STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205095	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kennebunk Center for Health & Rehabilitation, LLC	158 Ross Rd Kennebunk, ME 04043

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 48648 Based on interviews and record reviews, the facility failed to ensure that a resident's choice in the area of clothing were followed for 1 of 9 sampled residents (Resident #234). Findings: On 4/18/24 the Department of Licensing and Certification (DLC) received a referral from Adult Protective Services (APS) of an incident that occurred on 4/12/24 around 11:00 p.m. where a tooth became cracked during the removal of a sweater. A surveyor reviewed the facility incident report dated and learned that on the night of 4/12/24, two staff members were getting Resident #234 ready for bed and tried to remove his/her sweater. Resident #234 reportedly told the staff she/he did not want to remove the sweater and bit down on the neck of the sweater to prevent removal. The sweater was removed anyway and Resident #234's tooth broke during the removal. On 1/15/25 at 2:10 p.m. a surveyor spoke with the Director of Nursing about the incident and confirmed that the residents' right to keep the sweater on was not respected despite the resident clearly expressing he/she did not want the sweater removed.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Potential for minimal 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** 37648 Based on record reviews, and interviews, the facility failed to provide evidence to show Advance Directives were 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 Advance Directive, for 11 of 14 residents reviewed for Advance Directive. (Resident #8, #3, #35, #17, #18, #19, #37, #64, #226 and #230) Findings: 1. Resident #8 was admitted to the facility on [DATE]. A review of the electronic medical record and the paper 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 1/14/25 at 7:19 a.m., during an interview with the Administrator, the above was confirmed. 48648 2. Resident #18 was admitted to the facility on [DATE]. A review of the electronic medical record and the paper 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. 3. Resident #19 was admitted to the facility on [DATE]. A review of the electronic medical record and the paper 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. 4. Resident #64 was admitted to the facility on [DATE]. A review of the electronic medical record and the paper 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. 5. Resident #226 was admitted to the facility on [DATE]. A review of the electronic medical record and the paper 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. 6. Resident #230 was admitted to the facility on [DATE]. A review of the electronic medical record and the paper 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. (continued on next page)

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F 0578 Level of Harm - Potential for minimal harm Residents Affected - Some	On 01/14/25 at 12:04 p.m. a surveyor met with the facility social worker who confirmed the requirements for Advance Directives are not being met. She/he said they will ask upon admission but not always document or follow-up. On 1/14/25 at 12:48 p.m. a surveyor discussed concerns with the Director of Nursing who said that if we can't find them in the chart, they don't exist. Stated they placed calls to families for missing documentation yesterday. 51331 7. Resident #3 was admitted to the facility on [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 #35 was admitted to the facility on [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. 9. Resident #17 was admitted to the facility on [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.

