STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205109	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshall Health Care and Rehab	16 Beal Street MacHias, ME 04654

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and interviews, the facility failed to promote care for all residents in a manner that maintains each resident's dignity and respect during repositioning on 1 of 4 survey days (6/23/25), and during breakfast meal service on 1 of 4 survey days (6/26/25). Findings: 1. On 6/23/25 at 12:15 p.m., during a resident observation in the South wing dining room, Resident #38 [R38] was sitting in their wheelchair slouching/sliding out of the wheelchair. a Certified Nursing Assistant (CNA) was observed walking over to R38 and grabbed the pants/waistband of his/her pants and pulled the resident up to a proper sitting position which resulted in R38's pants being pulled up causing their incontinence brief being shifted to the side and bulging in the crotch area. On 6/23/25 at 12:20 p.m., during an interview with the CNA, the surveyor confirmed that using a residents pants as a repositioning tool is a dignity and respect concern, the CNA stated that she should have used a gait belt for repositioning. 2. On 6/26/25 at 8:00 a.m., during a resident observation in the [NAME] wing dining room, two surveyors observed R34 sitting in a wheelchair, positioned in the aisle between 2 tables. R34 looked around watching the other residents eat. R30 pointed out that R34 hasn't eaten to staff and invited R34 to sit at his/her table. At 8:30 a.m., a staff member asked R34 if he/she would like to eat and assisted R34 to sit at R30's table. R34 was served breakfast without silverware, at the time of positioning to table. At 8:37 a.m., staff gave R34 silverware to eat their meal. This was observed and confirmed with the Administrator at the time of the observation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to monitor and adequately treat 1 of 2 residents (Resident #255 [R255]) reviewed for Skin Conditions, when the facility failed to follow discharge orders for the use of a diuretic medication (a medication used to treat fluid retention [edema] associated with conditions such as heart failure), obtain and monitor daily weights, and failed to report a potentially significant weight gain. These failures resulted in harm to R255 who required hospitalization for the treatment of worsening signs and symptoms of diastolic congestive heart failure. Findings: On 6/26/25, review of R255's clinical record indicated the following: R255 has an active diagnosis of heart failure, and hypertensive heart disease with heart failure, and R255 had a Brief Interview for Mental Status (BIMS) score of 4 (indicates severe cognitive impairment). The hospital discharge instructions were signed into use for admission orders but not dated (See F711). The discharge instructions identified under Assessment and Plan, [Diastolic Congestive Heart Failure (D-CHF)] as chronic, stable - no exacerbation . [continue (cont)] home Lasix, [Potassium Chloride (KCL)]. Under the Special Instructions heading, directed the provider to be notified of the following signs/symptoms, increased difficulty breathing, Weight gain or low of 3 pounds on two consecutive days, and Swelling in your ankle of feet. The clinical record lacks evidence that the home Lasix (a medication used to treat fluid retention [edema] associated with conditions such as heart failure) was continued as directed. On 6/5/25 at 2:57 p.m., R255's admission weight was 164.1 pounds (Lbs). On 6/6/25, doctor's orders indicated, OBTAIN WEIGHT DAILY - notify [Doctor of Medicine (MD)] of weight gain or loss of 3 pounds on 2 consecutive days, one time a day for Monitoring obtain weight daily notify MD of weight gain or loss of 3 pounds on 2 consecutive days, with a start date of 06/07/2025. On 6/6/25 at 2:35 p.m., a