STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205121	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinnacle Health & Rehab at South Portland	42 Anthoine St So Portland, ME 04106

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations and interviews, the facility failed to promote care to residents in a manner that maintains each resident's dignity for 1 of 2 meals (Bayview and 200 unit) and failed to maintain a homelike environment for 2 of 2 meals observed on 2 of 3 survey days.Findings:1. During a meal observation on the 200 unit on 9/15/25 between 12:24 and 12:43 p.m. the following was observed:Table 1 contained 2 residents. One resident received their meal tray at 12:24 p.m., the staff served multiple other tables before returning to table 1 to give the second resident their meal at 12:34 p.m.Table 2 contained 2 residents. One resident received their meal tray at 12:26 p.m. The staff served multiple other tables before serving the second resident their meal at 12:29 p.m.Table three contained three residents. One resident was served at 12:27 p.m., the second resident was served at 12:39 p.m. At this time staff sat down with the second resident and provided feeding assistance although there were still residents that had not been served yet. The third resident was served at 12:43 p.m.2. During the meal observation of 200 dining room on 9/15/25 from 12:24 to 12:40 p.m., all meal trays were placed in front of each resident. No residents were asked if they wanted to keep the food on the tray.3. During an observation of Bayview unit lunch meal on 9/16/25 at 12:45 p.m. a surveyor observed all 9 residents in the dining room were sitting at the table with lunch trays. During an interview Registered Nurse (RN) #1 stated that since it's a dementia unit it's easier for staff to have the food on the tray to help prevent them grab each other's food.During an interview on 9/16/25 at 12:46 p.m. Certified Nurses Aid (CNA) #2 stated, she's never been told that each resident needed to be served at the table before moving to another table and has always just grabbed a tray and put it in front of the resident. In addition, she stated, that she just places the tray on the table, doesn't normally ask the residents if they want the plates placed on the table and had never been told to ask a resident what their choice was.On 9/16/25 at 12:15 p.m., during an interview, the Assistant Director of Nursing stated that residents should be asked if they want their plates removed for the tray for the meal.On 9/16/25 at 2:31 p.m., during an interview, the above was confirmed with Administrator and Director of Nursing.

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

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

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Pinnacle Health & Rehab at South Portland	42 Anthoine St So Portland, ME 04106

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on observations and interviews, the facility failed to ensure a residents call bell was within reach for 4 of 25 sampled residents for 2 of 3 days of survey with multiple observations. (Resident #5, #54, #7, and #67).Findings: 1. On 9/16/25 at 9:10 a.m., a surveyor observed Resident #5 seated in his/her Broda chair in his/her room, with the call bell tucked underneath the pillow on his/her bed, out of reach. At this time, Resident #5 stated he/ she was trying to get into bed and that he/she usually has to holler to get help. At 9:11 a.m., a surveyor pressed the call bell, and Certified Nursing Assistant #2 entered the room and stated that Resident #5 usually likes to go back to bed after breakfast and that the call light should not be under his/her pillow and should be within reach. On 9/16/25 at 9:27 a.m., the above finding was discussed with the Director of Nursing. 2. On 9/15/25 at 9:49 a.m., observation of Resident #54's call bell was hanging over the recliner chair at the head of the bed. At the foot of the bed, Resident #54 was in the wheelchair with the tray table in front of him/her. In a brief interview, the Surveyor asked if he/she could access the call bell. He/she wasn't sure and hasn't tried but did not know how to move the table that was in front of him/her. On 9/15/25 at 3:26 p.m., an additional observation, Resident #54 was lying in a low bed with the call bell still draped over the recliner chair out of reach of the resident Review of Resident #54's current care plan states, [Resident #54] is high risk for falls relating to confusion, gait/balance problems, incontinence, unaware of safety needs with nursing intervention of Be sure the residents call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. 3. On 9/15/25 at 9:59 a.m., observation of Resident #7 lying in bed with the call bell attached the blankets, hanging off the side of the bed above the floor, not within reach. In a brief interview, Resident #7 did not know where the call bell was located. Review of Resident #7's current care plan states, Resident #7 has ADL self-care performance deficit r/t UTI, fall with minor head injury, . Macular Degeneration with nursing interventions of [Resident #7] has poor vision and poor hearing requiring tactile and physical cues and high risk of falls relating to gait/balance problems, vison/hearing problems with nursing interventions of needs a safe environment with . a working and reachable call light. 4. On 9/15/25 at 3:26 p.m., observation of Resident #67 lying in a low bed with the call bell clipped to the call bell wall jack at the foot of the bed, not within reach of the resident. On 9/16/25 at 7:48 a.m., an additional observation of Resident #67 lying in a low bed with the call bell still clipped to the call bell wall jack at the foot of the bed, not within reach. On 9/16/25 at approx. 10:15 a.m., the above was discussed with the Director of Nursing who confirmed the residents should have access to their call bells at all times.

