STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205128	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maplecrest Rehab & Living Center	174 Main St Madison, ME 04950

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on observation, interviews, record review, and facility policy, the facility failed to assess a resident for self-administration of medications (Resident #20). Review of facility policy Self-Administration of Medications dated 11/28/16 states .Facility . should assess and determine, . whether Self-Administration of medications is safe and clinically appropriate, based on the resident's functionality and health condition .To ensure safe and appropriate Self-Administration, Facility should educate residents to ensure that a resident is able to; State the name, dose, strength, frequency, and purpose for use of his/her medications; Understand the possible side effects of his/her medications and that he/she should notify Facility staff if he/she experiences any such side effects; correctly administer .his/her medications . Facility should ensure that orders for Self-Administration list the specific medication(s) the resident may Self-Administer Facility should document in the Self-Administration of medications in the residents care plan Review of Minimum Data Set (MDS) dated [DATE] reveled Resident #20 had a Brief Interview for Mental Status (BIMS) of 12 of 15 indicating [he/she] moderate impairment. On 4/16/24 at 6:41 a.m., two surveyors observed Resident #20 lying in bed, a small medication cup containing vitamin D3, lopid (cholesterol medication), ferrous sulfate (iron), allopurinol (gout medication), Vitamin C, garlic oil, milk [NAME], senna and pantoprazole (9 pills). Resident #20 indicated I can't take my pills until I've had my breakfast. Review of entire clinical record lacked evidence that a self-administration assessment was completed for Resident #20. On 4/16/24 at 7:43 a.m., during an interview, CNA-M#2 indicated that Resident #20 likes to take [his/her] medications after breakfast so they leave them at bedside. On 4/17/24 on 10:05 a.m., during an interview, LPN#1 indicated that medications should not be left at bedside. On 4/17/24 at 10:08 a.m., during an interview, CNA-M#3 indicated Resident #20 likes to take [his/her] medications after breakfast but they don't leave them at bedside. On 4/17/24 at 10:56 a.m., during an interview, DNS indicated that a resident needs to have an order and an evaluation to self-administer medications. DNS further indicated that medications are not to be left at Resident #20's bedside. At this time, the above findings were confirmed.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205128	A. Building B. Wing	04/19/2024

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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 - Few	Reasonably accommodate the needs and preferences of each resident. 33640 Based on interviews and record review, the facility failed to follow a resident's schedule for bathing and to ensure that a resident has a choice about his/her care in the area of bathing for 1 of 1 resident (Resident #11). On 4/17/24 at approximately 10:00 a.m. ,during an interview with a surveyor, Resident #11 voiced his/her frustration that he/she has not been receiving his/her showers on a weekly basis. Further, Resident #11 stated he/she prefers a whirlpool twice a week because it helps make his/her joints feel better and helps with his/her chronic pain. On 4/17/24, a surveyor reviewed the facility's Whirlpool & Shower List which indicates the resident is scheduled to have a shower and/or whirlpool on Wednesday during the day shift. In a review of the resident's electronic bath record from 3/1/24 through 4/17/24 indicates that resident had a shower on 3/27/24 and 4/10/24. The resident did receive a bed bath on the days a shower and/or whirlpool was not provided. On 4/17/24, at approximately 11:30 a.m., during an Interview, the Director of Nurses (DON) confirmed the above findings. In an interview with the Licensed Practical Nurse, (LPN), Minimum Data Set Coordinator (MDS Coordinator) he/she stated that the care plan should be updated to reflect Resident #11's preferences for bathing. Further, she stated when a resident refuses bathing/and or a shower, the refusal should be reported to the charge nurse as to the reason of the Resident's refusal so that it can be documented. On 4/17/24, at approximately 2:15 p.m., the LPN, MDS Coordinator confirmed that these concerns will be addressed, and the care plan will be updated.

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F 0576 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. 42531 Based on interview, the facility failed to ensure that mail was delivered to all residents on 1 of 6 days, Monday through Saturday. (Saturday) Finding: During a group interview on 4/18/24 at 10:24 a.m., three residents indicated that they do not have mail delivered on Saturday. On 4/18/24 at 10:45 a.m., during an interview, the Director of Nursing indicated she was not aware that residents were not receiving their mail. On 4/18/24 at 11:56 a.m., during an interview, the Administrator indicated she contacted the post office and was told that Saturday mail had been on hold for approximately 4 years. The Administrator further indicated she asked to take Saturday mail off hold.

