STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205120	A. Building B. Wing	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterville Center for Health and Rehab	7 Highwood St Waterville, ME 04901

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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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. 49635 Based on interviews and record review, the facility failed to provide a resident access to personal funds (Resident #47 [R47]). Finding: On 9/9/24 at 11:41 a.m., in an interview with a surveyor, R47 stated, I didn't get the $40.00 for the last 2 months. I was fighting about that this morning. Corporate took it all instead of giving it to me. They said they need to find out why. Review of R47's financial statements indicated the facility's cost of care deduction for R47 was $1,251.00 per month, which left $40.00 dollars in an account for personal use. The facility deducted $1,291.00 for cost of care on 8/2/24 and 9/3/24 with out explanation for the increased charge. On 9/12/24 at 7:50 a.m., in an interview with a surveyor, the Nursing and Operations Assistant stated she became aware of this when R47's guardian came to do some shopping for R47 but there was not enough money in the account; an email was sent on 9/9/24 regarding this error, and compensation had to wait until a reply was received from the Corporate office. At this time a surveyor confirmed that a resident did not have access to the $80.00 of personal funds that was deducted without explanation.

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

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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 0578 Level of Harm - Minimal harm or potential for actual 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** 42531 Based on record review and interviews the facility failed to provide/obtain Resident and/or Resident's Representatives written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an Advance Directive for 8 of 8 Resident's reviewed for Advance Directives (Resident #26 [R26], R46, R251, R252, R43, R4, R64, and R34). Findings: Review of facility policy Advance Directive undated states, .As part of the admission process, [Facility] Social Service Department shall ask and document in the resident's medical record whether the resident has executed an Advance Directive (i.e., Living Will or Durable Healthcare Power of Attorney), if so, the social worker shall obtain a copy and place it in the resident's current medical record. In the absence of an Advance Directive, the social worker shall provide to the Resident and/or the admitting party written information about Maine's Advance Directive laws, the right to refuse or accept medical care, sample forms, and this policy. 1. R26 was admitted on [DATE] and has diagnoses to include recent liver transplant, chronic kidney disease, and presence of heart valve on admission. Review of R26's clinical record lacked evidence that the facility provided/obtained Resident and/or Resident's Representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an Advance Directive. 2. R46 was admitted on [DATE] and has diagnoses to include diabetes mellitus II, chronic obstructive pulmonary disease (COPD), hypertension, and end stage renal failure and is dialysis dependent. Review of R46's clinical record lacked evidence that the facility provided/obtained Resident and/or Resident's Representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an Advance Directive. 3. R251 was originally admitted on [DATE] and has diagnoses to include heart failure, diabetes mellitus and chronic kidney disease. Review of R251's clinical record lacked evidence that the facility provided/obtained Resident and/or Resident's Representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an Advance Directive. 4. R252 was admitted on [DATE] and has diagnoses to include recent history of heart attack, left bundle branch block and first degree atrioventricular block with recent pacemaker placement. Review of R252's clinical record lacked evidence that the facility provided/obtained Resident and/or Resident's Representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an Advance Directive. (continued on next page)

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	37440 5. R43 was admitted on [DATE] and had diagnoses to include multiple sclerosis, convulsions and multiple pressure ulcers. Review of R43's clinical record lacked evidence that the facility provided/obtained Resident and/or Resident's Representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an Advance Directive. 6. R4 was admitted on [DATE] and had diagnoses to include hypoxic ischemic encephalopathy, heart failure, acute respiratory failure, chronic obstructive pulmonary disease and acute kidney failure. Review of R4's clinical record lacked evidence that the facility provided/obtained Resident and/or Resident's Representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an Advance Directive. 7. R64 was admitted on [DATE] and had diagnoses to include chronic kidney disease, type 2 diabetes mellitus and heart failure. Review of R64's clinical record lacked evidence that the facility provided/obtained Resident and/or Resident's Representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an Advance Directive. 8. R34 was admitted on [DATE] and had diagnoses to include acute and chronic respiratory failure, type 2 diabetes mellitus, chronic obstructive pulmonary disease, obstructive sleep apnea, a traumatic brain injury and bipolar disorder. Review of R34's clinical record lacked evidence that the facility provided/obtained Resident and/or Resident's representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an Advance Directive. During an interview with four surveyors on 9/11/24 at 11:03 a.m., the Administrator and Social Worker confirmed above findings.

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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 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 2 of 4 units (Mountain Top Unit and Harbor Unit) for 3 of 3 facility tours (9/9/24, 9/10/24 and 9/12/24). Findings: 1. On 9/9/24, the following observations were made and confirmations received at time of observation: > On 9/9/24 at 12:52 p.m., in the Cranberry dining room on the Mountain Top Unit, a surveyor observed a pile of wet towels under the ice machine, the flooring had stripped away and the cabinet laminate had peeled back. Mildew was visible on the wall and the floor. At this time, in an interview, Certified Nursing Assistant #2 (CNA2) observed and confirmed the findings. > On 9/9/24 at 12:12 p.m., in the Blueberry dining room on the Mountain Top Unit, a surveyor observed fruit flies over the stove and around the sink. At this time, in an interview, Registered Nurse #2 (RN2) observed and confirmed the findings. > On 9/9/24 at 12:36 p.m., a surveyor observed fruit flies in Resident room [ROOM NUMBER] during an interview with Resident #3 (R3). 2. On 9/10/24 the following observations were made and confirmations received at time of observation: > On 9/10/24 at 8:15 a.m., a surveyor observed in Resident room [ROOM NUMBER], R3 sitting in his/her wheelchair by his/her bed. A fruit fly was observed flying in the room over a blue tote. R3 was observed waving the fly away. > On 9/10/24 at 8:16 a.m., in R5's room, a surveyor observed a fruit fly flying around during an interview. The resident was observed waving the fly away. > On 9/10/24 at 8:25 a.m., in the Cranberry dining room on the Mountain Top Unit, a surveyor observed fruit flies over the counter space. > On 9/10/24 at 11:53 a.m., in the Harbor Unit dining area, two surveys observed a fly buzzing around in the metal container containing a trifle cake partially covered with plastic wrap. Half of the trifle cake was gone and CNA1 confirmed the finding and remove the cake from the lunch service. 3. On 9/12/24 from 9:30 a.m. to 9:40 a.m., an Environmental Tour was conducted with the Administrator and the Director of Facilities Operations in which the following findings were observed: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	> The shower room across from Resident room [ROOM NUMBER] had sections of non-skid tape peeling up in the shower. > Resident room [ROOM NUMBER] had a bathroom wall that had chipped/gouged paint creating an uncleanable surface. R4's wheelchair had a right armrest that was ripped and torn. > Resident room [ROOM NUMBER] had a ceiling vent that was dusty/dirty. On 9/12/24 at 9:40 a.m. in an interview, a surveyor discussed and confirmed all the above findings with the Administrator and the Director of Facilities Operations.

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 49635 Based on interviews, policy review and record review, the facility failed to ensure a resident's right to remain free from a physical restraint in accordance with S483.12, resulting in an immediate jeopardy situation with psychosocial harm and the risk of physical harm including the potential to cause death [Resident #99 (R99)]. All residents remained at risk as the facility failed to develop and/or implement measures, to protect the residents from further use of unnecessary restraints. Findings: On 7/31/24 at 12:35 p.m., the State of Maine's Division of Licensing and Certification received an anonymous complaint alleging the facility was short staffed and CNAs (Certified Nursing Assistants) were tying residents to chairs. On 9/10/24 at 10:45 a.m., in an interview with a surveyor, the Life Enrichment and Pastoral Care staff member stated, I have never seen or noticed a resident tied to their chairs, but I think I know what you're talking about. That resident passed away. I can't remember what staff or what resident were involved but they were on Cove [Unit]. The surveyor was directed to ask Registered Nurse #1 (RN1). On 9/10/24 at 11:15 a.m., in an interview with the surveyor, RN1 stated she did not remember who the resident was or when the incident happened, but did remember she last saw the resident in bed around 5:00p.m.-5:30p.m., at which time the resident had visitors who were preparing to leave. RN1 stated she remembers the prior Interim Director of Nursing (IDON) asked about the resident being tied to a wheel chair in the days following the incident, RN1 told the prior IDON that she believed the family had restrained the resident. On 9/10/24 at 12:47 p.m., in an interview with a surveyor, the Certified Nursing Assistant -Medications #2 (CNA-M2) stated that she was aware of the possibility of someone having been tied to the bed or chair, and that CNA3 had been placed on administrative leave because of that, but that CNA3 returned quickly, and heard it was the family that had restrained the resident. On 9/12/24 at 8:52 a.m., in an interview the Director of Nursing (DON) stated she knows of the incident but was not here at the time. The DON provided the surveyor with a folder containing partial notes that appeared as a timeline . The notes did not indicate who wrote them or when, but did include a copy of the visitor log on the day of the incident, and 2 witness statements from facility employees CNA6 and CNA7 both dated 7/25/24. According to CNA6's witness statement dated July 25th, 2024, at approximately 6:30 p.m., CNA6 and CNA7 found R99 sitting in [his/her] wheelchair attempting to get out of it. This was due to a sheet wrapped around [his/her] waist, we witnessed that it was double knotted in the back of [his/her] wheelchair . The sheet seemed to act as a restraint due to the fact [he/she] couldn't get out of [his/her] wheelchair. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	According to CNA7's witness statement dated 7-25-24, at approximately 6:30 p.m., CNA7 and CNA6 found [R99] in [his/her] wheelchair trying to stand up but couldn't because there was a sheet tied around her waist then double knotted to the back of [his/her] wheelchair . the sheet seemed to act as a restraint. On 9/12/24 at 9:40 a.m., a surveyor confirmed with the DON that a physical restraint was used to confine R99 to a wheelchair without a physician's order, evaluation/assessment, monitoring or informed consent, and the clinical record lacked documentation regarding the medical need for a physical restraint. On 9/12/24 at 2:22 p.m., in an interview, CNA3 stated R99 was known for getting out of his/her wheelchair and walking from his/her room to the nurse station. CNA3 stated she last saw R99 in bed around 5:30 p.m., there were no visitors in the room at that time. CNA3 stated she was investigated for a day or two but was told it wasn't her fault. The facility's Restraint Use policy, dated 6/24/2014, states the resident has the right to be kept from any chemical/physical restraint imposed for discipline or convenience and not requested to treat his/her medical condition. For residents requiring some level of physical restraint use the following documentation must be in place: -Medical reason or use and type of device with a signed physician order. PRN (as needed) orders are not acceptable. -Documentation indicating the assessment of risk, the interdisciplinary process that determined the least restrictive device, and plan of care for the restrictive device. -Documentation must reflect either the MDS (Minimum Data Set)/Triggers CAA's (Care Area Assessments), continued assessment of the need for, or the medical improvement of the resident that may support a reduction in the means of restraint. -A daily documentation tool indicating the release of the restraint every 2 hours for a minimum of 15 minutes and the type of activity in which the resident participates to enhance mobility. -The resident and/or representative will be informed of risk and benefits and possible negative outcomes and a written consent for use will be obtained. -The consent must be signed by a competent resident, responsible party, or legal representative. -The resident / responsible party has the right to refuse a restraint. The medical record had no such documentation. The immediate jeopardy began on 7/25/24 when the facility failed to ensure R99's right to freedom from physical restraint, and all residents remained at risk of not being free from the use of unnecessary restraints. The immediate jeopardy was identified on 9/13/24. The Administrator, Director of Nursing, and Director of Clinical and Quality Assurance were notified of the immediate jeopardy at 2:25 p.m. on 9/13/24. Please See F-000 Initial Comments related to the IJ removal plan.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 49635 Based on employee record review, facility policy review, and interview, the facility failed to implement its own Abuse, Neglect and/or Misappropriation of Resident Funds or Property Prohibition policy to ensure Maine background checks were completed for new employees before they were permitted to work for 2 of 12 sampled employees (Certified Nursing Assistant #5 [CNA5] and Registered Nurse #1 [RN1]). Findings: The facility's Abuse, Neglect and/or Misappropriation of Resident Funds or Property Prohibition Policy Date: 7/1/2021 and Revised: April 21, 2023, indicates under A. Screening . 1. At a minimum this Community will do the following prior to hiring a new colleague: a. Criminal background checks are conducted per state/federal law/regulation and per [Facility] guidelines. 1. On 9/13/24, a review of CNA5's employee file indicated the date of hire as 6/12/23. CNA5's Maine background check was completed on 7/30/23 (48 days after date of hire and working). 2. On 9/13/24, a review of RN1's employee file indicated the date of hire as 11/6/23. RN1's Maine background check was completed on 9/13/24 (295 days later after date of hire and working). On 9/13/24 at 5:11 p.m., in an interview with a surveyor, the Human Resource Director stated the date of hire is the day an employee starts working in the facility. At this time a surveyor confirmed CNA5 and RN1 were hired and working with Resident's prior to the completion of a Maine background check.