skilled evaluation note indicated R255's Skin warm and pink . No edema present and No signs of difficulty breathing, Right lung clear, Left lung clear. The clinical record lacks evidence that a daily weight was obtained. On 6/10/25 at 11:12 a.m., R255 weighed 163.6 Lbs. The clinical record lacked evidence that R255 was weighed on 6/6/25, 6/7/25, 6/8/25, or 6/9/25 (4 days). On 6/14/25, the MD had a scheduled visit with R255 and indicated R255 was receiving furosemide (Lasix) 40 milligrams (mg) once daily. The clinical record lacked evidence that the MD addressed R255's heart failure or reviewed the total program of care at that time (See F711). The record lacks evidence that R255 received furosemide as indicated in the discharge instructions or the MD's note. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 6/19/25 at 12:05 p.m., a skilled evaluation note identified a new onset of non-pitting edema of both feet dependent on R255's position, and No signs of difficulty breathing, No shortness of breath noted, Right lung clear. Left lung clear. The clinical record lacked evidence that R255's weight was obtained on 6/11/25, 6/12/25, 6/13/25, 6/14/25, 6/15/25, 6/16/25, 6/17/25, 6/18/25, or 6/19/25 (9 days). On 6/24/25 at 1:43 p.m., R255 weighed 175.6 Lbs. At 3:32 p.m., a skilled evaluation note identified, non-pitting edema of both feet dependent on R255's position, and No signs of difficulty breathing, No shortness of breath noted. At 5:02 p.m., a health status note indicated [R255's] lower legs have +3 [pitting] edema noted. resident stated that it has been chronic. There is no evidence that the provider was notified of the 12 Lbs weight gain or the new onset of pitting edema, and the record lacked evidence that R255's weight was obtained on 6/20/25, 6/21/25, 6/22/25, or 6/23/25 (13 consecutive days from 6/11/25-6/23/25). On 6/26/25 at 10:29 a.m., a health status note indicated, [R255] was assessed at 1030, [R255] had new onset pitting edema in bilateral lower extremities, [shortness of breath (SOB)], wheezing in upper lobes, and new onset heart murmur. Physician contacted and order to send to [Down East Community Hospital ([NAME])] for evaluation and treatment. Ambulance arrived and resident was taken from facility at 1050 to [NAME]. On 6/26/25 at 3:08 p.m., during an interview with a surveyor and the Unit/Nurse Manager (U/NM), R255's medical record was reviewed. The U/NM stated that she reviewed the discharge instructions with the MD by phone and was directed to follow the discharge instructions completely. She pointed to the direction: OBTAIN WEIGHT DAILY - notify [Doctor of Medicine (MD)] of weight gain or loss of 3 pounds on 2 consecutive days, one time a day for Monitoring obtain weight daily notify MD of weight gain or loss of 3 pounds on 2 consecutive days, and stated this is why she entered the order for daily weights. She stated she followed the discharge medication list for orders as directed by the provider, but the list was handwritten because the hospital's computer systems were down. The order to continue home Lasix was on another page of the discharge instruction packet and not included on the medication list page. At 3:20 p.m., during an interview with a surveyor and U/NM, the MD note dated 6/14/25 was reviewed. U/NM stated the medication list in the note is reviewed and auto populated from the provider's office not from the facility and the provider may not know the resident was not on the furosemide (Lasix) due to a conflict in the computer systems. At this time the surveyor confirmed R255 was not receiving furosemide (Lasix) as ordered in the discharge instructions or as identified by the MD note, that the R255's weights were not obtained for 19 out of 22 days, that the provider was not notified of a 12 pound weight gain, and that R255 was hospitalized due to signs and symptoms of worsening congestive heart failure.