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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** 37648 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 (Windermere, Eagle, Sagamore and Regena, and Laundry Room) for 1 of 4 days of survey. Findings: Sagamore unit: On 1/14/25 at 8:09 a.m., observation of the shared bathroom for room [ROOM NUMBER] and 4 with a black substance around the base of the toilet and the caulking strip peeled up. On 1/13/25 at 11:32 a.m., and on 1/14/25 at 8:11 a.m., observations of the shared bathroom for room [ROOM NUMBER] and 9 with a commode bucket stored on the floor, a large brown circular stain on the floor to the left of the toilet, a brownish tan substance around the base of the toilet and the caulking strip peeled up. On 1/13/25 at 10:29 a.m., observation of the shared bathroom for room [ROOM NUMBER] and 10 with a gray basin stored on floor and leaning against the wall. On 1/16/25 at 3:16 p.m., the above was discussed with the Administer. 44049 Laundry Room: On 1/15/25 at 08:50 a.m. 2 surveyors observed dust and debris on the 2 fans, a heater on the wall, and 3 air vents on the clean linen side. Above the laundry folding table there was dust and debris on the pipes. On the dirty linen side, the sink was heavily stained and soiled including the eye wash station. The window is covered in dust and cobwebs. Behind the hot water tank there were multiple areas of dust and cobwebs. The pipes throughout were covered in dust/debris. On 1/16/25 at 10:00 a.m. During a tour of the physical environment the following concerns were observed: room [ROOM NUMBER] - Bathroom - Heavy staining around and in back of the toilet room [ROOM NUMBER] - Wall fan dusty room [ROOM NUMBER] - Heating Unit stained (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room [ROOM NUMBER] - Entry into Bathroom, floor tile chipped Pink basin in the floor room [ROOM NUMBER] - Pink Basin on the floor 51331 On 1/13/25 at 10:59 a.m. and on 1/14/24 at 12:00 p.m., observation of a shared bathroom for room [ROOM NUMBER] with a gray basin stored on floor under the sink. On 1/13/25 at 10:30 a.m. and on 1/14/25 at 12:23 p.m., observation of the shared bathroom for room [ROOM NUMBER] with a gray basin stored on the floor to the side of the toilet. On 1/13/25 at 10:48 a.m. and on 1/14/25 at 12:00 p.m., observation of the shared bathroom for room [ROOM NUMBER] with 2 gray basins stored on floor under the sink. On 1/13/25 at 10:12 a.m. and on 1/14/25 at 12:22 p.m., observation of the shared bathroom for room [ROOM NUMBER] with a gray basin stored under the sink.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37648 Based on observations, interviews, and record reviews the facility failed to provide Activities of Daily Living (ADL) care for 6 of 6 resident reviewed for ADL's (Resident #126, #6, #19, #64, #226 and #230). In addition, the facility failed to follow the care plan in the area of oral hygiene for 1 of 1 reviewed. (Resident #6). Findings: The facilities ADL Policy and Procedure issued 6/23 states, Purpose: To provide the level of care required by each individual resident and Procedure: Staff provide assistance to complete ADL activities per their person centered evaluation and care plan. These activities are broken down into eight areas. #1.Bathing/showering . #8 Personal hygiene and grooming. 1. On 4/10/24 the Division of Licensing and Certification received a complaint that Resident #126 did not receive appropriate care with his/her Activities of Daily Living (ADL). He/she was found wearing the hospital [NAME] a day after admission and for the 2 weeks Resident #126 was at the facility, his/her underwear were only changed twice, and he/she had the same socks on for 3 days in a row. Resident #126 was admitted on [DATE] for skilled services following a Chronic Obstructive Pulmonary Disease acute exacerbation. The care plan for ADL self-care performance deficit instructed nursing to provide bathing/showering, dressing and toilet use with extensive assist by 1 staff and bed mobility, transfers and personal hygiene/oral care with limited assistance by 1 staff. Review of Resident #126's Certified Nurses Aid (CNA) documentation for March 2024 lacked evidence of Activities of Daily Living which included bathing, dressing, oral hygiene, bladder and bowel elimination, bed mobility and transfers being provided on 3/8/24 both 3pm-11pm and 11pm-7am shifts and both 3/9/24 and 3/10/24 for the 3pm-11pm shifts. On 1/16/25 at 2:22 p.m., the above was discussed with the Director of Nursing who confirmed the lack of ADL documentation could not suggest Resident #126 received the appropriate ADL care. 2. On 1/13/25 at 10:31 a.m., observation of Resident #6, sitting upright in