STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205091	A. Building B. Wing	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Grove Center	27 Cool St Waterville, ME 04901

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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. 37440 Based on record reviews and interviews, the facility failed to ensure that the resident and/or resident representative were provided with written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advanced directive, was completed for 2 of 22 residents reviewed for advanced directives. (Residents #27, and #79) Findings: 1. Resident #27 was admitted to the facility in 10/2024. A review of the entire medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. On 3/19/25 at 11:56 a.m., in an interview, the Market Clinical Advisor confirmed that medical records lacked evidence that the facility offered or reviewed with the residents and/or resident representatives or that the residents and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. 51669 2. Resident #79 was admitted in February 2025. Social Services assessment, dated 2/14/25, states, . Resident Rights/Healthcare Decision Making/Advance Directives .Resident unable to hear or communicate with staff, trying to reach spouse Further review of the clinical record lacked evidence that the facility offered or reviewed with the resident and/or resident representative, or that the resident and/or resident representative were provided, written information concerning the right to formulate an advanced directive. On 3/18/25 at 9:02 a.m., during an interview, Resident #79 stated he/she is severely hard of hearing, even with hearing aids in, and cannot read well. On 3/19/25 at 11:32 a.m., during an interview, the finding was reviewed with the Market Clinical Advisor. (continued on next page)

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	On 3/19/25 at 12:47 p.m., during an interview, the Director of Social Services stated he might have spoken to Resident #79's spouse a couple weeks ago about formulating an advanced directive but did not document the conversation. Further review of Resident #79's clinical record lacked evidence of the conversation.

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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** 37440 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 3 of 3 units ([NAME] Unit, [NAME] Unit and [NAME] Unit) and the laundry room for 1 of 1 facility tour. Findings: On 3/20/25 from 11:00 a.m. to 11:30 a.m., a surveyor conducted an Environmental Tour with the Senior Maintenance Director, Administrator and the Maintenance Directo in which the following findings were observed: [NAME] Unit - Resident room [ROOM NUMBER] - The bathroom had urine around the base of the toilet and had a very strong odor of urine. - Resident room [ROOM NUMBER] - The sink countertop had chipped/missing laminate on the front edge. The sink overflow drain hole was broken open and rusty. The right side drawers under the sink were off-track and wouldn't close. The entire bathroom floor was dirty and dirty around the base of the toilet. The walls behind the head of the beds had paint that was chipped/gouged and missing, creating uncleanable surfaces. - Resident room [ROOM NUMBER] - There was a bed pan on the floor behind the toilet and a urine hat on top of glove box and both were unlabeled and unbagged. [NAME] Unit - Resident room [ROOM NUMBER] - The room wall, by the thermostat, had chipped/missing paint and was gouged exposing sheetrock which created an uncleanable surface. [NAME] Unit - The dining room walls had chipped/missing paint and were marred with black marks. - Resident room [ROOM NUMBER] - The baseboard heater had chipped/missing paint. The floor was dirty around the base of the toilet. There was dust and debris in the bathroom light lens. - Resident room [ROOM NUMBER] - The baseboard heater had chipped/missing paint and was broken apart with metal hanging down. - Resident room [ROOM NUMBER] - There was dust and debris in the bathroom light lens. The room baseboard heater had chipped/missing paint creating an uncleanable surface. There was an unlabeled urinal on the floor by the toilet and an unlabeled urinal on the toilet tank in the shared bathroom. There was a dirty plunger on the floor next to the toilet. - Resident room [ROOM NUMBER] - The room entrance door frame had chipped/missing paint. The baseboard heater had chipped/missing paint. The walls around the room had chipped/missing paint and had black marks on them. This created uncleanable surfaces. Laundry - There were 3 laundry carts with wheels that had untreated wooden bases creating uncleanable surfaces. - There was a cracked/broken 4-foot ceiling light lens. - There were 2 ceiling lights that were missing their 4-foot ceiling light lenses. On 03/20/25 at 11:30 a.m., in an interview, the Senior Maintenance Director, the Administrator and the Maintenance Director confirmed the findings.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on record review and interview, the facility failed to ensure that the State mental health authority for Pre-Admission Screening and Resident Review (PASRR) Level II was implemented for 1 of 6 sampled residents reviewed for PASRR (Resident #20, (R20). Findings: 1.Review of R20's PASRR Level II, dated 2/25/25, indicated R20 was approved for specialized services to include Initial psychiatric evaluation to determine diagnosis and develop plan of care. Review of R20's care plan, updated 2/16/25 states: Resident/Patient meets PASRR II Level of care with diagnosis of Bipolar and Anxiety: Serious Mental Illness: Resident/Patient will receive appropriate specialized services as indicated on PASRR Level II thru next review date. Resident will be offered/engage with behavioral health services. Resident will engage/ be offered counseling services to develop coping skills. Review of Resident #20's current orders, dated 3/2025 lacked evidence that an order was placed for Medi tele (psyche services). During an interview on 3/20/25 at 3:3:24 p.m., the [NAME] Unit Manger (JUM) reviewed R20's active orders and confirmed there was no order placed for psyche services, and R20 was not taking any psychotropic medicines. During an interview on 3/21/25 at 12:48 p.m., the Licensed Social Worker (LSW) states he has been working at the facility since November 2024 and recently realized his predecessor did not follow through with PASRR's. The LSW stated the Unit Manager(JUM) for Long Term Care does the referrals, and he uploaded her PASRRII on 3/4/25. The LSW stated he did not follow up with (JUM) to see if this was done. During an interview on 3/21/25 at 1:25 p.m., the Director of Nursing provided a surveyor with a progress note dated 3/20/25 stating This nurse approached the pt[patient] about Medi Tele services and educated the patient on the service. This nurse asked the pt[patient] if they would like to be seen by Medi Tele and receive services. The pt[patient] agreed and gave this nurse verbal consent to complete the referral form. The referral was completed and sent. DNS further stated, she could not find, and documentation indicated R20 was previously offered/refused Psyche Services.