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Pinnacle Health & Rehab at South Portland	42 Anthoine St So Portland, ME 04106

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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. Based on record reviews, and interviews, the facility failed to provide evidence to show Advance Directives were offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an Advance Directive, for 8 of 25 residents reviewed for advanced directives (Residents #4, #8, #29, #57, #68, #52, #34, #50).Findings: 1. Resident #4 was admitted to the facility in June 2022. A review of the entire electronic medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. 2. Resident #8 was admitted to the facility in October 2023. A review of the entire electronic medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. 3. Resident #29 was admitted to the facility in August 2025. A review of the entire electronic medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. 4. Resident #57 was admitted to the facility in August 2025. A review of the entire electronic medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive. On 9/16/25 at 2:55 p.m., during an interview, the Licensed Practical Nurse #2 confirmed above. 5. Resident #68 was admitted to the facility in October 2023. A review of the residents electronic medical record lacked evidence that the facility offered, reviewed, or provided written information concerning the right to formulate an advanced directive with the resident and/or resident representative. On 9/16/25 at 2:06 p.m., the above was discussed with the Director of Nursing. 6. Resident #52 was admitted to the facility in July 2024. A review of the resident's electronic medical record lacked evidence that the facility offered, reviewed, or provided written information concerning the right to formulate an advanced directive with the resident and/or resident representative. On 9/16/25 at 3:00 p.m., the above was confirmed by the unit manager, Registered Nurse (RN) #4. 7. Resident #34 was admitted to the facility in August 2025. A review of the resident's electronic medical record lacked evidence that the facility offered, reviewed, or provided written information concerning the right to formulate an advanced directive to the resident and/or resident representative. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. Resident #50 was admitted to the facility in July 2024. A review of the resident's electronic medical record lacked evidence that the facility offered, reviewed, or provided written information concerning the right to formulate an advanced directive to the resident and/or resident representative. On 9/16/25 at 2:29 p.m., during an interview, RN#4 confirmed that a yearly discussion regarding advanced directives is something we just need to do.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to adequately provide maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable environment on 2 of 3 Units (100's and 200's).Findings: 1. During an initial observation of room [ROOM NUMBER] on 9/15/25 at 9:22 a.m., the footboard on B bed was observed to have missing/peeling areas of luminant, making it an uncleanable surface. On 9/16/25 at 12:51 p.m., during an observation of room [ROOM NUMBER] with Licensed Practical Nurse (LPN) #2 in the presence of Resident #57, LPN#2 observed the footboard and stated that she's never noticed it before, but it definitely needed to be fixed. At this time, Resident #57 stated I don't know how, since it's been like that for at least two years. On 9/16/25 at 2:31 p.m., during and interview, the above was confirmed with Administrator and Director of Nursing. 2. On 9/15/25 at 10:06 a.m., observation of 105 and 107's shared bathroom had 2 stained ceiling tiles near and around the light fixture with one of the tiles with a blueish gray spotty growth. On 9/16/25 at 7:47 a.m., during an interview, both the surveyor and the Maintenance Director observed the stained ceiling tiles and discussed the blueish gray spotty growth. The maintenance director stated there was a water leak that was recently fixed and he will replace the tiles immediately.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview the facility failed to hold an Interdisciplinary Team Meeting (IDT) within 7 days of a completed Minimum Data Set (MDS) for 6 of 6 Residents reviewed for Minimum Data Set (MDS) (Resident's #4, #8, #13, #57, #5 and #16).Findings: 1. Review of Resident #4's clinical record revealed the following: -Annual MDS with completion date 6/23/25. Further review of Resident #4's clinical record revealed the IDT meeting was held on 7/7/25 (14 days after completed MDS). -Quarterly MDS with completion date 3/24/25. Further review of Resident #4's clinical record revealed the IDT meeting was held on 4/14/25 (21 days after completed MDS). -Quarterly MDS with completion date 12/20/24. Further review of Resident #4's clinical record revealed the IDT meeting was held on 1/9/25 (20 days after completed MDS). 2.Review of Resident #8's clinical record revealed the following: -Quarterly MDS with completion date 7/31/25. Further review of Resident #8's clinical record revealed the IDT meeting was held on 8/14/25 (14 days after the completed MDS). -Quarterly MDS with completion date 4/29/25. Further review of Resident #8's clinical record revealed the IDT meeting was held on 5/12/25 (13 days after the completed MDS). -Quarterly MDS with completion date 1/27/25. Further review of Resident #8's clinical record revealed the IDT meeting was held on 2/13/25 (17 days after completed MDS). 3. Review of Resident #13's clinical record revealed the following: -Quarterly MDS with completion date 6/30/25. Further review of Resident #13's clinical record revealed the IDT meeting was held on 7/17/25 (17 days after MDS completion). -Significant change MDS with completion date of 3/31/25. Further review of Resident #13's clinical record lacked evidence of an IDT meeting was held after this MDS. -Quarterly MDS with completion date 12/31/24. Further review of Resident #13's clinical record revealed the IDT meeting was held on 1/16/25 (16 days after MDS completion). 4. Review of Resident #57's clinical record revealed Quarterly MDS with completion date of 11/29/24. Further review of Resident #57's clinical record revealed the IDT meeting was held on 11/21/24 (8 days prior to completed MDS). 5. A review of Resident #5's clinical record revealed an MDS Quarterly Assessment was completed on 8/7/25. Further review of Resident #5's clinical record lacked evidence that an IDT meeting was held within 7 days following the assessment. 6. A review of Resident #16's clinical record revealed the following: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An MDS admission Assessment was completed on 11/12/24. Further review of Resident #16's clinical record revealed an IDT meeting was held on 11/25/24 (13 days after completed MDS) and lacked evidence that an IDT meeting was held within 7 days following the assessment. -An MDS Quarterly Assessment was completed on 5/15/25, and an IDT meeting was held on 6/5/25 (21 days after completed MDS). -An MDS Quarterly Assessment was completed on 8/15/25, and an IDT meeting was held on 8/28/25 (13 days after completed MDS). On 9/16/25 at 2:29 p.m., during an interview with 2 surveyors, the above findings were discussed with the Administrator and the Director of Nursing.

