STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205098	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hawthorne House	6 Old County Rd Freeport, ME 04032

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 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** 37015 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 interior for the 3 of 5 units ([NAME] - Long Hall, Kennebec, and Somerset units). Findings: On 5/8/24, from 11:55 a.m. to 12:10 p.m., a surveyor completed an environmental tour with the Director of Maintenance and the Maintenance Assistant. The following findings were confirmed: On the [NAME] unit, Long Hall: >room [ROOM NUMBER], the center of the floor was observed with 7 cracked floor tiles, creating an uncleanable surface. In the bathroom of room [ROOM NUMBER], a black substance was noted around the base of the toilet. >In the common area, the nonslip adhesive covering on the base of the wheelchair scale was observed to be torn and lifting up. On the Somerset unit: >The shared bathroom for rooms [ROOM NUMBERS] was observed with a stained floor tile under the sink. >The shared bathroom for rooms [ROOM NUMBERS] was observed with peeling and missing areas of laminate on the sink vanity, with the underlying wood exposed, creating an uncleanable surface. >The shared bathroom for rooms [ROOM NUMBERS] was observed with an area of patched drywall requiring paint. >The base and frame of the sit to stand lift was observed with dirt, debris, and a white powdered substance. >The wheelchair for Resident #3 was observed with a ripped right armrest, and a torn seat cushion exposing the foam padding. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205098	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hawthorne House	6 Old County Rd Freeport, ME 04032

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On the Kennebec Unit: >The shared bathroom for rooms [ROOM NUMBERS] was observed with a black substance at the base of the toilet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205098	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hawthorne House	6 Old County Rd Freeport, ME 04032

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 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 33639 Based on record review and interviews, the facility failed to issue a written transfer/discharge notice to a resident or their legal representative for a facility-initiated transfer/discharge for 2 of 2 sampled residents transferred/discharged to an acute care facility. (#13, #31) Findings: Documentation in Resident 13's clinical record indicated that he/she was discharged /transferred to an acute hospital on 3/24/24 and 7/2/23 and subsequently admitted . The clinical record lacked evidence that the facility issued a written discharge/transfer notice to the resident and/or legal representative. Documentation in Resident 31's clinical record indicated that he/she was discharged /transferred to an acute hospital on 5/25/23 and 9/21/23 and subsequently admitted . The clinical record lacked evidence that the facility issued a written discharge/transfer notice to the resident and/or legal representative. On 5/7/24 at 3:26 p.m., the surveyor confirmed the above findings in an interview with the Licensed Clinical Social Worker.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205098	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hawthorne House	6 Old County Rd Freeport, ME 04032

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 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 33639 Based on record review and interviews, the facility failed to issue a written transfer/discharge notice to a resident or their legal representative for a facility-initiated transfer/discharge for 2 of 2 sampled residents transferred/discharged to an acute care facility. (#13, #31) Findings: Documentation in Resident 13's clinical record indicated that he/she was discharged /transferred to an acute hospital on 3/24/24 and 7/2/23 and subsequently admitted . The clinical record lacked evidence that the facility issued a written discharge/transfer notice to the resident and/or legal representative. Documentation in Resident 31's clinical record indicated that he/she was discharged /transferred to an acute hospital on 5/25/23 and 9/21/23 and subsequently admitted . The clinical record lacked evidence that the facility issued a written discharge/transfer notice to the resident and/or legal representative. On 5/7/24 at 3:26 p.m., the surveyor confirmed the above findings in an interview with the Licensed Clinical Social Worker.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205098	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hawthorne House	6 Old County Rd Freeport, ME 04032