bed, his/her teeth were coated with a thick white/yellow debris at the gum line. In a brief interview, Resident #6 stated, staff help him/her with brushing his/her teeth. On 1/14/25 at 8:16 a.m. and at 11:56 a.m., observation of Resident #6 sitting upright in bed, his/her teeth were coated with a thick whitish/yellow/brown in color debris at the gum line. At this time, the resident was asked again if staff help him/her with brushing his/her teeth. He/she stated, yes. He/she was asked when the last time his/her teeth were brushed, the resident answered, I don't know On 1/16/25 at 8:36 a.m., observation of Resident #6 sitting up in bed, his/her hair is combed back into a ponytail, his/her teeth were thickly coated with whitish/yellow/ brown debris at the gum line. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #6's care plan stated Resident has oral/dental health problems Poor nutrition, Poor oral hygiene dated 5/17/23. Instructs nursing to Monitor/document/report PRN any s/sx of oral/dental problems needing attention: Pain (gums, toothache, palate), Abscess, Debris in mouth, Lips cracked or bleeding, Teeth missing, loose, broken, eroded, decayed, Tongue (black, coated, inflamed, white, smooth), Ulcers in mouth, Lesions and Provide mouth care as per ADL personal hygiene. Review of the Certified Nursing Aid (CNA) documentation from 1/3/25 through 1/15/25 for ORAL HYGIENE: The ability to use suitable items to clean teeth . Each day had documented oral care was completed. On 1/13/25 oral care was documented as completed with substantial /Max Assist: Helper does more than half the effort. On 1/14/25 oral care was documented as completed twice, with one Set-up or clean-up. Helper sets up or cleans up only and one with Dependent: Helper does all the effort. On 1/15/25 oral care was documented as completed with Supervision/touch assist: Helper gives verbal cues or touch assist. On 1/16/25 at 9:27 a.m., both the surveyor and the Director of Nursing (DON) observed Resident #6's teeth. The DON asked the resident if he/she would like help brushing his/her teeth, stating it looked like he/she needed his/her teeth brushed, the resident stated yes. 48648 3. On 1/13/25 at 9:20 a.m., a surveyor interviewed Resident #230 and learned that she/he was hoping to get a shower today because the CNAs couldn't do it yesterday, which is his/her regular bathing day. A review of Resident #230 Electronic Medical Record (EMR) showed their last documented shower was on 12/17/24 but no other documentation of showers, baths or refusals. On 1/13/25 at 9:30 a.m. a surveyor interviewed Resident #64 who was admitted to the facility on [DATE]. Resident #64 stated that he/she had refused most of his/her showers due to illness. A review of Resident #64's EMR showed no bathing documentation until 12/17/24, which was a refusal. A shower was documented on 12/24/24 and then no other bathing documentation. On 1/14/25 at 1:34 p.m., a surveyor interviewed Resident #226 and learned they do not get regular weekly showers or baths. A review of Resident #226's EMR showed no documentation of showers, baths or refusals since admission. On 1/14/25 at 1:45 p.m. A surveyor interviewed Resident #19 and learned they have not had a shower or a bath since admission on 12/17/24. She/he would very much like to have a shower, but the CNAs told him/her it takes too long because they have to wrap their arm and leg. A review of Resident #19's Electronic Medical Record failed to show any documentation of showers, baths or refusals. On 1/14/25 at 2:30 p.m. a surveyor met with the Director of Nursing (DON) and learned that CNAs are expected to document showers or baths in the EMR and if there is a refusal, they tell the nurse, and a progress note would document the refusal. A surveyor discussed the above findings with the DON.

