STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205138	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood A Continuing Care Center	220 Kennedy Memorial Dr Waterville, ME 04901

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 37648 Based on observations, interviews and record review, the facility failed to ensure that a resident's choice in the area of bathing and hygiene were being followed for 1 of 20 sampled residents (Resident #37). Findings: On 11/12/24 at 9:10 a.m., observation of Resident #37 lying in bed with a splint on his/her right hand. His/her face was unshaven with flakey skin around his/her scalp. During an interview, Resident #37 stated, Tuesdays is his/her whirlpool bath day and Since I hurt myself .I haven't gotten it for a few weeks. It's usually a whirlpool bath. The surveyor asked if he/she can shave him/herself. Resident stated, Before I hurt myself, I've been waiting for over a week. I'm right-handed, with this especially, showing the surveyor his/her right hand in the splint. The resident confirmed the split is always in place and he/she would like his/her face shaved. The surveyor then asked if he/she had asked the staff to help. He/she stated, yes, but they are always busy. At this time the Registered Nurse #3 (RN #3) entered the room. Resident #37 asked the RN #3 about his/her whirlpool which was scheduled today. The RN#3 stated the whirlpool girl is not here today. On 11/12/24 at 1:33 p.m., observation of Resident #37 in his/her wheelchair with an unshaven face. He/she confirmed he/she did not receive a whirlpool today stating, not yet, I haven't for several past Tuesdays. At this time, the Physical Therapy Assistant (PTA) stated resident #37 has not had a whirlpool yet so she got him/her up to do his/her exercise. The PTA then stated the resident had not received a whirlpool last week either. On 11/12/24 at 1:39 p.m., review of the shower schedule at the nurses station stated resident #37 was scheduled for a whirlpool on Tuesdays. At this time, RN #3 stated all showers/whirlpools are on the day shift. Review of Resident #37's Activities of Daily Living for bathing, from 9/1/24 through 11/12/24 lacked evidence of a whirlpool being provided on Tuesdays, or refusals for the following dates: 9/17/24, 9/24/24, 10/15/24, 10/29/24, 11/5/24 and lacked documentation of bathing from 10/3/24 through 10/14/24 and on 10/22/24. On 11/12/24 at 3:25 p.m., the above was discussed with the Director of Nursing. (continued on next page)

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: 205138	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER Lakewood A Continuing Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 220 Kennedy Memorial Dr Waterville, ME 04901	

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 7:45 a.m. observation of Resident #37 in bed with a shaved face. At this time, Resident #37 stated he/she did not get his/her whirlpool yesterday but is having one today.

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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 interview, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable environment on 3 of 3 units (the Skilled Unit, the Long-Term Care Unit and the Memory Care Unit) for 1 of 1 facility tour. Findings: On 11/14/24 from 9:15 a.m. to 9:45 a.m., two surveyors conducted an Environmental tour with the Facilities Director in which the following findings were observed: > Activity Room by front entrance - the ceiling, in the far-left corner of the room, had an area hanging down exposing sheetrock. There were multiple floor seams that were held down with black tape. > The skilled unit common area had a blue manual sit-to-stand lift and a mechanical [NAME] Plus sit-to-stand lift that had dirt/debris in the foot base areas; and had a manual sit-to-stand lift that had a foot base that had ripped/torn non-skid tape and chipped/peeling paint on the base and legs creating uncleanable surfaces. > Resident room [ROOM NUMBER] - The ceiling and wall, around the bathroom light fixture, was unpainted and had holes in them. > Resident room [ROOM NUMBER] - The ceiling and wall, behind the bathroom light fixture, was unpainted and had holes in them. The bathroom ceiling vent was dusty/dirty. > Resident room [ROOM NUMBER] - The bathroom floor was dirty around the base of the toilet. > A hallway ceiling tile, by the emergency exit near room [ROOM NUMBER], had a ceiling tile with a brown stain on it. > Resident room [ROOM NUMBER] - The ceiling and wall, around the bathroom light fixture, was unpainted and had holes in them. > Resident room [ROOM NUMBER] - There was a