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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** 50218 Based on facility policy, record review, and interviews the facility failed to provide residents/representatives written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive for 6 of 6 residents reviewed for advanced directives (Resident's #7, #23, #27, #39, #304 and #306). Findings: Review of facility policy Advanced Directive Policy and Procedure dated 10/18 states POLICY .Upon admission, the facility will inform and provide the resident/and/or resident's representative with information about advanced directive. PROCEDURE: Upon admission, identify if the resident has an advance directive and if not, determine if the resident wished to formulate an advance directive . All advance directive document copies will be obtained and located in the resident's medical record . 1. Resident #7 was admitted to facility on 3/5/19 with diagnoses to include multiple sclerosis. Review of annual Minimum Data Set (MDS) dated [DATE] revealed Resident #7 had a Brief Interview for Mental Status (BIMS) of 14 of 15 indicating he/she is cognitively intact. Review of Resident 7's clinical record lacked evidence that the facility provided resident/representatives written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. During an interview on 4/17/24 at 9:00 a.m. Resident #7 indicated that he/she doesn't remember ever being asked or offered an advanced directive. 2. Resident #23 was admitted to facility on 7/18/23 with diagnoses to include cerebral infarction, morbid obesity and the presence of a cardiac pacemaker. Review of Resident 23's clinical record lacked evidence that the facility provided resident/representatives written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. During an interview on 4/17/24 at 9:30 a.m., Resident #23 indicated that he/she doesn't remember ever being asked any questions regarding an advanced directive. 3. Resident #27 was admitted on [DATE] with diagnoses to include vascular dementia, and depression. Review of admission MDS dated [DATE] revealed Resident #27 had a BIMS of 5 of 15 indicating that he/she is cognitively impaired. Review of Resident #27's clinical record lacked evidence that he/she was offered/refused the opportunity to formulate an advanced directive upon his/her admission. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Resident #39 was admitted to the facility on [DATE] with diagnoses to include multiple myeloma, and atrial fibrillation. Review of quarterly MDS dated [DATE] revealed Resident #39 had a BIMS of 14 of 15 indicating he/she is cognitively intact. Review of Resident #39's clinical record lacked evidence that he/she was offered/refused the opportunity to formulate an advanced directive upon his/her admission. 5. Resident #304 was admitted on [DATE] with diagnosis to include diabetes mellitus, major depressive disorder, and post-traumatic stress. Review of admission MDS dated [DATE] revealed Resident #304 had a BIMS of 4 of 15 indicating he/she is cognitively impaired. Review of Resident #304's clinical record lacked evidence that he/she was offered/refused the opportunity to formulate an advanced directive upon his/her admission. 6. Resident #306 was admitted on [DATE] with diagnosis to include anxiety, and history of stroke. Review of admission MDS dated [DATE] revealed Resident #306 had a BIMS of 15 of 15 indicating he/she is cognitively intact. Review of Resident #306's clinical record lacked evidence that he/she was offered/refused the opportunity to formulate an advanced directive upon his/her admission. During an interview on 4/17/23 at 12:15 p.m., Resident #306 stated that he/she could not recall being asked or offered an advanced directive. On 4/16/24 at 12:56 and 4/17/24 at 8:14 a.m., during an interview, the Licensed Social Worker confirmed the clinical records lacked evidence the above residents were offered/refused the opportunity to formulate an advanced directive upon his/her admission. On 4/17/24 at 10:54 a.m., during an interview the above was discussed with the Director of Nursing. 37440 Surveyor: [NAME], [NAME] L 42531

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 37648 Based on observation, record review and interviews, the facility failed to ensure the resident representative was notified of an injury of unknown origin and failed to follow its own Notification of Changes policy and procedure for 1 of 1 sampled resident reviewed for injury of unknow origin (Resident #9). Findings: The Facilities Notification of Changes policy and procedure, developed September 2018 states, The nurse will immediately notify the resident, residents physician and the residents representatives for the following: An accident involving the resident, which results in injury and has the potential for requiring physician intervention and The nurse will notify the resident, resident physician and the resident representatives for non immediate changes of condition on the shift the changes occurs unless otherwise directed by the physician. On 4/16/24 at 7:15 a.m., observations were made of Resident #9 to have purple bruising around his/her left eye. At this time in an interview, surveyor asked how the bruise was obtained, Resident #9 stated, I don't know, while touching his/her face. The residents medical record contains a face sheet which indicates Resident #9 has a family representative and an Advanced Directive that was signed by the resident representative on 4/18/18. Review of nursing documentation dated 4/15/24 at 5:58 a.m., states, Resident woke up this morning with a large bruise under [his/her] left eye of unknown origin and a note on 4/15/24 at 2:03 p.m., states, I went to see [Resident] due to staff stating he/she was fine when he/she went to bed last night and this am has a left superficial bruise under his/her eye, no bruising in or around the eye more on his/her upper cheek toward eye. No swelling or documented falls. [Resident] does have a habit of sitting in his/her recliner and falling asleep with bedside table being on that side of him/her. Will monitor when in chair. When I asked [Resident] what happened to his/her eye he/she replied, I don't know it happened yesterday complaints of no pain. On 4/16/24 at 8:46 a.m., during an interview, the Director of Nursing (DON) stated she was made aware of Resident #9's bruise yesterday in the morning. The surveyor requested the state reportable incident for the injury of unknown origin. On 4/16/24 at 9:26 a.m., the DON provided the surveyor with the State reportable incident form which indicated N/A for the family/guardian notification. On 4/16/24 at 10:06 a.m., in an additional interview, the DON was asked why the state reportable incident for the injury of unknown origin, states N/A for the family/resident representative notification. The DON stated, the resident doesn't have any family then stated, the resident representative never comes in to see the resident but she will attempt to call the representative now. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/16/24 at 10:22 a.m., during an interview with the Licensed Social Worker she confirmed Resident #9 has a representative however, when they try to contact the representative, they leave a voice message but do not get a return call.

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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** 37440 Based on observations and interviews, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in good repair and in a sanitary condition for the 3 of 4 units (Lakewood, [NAME] Chase [NAME] and [NAME]), a common area and the Laundry room for 1 of 1 facility tours (4/18/24). Findings: On 4/18/24 from 8:40 a.m. to 9:00 a.m., a surveyor, the Administrator, the Maintenance Director and the District Manager for Health Care Services conducted a tour of the facility in which the following findings were observed: Lakewood - Resident room [ROOM NUMBER] (bed 2) - The wallpaper was peeling on the wall underneath the overhead bed light and next to the floor by the head of the bed. [NAME] Chase [NAME] - Resident room [ROOM NUMBER] - The wall, by the bed on the right side of the room, was marred and had chipped/missing paint creating an uncleanable surface. - Resident room [ROOM NUMBER] - The walls by the sink were marred and had chipped/missing paint, the drawers had chipped laminate and the bathroom wooden hand rail had a worn surface exposing untreated wood all of which created uncleanable surfaces. [NAME] Unit - Resident room [ROOM NUMBER] - The bathroom electric wall heating unit had chipped/missing paint creating an uncleanable surface. - Resident room [ROOM NUMBER] - The bathroom electric wall heating unit had chipped/missing paint creating an uncleanable surface. Nurse's station (common area) - The corner of the Nurse's station, facing the hallway, had a missing/broken piece of laminate near the bottom. Laundry Room - The cement floor had chipped/missing paint creating an uncleanable surface. - There were approximately 10 broken/cracked floor tiles. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The wooden shelving, under the stored chemicals and chemicals in use behind the washing machines, had chipped/ missing paint creating uncleanable surfaces. On 4/18/24 at 9:00 a.m., in an interview, the Administrator, the Maintenance Director, and the District Manager of Health Care Services confirmed the findings.