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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** 42531 Based on record review, observations, interviews, and facility policy, the facility failed to implement a care plan for 3 of 4 sampled residents (Resident (R20, R21, and R66). Findings: Review of the Person-Centered Care Plan policy dated 10/24/22 states a comprehensive person-centered care plan must be developed for each patient and must describe the following: .any specialized services or specialized rehabilitative services the Center will provide as a result of PASRR recommendations Care plans will be: . Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments, and as needed to reflect the response to care and changing needs and goals . 1. During an interview on 3/18/25 at 7:53 a.m., R20 stated his/her dental bridge fell out a while ago and is still waiting for it to be replaced. At this time R20 opened his/her mouth and a surveyor observed multiple missing teeth and what appeared to be a broken bridge on the inside of his/her mouth. R20 stated his/her gums were really sore. Review of R20's Physician progress note dated 2/12/25 states We saw [R20] for an emergency apt concerning [his/her] missing bridge. [R20] wanted bridge recemented inside [his/her] mouth. Had to explain, the patient had teeth removed and thus the bridge no longer fits and will never fit. Referred pt[patient] to dentist to start partial denture process. Review of R20's care plan updated 2/25/25 lacked evidence that a care plan was established for dental. During an interview on 3/20/25 at 3:24 p.m., the [NAME] Unit Manger (JUM) reviewed and confirmed R20's care plan did not include goals and interventions in the area of dental. During an interview on 3/20/25 at 3:30 p.m., the above was discussed with the Director of Nursing (DON). 2. Review of R21's care plan updated 1/7/24 states Self administration of medication, saline nasal spray, seasonal allergies. Patient will correctly and safely: self-administer medication. Ensure availability/adequate supply of medication(s) for self administration. To Ensure patients ongoing functional and cognitive skills permit continued safe medication self-administration. Observe for indications of the patient skipping doses or refusing to take medication. During an interview on 3/20/25 at 12:09 p.m., JUM reviewed and confirmed R21's clinical record did not contain evidence he/she was assessed for use of duo neb or inhaler per care plan intervention. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of R66 Provider orders active for March 2025 revealed he/she was taking a diuretic medication: Lasix for congestive heart failure (CHF), opioid medication: Tramadol for pain, and anticoagulant medication: Clopidogrel Bisulfate for blood clot prevention, and has 3 stage II wounds on the left lower extremity (left lower leg). Review of R66's care plan updated 2/11/25 lacked evidence that goals and interventions were put into place for the use of diuretics, opioid, or anticoagulant use, and stage II pressure sores on the left lower extremity. During an interview on 3/20/25 at 3:20 p.m., JUM reviewed and confirmed R66's care plan did not reflect above concerns, stating I will update the care plan. The above was discussed with DON 3/20/25 at 3:28 p.m.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 51669 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 1 of 4 residents reviewed for care planning (Resident #41). Finding: Review of Resident #41's clinical record revealed a Minimum Data Set (MDS) Quarterly Assessment was completed on 1/6/25. Further review of the clinical record lacked evidence that an interdisciplinary team (IDT) meeting was held within 7 days following the assessment. During an interview on 3/24/25 at 8:37 a.m., the Director of Social Services confirmed Resident #41's last IDT meeting was held 11/13/24 and that Resident #41's clinical record lacked evidence that an IDT meeting was held within 7 days of the MDS Quarterly assessment.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 37440 Based on observations, interviews, and a review of Safety Data Sheets (SDS), the facility failed to ensure that the resident's environment was free of accident hazards relating to the storage of an unlabeled medicated cream and chemicals being properly secured for 2 of 2 observations for 1 of 4 days of survey. (3/18/25) Findings: The Safety Data Sheet for Clinical Silicone Cream noted the following: 4. First Aid Measures: Eye Contact: Flush eyes with large amounts of water for at least 15 minutes. Remove contact lenses, if worn. If irritation, seek medical attention. Skin Contact: If irritation develops, wash area with water. Get medical attention if irritation persists. Inhalation: Remove victim to fresh air and keep at rest in a position comfortable for breathing. Seek medical attention