medication Administration Record (MAR) for February and March indicated Synthroid Oral Tablet, 112 mcg (Levothyroxine Sodium), give 1 tablet by mouth one time a day for low thyroid hormone may use home supply until arrives from pharmacy.Pharmacy Shipping Manifest indicated Levothyroxine 112 mcg was delivered to facility on 1/20/26, 2/1/26, 2/11/26, and 3/17/26.Lab Report, dated 5/12/26, indicated TSH levels 26.6 (ref range0.270-4.200). At this time, physician documented and ordered name brand Synthroid.The medical record lacked evidence the facility clarified Discharge Summary orders that indicted Patient takes Brand Name for Synthroid for approximately three months.

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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on record reviews and interviews, the facility failed to follow up on laboratory orders when there were no results for a lab ordered for 1 of 3 residents whose record was reviewed for thyroid treatment (Resident #3).Findings:1. Resident #3's medical record indicated an order for Comprehensive Metabolic Panel (CMP), Complete Blood Count with Diff (CBC with diff), and Thyroid Stimulating Hormone, (TSH), dated 3/10/26. The lab results included CMP and CBC with diff, however, lacked evidence of TSH.2. Resident #3's medical record indicated an order for Comprehensive Metabolic Panel (CMP), Complete Blood Count without Diff (CBC w/o diff),and Thyroid Stimulating Hormone, (TSH), dated 4/5/26. The lab results included CMP and CBC with diff, however, lacked evidence of TSH.On 6/2/26 at 1:36 p.m., during an interview with two surveyors, the Marketing Clinical Director stated labs were drawn in March and April however, the lab did not process them for TSH even though it was requested. At this time, she confirmed there was no follow-up to the provider regarding the TSH labs to be redrawn.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, record review and interviews, the facility failed to ensure that clinical records were complete and contained accurate information for 1 of 3 residents reviewed for falls (Resident #3) and 3 of 3 residents reviewed for Medication Administration Records (MAR) and Treatment Administration Records (TAR) (Resident #1, #3, and #4). Findings: Facility Policy titled Falls Management states; Any patient who sustains a injury to the head from a fall and/or has a fall unwitnessed by staff will be observed for neurological abnormalities by preforming neurological checks, per facility policy. Facility Policy titled Neurological Evaluations states; Neurological evaluations will be performed: Every 15 minutes x two hours, then every 30 minutes x two hours, then every 60 minutes x four hours, then every 8 hours until at least 72 hours has elapsed. 1. On 6/2/26 a review of Resident #3's clinical record showed he/she sustained an unwitnessed fall on 4/19/26. Further review of the record showed a telehealth visit on 4/19/26 at 1:00 a.m., in which the provider wrote staff are to Monitor per facility protocol with neuros as it was unwitnessed. A review of Resident #3's Neurological Evaluation Flow Sheet showed 4 missing neurological evaluations. On 6/2/26 at 1:30 p.m., during an interview with the Market Clinical Advisor, the above information was discussed. 2. On 6/2/26 a review of Resident #3's MAR/TAR for the month of May revealed; -A physician order dated 3/12/24 for Vital signs Short Term/Skilled pt [patient] q(every) shift x72 hours, then daily every evening shift. A review of the medical record lacked evidence that vital signs were completed on 5/5/26. - A physician order dated 4/24/26 for Wound Monitor: coccyx. Monitor site daily for status of surrounding tissue and wound pain. Monitor status of dressing, if applicable. every shift. A review of the medical record lacked evidence that wound monitoring was completed on 5/4/26, 5/5/26, and 5/6/26. - A physician order dated 4/24/26 for Wound Treatment: MASD (Moisture Associated Skin Damage)-coccyx. Cleanse with soap and water, apply orange cap (protect) BID (twice a day) and with any incontinence episode. A review of the medical record lacked evidence that wound treatments were completed on 5/4/26, 5/5/26, and 5/6/26. On 6/2/26 at 1:30 p.m., during an interview with the Market Clinical Advisor, the above information was discussed. 