large, spackled and unpainted area on the right wall by Resident 63's bed. The ceiling and wall, behind the bathroom light fixture, was unpainted and had holes in them. The bathroom ceiling vent was dusty/dirty. > Resident room [ROOM NUMBER] - The ceiling and wall, behind the bathroom light fixture, was unpainted and had holes in them. Memory Care Unit: > Resident room [ROOM NUMBER]A - Resident #50's wheelchair had ripped/cracked arm rests. > The hallway walls, outside Resident room [ROOM NUMBER] to Resident room [ROOM NUMBER] had chipped and missing paint and there was a corner wall joint missing drywall, leaving the metal corner exposed. A sit-to-stand lift had chipped/missing paint on the base and the legs and there was dirt and debris on the foot base area. The baseboard heater register had chipped and missing paint. > Resident room [ROOM NUMBER] - The ceiling and wall, behind the bathroom light fixture, was unpainted and had holes in them. The wall behind the soap dispenser was missing paint exposing sheetrock The bathroom walls were chipped/gouged in multiple places along the bottom perimeter of the wall. > The Personal Care Room on the memory care unit had a wall cabinet that had white tape covering the bottom edge of each of the two (2) cabinet doors. A tall cabinet had chipped laminate at the base of the cabinet. A shorter base cabinet had chipped laminate and missing laminate at the base of the cabinet and the front base trim piece was bowed. The countertop edges were chipped, exposing the underlying particleboard. The baseboard heater register had chipped/missing paint. There was an Olympic Warmette [linen warmer] full of towels, with a temperature control range of 75-150 degrees Fahrenheit, that had a plastic and cloth doll and a folded throw blanket on top of it. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Long term Care Unit: > Resident room [ROOM NUMBER]A - Resident #88's wheelchair had ripped/cracked arm rests. > Resident room [ROOM NUMBER]A - Both the left and right armrests were ripped/torn and created uncleanable surfaces. > Resident room [ROOM NUMBER]B - The electric wheelchair stored in the bathroom had tape on the left armrest created an uncleanable surface. On 11/14/24 at 9:45 a.m., in an interview with 2 surveyors, the Facilities Director confirmed the findings. 37648

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 48648 Based on a review of the Nursing Facility Reportable Incident submitted to the Division of Licensing and Certification on 10/21/24, the facility's internal investigation, written statements by staff, facility policy, clinical record review and interviews, the facility failed to protect a resident's right to be free from physical and emotional abuse by staff when a Certified Nursing Assistant (CNA #1) forcibly dressed and transferred a resident. (Resident #70) Findings: The incident on 10/21/24 came to the attention of DHHS-DLC in a facility reported incident dated 10/21/24 alleging that CNA #1 was abusive towards Resident #70. A surveyor reviewed the facility policy Resident Abuse, Neglect, or Exploitation stated that Abuse is The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Resident #70's medical records showed diagnoses of dementia, anxiety, depression, Post-traumatic stress disorder (PTSD) and agoraphobia. Resident #70 is a long term care resident of the facility. A surveyor reviewed Resident #70's care plan and found the following dated 3/7/2023: Provide care to (Resident #70) with 2 providers at all times. and Use patient approach. If resident becomes agitated, make him/her safe and approach later. On 11/12/24 at 12:00 p.m. a surveyor spoke with Resident #70 in his/her room and was told how nervous he/she gets and how difficult it is for him/her to leave her room and not have an anxiety attack. He/She did not remember the incident that occurred on 10/21/24. On 11/13/24 at 11:10 a.m. a surveyor interviewed RN #2 who cared for Resident #70 on 10/21/24. She/He stated that the resident is often resistant to care and requires a gentle, calm approach and time to accept care due to his/her history of PTSD and anxiety. They often have to reapproach several times to complete care that he/she may need. A surveyor reviewed a written witness statement from CNA #2 dated 10/21/24 states; I walked in on (CNA #1 forcing (Resident #70) to get dressed with an abrasive attitude, and also forced him/her into the sit/stand without proper securement while (Resident #70) yelled Why are you letting (him/her) do this Stop, Stop CNA #2 stated he/she told (CNA #1) to step out and he/she would take over. (CNA #1) continued to manhandle