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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 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** Based on observations and interviews, the facility failed to ensure that the resident's environment was free of accident hazards regarding water temperatures for 1 of 4 days (6/26/25) and water spills for 4 of 4 days of survey (6/23/25, 6/24/25, 6/25/25, and 6/26/25). Findings: 1. On 6/23/25 at 1:41 p.m., a surveyor observed a fluid puddle in the entry area of the [NAME] wing dining room. The fluid puddle covered the surface of 3 square foot tiles with a trail running along an additional 4 tiles. There were 3 residents observed at the other end of the dining room. At 1:43 p.m., a surveyor observed and confirmed the presence of the fluid puddle with a Dietary Aide. 2. On 6/24/25 at 8:37 a.m., a surveyor observed fluid on the floor in room [ROOM NUMBER] of the [NAME] wing. The fluid extended from the side of the furthest bed in the room to the doorway. Wet shoe prints observed past the spill in the direction of the window. Resident #42 (R42) was observed sitting in bed while eating breakfast. At 8:46 a.m., during an interview with R42, a surveyor observed a staff member walk through the fluid spill to talk to R42 then returned to the hall without addressing the hazard. At 8:53 a.m., a surveyor observed and confirmed with CNA3 the fluid on the floor in room [ROOM NUMBER] [NAME] wing, including the wet shoe prints, created an accident hazard for residents. 3. On 6/25/25 at 8:23 a.m., a surveyor and the Unit/Nurse Manager/Infection Control Preventionist (U/NM/ICP) observed fluid on the floor in the South wing hallway. The fluid extended down the hallway past approximately 6 resident rooms, there were 6 areas of fluid streaks and puddles in the hallway with no staff or wet floor signs to alert residents and staff of the wet floor areas. The surveyor confirmed the presence of the fluid streaks and puddles with the U/NM/ICP at the time of observation, she said it was probably from the floor machine. No staff were observed cleaning the floor at time of observation. 4. On 6/26/25 at 12:02 p.m., two surveyors identified hot water temperatures as follows on the: South Wing: Hallway bathroom at 12:01 p.m. = 121.4 degrees Fahrenheit room [ROOM NUMBER] at 12:06 p.m. = 121.8 degrees Fahrenheit West Wing: room [ROOM NUMBER] at 12:23 p.m. = 120.2 degrees Fahrenheit room [ROOM NUMBER] at 12:27 p.m. = 123.1 degrees Fahrenheit Repeat temperatures with Maintenance Director: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room [ROOM NUMBER] at 12:45 p.m. = 125.0 degrees Fahrenheit room [ROOM NUMBER] at 12:50 p.m. = 124.3 degrees Fahrenheit On 6/26/25 at 12:30 p.m., during an interview with a surveyor, the Maintenance Director stated that water temperatures are taken every Monday, and maintenance on the mixing valve is completed every 6 months and is due. The above findings were observed and confirmed with the Maintenance Director at the time of the repeat temperatures.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on record reviews and interviews, the facility failed to ensure the physician reviewed the resident's total program of care, ensure orders were complete, signed and dated for 2 of 4 residents reviewed under the general pathway (Resident #6 [R6] and [R255]). Findings: 1. On 12/27/24, a telephone order for R6 indicated, Update loperamide [a diarrhea medication] order to recommended dosage. This order was incomplete, signed by the provider, but not dated by the provider. A second telephone order indicated Give ½ of Resource juice [with (w/)] meds [twice a day (BID)]. The provider signed but did not date the order. On 6/26/25 at 9:18 a.m., during an interview with a surveyor and the Director of Nursing (DON), R6's medical record was reviewed. The DON stated the loperamide order was placed after pharmacy requested clarification. At this time the surveyor confirmed the order was incomplete, and the provider signed but did not date a total of 11 telephone orders over the past 6 months (12/27/24 (2 separate orders), 12/4/24 (2 separate orders), 12/2/24, 11/30/24, 11/25/24, 11/23/24, 11/22/24, 11/20/24, and 11/19/24). 2. On 6/5/25, R255's discharge instructions indicated under the Assessment and Plan: 1. Left Hip Fracture after mechanical fall, pain controlled with current medication. 2. Hypothyroid, chronic, stable, continue with current medication. 3. Diastolic Congestive Heart Failure (D-CHF), chronic, stable, continue home Lasix. Special Instructions directed to notify the provider for increased difficulty breathing, weight gain or loss of 3 pounds on two consecutive days, and/or swelling of the ankles or feet. These orders were signed by the facility's provider but not dated. The clinical record lacked evidence that the home Lasix was continued in the facility, or that the daily weights were monitored (See F684). On 6/14/25, a provider note addressed R255's Hip Fracture, and directed continue current medications, management, and physical therapy. The provider note also indicated R255 was currently prescribed Furosemide (Lasix). The provider note did not address R255's Diastolic Heart Failure for monitoring or management. On 6/26/25 at 3:20 p.m., during an interview with a surveyor and Unit/Nurse Manager (U/NM), the provider note dated 6/14/25 was reviewed. U/NM stated the medication list in the note is reviewed and auto populated from the provider's office not from the facility and the provider may not know the resident was not on the furosemide (Lasix) due to a conflict in the computer systems. The provider comes to the facility for assessments but returns to his office offsite for documentation and review. At this time the surveyor confirmed the provider did not review the full plan of care for R255 and did not date the signed orders on admission.