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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. Based on observations, record reviews, interviews and the facility policy, the facility failed to maintain a sanitary environment to help prevent the development and transmission of disease and infection related to respiratory care for 3 of 3 residents reviewed for respiratory care (Resident's #31, #19 and #57).Findings: Review of facility policy Oxygen Therapy, revised 12/6/22 states, .Change mask and/or cannula weekly and as needed . 1. On 9/15/25 at 9:25 a.m., observation of Resident #31 utilizing an oxygen nasal cannula tubing with a date of 9/5/25. Review of the electronic medical record lacked evidence of an order and/or the nasal cannula being changed weekly. On 9/16/25 at 10:00 a.m., during an interview, the Director of Nursing (DON) confirmed the above and stated all oxygen tubing is changed weekly by nursing and there should be an order in the resident's chart. 2. On 9/15/25 at 8:50 a.m. a surveyor observed Resident #19 utilizing an oxygen nasal cannula tubing with a date of 8/25/25. Review of the Treatment Administration Record (TAR) revealed, Oxygen maintenance weekly per protocol. Clean concentrator filter weekly. Replace nasal cannula weekly and PRN [as needed] . every Mon [Monday]. Further review of the TAR indicated the nasal cannula was replaced on 9/1/25 and 9/8/25. On 9/16/25 at 9:27 a.m., during an interview with the DON, a surveyor discussed the above finding, including that the label on Resident #19's nasal cannula indicated it had last been changed 8/25/25, despite documentation on the TAR indicating the cannula had been changed on 9/1/25 and 9/8/25. 3. On 9/15/25 at 9:23 a.m., and on 9/16/25 at 9:30 a.m., observations of Resident #57 to have a Continuous Positive Airway Pressure machine on top of the bedside table with the tubing/mask connected and not bagged. On 9/16/25 at 12:51 p.m., during a follow up observation with Licensed Practical Nurse #2 the above was confirmed.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on record review and interviews, the facility failed to monitor and document targeted behaviors and side effects of psychotropic medication to support the use of psychotropic medications for 3 of 5 residents reviewed for unnecessary medications (Resident #4, #6, and #31).Findings: 1. Resident #4 was admitted with diagnoses to include anxiety and psychosis and has diagnoses to include dementia, anxiety and a psychotic disorder. Review of Resident #4's pertinent medication orders revealed he/she was taking antipsychotic medication Risperdal Oral Tablet 0.25 MG (Risperidone) Give 0.25 mg by mouth two times a day, and antianxiety medication Lexapro Oral Tablet 10 MG (Escitalopram Oxalate) Give 10 mg by mouth in the morning. Further review of Resident #4's clinical record lacked evidence he/she was being monitored for side effects and behaviors for these medications. On 9/16/25 at 11:35 a.m. during a review of Resident #4's clinical record with Licensed Practical Nurse (LPN) #2, she confirmed Resident #4 is taking antipsychotic medication Risperdal and antianxiety medication Lexapro, and there are no orders for monitoring behaviors/side effects. On 9/16/25 at 2:31 p.m., during an interview, the above was confirmed with Administrator and Director of Nursing. 2. Review of Resident #6's medical record stated he/she has a diagnosis of anxiety, major depressive disorder, dementia with behavioral disturbance and psychosis. The current active physician orders for September 2025 reveal the following orders of: Seroquel (antipsychotic) 12.5 milligram (mg) daily, Lorazepam (antianxiety) 0.5 mg three times daily and every 4 hours as needed for agitation x 90 days and Zoloft (antidepressant) 75mg daily. Further review of Resident #6's clinical record lacked evidence and documentation of targeted behaviors and monitoring for side effects of these medications. 3. Review of Resident #31's medical record stated he/she has a diagnosis of bipolar disorder and dementia with behavioral disturbance. The current active physician orders for September 2025 reveal the following orders of: Seroquel (antipsychotic) 300 mg at bedtime, Divalproex Sodium 1500 mg at bedtime and Lorazepam (antianxiety) 1.5 mg at bedtime. Further review of Resident #31's clinical record lacked evidence and documentation of targeted behaviors and monitoring for side effects of these medications. On 9/16/25 at 3:00 p.m., the above was discussed with the Licensed Practical Nurse #2