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 49635 Based on interviews, facility policy review, and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Social Security Act, resulting in failure to protect the resident from further potential harm from the perpetrator. In addition, the facility failed to report to law enforcement or the State Survey Agency (SA) an incident of possible abuse including the violation of a resident's right to be free from a physical restraint in accordance with S483.12, which kept the resident from ambulating from a wheelchair [Resident #99 (R99)]. This had the potential to affect all residents in the facility. Findings: The facility's Abuse, Neglect and/or Misappropriation of Resident Funds or Property Prohibition Policy last revised on April 21, 2023 indicated under the Definitions heading: Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. It also states Timing: incidents and/or allegations of abuse . should be reported to the Administrator and/or his/her designee immediately. The Administrator or his/her designee will notify the State Agency of alleged violations involving abuse, neglect . and injuries of unknown source as soon as possible, but in no event later than 24 hours from the time the incident/allegation was made known to them. The Restraint Use Policy dated 6/24/2014 states The resident has the right to be kept from any chemical/physical restraint imposed for discipline or convenience and not requested to treat his/her medical condition. On 7/31/24 at 12:35 p.m., the State of Maine, Division of Licensing and Certification received an anonymous complaint alleging the facility was short staffed and CNAs (Certified Nursing Assistants) were tying residents to chairs. On 9/10/24 at 10:45 a.m. in an interview with a surveyor the Life Enrichment and Pastoral Care staff member stated, I have never seen or noticed a resident tied to their chairs, but I think I know what you're talking about. That resident passed away. I can't remember what staff or what resident were involved but they were on Cove [Unit]. The surveyor was directed to ask Registered Nurse #1 (RN1). On 9/10/24 at 11:15 a.m., in an interview with the surveyor, RN1 stated she did not remember who the resident was or when the incident happened, but did remember she last saw the resident in bed around 5:00p.m.-5:30p.m., at which time the resident had visitors who were preparing to leave. RN1 stated she remembers the prior Interim Director of Nursing (IDON) asked about the resident being tied to a wheel chair in the days following the incident, RN1 told the prior IDON that she believed the family had restrained the resident. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 9/10/24 at 12:47 p.m., in an interview with a surveyor, the Certified Nursing Assistant -Medications #2 (CNA-M2) stated that she was aware of the possibility of someone having been tied to the bed or chair, and that CNA3 had been placed on administrative leave because of that, but that CNA3 returned quickly, and heard it was the family that had restrained the resident. On 9/12/24 at 2:22 p.m., in an interview, CNA3 stated she last saw R99 in bed around 5:30 p.m., there were no visitors in the room at that time. CNA3 stated she was investigated for 1 to 2 days but was told it wasn't her fault. On 9/12/24 at 8:52 a.m., in an interview with a surveyor the Director of Nursing (DON) stated she knows of the incident but was not here at the time. The DON provided the surveyor with the name of the resident and a folder containing the facility's handwritten notes regarding the incident. The folder lacked evidence that the facility reported the incident to law enforcement agencies or to the SA . On 9/12/24 from 8:58 a.m.- 9:40 a.m., interviews were completed with a surveyor and the DON. During the interview: The Director of Clinical and Quality Assurance confirmed she did not report this incident to law enforcement or the SA. The IDON at the time of the incident joined the interview by phone, and confirmed she did not report this incident to law enforcement or the SA. The Interim Administrator at the time of the incident joined the interview by phone and confirmed she did not report this incident to law enforcement or the SA. On 9/12/24 at 9:40 a.m., in an interview with the DON a surveyor confirmed that the facility failed to report the incident to law enforcement or the SA within 24 hours and failed to report a Follow-Up Investigation within 5 working days. The immediate jeopardy began on 7/25/24 when the facility failed to report the violation of R99's right to be free from a physical restraint. All residents remained at risk of such reports not being made as the facility failed to implement policy and procedures to ensure reasonable suspicion of a crime against a resident is reported. Immediate Jeopardy was identified on 9/13/24. The Administrator, Director of Nursing, and Director of Clinical and Quality Assurance were notified of the immediate jeopardy at 2:25 p.m. on 9/13/24. Please See F-000 Initial Comments related to the IJ removal plan.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49635 Based on interviews, record review, and policy review, the facility failed to fully investigate an incident involving possible abuse including the use of an unnecessary physical restraint on a resident, which kept the resident from ambulating from a wheelchair (Resident #99 (R99). This had the potential to effect all residents in the facility. Findings: On [DATE] at 12:35 p.m., the State of Maine, Division of Licensing and Certification received an anonymous complaint alleging the facility was short staffed and CNAs (Certified Nursing Assistants) were tying residents to chairs. On [DATE] at 10:45 a.m., in an interview with a surveyor, the Life Enrichment and Pastoral Care staff member stated, I have never seen or noticed a resident tied to their chairs, but I think I know what you're talking about. That resident passed away. I can't remember what staff or what resident was involved but they were on Cove. The surveyor was directed to ask Registered Nurse #1 (RN1). On [DATE] at 11:15 a.m., in an interview with the surveyor, RN1 stated she did not remember who the resident was or when the incident happened, but did remember she last saw the resident in bed around 5:00p.m.-5:30p.m., at which time the resident had visitors who were preparing to leave. RN1 stated she remembers the prior Interim Director of Nursing (IDON) asked about the resident being tied to a wheel chair in the days following the incident, RN1 told the prior IDON that she believed the family had restrained the resident. On [DATE] at 12:47 p.m., in an interview with a surveyor, the Certified Nursing Assistant -Medications #2 (CNA-M2) stated that she was aware of the possibility of someone having been tied to the bed or chair, and that CNA3 had been placed on administrative leave because of that, but that CNA3 returned quickly, and heard it was the family that had restrained the resident. On [DATE] at 2:22 p.m., in an interview, CNA3 stated she last saw R99 in bed around 5:30 p.m., there were no visitors in the room at that time, she believed the visitors had gone home. CNA3 stated she was investigated for 1 to 2 days but was told it wasn't her fault. The facility's Abuse, Neglect and/or Misappropriation of Resident Funds or Property Prohibition Policy last revised on [DATE] indicates under the Investigation heading it states: As part of the investigation, the Administrator or his/her designee, shall coordinate the investigative process . and take the following action(s): Interview the resident, the accused, and potential witnesses. Witnesses may include anyone who: Witnessed or heard the incident; Came in close contact with either the resident the day of the incident (including other residents, family members, etc.); and Colleagues who worked closely with the accused colleague(s) and/or alleged victim the day of the incident. To the extent possible, all interviews should be summarized into a written statement, which is signed and dated. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterville Center for Health and Rehab	7 Highwood St Waterville, ME 04901