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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** 37648 Based on facility policy, record review and interviews, the facility failed to adequately evaluate a resident after an unwitnessed fall and complete neurological assessments as per facility policy for 1 of 2 residents reviewed for falls (Resident #125). Findings: The facilities Fall Prevention Program, last revised 3/23 states, If a fall occurs . Monitor resident's status for 72 hours. Some injuries may not be apparent immediately after the fall. The facilities Neurological Evaluation Policy, revised 4/23 states, The licensed nurse performs neurological evaluations whenever there is a possibility of a head injury, change in mentation, or an unwitnessed fall Purpose: Accurate evaluation and monitoring of changes in residence neurological status to allow prompt medical notification treatment Procedure: The neuro care flow sheet includes vital signs temperature, pulse, respirations, and blood pressure and information regarding pupil reaction of both eyes, level of consciousness, motor function, speech, facial symmetry, and headache . #2. Any resident, who has had an unwitnessed or witnessed fall and is on an anticoagulant/antiplatelet therapy, will have an initial neurological evaluation by the Licensed Nurse or Registered Nurse per state regulation followed by neurological monitoring per policy #3. After the initial evaluation, the neurological exam is repeated every 15 minutes x4 (1hr), every 30 mins x4 (2 hrs), every 2 hrs. x 4 (8 hrs), then every shift x3. #5. Any resident requiring emergency room treatment for injuries relating to a fall and head injury suspected, upon their return to the facility, the neurological evaluation will be initiated/re-initiated. Resident #125 was admitted on [DATE] with diagnosis of COVID-19 and orthostatic hypotension. Review of the medical record shows a care plan for Resident has had a fall with/without injury due to: Unsteady gait, poor insight initiated on 9/17/24 had a nursing intervention of Neuro-checks per facility protocol. From admission through discharge on 10/18/25, the resident had 4 unwitnessed falls. Review of facility documentation relating to the falls states the following: 1. A nurses noted dated 9/24/24 at 6:31 a.m., states Found resident on the bathroom floor. Left-side lying facing the bathroom door. Denies pain. Neuro-check initiated, within patient's baseline .will continue to monitor. The residents' medical record lacked evidence of Neurological monitoring per policy. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A nurses note dated 10/6/24 at 10:26 a.m., states, Resident found on floor in bathroom. States [he/she] slid off the toilet after getting dizzy. ROM (range of motion) and neuro intact, new skin tear measuring 0.2 x 6. 5 cm to right forearm. Steri-strips and dressing applied. Denies pain . Review of the neurological monitoring initiated on 10/6/24 at 7:30 a.m., has the following vitals documented with a time of 8:13 a.m., a Blood Pressure of 107/66, Pulse 88 regular, respirations 18, and a temperature of 98.3. Review of the 1st 15 minutes through the 4th 30 minutes, a total of 8 neurological evaluations, had the vitals documented with the same readings as the initial vitals at 8:13 a.m. In addition, the 3rd and 4th 2 hour evaluations and the 1st and 2nd shift evaluations were not completed. 3. A nurses note dated 10/13/24 at 9:30 a.m., states, Resident found with bruising on the side of [his/her] face, reporting that [he/she] fell overnight and feels foggy. TEH contacted and received new orders to send resident to ED for a CT scan to rule out head injury. A late entry nurses noted, effective 10/12/24 at 11:15 p.m., states, this writer found resident laying on left side on floor in room next to bed, large amount of water on floor, side table turned upside down on floor next to resident. Upper and lower extremities checked for any clicks/disfigurement. Resident transferred into bed with 2 staff members via hoyer lift. Full body assessment performed. Multiple old bruising and ecchymosises noted to body. Vital signs and neuro checks initiated . Review of the medical record states the resident returned from the emergency roiagnom on [DATE]. Further review, the medical record lacked evidence of neurological monitoring after the fall and upon return from the emergency room visit. On 1/16/25 at 2:22 p.m., both the surveyor and the Director of Nursing reviewed the above 3 falls. The Director of Nursing confirmed the neurological monitoring did not occur and/or the documentation for the neurological monitoring was incorrect with the vitals being the same throughout the monitoring.