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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. Based on observations, record review and interviews, the facility failed to ensure expired medications were removed from the supply available for use and failed to ensure that medications were stored properly as per manufacturers' recommendations for 2 of 3 medication rooms reviewed for medication storage (100 unit and 300 unit).Findings:1. On 9/15/25 at 1:05 p.m., observation of the 100 unit medication room with the Licensed practical Nurse #1 the following was observed: 2 unopened bottles of liquid acetaminophen with expiration date of 8/2025 and an unopened bottle of Iron 325mg tablets with expiration date of 8/2025.2. On 9/15/25 at 1:38 p.m., observation of the 300 unit medication room with the Registered Nurse #1 the following was observed: an unopened bottle of Vitamin D 25 micrograms with expiration date of 8/2025. The refrigerator contained an opened vial of Tuberculin Purified Protein with manufactures directions to Store at 35 degrees to 46 degrees (F) Fahrenheit. Review of the refrigerator temperature logs from 8/25 through 9/15/25 revealed the lack of temperature monitoring for 18 of 62 opportunities for the month of August and 10 of 29 opportunities for the month of September.On 9/15/25 at 3:14 p.m., during an interview, the above was discussed with the Director of Nursing who confirmed the medication refrigerators should have the temperature monitored twice daily.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on facility policy, observation, interviews and record review the facility failed to ensure a smoking assessment of resident capabilities and deficits to determine resident safety was completed for 1 of 1 resident reviewed for smoking (Resident #48).Finding:Review of facility policy, Resident Smoking/Vaping Policy, revised 9/5/19 states, .designated as a non-smoking facility. Residents and/or staff are prohibited from smoking tobacco or any other substance in any enclosed area of the building. The residents.are prohibited from smoking/vaping both inside and outside the facility. Potential admissions. are informed prior to admission that is a non-smoking facility. On 9/15/25 at 8:34 a.m., during an interview, Licensed Practical Nurse (LPN) #2 stated that Resident #48 goes outside to smoke and that he/she has a cell phone and a call pendant and hands a corresponding pager off to the nurse because Resident #48 goes off facility property unsupervised to smoke.On 9/15/25 at 9:12 a.m. during an interview, Resident #48 stated he/she goes outside to smoke but is not permitted to smoke on facility property and that a staff member does not accompany him/her. Resident #48 then removed a pager and a lanyard from his/her bag and stated that he/she wears the lanyard and leaves the pager with the nurse when he/she goes out to smoke.A review of Resident #48's clinical record revealed the following progress notes:A Nursing progress note, dated 7/17/25 states, Res [resident] told nurse [he/she] was allowed to go outside. nurse.was unsure if this was ok.went outside to check on [him/her] went around building and down the street we could not see [him/her]. When we came back in and asked CNA [Certified Nursing Assistant] if [he/she] was allowed to leave facility CNA said [he/she] goes across the street to smoke, [he/she] returned shortly after that.A Care Plan Team Nursing Note dated, 7/23/25 states, .We had some Confusion with self outings and limitations regarding electric wheelchair. We have worked out an acceptable solution for now. Expresses need to get out and be alone sometimes to think, smoke or cry Further review of Resident #48's clinical record lacked evidence of a smoking assessment.On 9/16/25 at 9:27 a.m., during an interview, the Director of Nursing (DON) stated the facility is a no-smoking facility for residents and that Resident #48 goes outside but is not permitted to smoke on facility premises.On 9/16/25 at 2:29 p.m. during an interview with 2 surveyors, the above finding was discussed with the Administrator and DON, including the lack of a smoking assessment of resident capabilities and deficits to determine whether or not supervision is required.