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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. 2. On 6/24/25 at 10:04 a.m. during a review of R40's EMAR and nursing progress notes, it was noted that R40 had an order for Tramadol HCl [hydrochloric acid] Oral Tablet 50 milligrams (mg) (medication used to treat moderate to moderately severe chronic pain in adults), Give 50 mg by mouth every 4 hours for pain. The EMAR shows documentation that on 5/26/25 at 4:00 p.m. R40 did not receive his/her dose of Tramadol documented that the medication not available but has been ordered and should be here this p.m On 5/27/25 the EMAR documents that his/her 1200 dose was on hold due to waiting for shipment from pharmacy, and the medications had already shipped so pharmacy unable to give this nurse an override code without emergency prescription sent in from MD (doctor of medicine). There is no evidence in R40's clinical record that an emergency prescription was sent into the pharmacy resulting in R40 missing his/her 1200 dose of Tramadol. On 5/27/2025 at 3:30 p.m., the EMAR documents that R40's 4:00 p.m. dose was not available, the medication was coming from pharmacy that evening, the medication was not available from the Pyxis (medication dispensing machine, emergency medicine supply) because they had no override code. On 6/25/25 at 12:17 p.m. during an interview and record review for R40 with the DON and the Unit/Nurse Manager/ICP, the nursing progress notes show that R40 did miss three doses of Tramadol due to unavailability from pharmacy. And the facilities failure to obtain the medication from their Pyxis, the nursing progress notes documents that the pharmacy would not provide a Pyxis code to the nurse that would allow her to get the Tramadol for R40. The DON stated the pharmacy should have given a code to use the Pyxis for the medication needed and that they did not use a local pharmacy to obtain the medication because Pharmerica (pharmacy) would not send the script over to the local pharmacy due to the medication already scheduled for delivery the night of 5/27/25. At this time the surveyor confirmed that R40 missed 3 doses of his/her tramadol for pain control. Based on record reviews and interview, the facility failed to ensure that physician ordered medications were available for use to meet the needs of the residents for 2 of 5 residents reviewed (Resident #202 [R202], and R40). Findings: 1. On 6/25/25, during a review of R202's electronic medication administration record (EMAR), it was noted that R202 had an order for Dexlansoprazole Oral Capsule Delayed Release 60 MG [milligram] (medication that treats lowers stomach acid). Give 1 capsule by mouth one time a day for GERD [gastroesophageal reflux disease] - Start Date- 06/17/25 09:00 [a.m.]. On 6/17/25 through 6/25/25 the EMAR report shows documentation that on 6/17/25 at 9:00 a.m. through 6/25/25 9:00 a.m. R202 did not receive his/her doses of Dexlansoprazole for a total of 9 missed doses due to being on order, ordered or not available (n/a). R202 had another order for Pantoprazole Sodium Oral Tablet Delayed Release 40 MG (medication that reduces stomach acid) Give 1 tablet by mouth one time a day for GERD - Start Date- 6/17/24 9:00 a.m. by mouth daily for GERD and R202 did not receive his/her doses of Pantoprazole for a total of 6 missed doses due to being on order, ordered or not available (n/a) on the following days 6/17/25 through 6/20/25, 6/22/25, 6/23/25. On 6/25/25 at 12:14 p.m. in an interview with the Director of Nursing [DON], a surveyor confirmed that R202 missed 9 doses of Dexlansoprazole and 6 doses of Pantoprazole.