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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. 37648 Based on observations and interviews, the facility failed to maintain a sanitary environment to help prevent the development and transmission of disease and infection related to respiratory care for 2 of 3 residents reviewed for respiratory care (Resident # 16 and #20). In addition, the facility failed to follow physician orders for 1 of 3 reviewed for respiratory care (Resident #16). Findings: The facilities Nebulizer Treatments Policy and Procedure revised 2/23, states, post treatment, disconnect the reservoir from the compressor and clean per manufacturer's Instructions, Place reservoir in a plastic bag Manufactures Instruction Manual for Power Neb Ultra Compressor Nebulizer, under section cleaning and maintenance states, clean after every use .disassemble mouthpiece or mask from cap .wash all items, except tubing in a hot water/dishwashing detergent solution. Rince under hot tap water for 30 seconds to remove detergent residue. Allow to air dry. Under section , Filter Change states, Filter should be changed every 6 months or sooner if filter discolors. 1. On 1/13/25 at 11:32 a.m., observation of Resident #16's nebulizer machine on the bedside dresser with mouthpiece/pipe stored on the back of the machine and the tubing dated 12/30. At this time, Resident #16, stated, he/she only needs it when he/she is congested. On 1/14/25 at 1:33 p.m., observation of Resident #16's nebulizer machine on the bedside dresser with mouthpiece/pipe stored on the back of the machine and the tubing dated 12/30. Review of Resident #16 physician orders dated 1/7/24 states, Change Nebulizer unit and tubing every night shift every Sun for Prophylaxis. Review of the Treatment Admission Records (TAR) for December 2024 states the nebulizer unit and tubing were changed on 12/29/24. The TAR for January 2025 states the nebulizer unit and tubing were changed on 1/5/25 and 1/12/25. In addition, the medical record lacked evidence of the filter being changed as per manufactures recommendations. On 1/16/25 at 12:59 p.m., during an interview with the Director of Nursing (DON), the surveyor discussed the above and asked how often the nebulizer filters are changed. The DON stated she was unsure and would get back to the surveyor. On 1/16/25 at 1:06 p.m., the DON returned and stated they do not have a record of changing nebulizer filters. 51331 2. On 11/13/25 at 11:07 a.m., on 1/14/25 at 12:10 p.m., and on 1/15/25 at 1:51 p.m., Observation of Resident #20's unbagged and unlabeled nebulizer pipe and tubing stored on their bedside table. On 1/15/25 at 1:51 p.m. the above information was confirmed with the Regional Director of Clinical Operations.

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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. 48648 Based on record review and interviews, the facility failed to ensure sufficient direct care staff were scheduled and on duty to meet the needs of residents that reside in the facility. This has the potential to affect all residents needing assistance with Activities of Daily Living (ADL's). Findings: Review of Payroll Based Journal staffing report revealed the facility triggered for excessively low weekend staffing during the fourth quarter of 2024 (July 1 - September 30). On 1/15/25 at 3:47 p.m., a surveyor met with the Administrator and reviewed weekend staffing for July 1, 2024, through September 30, 2024, the Administrator confirmed the facility did not have enough staff to meet resident needs on the weekends.

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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** 44049 Based on observations, and interviews, the facility failed to maintain adequate pharmaceutical services to ensure that outdated medications, were removed from the medication carts making them no longer available for use in 1 of 3 medication carts. Findings: On [DATE] at 9:06 a.m., a surveyor observed in medication cart on Eagle Wing a medication card for Ondansetron HCL 4 milligrams (mg) for Resident #13 had expired on [DATE]. The surveyor confirmed the finding with the Licensed Practical Nurse (LPN) #1. at 9:12 a.m. On [DATE] at 9:30 a.m., a surveyor discussed the above findings with the Director of Nursing.

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	205095	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kennebunk Center for Health & Rehabilitation, LLC	158 Ross Rd Kennebunk, ME 04043