3. On 6/2/26 a review of Resident #1's MAR/TAR for the month of May revealed: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A physician order dated 3/19/26 to Apply tubigrip (Tubi grip) size F from base of toes to knee [NAME]. On in morning, off in the evening - may leave 24/7 (for) dressing securement and change on dressing days in the morning for Edema and remove per schedule. A review of the medical record lacked evidence that the Tubi grip was applied on 5/4/26. -A physician order dated 11/14/24 to Monitor Swallowing during med pass: Document Y/N in supplementary documentation Did the patient cough when swallowing medications? Did the patient complain of or demonstrate pain or difficulty when swallowing medications? every day and evening shift If new onset or worsening request Speech Therapy Screen and complete EInteract Change In Condition, if not new initiate applicable care plan Interventions and document interventions and effectiveness in progress notes. A review of the medical record lacked evidence that swallowing was monitored on 5/4/26. -A physician order dated 11/13/24 for Non-Pharmacological Intervention (s) document Qshift Record Non-Pharm intervention in Supplementary Documentation. Document Effectiveness. If having pain follow providers direction which may include pain medication. every shift. A review of the medical record lacked evidence that non-pharmacological interventions were done on 5/4/26. -A physician order dated 4/8/26 for Wound: Cleanse wound, pat dry, apply Aquacel Ag to all wound bases, cover with ABD (abdominal) pad, conform to secure. Wrap with Coflex zinc lite. one time a day every Mon, Wed, Fri. A review of the medical record lacked evidence that wound treatment was done on 5/4/26. On 6/2/26 at 3:40 p.m. in an interview with two surveyors the Market Clinical Advisor confirmed the above MAR omissions. 4. On 6/2/26 a review of Resident #4's MAR/TAR for the month of May revealed: -A physician order dated 8/28/25 to Apply Petroleum to Bilateral feet/toes BID (two times a day) every day and evening shift for skin integrity. A review of the medical record lacked evidence that petroleum was applied on 5/4/26, 5/11/26, 5/17/26, 5/25/26, and 5/26/26. -A physician order dated 2/16/26 to Ask resident if they are having pain. Document pain level and new onset Y/N in supplementary documentation and document location of pain in emar PN every shift If new onset complete EInteract Change In Condition and Pain Evaluation, if not new initiate non-pharmalogical Interventions and document interventions and effectiveness. A review of the medical record lacked evidence that the Resident was asked about their pain level on 5/17/26. -A physician order dated 5/8/26 to Check air mattress Qshift. Settings-therapy:static, comfort:5, medium, cycle time:25 mins every shift for monitoring. A review of the medical record lacked evidence that the air mattress was checked on 5/17/26. -A physician order dated 6/6/26 for Does the patient need to have the Head of Bed Elevated to Avoid Shortness of Breath while lying flat? every shift for SOB. A review of the medical record lacked evidence that the head of the bed was assessed if it was elevated on 5/17/26. -A physician order dated 11/26/25 for Fluid Restriction - Total: 2000mLs/24 hours Document Qshift amount in supplemental documentation every shift for CHF 1000mLs on day shift 600mLs on evening shift 400mls on night shift'. A review of the medical record lacked evidence that the fluid restriction (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was completed on 5/4/26, 5/5/26, 5/11/26, 5/17/26, 5/19/26. 5/25/26, 5/26/26, and 5/27/26. -A physician order dated 8/22/25 for May keep and apply own supply of generic TAO w/ pain relief. every shift. A review of the medical record lacked evidence that the order was acknowledged on 5/17/26. -A physician order dated 4/8/26 for Micatin Cream 2 % (Miconazole Nitrate) Apply to perineal, groin topically two times a day for rashes. A review of the medical record lacked evidence that Micatin cream was applied on 5/4/26, 5/11/26, 5/17/26, 5/18/26, and 5/25/26. -A physician order dated 3/16/26 to Monitor for side effects of antidepressant medication due to use of Duloxetine and Bupropion. every shift Enter Side Effect Code in supplemental documentation: N: None DM: dry mouth, V: blurred vision, CO: constipation, U: urinary retention, H: hypotension, A: appetite changes, HA: headache, I: insomnia, DP: dyspepsia, WC: weight changes. A review of the medical record lacked evidence that side effects were monitored on 5/17/26 and 5/18/26. -A physician order dated 4/6/26 to Monitor