if discomfort continues or if you feel unwell. Ingestion: Never give anything by mouth to an unconscious person. Consult a physician if necessary. The Safety Data Sheet for FunkAway Beads Odor Eliminator noted the following: 4. First Aid Measures: Eye Contact: Rinse cautiously with water for several minutes. Remove contact lenses, if present and easy to do. Continue rinsing. If eye irritation persists, get medical advice/attention. Skin Contact: Wash skin with plenty of water. Inhalation: Remove person to fresh air and keep comfortable for breathing. Ingestion: If swallowed, rinse mouth with water(only if the person is conscious). Do not induce vomiting. Obtain emergency medical attention. . On 3/18/25 at 9:19 a.m., a surveyor observed of room [ROOM NUMBER] ([NAME] Unit) an unlabeled medicated cream and a chemical sitting on a small table in the shared bathroom between resident rooms [ROOM NUMBERS]. One was a 12-ounce container of FunkAway Odor elimination beads and the other one was a 4-ounce tube of Clinical Silicone Cream. On 3/18/25 at 9:35 a.m., the Market Clinical Advisor observed the chemicals with the surveyor and confirmed that the unlabeled medicated cream and the chemical should not have been in the bathroom and it was an accident hazard.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on observations, record reviews, interviews and facility policy, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to respiratory care for 4 of 5 residents reviewed for respiratory care (Resident [R] R13, R21, R46 and R65). Findings: Review of policy Nebulizer: Small Volume dated 11/1/23 states: .Upon completion of the treatment, .Rinse SVN, mouthpiece, and T piece with sterile water and dry. Place in treatment bag labeled with patient name and date . 1. On 3/19/25 at 8:41 a.m., observation of room [ROOM NUMBER], 3/19/25 at 7:30 a.m., and 11:39 a.m. revealed nebulizer located on top of Resident R13's side table with tubing attached with/to nebulizer pipe which is resting/stored on top of a stuffed animal without a barrier between the nebulizer pipe and the stuffed animal allowing potential cross contamination. On 3/19/25 at 11:30 a.m. observation and interview with Licensed Practical Nurse (LPN), she confirmed nebulizer tubing was not bagged, and stated she does not know why the nebulizer was in the room because R13 only needed it for an exacerbation and hadn't used it in over a week. Review of R13's orders active March 2025 revealed [he/she] last used the nebulizer on 3/13/25. On 3/19/25 at 11:47 a.m. the above was discussed with Director of Nursing. 2. On 3/18/25 at 8:24 a.m., and 3/19/25 at 7:38 a.m., observation of room [ROOM NUMBER]-1, a nebulizer was observed on R21's nightstand with tubing attached to pipe which is resting/stored on top of dresser without a barrier between the nebulizer pipe and the side table allowing potential cross contamination. During an interview on 3/19/25 at 7:34 a.m., the Licensed Practical Nurse (LPN) confirmed the above findings. 3. On 3/18/25 08:23 a.m., and 3/19/25 at 7:45 a.m., and on 3/20/25 at 11:45 a.m., observations of a Nebulizer on top of R46's tv stand tubing attached to mask dated 3/16 - stored in top draw and resting on personal items without a barrier between the nebulizer mask and personal items allowing potential for cross contamination. During an observation of R46 on 3/20/25 at 11:45 a.m. with [NAME] Unit Manager (JUM), she confirmed above findings. 51669 4. On 3/19/25 at 8:19 a.m., during an observation, Resident #65's unbagged continuous positive airway pressure (CPAP) mask was lying on the floor underneath his/her bed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/19/25 at 8:30 a.m., during an interview, Registered Nurse (RN) #6 stated when CPAP masks are not in use, they are stored in a plastic drawstring bag or sometimes the original device packaging. On 3/19/25 at 8:40 a.m., during an observation with a surveyor the [NAME] Unit manager confirmed the finding for Resident #65.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on record review and interview, the facility failed to identify a resident's current diagnosis of Post-Traumatic Stress Disorder (PTSD)/trauma to determine what trigger(s) might cause re-traumatization for 3 of 3 sampled resident reviewed with a current diagnosis of PTSD (Resident #(R)15, R27 and R35). Findings: 1. Resident (R) 35 was admitted in 2024 and has diagnoses to include post-traumatic stress disorder. Review of R35's care plan updated 1/22/25 lacked evidence that a trauma informed care plan was established to include triggers for this resident's PTSD diagnoses. Review of R35's admission Minimum Data Set (MDS) 3.0, Section I, Active Diagnoses, Psychiatric/Mood Disorder, I6100 was coded to indicate R35 had an active diagnosis for Post Traumatic Stress Syndrome (PTSD). The surveyor was unable to find information