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	205128	A. Building B. Wing	04/19/2024

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33640 Based on record review and interview, the facility failed to notify the resident, family and/or the resident's representative in writing of the transfers/discharge to an acute care hospital for 2 of 3 residents sampled for hospitalization s (Residents #8 and #11). Findings: 1. Documentation in Resident #8's clinical record indicated that the resident was transferred to the hospital on 1/29/24 and 3/4/24 and subsequently admitted . The clinical record lacked evidence that Resident #8 and/or the resident representative were provided with a written transfer/discharge notices upon either transfer. On 4/18/24 at 8:34 a.m., during an interview, the Minimum Data Set Coordinator confirmed the above findings. 2. Documentation in Resident #11's clinical record indicated that the resident was transferred to the hospital on 4/1/24 and returned to the facility on [DATE]. The clinical record lacked evidence that Resident #11 and/or a family member were provided with a written transfer/discharge notice upon transfer. On 4/17/24 at 11:45 a.m., during an interview, the Director of Nurses confirmed the above findings. 37648

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33640 Based on record review and interview, the facility failed to issue a bed hold notice which included the daily bed hold cost, to a resident, known family member or legal representative for 2 of 3 sampled residents who had been transferred to the hospital (Residents #8 and #11). Findings: 1. Resident #8's clinical record revealed the resident was transferred to an acute care hospital on 1/29/24 and 3/4/24 and subsequently admitted . The clinical record lacked evidence that Resident #8 and/or the resident representative were provided with a written bed hold notice. On 4/18/24 at 8:34 a.m., during an interview, the Minimum Data Set Coordinator confirmed the above findings. 2. Resident #11's clinical record revealed the resident was transferred to an acute care hospital on 4/1/24 and returned to the facility on [DATE]. The clinical record lacked evidence that Resident #11 and/or a family member were provided with a written bed hold notice. On 4/17/24 at 11:45 a.m., during an interview, the Director of Nurses confirmed the above finding. 37648

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 37648 Based on record review and interview, the facility failed to complete a Minimum Data Sets (MDS) with in 14 days of Assessment Reference Date (ARD) and failed to transmit the MDS electronically to the State MDS database within 14 days of completion for 7 of 7 residents reviewed for resident assessments. (#6, #8, #13, #25, #35, #44 and #318) Findings: 1. On 4/17/24, a review of Resident #6's clinical record indicated an Annual MDS with an ARD of 3/11/24 was due to be completed by 3/25/24 and submitted to the state MDS database by 4/8/24. As of 4/17/24 the Annual MDS had not been completed and submitted to the state MDS database. 2. On 4/17/24, a review of Resident #8's clinical record indicated a Discharge MDS with an ARD of 3/3/24 was due to be completed by 3/17/24 and submitted to the state MDS database by 3/31/24. As of 4/17/24 the Discharge MDS had not been completed and submitted to the state MDS database. 3. On 4/17/24, a review of Resident #13's clinical record indicated a Quarterly MDS completed on 3/20/24 was due to be transmitted to the state MDS database on 4/3/24 and a Discharge MDS with an ARD of 3/15/24 was due to completed by 3/29/24 and submitted to the state MDS database by 4/12/24. As of 4/17/24 both Quarterly and the Discharge MDS had not been completed and/or submitted to the state MDS database. 4. On 4/17/24, a review of Resident #25's clinical record indicated a Quarterly MDS with an ARD of 3/11/24 was due to be completed by 3/25/24 and submitted to the state MDS database by 4/8/24. As of 4/17/24 the Quarterly MDS had not been completed and submitted to the state MDS database. 5. On 4/17/24, a review of Resident #35's clinical record indicated a Quarterly MDS with an ARD of 3/13/24 was due to be completed by 3/27/24 and submitted to the state MDS database by 4/10/24. As of 4/17/24 the Quarterly MDS had not been completed and submitted to the state MDS database. 6. On 4/17/24, a review of Resident #44's clinical record indicated a Discharge MDS with an ARD of 2/5/24 was due to be completed by 2/19/24 and submitted to the state MDS database by 3/4/24. As of 4/17/24 the Discharge MDS had not been completed and submitted to the state MDS database. 7. On 4/17/24, a review of Resident #318's clinical record indicated an Annual MDS with an ARD of 3/4/24 was due to be completed by 3/18/24 and submitted to the state MDS database by 4/1/24. On 4/17/24 the Annual MDS was submitted after surveyor intervention, 16 days late. On 4/17/24 at 10:50 a.m., both the surveyor and MDS coordinator reviewed the above assessments. At this time, the MDS coordinator confirmed the above assessments have not been completed and/or submitted timely.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 42531 Based on record reviews, interviews, and facility policy the facility failed to update/implement goals and interventions in the areas of enteral feeding (Resident #37), and mobility (Resident #41) for 2 of 14 care plans reviewed. Findings: Review of facility policy Comprehensive Person-Centered Care Planning dated 1/19 states The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with Residents Rights, which includes measurable objectives and timeframes to meet a residents medical nursing, mental, and psychosocial needs . Review of facility policy Vital Signs/Height And Weight Measurements Policy last revised 3/19 states: Procedure: B. Weights will be obtained weekly and documented for the first four weeks after admission (to obtain a baseline) and on a monthly basis unless otherwise ordered by the resident's physician . E. A weight that indicates a variance of +/-3 lbs. from the last obtained weight will necessitate a re-weigh of the resident. a. The original and 2nd weight should be obtained on the same shift and documented. F. The charge nurse will be made aware of the differences in the resident's weight. G. The weight loss/gain will be discussed with the Nutrition and Food Services Director for further dietary interventions. 1. Resident #37 was admitted to facility on 3/6/23 with diagnoses to include amyotrophic lateral sclerosis and peripheral vascular disease. A physician order instructs nursing staff to obtain Weight 2 Times Weekly. The residents current care plan, last reviewed and updated on 2/14/24, states Obtain and document weight as ordered (report a loss or gain greater than 3 pounds to provider and dietician). Adjust tube feeding order as needed. A review of the documented weights reveal the following weighs gains/losses +/- 3 pounds(lbs.): On 2/12/24 weight was 159.50. On 2/16/24 weight was 147.80(11.7 lbs. weight loss and no re-weigh of resident). On 2/22/24 weight was 157.60(9.8 lbs. weight gain and no re-weigh of resident). On 2/26/24 weight was 154.40(3.2 lbs. weight loss and no re-weigh of resident). On 4/1/24 weight was 158.60. On 4/4/24 weight was 150.70(7.9 lbs. weight loss and no re-weigh of resident). On 4/8/24 weight was 157.80(7.10 lbs. weight gain and no re-weigh of resident). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205128	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/18/24 at 11:34 a.m., in an interview, the Director of Nursing confirmed that the facility did not implement Resident #37's care plan for weights as written and that he/she was not re-weighed as the facility policy stated. 2. On 4/16/24 at 7:26 a.m., during an interview, Resident #41 stated I don't get my walking, nobody walks me. Surveyor asked if he/she is walked daily, Resident #41 stated, they say but they don't . I can walk by myself, but they don't let me. On 4/16/24 at 12:26 p.m., Resident #41 was observed eating lunch in his/her bedroom. On 4/17/24 at 8:16 a.m., Resident #41 was again observed in his/her bedroom with a breakfast tray on the table. At this time, the resident stated that he/she always eats in his/her bedroom. Review of Resident #41's Activities of Daily Living (ADL) care plan initiated on 5/12/23 states, Restorative Nursing Program(RNP), Ambulation Deficits: [Resident] will maintain his/her ability to ambulate at least 160ft, two times per day with interventions of RNP Walk: Use gait belt, front-wheeled walker, verbal cues and contact guard assist x1. Further, review of the ADL verification worksheet documentation for walking from 2/1/24- 4/16/24, (79 day period), indicated on 25 days the resident was not walked and on 39 days the resident was only walked once a day. On 4/17/24 at 8:22 a.m., during an interview, the Director of Nursing (DON) stated, since COVID they do not have RNP program and no longer have a RNP aid but have started a walking program, Walk to Dining. The DON provided the surveyor with a list of residents who participate in the Walk to Dining program which included Resident #41. On 4/17/24 at 10:13 a.m. during an interview, the facilities Operation Education Coordinator confirmed Resident #41 is not participating in the walk to dining program and has not been walked twice a day as per the individualized care plan. 37440 37648