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 8:52 a.m., in an interview the Director of Nursing (DON) stated she knows of the incident but was not here at the time. The DON provided the surveyor with a folder containing partial notes that appeared as a timeline . The notes did not indicate who wrote them or when. The folder also contained a copy of the visitor log on the day of the incident, and 2 witness statements from facility employees CNA6 and CNA7 both dated [DATE]. Review of the documents indicated: - the resident was able to independently transfer from her bed to her chair . -The visitor log showed only one person had signed in to visit R99 on [DATE]. The visitor returned the visitor's badge at 2:02 p.m. - CNA3 last saw the resident in a wheelchair between 4:,d+[DATE]:30 p.m. when CNA3 went into R99's room to pick up a meal tray . There is no mention in the documents of R99 being restrained at this time. - RN1 last saw R99 in bed between ,d+[DATE]:30 p.m., when R99 received their evening meal tray. There is no mention in the documents of R99 being restrained at this time. -RN3 was notified at approximately 6:30 p.m. that R99 was trying to stand up while restrained to a wheelchair. The evening meal tray was observed on the floor. -There was a change for the worse in the resident's condition at 6:30 p.m., for which hospice was notified. - The resident was resisting the restraint but unable to get out of it. - The facility notes have no information about any visitors other than the one who returned the visitor's badge at 2:02p.m., when R99 transferred from the bed to the wheelchair, or who restrained R99 to the wheelchair. On [DATE] from 8:58 a.m.- 9:40 a.m., interviews were completed with a surveyor and the DON. During the interview: -The Unit Manager denied investigating the incident. She stated RN3 had texted her at 6:41 p.m. to inform her that R99 was found in the chair tied with the sheet behind it and like a double knot, that they had let [him/her] out. The UM notified the prior IDON and from there the Director of Clinical and Quality Assurance and the prior IDON took control of the incident. -The Director of Clinical and Quality Assurance denied investigating this incident. -The IDON at the time of the incident joined the interview by phone and confirmed that she had not spoken with the family or fully investigated this incident. -The Interim Administrator at the time of the incident joined the interview by phone and confirmed she had not spoken with the family or full investigated this incident. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	- The resident had a Brief Interview for Mental Status (BIMS) which indicated severe cognitive impairment; and was thus unable to be interviewed at the time of the incident. The resident died on [DATE] and was not available to be interviewed by surveyors. On [DATE] at 9:40 a.m., in an interview with the DON, a surveyor confirmed that the facility failed to fully investigate this incident, and at the time it was still unknown who had restrained R99 to the wheelchair. A surveyor requested the Incident Policy, and the DON provided the Accidents/Incidents Involving Residents policy dated [DATE] which requires each incident or accident must be detailed in the medical record of the resident, and each incident, accident, or medication error must be investigated immediately for determination of root cause. Review of the facility Incident Report #1944 dated [DATE] and timed as having been written at 8:38 p.m., states [6:30 p.m.]- [Certified Nursing Assistants] called nurse into [patient's] room where [he/she] was found restrained to [his/her] wheelchair by wrapping a bedsheet around [his/her] waist and the wheelchair ending with a double knot. Resident unable to give Description . There was no documentation in the medical record to indicated this incident occurred or was fully investigated. The immediate jeopardy began on [DATE] when the facility failed to fully investigate the violation of R99's right to be free from a physical restraint in accordance with S483.12. All residents remained at risk as the facility failed to implement its policy and procedures to report and thoroughly investigate an incident involving possible abuse including the use of an unnecessary physical restraint on a resident . Immediate Jeopardy was identified on [DATE]. The Administrator, Director of Nursing, and Director of Clinical and Quality Assurance were notified of the immediate jeopardy at 2:25 p.m. on [DATE]. Please See F-000 Initial Comments related to the IJ removal plan.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on record reviews, 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 3 Resident's reviewed for hospitalization (Resident #68 [R68], and R48). Findings: 1. R68 was admitted on [DATE] and has diagnoses to include dementia, dysphagia and atrial fibrillation. Review of R68's clinical record revealed on 9/5/24 he/she was transferred to an acute care hospital and subsequently admitted to the hospital. Further review of R68's clinical record lacked evidence that the Resident and/or Resident Representative was provided a written transfer/discharge notice. During a review of R68's clinical record on 9/11/24 at 1:40 p.m. with a surveyor, the Administrator confirmed the clinical record lacked evidence that a transfer notice was provided in writing to the Resident and/or Resident Representative. 37440 2. R48 was admitted on [DATE] and has diagnoses to include Escherichia coli, dysphagia, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and chronic respiratory failure. Review of R48's clinical record revealed on 7/22/24 he/she was transferred to an acute care hospital and subsequently admitted . Further review of R48's clinical record lacked evidence that the Resident and/or Resident Representative was provided a written transfer/discharge notice. During a review of R48's clinical record on 9/12/24 at 1:20 p.m. with a surveyor, the Administrator confirmed the clinical record lacked evidence that a transfer notice was provided in writing to the Resident and/or Resident Representative.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on record review and interview, the facility failed to issue written bed hold notices to include cost of care to the Resident and/or legal representative for 2 of 3 sampled Resident's reviewed for transfer to an acute care hospital (Residents #68 [R68], and R48). Findings: 1. R68 was admitted on [DATE] and has diagnoses to include dementia, dysphagia and atrial fibrillation. Review of R68's clinical record revealed on 9/5/24 he/she was transferred to an acute care hospital and subsequently admitted to the hospital. Review of R68's clinical record lacked evidence that the Resident and/or Resident Representative was provided a written bed hold notice upon this transfer. During a review of R68's clinical record on 9/11/24 at 1:40 p.m. in an interview with a surveyor, the Administrator confirmed the clinical record lacked evidence that a written bed hold notice was provided in writing to Resident and/or Resident Representative. 37440 2. R48 was admitted on [DATE] and has diagnoses to include Escherichia coli, dysphagia, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and chronic respiratory failure. Review of R48's clinical record revealed on 7/22/24 he/she was transferred to an acute care hospital and subsequently admitted to the hospital. Further review of R48's clinical record lacked evidence that the Resident and/or Resident Representative was provided a written bed hold notice upon this transfer. During a review of R48's clinical record on 9/12/24 at 1:20 p.m. in an interview with a surveyor, the Administrator confirmed the clinical record lacked evidence that a written bed hold notice was provided in writing to Resident and/or Resident Representative.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35904 Based on record reviews and interviews, the facility failed to ensure residents with a specialized mental health diagnosis had been referred to the appropriate state-designated authority for Pre-Admission Screening & Resident Review (PASRR) evaluation and determination for 3 of 3 residents reviewed for PASRR evaluation (Resident #90 [R90], R25, and R11). Findings: 1. Clinical record review indicates R90 was readmitted to the facility on [DATE], diagnoses to include bipolar disorder, anxiety disorder, and depression. Review of R90's PASRR Level I dated 5/31/24 indicates R90 had a Convalescence Categorical exemption (a time-limited 30-day exemption). R90's clinical record lacks evidence that the resident had been re-evaluated for a PASRR Level II determination after the Convalescent period ended. On 9/12/24 at 4:40 p.m., in an interview with the Administrator, a surveyor confirmed R90 had not been re-evaluated for a PASRR Level II determination after the Convalescent period ended.

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F 0675 Level of Harm - Actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49635 Based on record reviews and interviews , the facility failed to protect and promote a resident's right be free from a physical restraint in accordance with S483.12 [Resident #99 (R99)]. A reasonable and prudent person would suffer anxiety, distress, and fear from the involuntary loss of independent movement. Findings: On 7/31/24 at 12:35 p.m., the State of Maine, Division of Licensing and Certification received an anonymous complaint alleging the facility was short staffed and CNAs (Certified Nursing Assistants) were tying residents to chairs. The following is a result of the investigation: R99 was admitted on [DATE] to the facility on hospice. The resident had a Brief Interview for Mental Status (BIMS)which indicated severe cognitive impairment and was unable to make his/her needs known. Diagnoses included dementia, lung cancer, acute respiratory failure with hypoxia, and anxiety disorder with a history of panic attacks. The Care Plan initiated on 7/19/24 indicated the resident has difficulty breathing (dyspnea) on exertion. Remind me not to push beyond endurance. Review of the facility-provided Incident Report #1944 dated 7/25/24 and timed as having been written at 8:38 p.m ., states [6:30pm.] -[Certified Nursing Assistants] called nurse into Pt's (patient's) room where [he/she] was found restrained to [his/her] wheelchair by wrapping a bedsheet around [his/her] waist and the wheelchair ending with a double knot. Resident Unable to give Description . On 9/12/24 at 8:52 a.m., in an interview with a surveyor the Director of Nursing (DON) stated she knows of the incident but was not here at the time. The DON provided the surveyor with a folder which contained handwritten notes, 2 witness statements, and a copy of the visitor log for 7/25/24. Review of folder contents indicated: - the resident was able to independently transfer from her bed to her chair. -The resident had a change in condition at 6:30 p.m. on 7/25/24 for which hospice was notified. -Witness statements indicate the resident was found restrained at approximately 6:30 p.m. and was observed resisting the restraint by attempting to stand and get out of it. On 7/26/24 at 12:07 a.m., RN3's nurse note indicated he contacted hospice because R99 had changed from [his/her] baseline to severe anxiety and agitation, constantly shouting, and the Doctor had called back with new orders for Effexor [used to treat anxiety] and Clonidine [treats high blood pressure, withdrawal symptoms, anxiety, and post-traumatic stress disorder]. This behavior had started at 6:30 p.m., per the facility's hand written notes, when R99 was found by staff attempting to stand while restrained. On 9/13/24 at 2:25 p.m., during an interview with the DON, the Administrator, and the Director of Clinical and Quality Assurance 2 surveyors reviewed and confirmed R99 had increased anxiety and distress after the use of a physical restraint.