for side effects of antidepressant medication every shift Enter Side Effect Code in supplemental documentation: N: None DM: dry mouth, V: blurred vision, CO: constipation, U: urinary retention, H:hypotension, A: appetite changes, HA: headache, I: insomnia, DP: dyspepsia, WC: weight changes. A review of the medical record lacked evidence that side effects were monitored on 5/17/26. -A physician order dated 4/8/26 to Monitor R (right) elbow cellulitis, groin, perineal area Daily for status of surrounding tissue and wound pain. Monitor for status of dressing (s), if applicable Additional Documentation in NN if needed every shift. A review of the medical record lacked evidence that this was monitored on 5/4/26. -A physician order dated 4/6/26 to Monitor socially withdrawn behaviors Q Shift. Indicate the number of occurrences followed by the NPI #provided. If no behaviors, select not applicable every shift NPI:1 Music/TV 2 Redirect/divert 3 Call fam/RP to talk or visit w/ res 4 Toilet 5 1:1 talk 6 Reassure/orient 7 Assess pain/infec 8 Offer drink/snack 9 Quiet environment 10 Walk/wheel 11 activity /exercise 12 massage/back rub. A review of the medical record lacked evidence that the resident was monitored for social withdrawal on 5/4/26, 5/1/26, 5/17/26, 5/18/26, and 5/25/26. -A physician order dated 6/6/26 for order Non-Pharmacological Intervention (s) document Qshift Record Non-Pharm intervention in Supplementary Documentation. Document Effectiveness. If having pain follow providers direction which may include pain medication. every shift for pain. A review of the medical record lacked evidence that non-pharmacological interventions were documented on 5/4/26, 5/17/26, 5/18/26, and 5/25/26. -A physician order dated 1/8/26 for order Patient and family education heart failure management to include daily weight monitoring, symptom monitoring, medications, and diet (low sodium/fluid restriction if applicable) mark appropriate selection. every day and evening shift for CHF protocol Document response to education: (via supplemental documentation). A review of the medical record lacked evidence this education was done on 5/4/26, 5/17/26, and 5/18/26. -A physician order dated 6/24/25 for Vital Signs Short Term/Skilled Pt q shift x72 hrs then daily every day shift for skilled. A review of the medical record lacked evidence that vital signs were done on 5/18/26. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A physician order dated 5/11/26 for weigh one time a day every Mon. A review of the medical record lacked evidence that a weight was obtained on 5/11/26 and 5/18/26. -A physician order dated 5/15/26 for WOUND MONITOR: Right elbow, Left foot, 1st digit and left 2nd digit. Monitor daily for status of surrounding tissue and wound pain. Monitor for status of dressing, if applicable Additional Documentation in NN if needed every shift. A review of the medical record lacked evidence that the wound was monitored on 5/17/26, 5/18/26, 5/25/26, and 5/26/26. -A physician order dated 12/22/25 for WOUND MONITOR: Right leg, Left foot, 1st digit. Monitor daily for status of surrounding tissue and wound pain. Monitor for status of dressing, if applicable Additional Documentation in NN if needed every shift. A review of the medical record lacked evidence that the wound was monitored on 5/4/26. -A physician order dated 5/7/26 for WOUND TREATMENT: Diabetic - Left foot, 1st digit: Skin prep area daily. WOUND nurse will be in week of 5/18 to par callus and clean wound. every day shift. A review of the medical record lacked evidence that the wound was treated on 5/17/26, 5/18/26, 5/25/26, and 5/26/26. -A physician order dated 5/7/26 for WOUND TREATMENT: Skin tear - Left elbow: Skin prep daily until resolved. every day shift. A review of the medical record lacked evidence that the wound was treated on 5/11/26, 5/17/26, 5/18/26, 5/25/26, and 5/26/26. -A physician order dated 5/16/26 for Wound: left 2nd digit, cleanse with wound cleanser, apply medi honey and cover with opti foam one time a day. A review of the medical record lacked evidence that wound treatment was done on 5/17/26, 5/18/26, 5/25/26, and 5/26/26. -A physician order dated 3/19/26 to Wrap LLE (lower left leg) with Kerlix + Coban one time a day every 2 day(s) for edema. A review of the medical record lacked evidence that the leg was wrapped on 5/18/26 and 5/26/26. On 6/2/26 at 3:40 p.m. in an interview with two surveyors the Market Clinical Advisor confirmed the above MAR omissions.