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 42531 Based on interviews, record review and facility policy, the facility failed to provide residents with a continuous resident centered activities program for 3 of 4 residents reviewed for activity participation. (Resident's #12, #16, and #47). Findings: Review of facility policy Activities undated states .Activities Calendar: This is done monthly and posted in every room and bedside and beside the dining room door. This will include the daily and weekend scheduled activities and the birthdays for that month Review of activity calendars for June 2023 through April 2024 (11 months), lacked evidence that continuous resident centered activities were held on weekends. Review of Resident #12, #16, and #47's Resident Daily Activities Log dated March and April 2024 lacked evidence that activities were offered/refused on the weekend. During an interview on 4/18/24 at 10:24 a.m., Resident #12 indicated they only have activities on weekends if it's a holiday, because the activity director has no help. During an interview on 4/18/24 at 10:27 a.m., Resident #47 indicated [he/she] would like activities on weekends it gets very boring, During an interview on 4/18/24 at 10:29 a.m., Resident #16 indicated that it really bothers [him/her] that there are no scheduled activities on weekends. During an interview on 4/18/24 at 10:30 a.m., the Activity Director confirmed that there were no continuously scheduled activities on the weekends. During an interview on 4/18/24 at 10:45 a.m., the above was discussed with the Director of Nursing.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37440 Based on observation, interviews, and a review of Safety Data Sheets (SDS), the facility failed to ensure that the resident's environment was free of accident hazards relating to electric wall heating units for 3 of 3 observations and failed to ensure that that a chemical was properly secured for 1 of 4 days of survey. (4/16/24) Findings: 1. On 4/16/24 at 7:00 a.m., a surveyor observed an electric wall heating unit in the hallway across from Administrator office that had the metal front cover hanging half off exposing hot, sharp metal fins. At this time, the Administrator confirmed in an interview that the broken and sharp electric heater was an accident hazard. Additionally, the Administrator confirmed that the facility had vulnerable and independent ambulating residents. 2. On 4/16/24 at 7:50 a.m., a surveyor observed the bathroom electric wall heating unit in Resident room [ROOM NUMBER]/104 to be missing the front cover exposing hot, sharp metal fins. On 4/16/24 at 7:55 a.m., the Administrator confirmed in an interview that the broken and sharp electric heater was an accident hazard. 3. On 4/16/24 at 9:10 a.m., a surveyor observed the bathroom electric wall heating unit in Resident room [ROOM NUMBER] to be missing the front cover exposing hot, sharp metal fins. On 4/16/24 at 9:15 a.m., the Maintenance Director confirmed in an interview that the broken and sharp electric heater was an accident hazard. 4. On 4/16/24 at 9:35 a.m., a surveyor observed a 1 pound 14 ounce container of Sani-Cloth Bleach Germicidal Disposable Wipes in a box on a small table in the Embden Shower room. The door to the shower room was open. The Safety Data Sheet for Sani-Cloth Bleach Germicidal Disposable Wipes notes the following: Section 4 first aid measures: Inhalation - Call a poison Control Center or doctor for treatment advice. Skin contact - Wash thoroughly with soap and water. Call the poison Control Center or doctor for treatment advice. Eye contact - If in eyes, hold eye open and rinse slowly and gently with water for 15-20 minutes. Remove contact lenses, if present, after the first 5 minutes, then continues rinsing eye. Call poison Control Center or doctor for treatment advice. Ingestion - If swallowed: rinse mouth. Do not induce vomiting. Call physician or poison Control Center immediately. Only induce vomiting at the instruction of medical personnel. Never give anything by mouth to an unconscious person. On 4/16/24 at 9:38 a.m., the Director of Nursing (DON) confirmed the bleach wipes were left in an unsecured place and an accident hazard. Additionally, the DON confirmed that the facility had vulnerable and independent ambulating residents.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 42531 Based on record reviews and interviews, the facility failed to complete performance reviews at least once every twelve months for 3 of 3 Certified Nursing Assistants selected for review (Certified Nursing Assistant's (CNA) (CNA's #7, #8 and #9). Findings: 1. CNA#7 was hired on 1/7/22. Review of CNA#7's personnel file lacked evidence that a performance evaluation was completed in 2023 and 2024. 2. CNA#8 was hired on 5/5/22. Review of CNA#7's personnel file lacked evidence that a performance evaluation was completed in 2023 and 2024. 3. CNA#9 was hired on 7/15/19. Review of CNA#7's personnel file lacked evidence that a performance evaluation was completed in 2023 and 2024. On 4/18/24 at 9:45 a.m. during an interview, the Director of Nursing confirmed staff have not received their annual reviews.