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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. 35904 Based on record reviews, and interview the facility failed to ensure that physician orders were updated and/or followed for 1 of 5 Resident's reviewed for unnecessary medications. (Resident #29 [R29]). Findings: On 9/12/24 during R29's clinical record review, R29 had a new physician order filed in the paper record and scanned into the electronic record dated 9/4/24 to, 1) discontinue acetaminophen 650 mg (milligram [m.g]) 3 times daily, 2) Begin acetaminophen 1 g (gram) (1000 m.g equals 1 g) 3 times daily for chronic pain, 3) physical therapy evaluation and treatment for decreased mobility with the patient goal of regaining independence in bed mobility, and 4) occupational therapy evaluation and treatment for decreased mobility with the patient goal of regaining independence in bed mobility. Review of R29's clinical record lacked evidence that R29's acetaminophen order, physical therapy order, and occupational therapy order dated 9/4/24 was reviewed and/or updated by a provider. On 9/12/24 at 9:28 a.m. in an interview with a surveyor, Registered Nurse #4 (RN4), Charge Nurse on Memory Care Unit, states that R29 gets acetaminophen 325 m. g. two tabs by mouth three times per day according to his/her physician order. RN5 is unaware of the physician orders dated 9/4/24 pertaining to acetaminophen, physical therapy, and occupational therapy orders. On 9/12/24 at 9:34 a.m. in an interview with a surveyor, Licensed Practical Nurse #1 (LPN1) Unit Manager Memory Care Unit, states regarding the orders dated 9/4/24 for R29, that somebody filed this without addressing it. On 9/13/24 at 4:29 p.m. in an interview with LPN1, a surveyor confirmed that the facility failed to follow physician orders for the change in dose of acetaminophen, order for physical therapy evaluation and treatment, and order for occupational therapy evaluation and treatment. LPN1 states that this should have been addressed.

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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. 42531 Based on observations and interviews, the facility failed to provide a sanitary environment to ensure that respiratory equipment was clean to help prevent the development and transmission of disease and infection related to nebulizer and oxygen tubing for 3 of 3 residents reviewed for respiratory care (Resident #251 [R251], R3, and R47). Findings: Review of facility policy Nebulizer Cleaning dated 7/1/21 states ., store the nebulizer in a zip lock plastic bag . 1. Observations of R251 on 9/9/24 at 11:45 a.m., and 9/10/24 at 8:08 a.m., a nebulizer was observed on bedside table with tubing connected to mask lying on top of table not labeled or bagged. Observation of oxygen concentrator on opposite side of room with nasal cannula/tubing connected and observed lying on floor, undated and unbagged. Review of R251's active orders dated September 2024 lacked evidence of an order for oxygen or nebulizer use. During an interview on 9/09/24 at 11:49 a.m. with a surveyor, Registered Nurse (RN) #1 indicated R251 does not use a nebulizer or oxygen. During an observation of R251 on 9/10/24 at 9:50 a.m. with a surveyor, the Unit Manager (UM) indicated it was her expectation that nebulizer and oxygen tubing would be labeled and in bag when not in use. At this time the UM confirmed a nebulizer and oxygen tubing was not dated or bagged. 49635 2. On 9/9/24 at 11:04 a.m., a surveyor observed the filter to R3's oxygen concentrator to be heavily soiled, the oxygen tubing was dated 8/21/24, and the nebulizer mask and tubing were not stored in a sanitary manner. On 9/10/24 at 3:31 p.m., during an interview, the surveyor observed and confirmed the above findings with RN2. 3. On 9/09/24 at 12:04 p.m., a surveyor observed R47's concentrator was missing its filter. The label on R47's oxygen tubing was dated 7/21/24. On 9/10/24 at 3:29 p.m., during an interview with a surveyor, RN2 stated, the night nurse usually changes the oxygen tubing. The tubing is labelled with the date it was changed and should be changed weekly. At this time a surveyor observed and confirmed with RN2 that R47's oxygen tubing was labelled 7/21/24 and the filter was missing from the oxygen concentrator.

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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. 49635 Based on interviews, record review, and staffing schedule review, the facility failed to ensure sufficient staff were scheduled and on duty to meet the needs of resident's (Resident #25 [R25], R64, and R18) with the potential to affect all resident's. Findings: On 9/09/24 at 12:52 p.m., in an interview with a surveyor, Certified Nursing Assistant #2 (CNA2) stated, it's hard to provide care timely, lately it's me; a nurse will have 2 floors, and a med tech (Certified Medication Assistant - Medications [CNA-M]). On 9/10/24 at 7:30 a.m., in an interview with a surveyor, R25 states they had not received a bath 3 times in a row in the past month because staff wouldn't provide it. Record review of R25's Care Plan indicates, [R25] requires extensive assist for toileting and personal hygiene, and physical assist with bathing and patient to have a shower twice a week and prn [as needed]. On 9/10/24 at 10:45 a.m., in an interview with a surveyor, RN1 states there is a delay in care due to staffing. Resident's still get what they need but they may be sitting in incontinence for too long before staff can respond. On Cove Unit, a lot of resident's require 2-assist, and a resident that needs the Hoyer lift can be very time consuming. I only have two people on the floor, I don't have anyone on the floor for that amount of time (spent with a 2-assist Resident for Activities of Daily Living Living). On 9/10/24 at 3:13 p.m., in an interview with a surveyor, CNA-M3 states, resident's on Mountain Top Unit get everything they need as long as they are full staffed. Showers are the hardest to provide as a lot of resident's are 2-assist for showers. CNA-M3 clarified, 2-assist are not just resident's that require the Hoyer lift, but resident's who use psychiatric medications also need 2-assist for staff safety. CNA-M3 stated Memory Lane and Harbor are the units that will skip bathing care for resident's related to staffing. On 9/11/24 at 8:26 a.m., in an interview with a surveyor, R18 states, there have been a few days where I missed my shower days. It only happens when there are only 2 aides (CNA's) on the floor for 28 residents with 28 meals to pass out. Shower time is usually during breakfast time. On 9/12/24 at 8:51 a.m., during an interview with the Scheduler, and the Director of Nursing (DON), staffing schedules were reviewed with a surveyor. The facility did not meet minimum staffing ratios on day shifts for 9/4/24, 8/31/24, 8/29/24, 7/26/24, and 7/22/24. The DON states they are working on staffing to meet the minimum ratio then will work up to staffing for acuity. At this time a surveyor confirmed the facility is not staffing based on the resident's needs.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 37440 Based on performance evaluation review and interview, the facility failed to complete annual performance evaluations at least every 12 months for 1 of 5 sampled employees (Certified Nursing Assistant #2 [CNA2]). Findings: 1. CNA2 was hired on 7/1/21. The facility was unable to provide evidence of completed annual performance evaluations for 2023 and 2024. On 9/13/24 at 1:00 p.m., in an interview with a surveyor, the Administrator confirmed that CNA2 had not received annual performance evaluations in 2023 and 2024.

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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. 42531 Based on record review, observations and interviews the facility failed to ensure that two people who are authorized to administer medications signed the Narcotic Bound Book [a logbook used to record medication] Shift Count page indicating that they counted all the controlled substances at the change of shift for multiple shifts on 2 of 3 units observed for medication storage (Cove and Harbor). Findings: 1. Review of bound controlled medication book labeled Harbor Log #119 lacked evidence that controlled medication counts were conducted by the oncoming nurse on 8/17/24 at 18:20 (6:20 p.m.). Further review of controlled medication book lacked evidence that controlled medication counts were conducted by the outgoing nurse on 8/17/24 at 5:40 a.m., 8/18/24 at 6:00 a.m., and on 8/28/24 at 6:00 a.m. During an interview on 9/10/24 at 6:30 a.m. with a surveyor, Certified Nursing Assistant- Medications #1 (CNA-M1) confirmed above findings. 2. Review of bound controlled medication book labeled Cove #21 lacked evidence that controlled medication counts were conducted by the oncoming nurse on 7/26/24 at 18:00 (6:00 p.m.), on 7/27/24 at 5:30 a.m., on 8/7/24 (no time noted), and on 9/3/24 at 21:00 (9:00 p.m.). Further review of controlled medication book lacked evidence that controlled medication counts were conducted by the outgoing nurse on 7/5/24 on 5:30 a.m., on 7/11/24 at 18:00 (6:00 p.m.), on 7/25/24 at 6:00 a.m., on 8/8/24 at 6:00 a.m., on 8/10/24 at 18:00 (6:00 p.m.), on 8/11/24 at 6:00 a.m., and on 9/4/24 5:30 a.m. During an interview on 9/10/24 at 7:59 a.m. with a surveyor, CNA-M2 confirmed above findings. During review of controlled medication books #119 and #21 with a surveyor on 9/10/24 at 8:45 a.m., the Administrator confirmed the above findings. During a follow up interview on 9/10/24 at approximately 11:20 a.m. with a surveyor, the Director of Nursing confirmed that controlled medication should be counted during each shift change and was aware of the above concerns because the facility has a previous performance improvement plan in this area, but no one followed through with it.