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 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 37648 Based on 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 assessment for 3 of 4 potential interdiciplanary meetings. (Resident #37). Finding: On 5/6/24 at 10:37 a.m., during an interview, Resident #37 stated he/she had only participated in one care plan meeting in the past year. Review of Resident #37's IDT care plan meeting notes indicated IDTs occurred on 7/26/23 and on 11/1/23. The medical record lacked evidence that he/she was invited and/or participated in his/her IDT meeting. In addition, the IDT meeting which occurred on 2/7/24 stated Resident #37 did not attend because resident in middle of dressing change. On 5/7/24 at 12:14 p.m., during an interview, the Licensed Social Worker confirmed the above.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205098	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hawthorne House	6 Old County Rd Freeport, ME 04032

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 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, record reviews, and interviews, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to oxygen and nebulizer mask/tubing for 6 of 6 residents reviewed for respiratory care (Residents #2, #3, #16, #37, #69 and #172). In addition, the facility failed to follow the physician order for 1 of the 6 sampled residents (Resident #172) for 2 of 3 day of survey (5/6/24 and 5/7/24). Findings: The facilities Respiratory Therapy policy and procedure, revised to 2/2022 States, under Infection Control Considerations Related to Oxygen Administration instructs nursing to . Change the oxygen cannula and tubing every seven (7) days or as needed. Keep the oxygen cannula in tubing used PRN in a plastic bag they're not in use. Check and clean filters for oxygen concentrators every seven days. Under Infection Control Considerations Related to Medication Nebulizers/Continuous Aerosol instructs nursing to, after completion of therapy remove the nebulizer container, rinse the container with fresh tap water, dry on a clean paper towel or gauze sponge . store the circuit in plastic bag, marked with date and residents name, between uses . Discard the administration setup every seven (7) days. 1. On 5/6/24 at 9:54 a.m. and on 5/7/24 at 12:24 p.m., observations of Resident #2's unlabeled or dated oxygen nasal cannula being stored by lying across his/her bed. Review of Resident #2's medical record lacked evidence of an order or documentation of the nasal cannula changed weekly. 2. On 5/6/24 at 10:04 a.m. and on 5/7/24 at 12:25 p.m., observations of Resident #3's oxygen nasal cannula with a date of 4/14/24 wrapped up and stored on top of the bedside dresser. In addition, Resident #3's Treatment Administration Record (TAR) had documentation of the nasal cannula being changed on 4/21/24, 4/28/24 and 5/5/24. 3. On 5/6/24 at 11:55 a.m. and on 5/7/24 at 12:27 p.m., Resident #16's nebulizer mouth piece and nebulizer container still assembled and stored on the back of the nebulizer machine, there was no bag available for storage. 4. On 5/6/24 at 10:37 a.m. and on 5/7/24 at 12:38 p.m., observations of Resident #37's room to have an Oxygen tank with a unlabeled or dated nasal cannula tubing wrapped up and stored hanging on the handle of the oxygen caddy. Review of Resident #37's TAR indicated he/she has not utilized oxygen within the past month. 5. On 5/6/24 at 10:07 a.m. and on 5/7/24 at 10:02 a.m., observations of Resident #69's unlabeled or dated oxygen nasal cannula wrapped up and stored on top of the bedside dresser. Review of Resident #69's medical record lacked evidence of documentation of the nasal cannula being changed weekly. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205098	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hawthorne House	6 Old County Rd Freeport, ME 04032

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. On 5/6/24 at 12:58 p.m. and 5/7/24 at 12:39 p.m., observation of Resident #172 wearing an unlabeled or dated oxygen nasal cannula with the concentrator set at 1 liter per minute (LPM). At this time, Resident #172 stated that he/she is on 1 LPM of oxygen for his/her shortness of breath (SOB). Review of Resident #172's medical record lacked evidence of an order or documentation of the nasal cannula being changed weekly. However the surveyor noted a Physician order dated 5/1/24 states, for Dyspnea, apply Oxygen at 2L[Liters] per NC [Nasal Cannula] of SOB and/or O2 sat less than 90% and Notify Provider as needed. On 5/7/24 at 1:43 p.m., both the surveyor and the Acting Director of Nursing (DON) observed the above oxygen nasal cannula's storage, the unlabeled or dated tubing, Resident #3's TAR which documented the nasal cannula tubing had been changed weekly x3 and R#172's oxygen concentrator set at 1LPM. The Acting DON adjusted Resident #172's the oxygen to reflect the current physician orders at 2 LPM and confirmed the above stating that oxygen tubing should be changed weekly and documented on the TAR and should be stored in a plastic bag when not in use. 33639