in the clinical record that indicated what R35's PTSD was caused by or what events might cause re-traumatization. During an interview with 4 surveyors on 3/21/25 at 3:00 p.m., Market Clinical Advisor confirmed Resident #35 did not have a trauma informed care plan. 51669 2. Resident #15 was recently admitted and has diagnoses to include Post-Traumatic Stress Disorder. Review of Resident #15's Admission Minimum Data Set (MDS), Section I, 16100. Post Traumatic Stress Disorder (PTSD), indicated Resident #15 has an active diagnosis of PTSD. Review of Resident #15's care plan, revised 3/18/25, includes, Focus: PASSR Level II: diagnosed with PTSD . but lacked evidence that a trauma informed care plan was established to include Resident #15's trigger(s) for PTSD. During an interview on 3/21/25 at 3:10 p.m., the Market Clinical Advisor confirmed Resident #15 did not have a trauma informed care plan. 37440 3. Resident #27 was admitted to the facility on [DATE] to include a diagnosis of PTSD. On 3/21/25, a review of Resident #27 's clinical record, in the Minimum Data Set (MDS) 3.0, Section I, Active Diagnoses, Psychiatric/Mood Disorder, I6100 was coded to indicate Resident #27 had an active diagnosis for PTSD. The surveyor was unable to find information in the clinical record that indicates what Resident #27 's PTSD was caused by, what trigger(s) might cause re-traumatization, and measures to avoid trigger(s) that might cause re-traumatization. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/21/25 at 3:15 p.m., in an interview, the Market Clinical Advisor confirmed that Resident 27's care plan lacked what indicated what Resident #27 's PTSD was caused by, what trigger(s) might cause re-traumatization, and measures to avoid trigger(s) that might cause re-traumatization.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37015 Based on observations, interviews, and record reviews, the facility failed to ensure sufficient direct care staff were scheduled and on duty to meet the needs of residents that reside on 3 of 3 units. Findings: 1. On 3/18/25 at 8:45 a.m., in an interview with a surveyor, RN5 stated the facility had changed to primary nursing and had taken away the medication technician position approximately 1 month ago. This change has resulted in nurses having to administer their own medications and treatments, often up to an hour late. On this day, the nurse had a discharge scheduled at 9:00 a.m., as well as an IV antibiotic to administer. RN5 stated wound care would be provided late due to lack of staffing. 2. On 3/20/25 at 11:20 a.m., a surveyor requested to observe wound care for Resident #9. LPN2 stated he/she would not be able to get to the twice daily wound care until 1:30 - 2:00 p.m. due to the workload and tasks to be completed. LPN2 stated he/she usually tries to complete the wound care before lunch, but today, he/she is unable to complete the wound care on time as there are only 2 licensed nurses, and 2 CNA's (Certified Nursing Assistants) on the unit. There are 2 admissions, and 2 discharges scheduled today, and on LPN2's assignment, 1 extensive wet to dry dressing change, Resident #9's dressing change, Resident #50's dressing change, and a new resident requiring care for 2 draining fistulas. LPN2 stated he/she also was responsible for all medication administration, blood glucose testing and insulin administration. 51669 3. Review of Payroll Based Journal staffing report revealed the facility triggered for low weekend staffing during the first quarter of 2025 (October 1, 2024 - December 31, 2024). On 3/19/25 at 3:00 p.m., during an interview, Resident #10 stated the primary concern at Resident Council meetings is lengthy call bell response times and that when staff come in to answer a call bell, they do not ask the other resident in the room if they need anything. On 3/20/25 at 11:05 a.m., during an interview Registered Nurse (RN) #4 stated the unit manager does not work the floor on the [NAME] unit and only does direct care if staff really needs help. RN #4 then stated that under the new staffing model, the medication tech (MT) goes home at 2:00 p.m., and the nurse takes over and administers all medications and treatments between 2:00-6:00 p.m. and then, the MT comes back from either 5:00-9:00 p.m. or 6:00-10:00 p.m. RN #4 then stated that last night, a resident fell at 3:30 p.m., and she had barely finished admitting another resident, when a third resident fell , all while she should be giving medications because the MT left. On 3/24/25 between 9:43 -10:15 a.m., during an interview, a surveyor reviewed weekend staffing for October 1, 2024 through December 31, 2024 with the Staffing Coordinator, and the Director of Nursing (DON). The DON stated she was aware of the shortages in the first quarter and confirmed the facility did not have enough staff to meet resident needs on the weekends.