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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** Based on observations and interviews, the facility failed to ensure medications were stored properly in two medication storage refrigerators for 2 of 3 medication storage refrigerators reviewed (1 on [NAME] Wing, and 1 on South Wing), failed to ensure that an expired immunization was removed from the supply available for use in 1 of 3 medication storage refrigerators reviewed (West Wing), and failed to monitor medication refrigerator temperatures for 3 of 3 medication storage refrigerators (West Wing Medication refrigerator/freezer, South Wing Immunization refrigerator, and South Wing refrigerator/freezer). Findings: On [DATE] at 8:44 a.m., in an observation and interview with the Unit/Nurse Manager/Infection Control Preventionist (Unit/NM/ICP], a surveyor and the Unit/NM/ICP observed, on the [NAME] Wing, in the medication storage room, significant ice buildup in the dormitory style refrigerator (small combination refrigerator/freezer unit that is outfitted with one exterior door) which is inappropriate for storing medications due to temperature fluctuations. The refrigerator contained several medications along with an expired vial of Prevnar 20, 0.5 ml (millimeter) filled syringe (pneumonia vaccine) available for use with an expiration date of [DATE], 43 days past its expiration date. On [DATE] at approximately 8:50 a.m., in an observation and interview with the Unit/NM/ICP, a surveyor and the Unit/NM/ICP observed, on the South Wing, in the medication storage room, significant ice buildup in the dormitory style refrigerator (small combination refrigerator/freezer unit that is outfitted with one exterior door) which is inappropriate for storing medications due to temperature fluctuations. The refrigerator contained several medications. On [DATE] at approximately 8:51 a.m., in an observation and interview with the Unit/NM/ICP, a surveyor and Unit/NM/ICP observed, on the South Wing, in the medication storage room, a refrigerator intended to store immunizations lacked evidence that refrigerator temperatures were monitored. On [DATE] at 9:10 a.m., in an observation and interview with the Director of Nursing (DON), a surveyor and DON observed, on the South Wing that the vaccine refrigerator was noted to have an internal temperature reading of 40 degrees Fahrenheit. The DON confirmed that vaccines were kept in the refrigerator for resident use. There was no observed temperature log to ensure that the refrigerator temperatures were being monitored to ensure medications and vaccines were stored at appropriate temperature. On [DATE] at 9:11 a.m., the DON produced a temperature logbook, titled Medication, refrigerator/freezer temperature, Wing South, Month, Jun (June), Year, 2025. The temperature logbook was missing documented temperatures for [DATE] and [DATE], 2 of 25 days. On [DATE] at 9:11 a.m., the DON produced a temperature logbook, titled Immunization, Refrigerator Temperature, Wing South, Month Jun (June), Year 2025. The temperature logbook was missing documented temperatures for [DATE]-[DATE], [DATE]-[DATE], 21 of 25 days. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 9:23 a.m., the DON produced a temperature logbook, titled Medication, Refrigerator/Freezer Temperature, Wing West, Month June, Year 2025. The temperature logbook was missing documented temperatures for [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE], 6 of 25 days. On [DATE] at 9:25 a.m. in an interview with the DON, a surveyor confirmed the above findings.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on interview and employee personnel record reviews, the facility failed to implement and maintain an effective training program by failing to ensure that 2 of 5 Certified Nursing Assistant's (CNA) employed, completed training (CNA1 and CNA2). Finding: 1. CNA1 was hired on 6/24/24. A review of CNA1's education record lacked evidence that she received the required in-service trainings for abuse, resident rights and behavioral trainings. On 6/26/25 at 2:27 p.m., during an interview and a record review of CNA1's training with the Business Office Manager she stated that CNA1 has not had the trainings listed above, that she is always calling them to get the trainings done. At this time the surveyor confirmed this finding. 2. On 6/26/25, review of CNA2's employee file indicated the date of hire was 5/2/22. The employee file lacked evidence that CNA2 received annual in-service trainings for communication, resident rights, behavioral health, dementia management, abuse prevention, and/or training to ensure continuing competency of nurse aids for a minimum of 12 hours per year. At 2:49 p.m., during an interview with a surveyor, the Business Office Manager confirmed CNA2 had an annual evaluation but has not completed the annual trainings. At this time the surveyor confirmed this finding.