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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. 42531 Based on observations, interviews, record reviews, and policy review, the facility failed to adequately date and properly dispose of biological's according to manufacturer specifications and expired medications on 1 of 1 unit (Cove). In addition, the facility failed to adequately store controlled substances in a permanently affixed compartment and double locked in 2 of 2 medication rooms observed (Cove and Harbor). Furthermore, the facility failed to ensure proper vaccine storage temperatures for 1 of 1 unit (Cove) and failed to monitor and record medication refrigerator temperatures for 3 of 4 medication refrigerators observed (Cove and Harbor). Findings: 1. Review of facility policy Storage and Expiration Dating of Medications and Biological's dated 12/1/07 states .Facility should ensure that medications and biological's that (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines . Medications with a manufactured expiration date expressed with month and year will expire on the last day of the month .Facility personnel should inspect nursing station storage areas for proper storage compliance on a regularly scheduled basis . Observation of vaccination refrigerator located on the Cove Unit on 9/10/24 at 8:17 a.m., with Registered Nurse #1 (RN1) revealed the following vaccinations stored with unexpired vaccinations and available for use: -1 Flu Vaccine (Flu Zone Quad 2022-2 60Mcg (micrograms)/0.5ml (milliliter) syringe expiration date June 30, 2023. -10 boxes containing 10 individual dose syringes of influenza vaccine Afluria with expiration date May 31, 2024 (total of 100 doses) -5 individual doses of Prevnar 20 0.5ml syringe with expiration date July 2024. -1 Prevnar 20 0.5ml syringe with expiration date 12/28/23 -1 multi dose vial of Moderna COVID-19 vaccine 100 mcg/0.5ml vial use by day 6/9/23 -1 multidose vial of Moderna Covid Bival (18 50 mcg/0.5ml) with use by date 6/13/23. -2 multidose vial of Pfizer COVID-19 30mcg/0.3ml vial use by date 1/6/23 -1 multidose vial of Pfizer COVID-19 30mcg/0.3ml vial use by date 12/2/22. 2. Review of facility policy Storage and Expiration Dating of Medications and Biologicals dated 12/1/07 states Store all drugs and biological's in locked compartments, including the storage of Schedule II-V medications in separately locked, permanently affixed compartments. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of Cove Medication Room on 9/10/24 at 8:15 a.m. with a surveyor and RN1, the following was observed: -Mini Controlled medication refrigerator located on top of counter containing an unlocked, unaffixed small index card sized metal box containing 1 box of Lorazepam 2mg (milligram)/ml concentrate, and one box of Lorazepam 2mg/ml concentrate lying on the shelf. At this time RN1 confirmed above findings. On 9/10/24 at 8:22 a.m., observation of the Harbor Medication room with Licensed Practical Nurse #3 (LPN3), the surveyor noted mini refrigerator containing 1 box of Lorazepam 2mg/ml concentrate located in refrigerator door. During an observation with surveyor on 9/10/24 at 8:45 a.m., the Administrator confirmed above findings 3. Review of facility policy Storage and Expiration Dating of Medications and Biologicals dated 12/1/07 states Facility should ensure that medications and biological's are stored at their appropriate temperatures according to the United States Pharmacopeia (USP) guidelines for temperature ranges and manufacturer guidance. Facility staff should monitor the temperature of vaccines twice a day. Refrigeration: 36*-46* F (Fahrenheit) or 2*-8* C (Celsius). Facility should monitor the temperature of medication storage areas at least once a day. Facility should monitor cold storage containing vaccines two time a day per CDC (Centers for Disease Control) guidelines . Review of provided Cove Refrigerator temperature logs revealed the following: --Review of Cove Tall Refrigerator Temperatures dated August 2024 revealed temperatures were taken 7 of 31 days. -Review of Cove Vaccine Refrigerator Temperatures dated September 2024 revealed temperatures were taken 1 of 10 days -Review of Cove Controlled Refrigerator Temperatures dated September 2024 revealed temperatures were taken 4 of 10 days. -Review of Unlabeled Cove Refrigerator Temperatures dated August 2024 revealed temperatures were taken 12 of 31 days. Review of facility provided Harbor Medication Refrigerator Log revealed the following: -Review of Harbor Medication Refrigerator Log dated July 2024 revealed temperatures were taken 7 of 31 days. -Review of Harbor Medication Refrigerator Log dated August 2024 revealed temperatures were taken 11 of 31 days. -Review of Harbor Medication Refrigerator Log dated September 2024 revealed temperatures were taken 10 of 30 days. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observations of Cove and Harbor Units with surveyor on 9/10/24 at 8:45 a.m., the Administrator confirmed above findings.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 37440 Based on observations, interviews, Resident Council Meeting Minutes and lunch meal test trays, the facility failed to serve hot foods hot, and cold foods cold for 2 of 4 lunch meals (lunch 9/9/24, and lunch 9/10/24) tested for appetizing temperatures (Resident #4 [R4], R5, R16, R34, R47, and R59). Findings: 1. On 9/09/24 at 11:13 a.m., in an interview with a surveyor, R59 states, The food is lukewarm most of the time. 2. On 9/09/24 at 11:50 a.m., in an interview with a surveyor, R47 states, The vegetables are soft and squishy. 3. On 9/9/24 at 11:55 a.m., a surveyor received a test tray from the Harbor Unit with Hot Potato salad, [NAME] Beans and a Hamburger. The temperature of the Hot Potato salad was 95.3 degrees Fahrenheit (F). The temperature of the [NAME] Beans was 95 degrees F. The temperature of the Hamburger was 99.6 degrees F. The hot foods on the test tray were found not to be palatable at those temperatures by the surveyor. 4. On 9/09/24 at 1:59 p.m., in an interview with a surveyor, R4 states, The food that comes is always cold and has to be reheated. It is never hot and is not good to eat and tastes terrible when it's not hot and cold foods not cold. 5. On 9/09/24 at 2:05 p.m., in an interview with a surveyor, R34 states, I like my food hot, and it always comes cold. The staff has to heat it for me. 6. On 9/10/24 at 8:20 a.m., a surveyor discussed the lunch meal and food temperatures from the Harbor unit the surveyor received on 9/9/24 with the Interim Food Service Director. The surveyor discussed with him that the meal was not hot and not palatable. At this time, the Interim Food Service Director confirmed that those temperatures were not appropriate, the food was not hot and that it would not be palatable at that temperature. 7. On 9/10/24 at 11:15 a.m., in an interview with a surveyor, Registered Nurse #1 (RN1) states, On days like today, I have someone that has to go to dialysis, and [he/she] is very particular about [he/she] doesn't want to be up early and doesn't want to sit in [his/her] chair long before [he/she] is taken. We try to accommodate that the best that we can but then it becomes an issue of well now I have only two Certified Nursing Assistant's (CNA's) and they're tied up in this room for a solid half hour and its right smack dab during breakfast. So lately I go and help the CNA, and I have one CNA go and do breakfast but then then you have all these Resident's that are complaining their foods cold. By the time we get the trays all passed, sometimes some are really cold and then we're running back and forth trying to heat it up. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. On 9/10/24 at 11:40 a.m., in an interview with a surveyor, a family member of R16 states, The food comes up to the second-floor dining room cold. It comes up and just sits there in the cart. Sometimes the carts are even delivered before the Residents are out to the table so the cart will sit there for half hour before the trays are delivered. The CNA's have to heat up many of the meals because they are cold, and the residents don't like it cold. I have complained to the nursing staff many times and it doesn't seem to make a difference. 9. On 9/10/24 at 8:16 a.m., in an interview with a surveyor, R5 states, The food is disgusting. There is a lack of seasoning, and the food is warm but not hot. Flavor and texture of meat has been so bad that I have become a bit of a vegetarian but recently told them to stop sending salad because the lettuce has been rusty. I do not enjoy meals anymore. 10. On 9/10/24 at 11:55 a.m., a large, enclosed food cart came up from the kitchen to the Harbor Unit. A small, enclosed food cart came up at 12:03 p.m. from the kitchen. Both carts were in the Harbor dining room at 12:05 p.m. in the unit. Three CNA's started serving the Residents. It was not until 12:25 p.m. that the large cart was emptied, and 13 residents were served at the table. The surveyors observed a CNA heating up a resident's meal. 11. On 9/10/24 at 12:40 p.m., two surveyors received a test tray from the Harbor Unit with Breaded Italian Style Chicken, Rice Pilaf and California Mixed Blend Vegetables. The temperature of the Breaded Italian Style Chicken was 116 degrees Fahrenheit (F). The temperature of the Rice Pilaf was 116.7 degrees F. The temperature of the California Mixed Blend Vegetables was 117 degrees F. The hot foods on the test tray were found not to be palatable at those temperatures by the surveyors. On 9/10/24 at 2:20 p.m., in an interview with a surveyor, the Interim Food Service Director confirmed that the food temperatures for the lunch tray were not hot like they were supposed to be. He stated that the company policy is food heated appropriately and held at least 140 degrees F. 12. Review of the Facility's Resident Council minute meetings reveals the following: 8/6/24 at 2:00 p.m. - The majority states: 1. They are still not getting menus choose alternate dishes. Would like to see a variety of meals and not just sandwiches. 2. Meals are still being served cold. 7/9/24 - [Resident] had mentioned, [he/she] has not been receiving menus to fill out and receiving cold meals daily. Majority states not given menus weekly, not offered, no menus to fill out. Majority states portions are too small a lot of the time. On 9/11/24 at 8:30 a.m., in an interview, the surveyor discussed the findings with the Administrator. 42531

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49635 Based on record review, observations, and interview, the facility failed to provide adaptive built-up utensils and Kennedy cups for 1 of 5 residents reviewed for nutrition (Resident #11 [R11]). Findings: Clinical record review indicates R11 was admitted on [DATE], diagnoses to include generalized muscle weakness, dysphagia (difficulty swallowing), and protein-calorie malnutrition. R11's Care Plan initiated on 7/9/24 states, [R11] has or may have a nutritional problem, the interventions for this include Adaptive equipment at meals: Kennedy cup, rimmed plate, built-up utensils. The Dietary Communication Slip dated 11/26 states Please issue weighted utensil. On 9/09/24 at 12:58 p.m., a surveyor observed R11 eating lunch in bed. The meal ticket on the tray indicates use of a Kennedy cup, and built-up utensils. R11's meal tray did not include a Kennedy cup or built-up utensils. On 9/10/24 at 8:30 a.m., a surveyor observed R11's breakfast tray did not include a Kennedy cup or built-up utensils. On 9/11/24 at 12:09 p.m., a surveyor observed R11 lying in bed, 2 open face cups with a straw and a standard spoon observed on the bedside table. At 12:29 p.m., a surveyor observed Licensed Practical Nurse #2 (LPN2) deliver R11's lunch tray. The lunch tray did not include a Kennedy cup or built-up utensils. On 9/11/24 at 12:29 p.m., in an interview with a surveyor, the LPN2 states, she has seen R11 use adaptive dishes before but not in a while. At this time the surveyor confirmed adaptive equipment was not provided to R11 as directed by the Dietary Communication, R11's meal ticket, or the Care Plan.