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Oak Grove Center	27 Cool St Waterville, ME 04901

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37015 Based on record reviews, observations and interviews, the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation by failing to ensure that two people who are authorized to administer medications signed the Shift Count page indicating that they counted all controlled substances at the change of shift for multiple shifts, on 1 of 3 units reviewed ([NAME]). Findings: A review of the facility's policy and procedure: Controlled Drugs: Management Of, State of Maine, last revised 7/1/24, page 6, Section 5. Ongoing Inventory of Controlled Substances (Shift Count): 5.1 stated, Follow the Index Page to perform a complete count of all Schedule II to IV controlled substances at the change of shifts or at any time in which narcotic keys are surrendered from one licensed nursing staff to another. 5.1.3. Both medication nursing staff members participating in the count must: 5.1.3.3. Sign the shift count page in the 'Controlled Substances Book' to acknowledge a correctly reconciled count. On 3/20/25 at approximately 12:30 p.m., during a medication storage observation of the [NAME] unit medication cart, a surveyor reviewed the Controlled Substance Books and Shift Counts which indicated the facility counts at the change of each shift, approximately 3 times a day. The person authorized to administer medications coming on duty or the person authorized to administer medications going off duty both failed to sign the Shift Count page of the Controlled Substances Book that indicated the controlled substances count was completed on multiple days. At this time, the findings were discussed and confirmed with (Registered Nurse) RN #3 and RN #4. On 3/20/25 at 12:50 p.m., in an interview with the Director of Nursing and the Market Clinical Advisor, the surveyor discussed that multiple days on the [NAME] unit were missing staff signatures for verification and completion of the controlled medication count on the following dates: 11/25/24, 11/26/24, 11/29/24, 2/3/25, 2/4/25, 2/24/25, 2/25/25 (a.m. and p.m.), 3/6/25 (a.m. and p.m.), 3/7/25 (a.m. and p.m.), 3/11/25, 3/12/25, 3/18/25, and 3/19/25.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 51669 Based on observations, interviews and record reviews, the facility failed to ensure medications and treatments were stored properly, including removal of expired medications from available supply, on 3 of 5 days of survey (3/18/25, 3/19/25, 3/20/25). Additionally, the facility failed to obtain physician orders for medications located at a resident's bedside, for 2 of 2 sampled resident (Resident #65 and #79). Findings: Review of policy Medication Self-Administration, revised 10/15/2024, states, Patients who wish to self-administer medications will be evaluated for safe and clinically appropriate capability .If it is determined that the patient is able to self-administer: A physician/advanced practice provider (APP) order is required . Self-administration and medication self-storage must be care planned .patient must be provided with a secure, locked area to maintain medications . Review of policy, Bedside Medication Storage, dated 1/2024, states, The interdisciplinary team (IDT) will review and approve resident competencies and understanding prior to permission of bedside storage of medications .A written order for the bedside storage of medications is present in the resident's medical record .Bedside storage of medications is indicated on the resident medication administration record (MAR) . the manner of storage prevents access by other residents. Lockable drawers or cabinets are required . The facility's policy, titled 4.1 Storage of Medication, dated 1/25, stated, Procedures 4. Medications should be stored so that various routes of administration are separated. Internally administered medications are stored separately from medications used externally, such as lotions, creams, ointments, and suppositories. Section 12 stated, Insulin products should be stored in the refrigerator until opened. Note the date on the label for insulin vials and pens when first used. The opened insulin vial may be stored in refrigerator or at room temperature. (Refer to specific product labeling for additional detail). Opened insulin pens should be stored at room temperature. Do not freeze insulin. If insulin has been frozen, do not use. Section 14 stated, Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal. According to the Institute for Safe Medication Practices website, Safety Tips for Storing Insulin, states Write the date you open the insulin on the product. On the day you open the insulin vial, pen, or cartridge, or start keeping it outside the refrigerator, write the date on the label. This will help you remember when to stop using it. Insulin expires 28 days after it is opened. 1. On 3/18/25 at 7:50a.m., during an observation of Resident #65's room, a Fluticasone/Salmeterol 250mcg-50mcg inhalation device was located on Resident #65's over-the-bed table. Review of Resident #65's clinical record lacked evidence of an order to self-administer medications. Further review of the clinical record lacked evidence of an IDT assessment. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/18/25 at 2:39 p.m., during an interview, Registered Nurse (RN) #1 stated she left Resident #65's Advair inhaler at the bedside so he/she could take his/her dose after breakfast. At this time, RN #1 stated medications should not be left at the bedside, and that Resident #65 does not have an order to self-administer medications. During an interview on 3/18/25 at 2:45 p.m., the finding was reviewed with the [NAME] Unit Manager. 