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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. 37648 Based on observations, interviews, record review and the facility's own Personal Appearance and Dress guidelines and the Personal Hygiene for Food Handlers policy and procedures, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner, failed to serve food in accordance with professional standards for food service safety, failed to monitor food temperatures to prevent food borne illness prior to serving residents for 1 of 2 days of survey (1/13/25), and failed to ensure that plumbing fixtures were properly installed to prevent backflow as required by the Maine State Plumbing Code. This has the potential to affect all residents in the facility. Findings: The facilities Personal Hygiene for Food Handlers, revised on 2/22 states, Hair restraints such as hats, hair coverings or nets, and beard restraints are worn at all times when in the kitchen and Facial hair should be neatly trimmed and covered by mask or beard guard. The 10-114 State of Maine Rules Chapter 226, definition Section A, 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. 1. On 1/13/25 from 9:18 a.m. to 9:40 a.m., a surveyor completed a tour of the kitchen with the Food Service Manager (FSM) in which the following findings were observed: - The Kitchen floor around and under the prep sink and the 3 bay sink had crumbs, food, dirt and debris throughout. - The kitchen prep sink air gap was not plumbed in accordance with code requirements to prevent food contamination. - The kitchen ice machine air gap was not plumbed in accordance with code requirements to prevent food contamination. - The tray line table lower shelf was heavily soiled with dirt and debris. - The shelving unit containing cereal was visibly dirty with dirt and debris. - The dish washer hood exhaust was coated with thick dust. - The walk-in freezer had a large brown ice puddle, a cookie wrapper, crumbs and debris on the floor. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The walk-in refrigerators fan was coated with a thick layer of dust, a container containing egg salad with an exp. date of 1/10 and a wrapped chicken salad sandwich with exp. date of 1/12. - The food mixer safety shield and cage were visibly soiled with white debris/dried liquid 2. On 1/13/25 from 11:32 a.m. to 11:56 a.m., a surveyor observed the Kitchen staff at the steam table and tray line preparation serving lunch, in which the following was observed: [NAME] #1 had a scruff mustache/beard without a hair restraint. [NAME] #2 had a mustache with a patchy beard on his chin without a hair restraint, and no name tag. Dietary Aid #1 had a mustache and beard without a hair restraint. Dietary Aid #3 had a mustache without a hair restraint. Cook #1 prepared the residents plates, during this time, he picked up a grilled cheese sandwich with his gloved hands and cut off the edges, then placed it on a plate. Next, using his hand, he picked up a piece of steak. Then he opened the steamer cabinet and removed a cup of soup. With the same gloved hands, he picked up a piece of fish and plated it. Then again opened the steamer cabinet and obtained another cup of soup and handed it off to [NAME] 2. At approx. 11:44 a.m., the surveyor alerted the FSM, of the lack of hair restraints and hand hygiene. Without intervention, the FSM continued to observe, [NAME] #1 plate another piece of fish using the same gloved hands. Then he obtain a chicken salad sandwich in a bag. He removed it from the bag, cut off the edges and placed it back into the bag and handed it back to [NAME] #2. He then picked up another grill cheese sandwich, cut off the edges and plated it. Again, he picked up another piece of fish, held it with the same gloved hands and cut it up. At this time, the above observations were confirmed with the FSM. 3. On 1/13/25 at 11:56 a.m., both the FSM and the surveyor reviewed the Kitchen Production Report: Lunch team table temperatures. Temperatures were not obtained prior to serving, for the gravy (separate from steak), mashed potatoes, grilled cheese sandwiches, peas/carrots and chicken salad sandwich. 4. On 1/14/25 from 6:18 a.m. to 6:32a.m., an additional tour of the kitchen in which the following findings were observed again observed: - [NAME] #2 had a mustache with a patchy beard on his chin without a hair restraint. At this time, the above was confirmed with the FSM.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37648 Based on interviews and record review, the facility failed to ensure the terms and conditions of a binding arbitration agreement were clearly communicated to the residents or their representatives and not required as a condition of admission due to the agreement being a part of the admission paperwork for 5 of 5 residents reviewed for Arbitration (Resident #126, #230, #23, #64, and #19). Findings: 1. On 1/13/25 at 9:15 a.m., a surveyor conducted an entrance conference with the Administrator and the Director of Nursing and was told, when asked, that no residents in the facility had signed an arbitration agreement. During a record review for Resident #19, a surveyor located a signed Arbitration agreement in Resident #19's Electronic medical Record (EMR). 2. On 1/16/25 at 9:32 a.m., during an interview, the Admissions and Marketing Director stated she is responsible for having the resident/family representative sign the admission packet which also contains the Resident and Facility Arbitration Agreement upon admission or within 48 hours. The admission packet is now digital stating, We use Docusign, they can do it at home. I either do it with the resident or family. I email to family, the resident is with me, I go over it with them and ask, Can sign I for you. I need to know who is signing before I go, because I have to generate the packet with who is going to sign .it's easier than going through each individual piece of paper for them to sign. The surveyor asked how she explains the arbitration agreement to residents or family, she stated, My talking points, the Center offers