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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. 37440 Based on observations, interviews, facility logs and the facility's Dish Machine Temperatures policy, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for a wall mounted fan, food disposals, the dishwasher, the standing floor mixer, ceiling air vents, ceiling tiles, and the walk-in freezer; failed to ensure hair protection was worn by staff; failed to ensure foods were dated/labeled appropriately; failed to ensure kitchen sanitizer was monitored and failed to ensure that kitchen and unit refrigerator/freezer and dishwasher temperatures were monitored appropriately for 1 of 1 kitchen tours (9/9/24) and 2 of 2 kitchen observations (9/9/24 and 9/10/24). This has the potential to affect all residents that eat food prepared by kitchen staff. Findings: Review of the facility's Dish Machine Temperatures policy revised 1/24 noted: Dish machine wash and rinse water should be maintained at temperatures that meet guidelines established by the Food and Drug administration. State or local regulations will apply if stricter. Note: The range for optimal cleaning performance of the Diversey dish detergent is 150 Fahrenheit (F) to 165 F. Supervisor: If documentation of temperatures and test strips/max temperatures results has been assigned to a food and nutrition associate, confirm that it is completed at each meal period. Director: In the event of inappropriate temperature, make management decision concerning adequacy of sanitation of service ware. If due to inappropriate water temperature, high temperature machine, implements disposable service ware or use three compartment sink for sanitation. Notifies nursing units of use of disposal service ware. Contact sources of repairs. Documents action taken on the back of form. Director/designee: Verifies completion of logs, initials weekly. Initial Kitchen Tour on 9/9/24 from 10:45 a.m. to 11:30 a.m. with a surveyor and Kitchen Supervisor in which the following findings were observed: -The wall mounted fan in the dietary office was heavily soiled with dust/dirt. -A male kitchen worker with facial hair was not wearing facial hair protection. -2 food disposal units had dried food and dried liquid residue on the outside of them. -The high temperature dishwasher was only washing at 110 F and would not reach 150 F after 5 tries. - There were 4 ceiling air vents and 6 ceiling tiles that were dusty/dirty. -The standing floor mixer had chipped/missing paint on the mix arm and the base. -The walk-in freezer had ice build-up on 2 boxes of sheet cakes and on 1 blueberry pie. Additionally, there were 2 bags of waffles, 2 bags of tater tots, 4 bags of hot dog buns, 2 bags of sliced potatoes and 1 bag of French fries that were unlabeled and undated. On 9/9/24 at 11:30 a.m., in an interview a surveyor, the Kitchen Supervisor confirmed the findings. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 9/10/24 at 8:00 a.m., a surveyor observed a male kitchen worker with facial hair who was not wearing facial hair protection. At this time, the Interim Food Service Director confirmed the finding. The surveyor had requested the Dish machine Temperature Logs, the kitchen/unit refrigerators/freezers daily temperatures and Sanitizing Testing Logs for June, July, August and September 2024 on 9/9/24, 9/10/24, 9/11/24, and finally received them on 9/12/24 from the Administrator at 8:20 a.m. The surveyor reviewed them with the Administrator and found many missing days of monitoring and documenting temperatures. Monitoring and Documentation of Dish Machine Temperature Logs: 2024 June - missing 14th - 30th July - missing 1st - 31st August - missing 18th - 31st September - missing 1st - 13th Monitoring and Documentation of Sanitizing Testing Logs: 2024 June - missing 14th, 15th, 25th -30th Monitoring and Documentation of Refrigerator/Freezer Temperatures: 2024 Kitchen: June - Refrigerator and Freezer - missing 26th -30th Harbor Unit(2nd floor)(1 Refrigerator/Freezer): June - missing 3rd-30th July - missing 20th-31st August - missing 1st-31st September - missing 1st-5th and 10th-30th Cove Unit(2nd floor)(2 Refrigerators/Freezers): #1 June - missing 28th-30th #1 July - missing 1st-31th #1 August - missing 2nd-9th, 11th, 13th and 15th-31st #1 September - missing 11th-21st and 10th-30th #2 June - missing 1st-30th #2 July - missing 1st-31st #2 August - missing 1st-31st #2 September - missing 7th, 8th and 12th-30th Memory Unit(3rd floor)(3 Refrigerators/Freezers): #1 June 2024- missing 26th-30th #1 July 2024 - missing 20th-31st #1 August - missing 1st-31st #1 September 2024- missing 1st-30th #2 June 2024- missing 1st-30th #2 July 2024 - missing 1st-31st #2 August - missing 1st-31st #2 September 2024- missing 1st-30th #3 June 2024- missing 1st-30th #3 July 2024 - missing 1st-31st #3 August 2024- missing 1st-31st #3 September 2024- missing 1st-30th Mountaintop Unit(4h floor)(2 Refrigerators/Freezers):2024 #1 June 2024 - missing 28th-30th #1 July 2024 - missing 28th-31st #1 August - missing 1st-31st #1 September 2024- missing 1st-30th #2 June 2024- missing 1st-30th #2 July 2024 - missing 1st-31st #2 August - missing 1st-31st #2 September 2024- missing 1st-30th On 9/12/24 at 8:24 a.m., in an interview with a surveyor, the Administrator confirmed that temperatures were not monitored and documented daily for the Dish machine Temperature Logs, the kitchen/unit refrigerators/freezers daily temperatures, and Sanitizing Testing Logs for June, July, August and September 2024.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 35904 42531 Based on the cumulative effect of deficiencies cited during the recertification survey from 9/9/24 through 9/17/24, the facility failed to ensure the facility was Administered in a manner that enabled residents to attain or maintain their highest practicable well-being as evidenced by Federal findings listed under S483.10 - Resident Rights (F567, F578, F584); S 483.12 - Freedom from Abuse, Neglect, and Exploitation (F604, F607, F609, and F610); S483.15 - Admission, Transfer, and Discharge (F623, and F625); S483.20 - Resident Assessments (F645); S483.24 - Quality of Life (F675); S483.25 - Quality of Care (F684, F695); S483.35 - Nursing Services (F725, and F730); S483.45 - Pharmacy Services (F755, and F761); S483.60 - Food and Nutrition Services (F804, F810, and F812); S483.70 - Administration (F842); S483.80 - Infection Control (F880, and F883); S483.90 - Physical Environment (F908); and S483.95 - Training Requirements (F940, F942, F943, F944, F946, F947, and F949). These failures to ensure a process was in place to monitor staff development and resident care resulted in the facility failing to assist Resident's to maintain their highest functional and practicable well-being and has the potential to affect all 91 Resident's. In addition, the Administration failed to follow the Facility Assessment ensuring staff education/training and competencies were completed. Findings: 1. Based on interviews and record review, the facility failed to provide a Resident access to personal funds (Resident #47 [R47]). (F567) 2. Based on record review and interviews the facility failed to provide/obtain Resident and or Resident Representatives written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an Advance Directive for 8 of 8 Resident's reviewed for Advance Directives (Resident #26 {R26], R46, R251, R252, R43, R4, R64, and R34). (F578) 3. 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 2 of 4 units (Mountain Top Unit and Harbor Unit) for 3 of 3 facility tours (9/9/24, 9/10/24 and 9/12/24). (F584) 4. Based on interview, internal facility notes, policy review and record review, the facility failed to ensure a Resident's right to remain free from a physical restraint which kept the Resident from ambulating from his/her wheelchair resulting in an immediate jeopardy situation with psychosocial harm and the risk of physical harm including the potential to cause death [Resident #99 (R99)]. All Residents (91 of 91 Residents) remained at risk as the facility failed to develop and/or implement measures to report, fully investigate, and protect the Resident's from further use of unnecessary restraints. (F604) (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Based on employee record review, facility policy review, and interview, the facility failed to implement its own Abuse, Neglect and/or Misappropriation of Resident Funds or Property Prohibition policy to ensure Maine background checks were completed for new employees before they were permitted to work for 2 of 12 sampled employees (Certified Nursing Assistant #5 [CNA5] and Registered Nurse #1 [RN1]). (F607) 6. Based on interviews, facility policy review, record review and facility notes, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Social Security Act, resulting in failure to protect the resident from further potential harm from the perpetrator. In addition, the facility failed to report to the State Survey Agency (SA) an incident of possible abuse including the violation of a resident's right to be free from a physical restraint, which kept the resident from ambulating from a wheelchair [Resident #99 (R99)]. This had the potential to affect all residents in the facility (91 of 91 Resident's). (F609) 7. Based on interviews, record review, policy review, and review of the facility's handwritten notes, the facility failed to fully investigate an incident involving possible abuse including the use of an unnecessary physical restraint on a resident, which kept the resident from ambulating from a wheelchair (Resident #99 (R99). This had the potential to affect all residents in the facility (91 of 91 Resident's). (F610) 8. Based on record reviews, 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 3 Resident's reviewed for hospitalization (Resident #48 [R48], and R68). (F623) 9. Based on record review and interview, the facility failed to issue written bed hold notices to include cost of care to the Resident and/or legal representative for 2 of 3 sampled Resident's reviewed for transfer to an acute care hospital (Resident #68 [R68], and R48). (F625) 10. Based on record reviews and interviews, the facility failed to ensure Residents with a specialized mental health diagnosis had been referred to the appropriate state-designated authority for Pre-Admission Screening & Resident Review (PASRR) evaluation and determination for 3 of 3 Residents reviewed for PASRR evaluation (Resident #90 [R90], R25, and R11). (F645) 11. Based on observations, record reviews, and interview, the facility failed to ensure a Resident was free from psychosocial harm when a Resident was restrained to a wheelchair, preventing them from ambulating, which resulted in increased anxiety, distress, and increased perception of pain [Resident #99 (R99)]. (F675) 12. Based on record reviews, and interview the facility failed to ensure that physician orders were updated and/or followed for 1 of 5 Resident's reviewed for unnecessary medications. (Resident #29 [R29]). (F684) 13. Based on observations and interviews, the facility failed to provide a sanitary environment to ensure that respiratory equipment was clean to help prevent the development and transmission of disease and infection related to nebulizer and oxygen tubing for 3 of 3 residents reviewed for