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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. 50218 Based on observation, interview's, and record review, the facility failed to reconcile the narcotic book during shift change on 1 of 3 units (Emden Unit).,failed to monitor and record refrigerator temperatures containing biological's and vaccines in medicaion room (long term care medication room). Findings: 1. On 4/16/24 at 6:20 a.m., During review of long-term care controlled substance log with Certified Nursing Assistant/Medication Technician (CNA-M) #2 a surveyor noted the control substance log index was missing entries for page 49, 55, 59 and 60. At this time CNA-M #2 confirmed the index was missing entries. Review of untitled long term care narcotic log index on 4/17/24 revealed the following: -Index indicated page 48 belonged to Resident #304 for the medication lorazepam. Review of page 48 revealed it belonged to Resident #1 for medication Lyrica with received date 3/28/24. -Index indicated page 49 was missing a name but had quotations and arrows pointing down indicating it also belonged to Resident #304 for the medication lorazepam. Review of page 49 revealed it belonged to Resident #304 with received date 3/28/24. -Index indicated page 55 was blank. Review of page 55 revealed it belonged to Resident #17 for the medication tramadol received 4/6/24 -Index indicated page 59 was blank. Review of page 59 revealed it belonged to Resident #1 for the medication alprazolam with received date 4/11/24. -Index indicated page 60 was blank. Review of page 60 revealed it belonged to Resident #60 for the medication lorazepam with received date 4/12/24. On 4/17/24 at 11:43 a.m., Interview with Licensed Practical Nurse (LPN) #1 confirmed long-term care controlled substance log index was not filled out correctly. LPN #1 indicated that 2 nurses are supposed to enter new medications into the controlled substance log and should be in the index. On 4/17/24 at 10:49 a.m., Director of Nursing Service (DNS) indicated that when narcotics are delivered from pharmacy, the nurse signs them in, takes them out of package and immediately puts it in bound book on next blank page and should be putting them in index. At this time a surveyor confirmed the above findings. 2. Review of facility provided Maine Immunization Program Refrigerator Temperature logs dated February 2024 through April 2024 revealed the following: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy Policy 3.5 Biologicals and Vaccines dated 1/1/16 states . Facility staff should monitor the temperature of refrigerators and freezers where vaccines are stored two times a day per [Center for Disease Control] CDC guidelines On 4/17/24 at 10:37 a.m., during a medication room observation of long term care medication room, with LPN #1, vaccinations and biologicals were observed in the medication refrigerator. Review of facility refrigerator temperature logs revealed the following: -February 2024 temperature log lacked evidence that temperatures were documented twice daily on 2/18/24, 2/22/24, 2/23/24, 2/24/24, and 2/29/24. Documented once daily on 2/1/24, 2/2/24, 2/5/24, 2/6/24, 2/7/24, 2/8/24, 2/12/24, 2/13/24, 2/15/24, 2/16/24, 2/17/24, 2/19/24, 2/20/24, 2/21/24, 2/25/24, 2/26/24, 2/27/24, and 2/28/24. -March 2024 temperature log lacked evidence that temperatures were documented twice daily on 3/1/24-3/22/24 (22 days), 3/24/24, 3/28/24, and 3/29/24. Documented once daily on 3/23/24, 3/26/24, 3/27/24, and 3/30/24. -April 2024 temperature log lacked evidence that temperatures were documented twice daily 4/13/24. Documented once daily on 4/8/24 and 4/14/24. On 4/18/24 at 8:20 a.m., interview with LPN #5 revealed that he was never told to take refrigerator temperatures and assumed this was a night shift task. On 4/18/24 at 8:27 a.m., interview with LPN # 2 indicated she believed that documenting refrigerator temperature is a night shift task. On 4/18/24 at 9:03 a.m. , interview with Registered Nurse Manager (RN) #1 indicated refrigerator temperatures should be checked twice a day and is unaware who is currently responsible for this task. At this time RN#1 confirmed above findings. 42531