2. On 3/19/25 at 8:24 a.m., during an observation of Resident #79's room, a 1.5 fluid ounce bottle of Deep Sea Premium Saline 0.65% nasal moisture spray was located on the windowsill next to Resident #79's recliner. At this time, Resident #79 stated he/she was given the medication in the hospital and uses the medication a couple times a day. Review of Resident #79's active orders lacked evidence of a physician order for the saline nasal spray and lacked evidence of an order to self-administer medications. Further review of the clinical record lacked evidence of an IDT assessment. On 3/19/25 at 8:40 a.m., a surveyor and the [NAME] Unit Manager observed the nasal spray on Resident #79's windowsill. At this time, the Unit Manager stated residents who self-administer medications must have an assessment to determine if it is safe to self-administer, an order to self-administer, a physician order for the medication, and the medication must be stored in a lock box. On 3/19/25 at approximately 11:00 a.m., the above findings were discussed with the Market Clinical Advisor. 37015 3. On 3/18/25 at 9:45 a.m., during a medication storage observation of Medication Cart B on [NAME] Unit, the following topical medications were observed undated when opened and stored in a drawer with oral medications: Therahoney, Anasep wound gel, zinc oxide skin protectant cream, Diclofenac gel, Prevent silicone cream. Oral medications stored among the topical medications included: Lactulose oral solution and Guaifenesin liquid. Also observed with these medications was a bottle of antifungal powder prescribed to Resident #9. (Registered Nurse) RN #1 stated the medication had been discontinued a while ago. Another bottle of antifungal powder had the pharmacy label torn off and was open and available for use. A review of the provider orders for Resident #9 noted the order for antifungal powder had been discontinued on 3/5/25. 4. On 3/20/25 at 9:00 a.m., during a medication administration observation on the [NAME] Unit, a surveyor observed an Insulin Lispro Kwik-Pen prescribed to Resident #4, in use and undated when opened stored in Medication Cart B. The surveyor brought this to the attention of the RN who threw it away at this time. 5. On 3/20/25 at 12:00 p.m., during an observation of the nurse treatment cart on the [NAME] Unit, a surveyor observed the following 7 insulin pens that were all prescribed to current residents and were open and available for use: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	> 2 - Undated when opened Insulin glargine-yfgn (U100) > Insulin Lispro Kwikpen (U100) labeled as opened on 2/16/25 (expired) > Undated Insulin Lispro Kwikpen (U100) > Insulin Lispro Kwikpen (U100) labeled as opened on 1/27/25 (expired) > Undated Insulin Glargine Solostar pen > Undated Basaglar Kwikpen (U100) On 3/20/25 at 12:05 p.m., the surveyor brought the above insulin pens to the JUM ([NAME] Unit Nurse Manager). 6. On 3/20/25 at 12:10 p.m., during an observation of the [NAME] Unit Medication Room with RN #2, a surveyor observed the emergency stock of intravenous antibiotic medications, stored in 3 plastic boxes with compartments. The following were noted: > 2 vials of Zosyn (piperacillin 3 grams/tazobactam 0.375 grams) - expired 1/25 > 2 vials of Cefazolin 1 gram - expired 11/24 7. The small medication refrigerator located on the floor was observed to have a large ice buildup. A stack of insulin pens were observed stored next to the ice buildup. At this time, the surveyor brought the expired antibiotics to the JUM and notified him/her of the ice buildup in the medication refrigerator. 8. On 3/20/25 at approximately 12:30 p.m., during an observation of the treatment cart on [NAME] Unit with RN #3, a surveyor observed 3 vials of single dose Shingrix vaccine stored in a plastic bag with a sticker which stated Keep Refrigerated. RN #3 removed the vaccines from use at this time. On 3/20/25 at 12:50 p.m., the surveyor discussed the above findings with the Director of Nursing and the Market Clinical Advisor.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 37440 Based on observations and interviews, the facility failed to maintain garbage storage areas in a sanitary condition to prevent the harborage and feeding of pests for 1 of 3 dumpsters for 1 of 4 days(3/18/24) and 1 of 3 dumpsters for 3 of 4 days of survey. (3/18/25, 3/19/25, and 3/20/25) Findings: 1. On 3/18/25 at 6:30 a.m., a surveyor observed 1 dumpster with the right-side slide door open exposing trash. Additionally, there was trash/debris on the ground. Another dumpster had a right-side top cover that was broken and open exposing trash. 2. On 3/19/25 at 8:00 a.m., a surveyor observed a dumpster had a right-side top cover that was broken and open exposing trash. 3. On 3/20/25 at 8:00 a.m., a surveyor observed a dumpster had a right-side top cover that was broken and open exposing trash. On 3/19/25 at 7:45 a.m., during an interview, the [NAME] stated the dumpsters are always supposed to be closed, but one of them has had a broken flap for a couple of weeks and she's not sure what they are doing about it. On 3/20/25 at 1:00 p.m., in an interview, the Administrator 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on record reviews and interviews, the facility failed to ensure that clinical records were complete and contained accurate information for 5 of 7 sampled residents reviewed for respiratory (Resident #[R] R15, R20, R21, R41 and R44). Findings: 1. Review of R20's Preadmission Screening and Resident Review (PASRR) level II dated 2/25/25 revealed [he/she] has a Mental health disability and is qualified for Specialized services: You will need to be provided the following specialized services: Service or Support: Initial psychiatric evaluation to determine diagnosis and develop plan