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205098	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hawthorne House	6 Old County Rd Freeport, ME 04032

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 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** 37648 Based on record review, the Centers for Disease Control (CDC) guidance, observations and interviews the facility failed to adequately monitor vaccine storage temperatures on 1 of 1 immunizations refrigerator (Kennebec unit) and failed to ensure an expired medication was removed from the supply available for use on 1 of 4 medications carts observed ([NAME] Short Hall) Findings: Facilities Vaccine Storage and Handling Requirements and Considerations, states under Handling Vaccine: Maintain a daily temperature log that clearly shows when temperatures are not correct .check unit temperature two times per day, once in the morning and once in the evening, and record them on the temperature log posted on the storage unit. Review of CDC guidance Vaccine Storage and Handling Toolkit dated ,d+[DATE] states .Refrigerators should maintain temperatures between 2 C and 8 C (36 F and 46 F) .Every vaccine storage unit must have a Temperature Monitoring Device (TMD). An accurate temperature history that reflects actual vaccine recommended temperature range. 1. On [DATE] at 11:36 a.m., observation of Immunization refrigerator on the Kennebec unit with the Licensed Practical Nurse (LPN). The refrigerator contained the following immunizations: 14 boxes of Influenza vaccines, 11 individual COVID-19 vaccines and 2 Pneumonia vaccines, a Prevnar 13 and a Prevnar 20. Review of the Maine Immunization Program Refrigerator Temperature Log which was attached to the front of the refrigerator indicates temperature monitoring to be completed twice daily. Review of the following months lacked monitoring of temperatures twice daily: > [DATE] out of 31 days a temperature was documented once a day. The remaining days there was no temperature monitoring. > February 2024, 11 out of 29 days a temperature was documented once a day. The remaining days there was no temperature monitoring. > [DATE] out of 31 days a temperature was documented once a day. The remaining days there was no temperature monitoring. > [DATE] out of 30 days documented temps once daily. The remaining days there was no temperature monitoring. > As of [DATE] 1 of 5 days a temperature was documented once a day. At this time, the lack of temperature monitoring for immunizations was confirmed with the LPN. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205098	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hawthorne House	6 Old County Rd Freeport, ME 04032

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On [DATE] at 10:32 a.m., during observation of the [NAME] Short Hall medication cart with the Certified Medication Technician (CNA-M) an opened bottle of Milk of Magnesium with the expiration date of , d+[DATE] was noted. At this time, the CNA-M confirmed and discarded the expired medication. On [DATE] at approx. 2:15 p.m., the above was discussed with the Acting Director of Nursing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205098	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hawthorne House	6 Old County Rd Freeport, ME 04032

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44049 Based on observations and interviews, the facility failed to serve and store food in a sanitary manner on 2 of 3 survey days. Findings: 1. On 5/6/24 at 9:05 a.m., during initial kitchen tour, with the Director of Food Service, a surveyor observed in the walk-in refrigerator, a bag of hard-boiled eggs that were not dated and not labeled. This was confirmed with the Director of Food Service at that time. 2. On 5/8/24 at 10:30 a.m., during a return observation of the Kitchen with the Food Service Director, a surveyor observed a light to moderate amount of dust & debris on all ceiling vents. Also observed a large stand mixer that the cook stated that they rarely use it and have not used it in over a month, had a small amount of dark liquid on the bottom of the bowel and the entire mixer was cover with a light amount of dust and scattered food particles. This was confirmed with the Food Service Manager at that time.