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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 and the facility's current Cleaning Dishes/Dish Machine policy, Dish Machine Temperature and Sanitizer Log Form policy, Food Storage Procedure, Sink/Bucket Sanitizer logs, Daily High-emp Ware Wash Checklist logs and Freezer and Refrigerator Temperatures Form logs, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for a ceiling air handling unit, ceiling tiles, ceiling lights, ceiling vents, and wall mounted fans. In addition, the facility failed to ensure products in the reach-in refrigerator and the dry storage room (including a chest freezer) were labeled and/or dated for 1 of 1 kitchen tours. Further, the facility failed to ensure that the dish machine was maintaining proper temperature ranges for proper washing/cleaning and that the refrigerators and freezers were monitored and temperatures documentation consistently. This has the potential to affect all residents. Findings: The facility's Cleaning Dishes/Dish Machine policy noted: All flatware, serving dishes, and cookware will be clean, rinse, and sanitized after each use. The dish machine will be checked prior to meals to assure proper functioning and appropriate temperatures for cleaning and sanitizing. Procedure: 1. Prior to use, verify proper temperatures and machine function. Confirm that soap and rinse dispensers are filled and have enough cleaning product for the shift. Note: staff should check the dish machine gauges throughout the cycle to assure proper temperatures for sanitation. Thermal strips may be used as verification that the temperature is adequately hot, but cannot verify actual temperatures. The facility's Dish Machine Temperature and Sanitizer Log Form noted: Policy: Dishwashing staff will monitor and record dish machine temperatures to assure proper sanitizing of dishes. Procedure: 1. Staff will monitor dish machine temperatures throughout the dishwashing process. 2. Staff will record dish machine temperatures for the wash and rinse cycles after each meal. a. The director of food and nutrition services will spot check this log to assure temperatures are appropriate and staff is correctly monitoring dish machine temperatures. 3. Staff will be trained to report any problem with the dish machine to the director of food and nutrition services as soon as they occur. 4. The director of food and nutrition services will promptly assess any dish machine problems and take action immediately to assure proper sanitation of dishes. The facility's Food Storage policy noted: Procedure: 4. Plastic containers with tight fitting covers must be used for storing cereals, cereal product, flour, sugar, dried vegetables, and broken lots of bulk food. All containers must be legible and accurately labeled and dated. 7. c. Food should be dated as it is placed on the shelves if required by state regulation. 14. Refrigerated food storage: b. Thermometers should be checked at least two times a day. F. All foods should be covered, labeled and dated. All foods will be checked to assure that foods including leftovers will be consumed by their safe use by dates, or frozen where applicable, or discarded. 15. Frozen foods: c. All food should be covered, labeled and dated. All foods will be checked to assure that foods will be consumed by their safe use by dates or discarded. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/16/24 from 6:05 a.m. to 6:30 a.m., a surveyor conduced a tour of the kitchen in which the following findings were observed: 1. > The ceiling air handling unit and two ceiling tiles around that unit were moderately soiled with dust/dirt. > There were two ceiling lights that had dust/debris in the lenses. > There were two wall mounted fans, over food preparation areas, that were dusty/dirty. > The dish room had 4 ceiling tiles with dried food particles and liquid residue on them. The wall mounted fan was dusty/dirty. The ceiling vent was dusty/dirty. > The reach-in refrigerator had a package of whipped topping with no thaw date. Directions on the package stated that once thawed, the product was good for 14 days. > The dry storage room had 12 bags of crackers that was unlabeled. A large bag of noodles that was unlabeled and undated. The large chest freezer had a package of whipped topping with no date it was frozen. Directions on the package stated that the product was only good for 9 months when frozen. On 4/16/24 at 7:45 a.m., in an interview, the Food Service Director (FSD) confirmed the findings. 2. On 4/16/24 from 6:05 a.m. to 6:30 a.m., during a kitchen tour, a surveyor observed the facility had a high temperature dish machine. The dish machine was run 5 times in a row and could not reach the 150 degrees Fahrenheit required during the wash cycle. In an interview with the surveyor during this time, the morning dietary aide stated she knew that the wash temperature needed to be a least 150 degrees Fahrenheit and the rinse temperature needed to be at least 180 degrees Fahrenheit. She stated that the dish machine had been acting up and not working properly. She additionally stated that a company had been called and they said a part was needed. She stated the facility was still using the dish washer even though it did not work properly and consistently as far as wash temperatures were concerned. On 4/16/24 at 7:45 a.m., in an interview, the FSD confirmed the dish washer was not washing at the required temperature. On 4/16/24 at 11:30 a.m., in an interview, the surveyor reviewed the finding with the Administrator. The facility immediately stopped using the dish machine and started using paper and plastic for meal service. On 4/18/24 at 9:28 a.m., a surveyor reviewed kitchen documentation for refrigerators and freezers temperatures, dish washer temperatures and sanitation bucket/sink logs revealing monitoring and documentation was not consistently completed for January, February, March and April 2024. Daily High-Temp Dish Washing Log: Missing dates of monitoring and documenting and low wash temperature. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	January 2024: 4-supper, 5-lunch, 6-supper, 8-supper, 17-breakfast, and 25-supper. February 2024: No documentation provided. March 2024: 1-supper, 24-lunch and low wash temperature, 29- low wash temperature at supper, 30-breakfast and 31-lunch and low wash temperature at supper. April 2024: 3- low wash temperature for breakfast and lunch, 5- low wash temperature for supper, 7- low wash temperature for supper, 8- low wash temperature for lunch and supper, 9- low wash temperature for lunch and supper, 10- low wash temperature for breakfast and supper, 11- low wash temperature for breakfast/lunch and supper, 12- low wash temperature for breakfast and supper, 13- low wash temperature for supper, 14- low wash temperature for breakfast and supper, 15- low wash temperature for breakfast and supper and 16- low wash temperature for breakfast and supper. Sink/Bucket Sanitizer: Missing Monitoring and Documentation Dates January 2024: No Documentation February 2024: No Documentation March 2024: No Documentation April 2024: No Documentation from 1-14. Freezer and Refrigerator Temperature Log: Missing Monitoring and Documentation Dates January 2024: Milk Cooler: 4-evening, 6-morning and evening, 7-morning, 10-evening, 11-evening, 13-morning and evening, 14-morning, 15-evening, 16-evening, 17-evening, 20-morning, 21-morning, 22-evening, 23-evening, 24-evening, 27-morning, 28-morning, 30-evening and 31-evening. Vegetable Refrigerator: 4-evening, 6-morning and evening, 7-morning, 10-evening, 11-evening, 13-morning and evening, 14-morning, 15-evening, 16-evening, 17-evening, 20-morning, 21-morning, 22-evening, 23-evening, 24-evening, 27-morning, 28-morning, 30-evening and 31-evening. True Unit: 4-evening, 6-evening, 7-morning, 10-evening, 11-evening, 13-morning and evening, 14-morning, 15-evening, 16-evening, 17-evening, 20-morning, 21-morning, 22-evening, 23-evening, 24-evening, 27-morning, 28-morning, 30-evening and 31-evening. Kitchen Refrigerator: 3-evening, 4-evening, 5-evening, 7-evening, 11-morning and evening, 13-morning, 14-morning, 19-morning and 29-evening. Cook Refrigerator: 3-evening, 21-morning and 29-evening. Vegetable Freezer: 4-evening, 6-morning and evening, 7-morning, 10-evening, 11-evening, 13-morning and evening, 14-morning, 15-evening, 16-evening, 17-evening, 20-morning, 21-morning, 22-evening, 23-evening, 24-evening, 27-morning, 28-morning, 30-evening and 31-evening. Chest Freezer: 4-evening, 6-morning and evening, 7-morning, 10-evening, 11-evening, 13-morning and evening, 14-morning, 15-evening, 16-evening, 17-evening, 20-morning, 21-morning, 22-evening, 23-evening, 24-evening, 27-morning, 28-morning, 30-evening and 31-evening. Ice Cream Freezer: 4-evening, 6-evening, 7-morning, 10-evening, 11-evening, 13-morning and evening, 14-morning, 15-evening, 16-evening, 17-evening, 20-morning, 21-morning, 22-evening, 23-evening, 24-evening, 27-morning, 28-morning, 30-evening and 31-evening. Kitchen Freezer: 2-evening, 3-evening and 29-evening. Freezer: 1 through 31-evening, 18-morning, 19- morning, 22 through 26-morning and 28 through 31-mrning. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	February 2024: Milk Cooler: 1-evening, 3-morning and evening, 4- morning, 7-evening, 8-evening, 9-morning and evening, 10-morning and evening, 11- morning, 12-evening, 13-evening, 14-evening, 15-morning and evening, 16-morning and evening, 17-morning and evening, 18-morning, 19-evening, 20-evening, 24-morning and evening, 25-morning, 26-evening, 27-evening, 28-evening and 29-evening. Vegetable Refrigerator: 1-evening, 3-morning and evening, 4- morning, 7-evening, 8-evening, 9-morning and evening, 10-morning and evening, 11- morning, 12-evening, 13-evening, 14-evening, 15-morning and evening, 16-morning and evening, 17-morning and evening, 18-morning, 19-evening, 20-evening, 24- morning and evening, 25-morning, 26-evening, 27-evening, 28-evening and 29-evening. True Unit: 1-evening, 3-morning and evening, 4-morning, 5-evening, 7-evening, 8-evening, 9-morning and evening, 10-morning and evening, 11-morning, 12-evening, 13-evening, 14-evening, 15-morning and evening, 16-morning and evening, 17-morning and evening, 18-morning, 19-evening, 20-evening, 24-morning and evening, 25-morning, 26-evening, 27-evening, 28-evening and 29-evening. Kitchen Refrigerator: 28-morning, 1 through 29 no documentation for evenings Chest Freezer: 1-evening, 3-morning and evening, 4- morning, 7-evening, 8-evening, 9-morning and evening, 10-morning and evening, 11- morning, 12-evening, 13-evening, 14-evening, 15-morning and evening, 16-morning and evening, 17-morning and evening, 18-morning, 19-evening, 20-evening, 24- morning and evening, 25-morning, 26-evening, 27-evening, 28-evening and 29-evening. Ice Cream Freezer: 1-morning and evening, 3-morning and evening, 4- morning, 5-evening, 7-evening, 8-evening, 9-morning and evening, 10-morning and evening, 11- morning, 14-evening, 15-evening, 16-evening, 17- morning and evening, 18-morning, 19-evening, 24- morning and evening, 25-morning, 26-evening, 27-evening, 28-evening and 29-evening. Kitchen Freezer: 28-morning, 1 through 29 no documentation for evenings Veggie Freezer: 1-evening, 3-morning and evening, 4- morning, 5-evening, 7-evening, 8-evening, 9-morning and evening, 10-morning and evening, 11- morning, 12-evening, 13-evening, 14-evening, 15- morning and evening, 16- morning and evening, 17- morning and evening, 18-morning, 20-evening, 21-evening, 24- morning and evening, 25-morning, 26-evening, 27-evening, 28-evening and 29-evening. March 2024: Milk Cooler: 2-morning, 3-morning and evening, 12-morning, 17-evening, 18-evening-19-evening and 28-morning. Vegetable Refrigerator: 2-morning, 3-morning and evening, 4-morning and evening, 15-evening, 17-evening, 18-evening, 19-evening, 23-morning and 29-morning. True Unit: 3-morning and evening, 4-morning and evening, 15-evening, 17-evening, 18-evening, 19-evening, 23-morning and 28-morning. Kitchen Refrigerator: 1-morning and evening, 2-evening, 3-evening, 4-evening, 5-evening, 6-evening, 7-evening, 8-evening, 9- morning and evening, 10-morning and evening, 11-evening, 12-evening, 13-evening, 14-evening, 15-evening, 16- morning and evening, 17- morning and evening, 18-evening, 19-evening, 21-evening, 24-evening, 28-evening, 28-evening and 30-morning and evening. Chest Freezer: 2-morning, 3-morning and evening, 9-morning and evening, 15-evening, 16-morning, 17-evening, 18-evening, 19-evening, 23-morning and 25-evening. Ice Cream Freezer: 3-morning and evening, 4-morning and evening, 15-evening, 17-evening, 18-evening, 19-evening, 23-morning and 28-morning. Kitchen Freezer: 1-morning and evening, 2-evening, 3-evening, 4-evening, 5-evening, 6-evening, 7-evening, 8-evening, 9-morning and evening, 10-morning and evening, 11-evening, 12-evening, 13-evening, 14-evening, 15-evening, 16-morning and evening, 17- morning and evening, 18-evening, 19-evening, 21-evening, 24-evening, 28-evening, 28-evening and 30-morning and evening. Freezer: 2-morning, 3-morning and evening, 4-evening, 7-evening, 15-evening, 16-morning, 17-evening, 18-evening, 19-evening, 23-morning and 28-morning and evening. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205128	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maplecrest Rehab & Living Center	174 Main St Madison, ME 04950