respiratory care (Resident #251 [R251], R3, and R47). (F695) (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	14. Based on interviews, record review, and staffing schedule review, the facility failed to ensure sufficient staff were scheduled and on duty to meet the needs of Resident's (Resident #25 [R25], R64, and R18) with the potential to affect all Resident's (91 of 91 Resident's). (F725) 15. Based on performance evaluation review and interview, the facility failed to complete annual performance evaluations at least every 12 months for 1 of 5 sampled employees (Certified Nursing Assistant #2 [CNA2]). (F730) 16. Based on record review, observations and interviews the facility failed to ensure that two people who are authorized to administer medications signed the Narcotic Bound Book Shift Count page indicating that they counted all the controlled substances at the change of shift for multiple shifts on 2 of 3 units observed for medication storage (Cove and Harbor). (F755) 17. Based on observations, interviews, record reviews, and policy review, the facility failed to adequately date and properly dispose of biological's according to manufacturer specifications and expired medications on 1 of 1 unit (Cove). In addition, the facility failed to adequately store controlled substances in a permanently affixed compartment and double locked in 2 of 2 medication rooms observed (Cove and Harbor). Furthermore, the facility failed to ensure proper vaccine storage temperatures for 1 of 1 unit (Cove) and failed to monitor and record medication refrigerator temperatures for 3 of 4 medication refrigerators observed (Cove and Harbor). (F761) 18. Based on observations, interviews, Resident Council Meeting Minutes and lunch meal test trays, the facility failed to serve hot foods hot, and cold foods cold for 2 of 4 lunch meals (lunch 9/9/24, and lunch 9/10/24) tested for appetizing temperatures (Resident #4 [R4], R5, R16, R34, R47, and R59). (F804) 19. Based on record review, observations, and interview, the facility failed to provide adaptive built-up utensils and Kennedy cups for 1 of 5 residents reviewed for nutrition (Resident #11 [R11]). (F810) 20. Based on observations, interviews, facility logs and the facility's Dish Machine Temperatures policy, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for a wall mounted fan, food disposals, the dishwasher, the standing floor mixer, ceiling air vents, ceiling tiles, and the walk-in freezer; failed to ensure hair protection was worn by staff; failed to ensure foods were dated/labeled appropriately; failed to ensure kitchen sanitizer was monitored and failed to ensure that kitchen and unit refrigerator/freezer and dishwasher temperatures were monitored appropriately for 1 of 1 kitchen tours (9/9/24) and 2 of 2 kitchen observations (9/9/24 and 9/10/24). This has the potential to affect all residents that eat food prepared by kitchen staff. (F812) 21. Based on record reviews, and interview, the facility failed to ensure that clinical records were complete and contained accurate information for 3 of 20 residents reviewed for documentation (Resident #46 [R46], R3, and R47). (F842) 22. Based on observations, and interviews the facility failed to maintain an Infection Control Program designed to help prevent cross contamination and/or development of infection by maintaining a safe and sanitary environment related to enhanced barrier precautions (EBP's) pertaining to Residents (Resident #70 [R70], R87, and R84) with a wound(s) for 2 of 5 days of survey (9/9/24, and 9/10/24). (F880) (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	23. Based on record review, and interview, the facility failed to ensure Residents were offered pneumococcal vaccinations in accordance with their policy and the Centers for Disease Control and Prevention (CDC) recommendations for 5 of 5 residents reviewed for immunizations (Resident [R] 87, R90, R29, R1, and R70). (F883) 24. Based on observations, interviews, the facility's Dish Machine Temperatures, and a food equipment service company work log, the facility failed to ensure that the kitchen high temperature dish machine was maintained in good repair and in safe operating condition for 1 of 1 dish machine observations (9/9/24) and failed to ensure proper cleaning and sanitizing of dishes for 1 of 1 kitchen tours (9/9/24). (F908) 25. Based on interview and employee personnel record reviews, the facility failed to implement and maintain an effective training program by failing to ensure that 1 of 1 Certified Nursing Assistant's (CNA) employed for less than 1 year, completed training prior to independently providing services to Residents (CNA4). (F940) 26. Based on employee files review and interview, the facility failed to develop and implement an education program that included training on Resident Rights for 1 of 5 Certified Nursing Assistant's (CNA) reviewed (CNA4). (F942) 27. Based on review of Certified Nursing Assistant's (CNA) in-service training and interview, the facility failed to ensure that 1 of 1 CNA completed yearly training for Abuse, Neglect, Exploitation and Misappropriation of Property (CNA1). (F943) 28. Based on record review and interview, the facility failed to ensure staff received mandatory training on its Quality Assurance and Performance Improvement Program (QAPI), which included the staff's role and communication with the program, for 1 of 5 employee files reviewed (Certified Nursing Assistant #4 [CNA4]). (F944) 29. Based on review of Certified Nursing Assistant's (CNA) in-service training and interview, the facility failed to ensure that 1 of 1 CNA completed Compliance and Ethics Training on hire (CNA4). (F946) 30. Based on Certified Nursing Assistant's (CNA) employee education records review and interviews, the facility failed to monitor and ensure that CNA's attended the required 12 hours of annual in-service education, for 1 of 5 randomly selected CNA's employed greater than 1 year (CNA3). (F947) 31. Based on review of Certified Nursing Assistant's (CNA) in-service training and interview the facility failed to maintain an effective training program for staff when 2 of 10 sampled Certified Nursing Assistant's did not receive annual training for Behavioral Health (Certified Nursing Assistant #4 [CNA4], and CNA5). (F949) 32. Based on review of the staffing schedules, daily resident census, and interview, the facility failed to ensure staffing minimums were met in accordance with the State of Maine Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities, Chapter 9.A.4.A., 5 days out of 35 days reviewed for minimum staffing (7/22/24, 7/26/24, 8/29/24, 8/31/24, and 9/4/24). (State of Maine's T0222) (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	33. Based on observations and interviews, the facility failed to have the current menu plan posted and readable for personnel, Resident's and dietetic services staff on 5 of 5 Units (Harbor, Cove, Memory Care, Blueberry Hill, and Cranberry Island) for 3 of 5 days of survey (9/9/24, 9/10/24, and 9/11/24). (State of Maine's T0480) On 9/13/24 at 6:50 p.m., during an interview, the Administrator confirmed the facility failed to ensure the facility was Administered in a manner that enabled residents to attain or maintain their highest practicable well-being.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interview, the facility failed to ensure that clinical records were complete and contained accurate information for 3 of 20 residents reviewed for documentation (Resident #46 [R46], R3, and R47). Findings: R46 was admitted on [DATE] and has diagnoses to include diabetes mellitus II, chronic obstructive pulmonary disease (COPD), hypertension, vision loss, depression, chronic pain, and end stage renal failure - dialysis dependent. Review of R46's clinical record revealed active orders dated September 2024 and revealed the following: -Order with start date of 12/6/23 for Bupropion HCl ER (XL) Oral Tablet Extended Release 24 Hour (Bupropion HCl). Give 150 mg (milligram) by mouth one time a day for depression 150 mg. -Order with start date of 7/12/24 for Famotidine Oral Tablet 10 mg. Give 1 tablet by mouth one time a day every [Mon, Wed, Fri, Sun] for GERD (gastroesophageal reflux disease). -Order with start date of 2/15/24 for Apixaban Oral Tablet 5 MG (Apixaban). Give 1 tablet by mouth two times a day for anticoagulation. Review of clinical record lacked evidence it was given on 9/8/24 at 7:00 a.m. -Order with start date of 2/15/24 for Carvedilol Oral Tablet 12.5 MG (Carvedilol). Give 1 tablet by mouth two times a day related to essential (Primary) hypertension. Hold for Systolic BP <110 or HR <60. -Order with start date of 2/15/24 for Timolol Maleate Ophthalmic Solution 0.5 % (Timolol Maleate (Ophth). Instill 1 drop in right eye two times a day related to unspecified vision loss. -Order with start date of 11/28/24 for Sevelamer carbonate 800mg tablet. Give 2 tablet by mouth three times a day for Monitoring related to end stage renal disease. Administer with meals. -Order with start date of 7/3/24 for Tramadol HCl Oral Tablet 50 mg. Give 1 tablet by mouth three times a day for pain related to chronic pain syndrome. Review of R46's clinical record lacked evidence the above medications were given or refused on 9/8/24. -Order with start date of 2/15/24 for Humalog Kwik Pen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Lispro.) Inject 8 unit subcutaneously before meals for diabetes. Review of R46's clinical record lacked evidence it was given or refused on 9/7/24 at 1600 (4:00 p.m.). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Order with start date of 2/15/24 Humalog Kwik Pen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 100 - 199 = 4 units; 200 - 299 = 6 units; 300 - 399 = 8 units; 400 - 499 = 10 units; 500 - 599 = 14 units, subcutaneously before meals for diabetes. Review of R46's clinical record lacked evidence it was given or refused on 9/7/24 at 1600 (4:00 p.m.). During a record review on 9/11/24 at 7:20 a.m. with a surveyor, the Director of Nursing confirmed the above findings. 49635 2. On 9/10/24 at 3:31 p.m., during an interview, the surveyor observed and confirmed R3's oxygen concentrator to be heavily soiled and the oxygen tubing was dated 8/21/24 with the Registered Nurse #2 (RN2). On 9/10/24 at 3:51 p.m., during an interview with a surveyor, RN2 reviewed R3's clinical record and states, It looks like the tubing was changed on 8/28/24, and 9/4/24. At this time a surveyor confirmed the documentation for R3's oxygen tubing was not accurate as the tubing had not been changed. 