arbitration for legal matters. If you accept you are waiving your right to a judge or jury, that's my [NAME], if they want more detail I'll explain if you go to court with a lawyer or arbitration. The Surveyor asked, if the admission contract is emailed how does she explain the arbitration agreement, They have to read it and call me if they have any questions. Everything is self-explanatory for them to be able to do it on their own. On 1/16/25 at 11:06 a.m., during an additional interview with 3 surveyors present, the Admissions and Marketing Director was asked if she explained that signing an arbitration, after 30 days, it's binding even after discharge and readmission. She stated, I don't think it's a forever signature and they get a new one with every admission. At this time, the surveyors and the Admissions and Marketing Director reviewed the facilities arbitration agreement which states, The Resident also understands that: (1) he/she has the right to seek legal counseling concerning this agreement and (2) this agreement may be rescinded by written notice to the Facility from the Resident within 30 days of the Resident's signature below. If not rescinded within 30 days, this agreement shall remain in effect for all care and services subsequently rendered at the Facility, even if such care and services are rendered following the Resident's discharge and readmission to the Facility. The Admissions and Marketing Director confirmed she was unaware that an arbitration agreement would be a permanent decision and believed with each new admission a new agreement could be made. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 4/10/24 the Division of Licensing and Certification received a complaint from Resident #126's representative stating, I should have been alerted when they had me sign a Resident and Facility arbitration agreement upon admission. On 1/17/25 at 3:28 p.m., during a telephone interview with Resident #126's representative, she stated, The woman that was in charge of the admittance, she said, Oh, you have to sign all these papers, she didn't really explain a lot of stuff to me. At that point I was exhausted. I've been going back to Southern Maine Medical everyday and at that point I just wanted to get [Resident #126] in there. So, I signed whatever paperwork I needed. The surveyor asked if it was clearly explained that signing the arbitration agreement was not a requirement for admission, she stated, Not that I can remember. I signed the paperwork because it was pressure from her but also pressure on my part because there wasn't any other facilities available. At that point, it was like, I'll do what I have to do to get [Resident #126] in there. On 1/16/25 at 11:32 a.m., during an interview with 3 surveyors, the Administrator and the Admissions and Marketing Director the above was discussed; the arbitration is in the admission packet, residents or families are signing all the paperwork for an admission. At this time, the surveyor expressed the concern that the Admissions and Marketing Director was not fully aware of the terms and conditions of an arbitration and therefore would not be able to clearly explain those terms and conditions appropriately to residents and family representatives. 48648 4. On 1/16/25 at 10:10 a.m., a surveyor met with Resident #19 and asked if he/she signed an arbitration agreement with the facility during admission. He/She did not think so but said there were so many documents. It was overwhelming. A surveyor let him/her know that she had signed an arbitration agreement and explained what that meant. Resident #19 stated, I would not have signed that if I had understood. I don't remember anyone explaining that. 5. On 1/16/25 at 10:20 a.m. a surveyor met with Resident #64 who had overheard the conversation about the arbitration agreement and wanted to know if she/he had signed one. After confirming that Resident #64 had signed one and it was in their EMR. Resident #64 stated that no one explained this and she/he thought all the forms had to be signed for admission to the facility. 6. On 1/26/25 at 10:45 a.m., a surveyor met with Resident #230 after locating a signed arbitration agreement in their EMR. Resident #230 was unaware this was not a required part of the admission packet. Upon explaining what an arbitration agreement meant, Resident #230 stated I probably would not have signed that had I known. 7. On 1/26/25 at 11:00 a.m., a surveyor met with Resident #23 after locating a signed arbitration agreement in their EMR. After a surveyor explained the agreement and asked if anyone had explained this before she/he signed it. She/he stated that she does not remember anyone explaining this agreement. There were so many papers to sign when I got here and she didn't know what she was signing. I thought they were just admission papers. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/6/25 at 2:30 p.m., a surveyor met with the Administrator and the Admissions Coordinator with 3 other surveyors present. At this time the Administrator apologized for saying there were no arbitration agreements. He was not feeling well on Monday (1/13/25). They were both unaware that residents did not understand they had signed a binding agreement that limits their rights to choose a dispute resolution method.