of care. Review of R20's clinical record lacked evidence this was done. Review of R20s clinical record revealed order with start date of 2/13/25 states. Is resident free from side effects of psychotherapeutic medications? (if no, document side effects in PN) every shift AND as needed. Review of R20's care plan updated 2/13/25 states is at risk for complications related to the use of psychotropic drugs Medication as ordered. Resident will have the smallest most effective dose without side effects for 90 days. Monitor for side effects and consult physician and/or pharmacist as needed Review of R20's medication orders lacked evidence that R20 had any psychotropic medication orders. During an interview on 3/20/25 at 3:3:24 p.m., the [NAME] Unit Manger (JUM) reviewed R20's active orders and confirmed there was no order placed for psyche services, and R20 was not taking any psychotropic medicines. 2. Review of R21's active provider orders for March 2025 revealed order with start date of 10/30/24 to Please give patient 4 duo nebs to room daily for his own QID use every day shift. And order with start date of 4/17/24 for Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate) 2 puff inhale orally two times a day for sob Ok to have inhaler by bedside. Review of R21's Self -Administration of Medications Evaluation dated 9/20/23 states: What type(s) of medications has the patient requested to self-administer? :Nasal Saline Further review of clinical record lacked evidence that a self-administration evaluation was completed for R21 for the use of duo nebs or inhaler. Review of R21's care plan updated 1/7/24 states Self-administration of medication, saline nasal spray, seasonal allergies. Patient will correctly and safely. Self-administer medication. Ensure availability/adequate supply of medication(s) for self-administration. Ensure patients ongoing functional and cognitive skills permit continued safe medication self-administration. Observe for indications of the patient skipping doses or refusing to take medication. Review of clinical record lacked evidence that R21 was assessed to self-administer duo nebs or inhaler. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 3/20/25 at 12:00 p.m., Resident R21 was observed in [his/her] room, and was holding a nebulizer pipe in [his/her] lap. At this time R21stated he/she keeps [his/her] duo nebs and inhaler in [his/her] desk and uses them when [he/she] needs to. At this time R21 opened his/her desk draw and pointed to [his/her] medications. R21 stated the last time [he/she] used the inhaler was this morning and just finished a nebulizer treatment. When asked how long [he/she] has kept the medications in [his/her] room R21 replied It's been a while. During an interview on 3/20/25 at 12:09 p.m., the [NAME] Unit Manger (JUM) reviewed R21's clinical record and confirmed it did not contain evidence he/she was assessed for use of duo neb or inhaler. The above was discussed with the Market Clinical Advisor (MCA) on 3/20/25 at approximately 1:00 p.m. 51669 Review of Falls Management policy, revised 3/15/24, states, . in the event a fall occurs, an assessment will be completed to determine possible injury . Document circumstances of the fall, post-fall assessment, and patient outcome . 3. Resident #44 has diagnoses to include repeated falls. Review of Resident #44's clinical record revealed he/she sustained a fall on 11/14/24, 11/22/24, and 3/8/25 and lacked evidence that a post-fall fall risk assessment was completed following the falls. During an interview on 3/20/25 at 11:05 a.m. Registered Nurse (RN) #4 stated after a resident falls, a post-fall risk assessment is completed. During an interview on 3/21/25 at 1:38 p.m., the finding was discussed with the Director of Nursing, the Administrator, and the Market Clinical Advisor. At this time, the Director of Nursing reviewed Resident #44's entire clinical record and confirmed that it lacked evidence of a post-fall fall risk assessment for the above falls. 4. Resident #15 diagnoses include anxiety, Bipolar disorder, and psychotic disturbance. Review of Resident #15's active physician orders revealed: -Order with a start date of 3/18/25 for Seroquel 100mg oral tablet, give 1 tablet by mouth one time a day for bipolar d/o [disorder] with agitation - Order with a start date of 2/1/25 for Quetiapine Fumarate Oral Tablet 300mg, give 1 tablet by mouth at bedtime for psychosis Review of Review of Resident #15's Care plan, updated on 2/25/25, revealed, Resident is at risk for complications related to the use of psychotropic meds .Monitor for side effects . Further review of the clinical record lacked evidence of monitoring for side effects for the above medications. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Resident #41 has diagnoses to include End Stage Renal Disease (ESRD) and is dependent on dialysis. Review of Resident #41's Care Plan, updated 2/26/25 includes, Central tunneled jugular dialysis catheter for ESRD and dialysis Review of Resident #41's active physician orders revealed: -Order with a start date of1 2/10/24 for, Transfer to hemodialysis unit .on MWF [Monday, Wednesday, Friday] for treatment -Order with a start date of 2/25/25, Do not shower while still on tunneled dialysis catheter in place. Record review revealed a nursing progress note, dated 3/15/25, states, Patient had shower today. Skin assessment done . Review of Resident #41's bathing task revealed he/she received a shower on 3/10/25 and resident refused a shower on 3/15/25. Review of the nursing documentation on the March 2025 Treatment Administration Record (TAR) indicates Resident #41 has not received a shower during the month of March. During an interview on 3/21/25 at 1:42 p.m., the above findings were confirmed with the Director of Nursing.