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Pinnacle Health & Rehab at South Portland	42 Anthoine St So Portland, ME 04106

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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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on record review and interview, the facility failed to identify a resident's past history of trauma to determine what trigger(s) might cause re-traumatization and failed to revise the care plan to include trauma informed care for 1 of 1 residents reviewed for trauma. (#38) A review of the clinical record noted Resident #38 was admitted in May 2025. Medical diagnoses included vascular dementia. A brief trauma questionnaire, completed on 6/9/25, indicated Resident #38 had a history of significant trauma. The questionnaire stated family had identified showers provided by men were a trigger, and that showers should be provided by women only. The record lacked evidence that the results of the brief trauma questionnaire had been communicated to Resident #38's provider. The most recent MDS (Minimum Data Set) 3.0 Quarterly Assessment, dated 8/19/25, noted a BIMS (Brief Interview of Mental Status) score of 7, indicating severe cognitive impairment. The care plan, last revised 9/9/25, did not include the resident's history of trauma or interventions to prevent re-traumatization during care, such as having only female staff provide showers. On 9/16/25 at 4:45 pm, in an interview with the Director of Nursing, a surveyor discussed the results of the brief trauma questionnaire and that staff had not acted upon the findings to ensure Resident #38 received trauma informed care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205121	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for 1 of 1 walk in refrigerators on 1 of 3 survey days.Findings:During an observation of the walk in refrigerator on 9/15/25 at 8:20a.m., with Certified Dietary Manager (CDM), a surveyor observed a double fan on the right side over the shelving units containing food to have obvious built up/debris. CDM states that she will clean it. During an interview on 9/16/2025 at 2:31p.m., the above was confirmed with Administrator and Director of Nursing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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. Based on record review and interviews, the facility failed to ensure records were complete and contained accurate information for 1 of 1 resident reviewed for pacemaker (Resident [R]13).FindingsResident [R]13 was admitted in 2022 and was admitted for end of life (Hospice) with diagnoses to include heart dysrhythmia with presence of a pacemaker.Review of R13's care plan updated 7/17/25 states [R13] has a pacemaker r/t Dysrhythmias .Observe for/document/report PRN any s/sx of altered cardiac output or pacemaker malfunction: dizziness, syncope, difficulty breathing (Dyspnea), pulse rate lower than programmed rate, lower than baseline B/P. Review of R13's active orders lacked evidence that orders were obtained for the pacemaker.During an interview on 9/16/25 at 11:36 a.m. Licensed Practical Nurse (LPN)2 provided document dated 4/29/22 which states Reason for exam Dx: Pacemaker .Implanted date 4/9/22 .Encounter Summary: Scheduled device follow up Plan for routine follow up Review of R13's clinical record with UM lacked evidence that this was done. UM confirmed there were no orders or follow up appointments made because she was on hospice on admission.During an interview on 9/16/25 at 10:31 a.m., Medical Doctor (MD) stated that it is his expectation that someone with a cardiac pacemaker would have orders to include pacemaker checks, and appointments. At this time MD reviewed R13's clinical record and confirmed there are no orders for this pacemaker.