3. On 9/10/24 at 3:29 p.m., during an interview, a surveyor and RN2 observed and confirmed R47's oxygen tubing was labelled 7/21/24 and the filter was missing from the oxygen concentrator. On 9/10/24 at 3:51 p.m., during an interview with a surveyor, RN2 reviewed R47's clinical record and states, it looks like the oxygen tubing was changed 7/28/24, 8/4/24, 8/11/24, 8/18/24, 9/1/24, and 9/8/24. The surveyor confirmed at this time that documentation was not accurate as the tubing had not been changed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 35904 Based on observations, and interviews the facility failed to maintain an Infection Control Program designed to help prevent cross contamination and/or development of infection by maintaining a safe and sanitary environment related to enhanced barrier precautions (EBP's) pertaining to Residents (Resident #70 [R70], R87, and R84) with a wound(s) for 2 of 5 days of survey (9/9/24, and 9/10/24). Findings: On 9/9/24, from 10:30 a.m. to 3:45 p.m., a surveyor observed no signage or personal protective equipment (PPE) other than gloves for R70's room who has a wound and is on EBP's. On 9/10/24, from 7:30 a.m. to 3:45 p.m., a surveyor observed no signage or PPE other than gloves for R70's room who has a wound and is on EBP's. On 9/9/24, from 10:30 a.m. to 3:45 p.m., a surveyor observed no signage or PPE other than gloves for R87's room, who has a wound and is on EBP's. On 9/10/24, from 7:30 a.m. to 3:45 p.m., a surveyor observed no signage or PPE other than gloves for R87's room who has a wound and is on EBP's. On 9/9/24, from 10:30 a.m. to 3:45 p.m., a surveyor observed no signage or PPE other than gloves for R84's room, who has a wound and is on EBP's. On 9/10/24, from 7:30 a.m. to 3:45 p.m., a surveyor observed no signage or PPE other than gloves for R84's room who has a wound and is on EBP's. On 9/10/24 at 11:15 a.m. during a tour of the Memory Care Unit, LPN1 Unit Manager of Memory Care Unit and a surveyor observed no signage or PPE for EBP's for R70, R87, and R84's rooms. In an interview with LPN1 Unit Manager of Memory Care Unit, a surveyor confirmed no signage or PPE for R70, R87, and R84's rooms. The LPN1 Unit Manager of Memory Care Unit state there should have been signage and PPE because R70, R87, and R84 are on EBP's.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35904 Based on record review, and interview, the facility failed to ensure Residents were offered pneumococcal vaccinations in accordance with their policy and the Centers for Disease Control and Prevention (CDC) recommendations for 5 of 5 residents reviewed for immunizations (Resident [R] 87, R90, R29, R1, and R70). Findings: Review of the facility Pneumococcal Vaccine Policy Statement, 1. Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated., and 7. Administration of the pneumococcal vaccines or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. 1. R87's admitted to the facility was on 1219/23. During review of immunization records, a surveyor could not locate evidence that R87 was reviewed, offered, or received a pneumococcal vaccine according to CDC recommendations. The Resident is over [AGE] years of age. 2. R90's admitted to the facility was on 8/1/24. During review of immunization records R90 received a PPSV23 immunization on 2/29/11. A surveyor could not locate evidence that R90 received a pneumococcal vaccine according to CDC recommendations. The Resident is over [AGE] years of age. On 8/1/24, R90's representative signed a consent for R90 to receive a PPSV23 and as of 9/12/24 R90 has not received a PPSV23. 3. R29's admitted to the facility was on 12/8/23. During review of immunization records, a surveyor could not locate evidence that R29 was reviewed, offered, or received a pneumococcal vaccine according to CDC recommendations. The Resident is over [AGE] years of age. 4. R1's admitted to the facility was on 1/24/24. During review of immunization records, R1 received a PPSV23 on 8/7/23. A surveyor could not locate evidence that R29 was reviewed, offered, or received a pneumococcal vaccine according to CDC recommendations. The Resident is over [AGE] years of age. 5. R70's admitted to the facility was on 3/11/22. During review of immunization records, R1 received a PCV13 on 1/20/23. A surveyor could not locate evidence that R70 was reviewed, offered, or received a pneumococcal vaccine according to CDC recommendations. The Resident is over [AGE] years of age. On 9/12/24 at 4:40 p.m., during an interview with the LPN1 Memory Care Unit Manager, a surveyor confirmed that R87, R90, R29, R1, and R70 were not reviewed, offered, or received a pneumococcal vaccine according to CDC recommendations, and should have been.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37440 Based on observations, interviews, the facility's Dish Machine Temperatures, and a food equipment service company work log, the facility failed to ensure that the kitchen high temperature dish machine was maintained in good repair and in safe operating condition for 1 of 1 dish machine observations (9/9/24) and failed to ensure proper cleaning and sanitizing of dishes for 1 of 1 kitchen tours (9/9/24). Findings: Review of the facility's Dish Machine Temperatures policy revised 1/24 noted: Dish machine wash and rinse water should be maintained at temperatures that meet guidelines established by the Food and Drug administration. State or local regulations will apply if stricter. Note: The range for optimal cleaning performance of the Diversey dish detergent is 150 Fahrenheit (F) to 165 F. Supervisor: If documentation of temperatures and test strips/max temperatures results has been assigned to a food and nutrition associate, confirm that it is completed at each meal period. Director: In the event of inappropriate temperature, make management decision concerning adequacy of sanitation of service ware. If due to inappropriate water temperature, high temperature machine, implements disposable service ware or use three compartment sink for sanitation. Notifies nursing units of use of disposal service ware. Contact sources of repairs. Documents action taken on the back of form. Director/designee: Verifies completion of logs, initials weekly. Review of a food equipment service company work log, dated 8/29/24 noted: [NAME] dishwasher -Came in and replaced upper float switch, wash and rinse thermometers, rinse pressure gauge, and toggle switch. Noticed that there was another water level float that is broken as well. Ran machine and watched for any leaks. Operated unit and watched gauge. Unit not heating at all. Found low flow probe getting continuity when closed but not sending contact to border element. Need float switches. Need low water probe, float assembly, one tech 2 hours. Please quote. On 9/9/24 from 10:45 a.m. to 11:30 a.m., a surveyor completed an initial kitchen tour with the Kitchen Supervisor. During this time, the kitchen staff operated the high temperature dishwasher 5 times for surveyor observation and the dishwasher was only washing at 110 degrees ( ) Fahrenheit (F) and would not reach 150 F according wash temperature gauge. The surveyor also noted a sign on the dishwasher that said Remember to turn water off or it could flood the kitchen! T. Y. At this time, the Kitchen Supervisor stated that the dish machine wash temperature gauge was not working accurately, and the machine has been having a lot of problems and that the water has to be shut off every time they're not using it or it will flood the kitchen. The Kitchen Supervisor confirmed that the dish machine wash temperature was 110 F and not up to 150 F and that the dish machine leaked water and was not operating safely and properly. On 9/9/24 at 11:45 a.m., in an observation and interview in the kitchen with a surveyor, the Director of Facilities Operations stated that the dish machine had been worked on 2 weeks ago and they found it needed more parts. He stated that the kitchen was not to be using the dish machine. He confirmed at this time that the dish machine was not maintained in a safe operating condition, was not washing at the proper wash temperature and the water was running all the time when used and it should not be used until fixed. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/10/24 from 8:00 a.m. to 8:20 a.m., in an observation and interview in the kitchen with a surveyor, the Interim Food Service Director stated that when the dish machine broke down about 2 weeks ago, the facility had it worked on, and it was found out it needed more parts. He stated that he instructed the kitchen staff to wash dishes by hand in the 3 bay pot sink until further notice. He stated that he was unaware that the kitchen staff was using the dish machine. He was going to lock it out but forgot, he said. At this time, the Interim Food Service Director confirmed that the dish machine was not washing dishes at the proper temperature, was not in a safe operating condition and the water was running all the time when used and it should not be used until fixed. On 9/10/24 at 9:35 a.m., in an interview, a surveyor discussed with the Administrator the kitchen dish washer issues and that the equipment was not being maintained in proper working condition but was still being used by the staff. She confirmed the staff was still using the dishwasher and it was not functioning properly and not maintained in a safe operating condition. She stated that it would not be used from this time forward until fixed. Review of a food equipment service company work log, dated 9/11/24 noted: Installed new float switch and filled unit. Found wash heater high limit tripped. Reset OK, brought unit up to temp on wash. Found booster not working period addressed this on separate call. Pics in file room period found machine time are not working. Unrelated issue opening new call.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 42531 Based on employee files review and interview, the facility failed to develop and implement an education program that included training on Resident Rights for 1 of 5 Certified Nursing Assistant's (CNA) reviewed (CNA4). Findings: CNA4 was hired on 6/27/22. A review of CNA4's education records revealed she has not received yearly education for Resident Rights since 6/27/22. On 9/13/24 at 2:10 p.m. in an interview with a surveyor, the Human Resource Director confirmed that CNA4 had not received the above In-service training in 2023 and 2024.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 42531 Based on review of Certified Nursing Assistant's (CNA) in-service training and interview, the facility failed to ensure that 1 of 1 CNA completed yearly training for Abuse, Neglect, Exploitation and Misappropriation of Property (CNA1). Finding: A review of the Facility Assessment for 2024-2025 revealed Required in-service training for new aides. In-service training must: Be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year. Include dementia management training and resident abuse prevention training. For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. CNA4 was hired on 6/27/22. A review of CNA4's education records revealed she has not received yearly education for Abuse, Neglect, Exploitation and Misappropriation of Property since hired. On 9/13/24 at 2:10 p.m. in an interview with a surveyor, the Human Resource Director confirmed that CNA4 had not received the above in-service training in 2023 and 2024.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 42531 Based on record review and interview, the facility failed to ensure staff received mandatory training on its Quality Assurance and Performance Improvement Program (QAPI), which included the staff's role and communication with the program, for 1 of 5 employee files reviewed (Certified Nursing Assistant #4 [CNA4]). Finding: CNA4 was hired on 6/27/22. A review of CNA4's education records lacked evidence she received annual mandatory training regarding the facilities QAPI program. On 9/13/24 at 2:10 p.m. in an interview with a surveyor, the Human Resource Director confirmed the CNA4 had not received the above in-service training in 2023 and 2024.