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	April 2024: Milk Cooler: 1-evening, 3-morning and evening, 4-morning, 5-evening, 7-evening, 8-evening, 9-morning and evening, 10-morning and evening, 11-morning, 12-evening, 13-evening, 14-evening, 15-morning and evening, 16-morning and evening, 17-morning and evening, 18-morning, 19-evening, 20-evening, 24-morning and evening, 25-morning, 26-evening, 27-evening, 28-evening and 29-evening. Vegetable Refrigerator: 1-evening, 3-morning and evening, 4-morning, 5-evening, 7-evening, 8-evening, 9-morning and evening, 10-morning and evening, 11-morning, 12-evening, 13-evening, 14-evening, 15-morning and evening, 16-morning and evening, 17-morning and evening, 18-morning, 19-evening, 20-evening, 24-morning and evening, 25-morning, 26-evening, 27-evening, 28-evening and 29-evening. True Unit: 1-evening, 3-morning and evening, 4-morning, 5-evening, 7-evening, 8-evening, 9-morning and evening, 10-morning and evening, 11-morning, 12-evening, 13-evening, 14-evening, 15-morning and evening, 16-morning and evening, 17-morning and evening, 18-morning, 19-morning and evening, 21-morning and evening, 24-morning and evening, 25-morning, 26-evening, 27-evening, 28-evening and 29-evening. Kitchen Refrigerator: 1 through 4-evening, 9-morning, 11- evening, 12-evening, 13- morning and evening. Chest Freezer: no documentation provided Ice Cream Freezer: no documentation provided Kitchen Freezer: 1 through 4-evening, 11- evening, 12-evening, 13- morning and evening. Freezer: no documentation provided On 4/18/24 at 9:33 a.m. in an interview, the FSD and the Nutritional Services Coordinator confirmed the finding.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205128	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maplecrest Rehab & Living Center	174 Main St Madison, ME 04950