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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. 37440 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 2/1/24, were effective. The Federal citations F584, F625, F656, F689, F725, F842 and F880 were cited again during the annual Long Term Care Recertification Survey dated 3/24/25. Findings: During the Annual Long Term Care Survey Process for Federal Recertification dated 3/24/25, it was determined that F584, F625, F656, F689, F725, F842 and F880 would be recited for the same reasons: F584 for failure to adequately provide housekeeping and maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable environment; F625 failure to issue a written bed hold notice to include cost of care to the Resident and/or resident representative; F656 for failure to implement a comprehensive person-centered care plan; F689 for failure to ensure that the resident's environment was free of accident hazards relating to the storage of chemicals being properly secured; F725 for failure to ensure sufficient direct care staff were scheduled and on duty to meet the needs of residents; F842 for failure to ensure that clinical records were complete and contained accurate information and F880 for failure to maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases. On 3/24/25 at 12:28 p.m., during an interview, the above findings were discussed with the Administrator.

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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 - Few	Provide and implement an infection prevention and control program. 37015 Based on observations, interviews, clinical record review, and facility policy review, the facility failed to maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases for residents requiring Enhanced Barrier Precautions (Resident #33) on 1 of 3 facility units. Findings: On 3/18/25 at 1:20 p.m., a surveyor observed 2 CNAs (Certified Nursing Assistants) wearing gloves enter Resident #33's room with a mechanical hoyer lift. The resident's door was posted with a Contact Precautions sign which included a picture of a person wearing a gown, gloves, mask and face shield. The instructions stated Perform hand hygiene before and after patient contact, contact with environment and after removal of PPE (personal protective equipment). Wear N95/approved KN-95 respirator, gown, face shield and gloves upon entering this room. Change gown after EACH patient contact (written in red). Keep room door closed. Patient must wear a face mask when out of room and maintain social distancing. Perform all procedures/tests in patient room, if able. Pull curtain between roommates. Please do not remove dedicated or single use disposable equipment from this room. When dedicated equipment is not possible, disinfect shared patient equipment with EPA-approved disinfectant. The surveyor observed Resident #33 had a foley catheter hanging from the bed. One CNA picked up the foley catheter and placed it across the resident's legs while the other CNA was hooking the hoyer pad to the hoyer lift. At this time the surveyor requested to speak with both CNAs and asked them what type of PPE they should be wearing. One CNA stated gloves. The surveyor noted the posted sign and asked if the resident required the PPE as per the posted precautions. The CNA stated the resident was on Advanced Barrier Precautions, and that only when staff provide foley or pericare is a gown required, otherwise, only gloves are required. On 3/18/25 at 1:25 p.m., the surveyor asked LPN #1, what type of precautions Resident #33 required. LPN #1 stated the resident had ESBL (Extended-Spectrum Beta-Lactamase) in the urine, and an SP (supratubic) tube. The LPN stated when providing care for the foley (SP tube), we gown up. On 3/18/25 at 1:30 p.m., in an interview with the surveyor, the Unit Manager (JUM) stated Resident #33 had a history of ESBL which had been treated in November, 2024. However, the resident had been treated in the emergency department (ED) over the weekend and was diagnosed with a urinary tract infection (UTI). The JUM stated he/she was not sure what kind of precautions the resident was currently on. A review of Resident #33's record noted a provider note, dated 3/18/25, which stated recent ED visit with diagnosis of UTI - per culture and sensitivity - Pseudomonas aeruginosus, Serratia marcescens. Resident #33's care plan, last revised 3/18/25, stated the resident required Enhanced Barrier Precautions. On 3/19/25 at 10:25 a.m., a surveyor observed Resident #33's door with the same Contact Precautions sign. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205091	A. Building B. Wing	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Grove Center	27 Cool St Waterville, ME 04901

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 - Few	On 3/19/25 at 11:30 a.m., in an interview with the surveyor, the Director of Nursing (DON) and the Market Clinical Advisor stated Resident #33 was previously on Enhanced Barrier Precautions for ESBL in the urine and use of an indwelling urinary catheter. At some point, the signage on the door was changed to Contact Precautions. The resident was seen in the ED over the weekend and was currently undergoing treatment for an active UTI. The DON stated Resident #33 required Enhanced Barrier Precautions at the present time and confirmed that staff were not following correct precautions as posted when observed yesterday. The Market Clinical Advisor stated staff received education last night on proper procedures for use of Enhanced Barrier Precautions. The facility's policy regarding Enhanced Barrier Precautions, with a revision date of 12/16/24, stated In addition to Standard Precautions, Enhanced Barrier Precautions (EBP) will be used (when Contact Precautions do not otherwise apply) for novel or targeted multi-drug resistant organisms (MDROs). Section 4, Implement Contact Precautions versus EBP per following table, stated under Patient Status: Has a wound or indwelling medical device without secretions or excretions that are unable to be covered or contained and not known to be infected or colonized. United States Centers for Disease Control and Prevention (CDC) recommendations poster for use of EBP's, dated 7/31/22, stated, Providers and staff must also wear gloves and a gown for the following high contact resident-care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, wound care: any skin opening requiring a dressing.