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33640 Based on record review, 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 linen handling, urinary collection devices for 3 of 3 days of survey on 2 of 3 units ([NAME] and Lakewood). Findings: 1. The facility's Linen Handling Policy notes under handling laundry: Soiled linen is considered to be potentially contaminated and standard precautions will be used when being handled. Gloves will be worn when handling soiled linens. Linens will be bagged (a pillowcase may be used) at the point of collection (resident room) and then soared linens are transported to laundry bins. On 4/16/24 at 7:23 a.m., a surveyor observed Certified Nursing Assist (CNA) #4 carrying soiled linen on the [NAME] unit from resident room [ROOM NUMBER] to the soiled utility room. CNA #4 was not wearing gloves and the linen was not bagged as per the facility's Linen Handling Policy. At this time, CNA #4 confirmed that she had transported the linen to the soiled linen room unbagged and that she was not wearing gloves. On 4/16/24 at 9:20 a.m., the surveyor discussed the finding with the Director of Nursing (DON). 2. On 4/17/24 at 8:11 a.m., and on 4/18/24 at 8:27 a.m., observation of Lakewood Unit, room [ROOM NUMBER]/108 shared bathroom had a urinal hanging on the side of the trash can next to the toilet. This was discussed with the Administer on 4/18/24 at 10:34 a.m. 3. On 4/16/24, 4/17/24, and 4/18/24., observation of [NAME] Unit, room [ROOM NUMBER]/425 shared bathroom had an unlabeled bed pan and an unlabeled urinal stored on the floor beside the toilet. On 4/18/24 at approximately 9:30 a.m., in an interview with a surveyor, the Director of Nurses confirmed the above observations did not support good infection control practice. 37440 37648

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	205128	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maplecrest Rehab & Living Center	174 Main St Madison, ME 04950

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 42531 Based on Certified Nurse's Aide (CNA) employee education record reviews and interview, the facility failed to monitor and ensure that a CNA attended the required 12 hours of annual in-service education, for 3 of 3 randomly selected CNA's employed greater than 1 year. (#7, #8, and #9). Findings: 1.CNA #7 was hired on 1/7/22. Review of CNA #7's Employee In-service/attendance records revealed CNA #7 has only 3.5 documented in-service hours from 1/7/22 through 14/18/24. 2. CNA #8 was hired on 5/5/22. Review of CNA #8's Employee In-service/attendance records revealed CNA #8 has only 4 documented in-service hours between 5/22/22 through 4/18/24. 3. CNA #9 was hired on 7/15/19. Review of CNA #9's Employee In-service/attendance records revealed CNA #9 has only 3.5 documented in-service hours from 7/15/19 through 4/18/24. During an interview on 4/18/24 at 9:45 a.m., Director of Nursing confirmed the above CNA staff have not completed 12 hours of yearly in-service hours.