Resident #70. A surveyor reviewed a written statement dated 10/21/24 by an RN #1 who was involved following the incident on 10/21/24 stated Resident #70 expressed pain in the area (back) that was reddened following the incident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A surveyor reviewed a written interview by the facility with CNA #1 dated 10/23/24 at 15:58; CNA #1 was asked if he/she forced the patient's arms into his/her shirt. CNA #1 stated I did force his/her arm into the shirt, by the elbow. I probably should have backed off or had the nurse come in. CNA #1 stated this was a mistake. On 11/13/24 at 11:06 a.m. a surveyor spoke with the administrator and was told the incident on 10/21/24 towards Resident #70 was unfortunately abusive and CNA #1 was fired. On 11/13/24 at 1:46 p.m. a surveyor interviewed CNA #2, who was a witness and reporter of the incident on 10/21/24. CNA #2 stated that she/he told CNA #1 to stop when he/she saw how forcibly she was handling Resident #70 and hearing Resident #70 yell for help and to stop. CNA #1 refused to stop and leave the room when CNA #2 begged him/her to stop and leave the room. CNA #2 stayed to protect Resident #70 the best he/she could and then immediately reported the incident to RN#1 once he/she felt Resident #70 was safe. On 11/15/24 at 9:49 am a surveyor spoke with CNA #1 on the phone and when asked about the reported incident on 10/21/24; Well, they said I made the wrong move. I don't know what I'm doing. I feel like I try to do the best to my abilities. It was a mistake. I try to do a good job. A surveyor reviewed a document dated 10/25/24 titled Employee Warning Notice to Employee (CNA #1) that showed the facility dismissed CNA #1 for abuse of resident on 10/21/24.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 51669 Based on the facility's policy, record review, and interview, the facility failed to notify the State Agency after an allegation of potential neglect concerns were identified, failed to investigate an unwitnessed fall resulting in a major injury, and failed to ensure that the facility's investigation was sent to the State Agency within 5 business days of the incident for 2 of 4 complaint investigations reviewed during an annual survey. Findings: A review of the facility's policy, Policy/Procedure #23-007, Reporting and Investigating Compliance Concerns, Section B. Investigations, states, Any alleged violation will be acted upon promptly by the individual receiving a report of non-compliance from a Workforce Member . A review of the facility's policy, Policy/Procedure #004, Resident Abuse, Neglect, or Exploitation, states, Section III. Reporting and Procedures .7. A Nursing Facility Reportable Incident Form will be completed, and written documentation of action taken shall be maintained. 8. The Administrator, Director of Nursing, or designee will report all incidents of actual or suspected resident abuse, neglect, or exploitation to the Division of Licensing and Certification within 24 hours . and The Director of Nursing or designee will submit the findings to the State Survey Agency within 5 working days of the initial incident or per state regulations. 1. On 8/14/24 at 11:17 a.m., the Division of Licensing and Certification received a complaint alleging that agency Certified Nursing Assistant (CNA) #4 did not provide adequate rounding or toileting for assigned residents on the 8/9/24 11:00 p.m. to 7:30 a.m. shift. A review of a facility-provided email, dated 8/11/24 at 11:07 a.m., addressed to [Unit Manager], [Scheduler], [MDSC], and [Director of Nursing (DON)], states that .Friday [8/9/24] . [CNA4] did not chart and did not complete adequate rounds. Day shift CNAs complained that the Residents assigned to [CNA4] were soaked with urine when they went to get them up . I followed up .and confirmed this report . During an interview on 11/13/24 at 3:40 p.m. with the Director of Nursing (DON), a surveyor requested evidence that an incident report had been completed for the above complaint. A surveyor reviewed the facility-provided email with the DON, and the DON stated the incident happened 2 days after she started and didn't know where the incident reports were and stated the Administrator may have the incident reports. During electronic medical record (EMR) review with the Minimum Data Set Coordinator (MDSC) on 11/14/24 at 11:57 a.m., confirmed that the last login for CNA #4 last logged onto the system on 8/2/24 at 12:43 a.m. and there was no evidence that CNA #4 had logged into or documented in the EMR on 8/9/24 between 11p. m.-7:30 a.m. or any dates thereafter. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/13/24 at 3:46 p.m., the Administrator stated that when documentation is not complete, the facility requests, through the staffing agency, that the agency staff member complete late entry documentation. The Administrator further stated that she was not included in the complaint email and was not aware of the reported concerns. The Administrator stated she would have to investigate this further and determine if an incident report was completed. During a follow-up interview in the presence of 5 surveyors, on 11/14/24 at 9:07 a.m., the Administrator confirmed that the State Agency was not notified of the above concerns. 37648 2. On 10/18/24, the facility initially reported to the State Agency that Resident #22 had an unwitnessed fall with fracture. On 11/12/24, the facility was not able to verify nor provide evidence that an investigation was completed, and a 5-day report was sent to the State Agency on this incident. On 11/13/24 at 11:00 a.m., during an interview, the Director of Nursing confirmed she could not find the completed investigation and could not find a 5-day report of the incident.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 37440 Based on interviews, observations and record review, the facility failed to ensure that physician orders were followed for 1 of 2 Resident's reviewed for oxygen. (Resident #3) Additionally, the facility failed to follow recommendations given by Physical Therapy (PT) for 1 of 1 residents reviewed for restorative care (Resident #87). Findings: 1. On 11/12/24 during Resident #3's clinical record review, Resident #3 had a current physician order filed in the paper record and scanned into the electronic record dated 8/26/24 that noted: O2 [oxygen] therapy cont[continuous]/daily 4L[liters] via Nasal Canula q [every] shift am [morning] pm [evening] NOC [night] - 8/26/24. On 11/12/24 at 11:20 a.m., a surveyor observed Resident #3's oxygen concentrator set at 3 liters. On 11/13/24 at 9:00 a.m., a surveyor observed Resident #3's oxygen concentrator set at 3 liters. On 11/13/24 at 3:20 p.m., a surveyor and the Director of Nursing [DON] reviewed Resident #3's Treatment Administration Record (TAR) for oxygen administration and found documentation from September 6, 2024 to November 13, 2024 that showed the oxygen concentrator was set at 3 liters instead of 4 liters consistently. Resident #3's oxygen percentages stayed in the 90s during this time. At this time, the DON confirmed in an interview that staff were not following the physician 's orders for 4 liters of oxygen continuous. On 11/14/24 at 8:20 a.m., a surveyor observed Resident #3's oxygen concentrator set at 3 liters. On 11/14/24 at 8:30 a.m., in an interview, LPN #2 (Licensed Practical Nurse) confirmed that he set the oxygen concentrator at 3 liters because Resident #3 doesn't need 4 liters and that it was not following the physician 's orders for 4 liters of oxygen continuous. On 11/14/24 at 8:35 a.m., a surveyor discussed with the DON that staff continued not to follow the physician 's orders for 4 liters of oxygen continuous. 51331 2. On 11/13/24 at 11:20 a.m., during an interview, Resident #87 stated he/she asks for staff to take him/her on walks often, but they frequently tell him/her there are not enough staff to accommodate this request. Review of PT note dated 10/8/24 states Reviewed goals, POC (Plan of Care), and progress. Patient will remain at Lakewood on the LTC (Long Term Care) unit with FMP (Functional Maintenance Program) in place for ambulation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the PT/OT/ST (Occupational Therapy/Speech Therapy) Recommendations to Caregivers form states pt [patient] to be out of bed in AM for breakfast and meals. No eating in bed please, stand close to pt. when walking [he/she] becomes easily distracted and becomes unsteady,give consistent verbal cues to pick feet up, stay closer to walker, pay attention, walk in hallway (to dining room, shower room, and activities room), and encourage daily walks in hallway. On 11/13/24 at 4:00 p.m., during an interview, the Administrator stated there was a lack of communication and the recommendation for the FMP was never followed up on.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37440 Based on observation, interview, 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 the storage of chemicals being properly secured for 2 of 2 observations for 2 of 3 days of survey. (11/12/24 and 11/13/24) Findings: The Safety Data Sheet for Clorox Healthcare Hydrogen Peroxide Cleaner Disinfectant Wipes noted the following: 4. First Aid Measures General advice: Show this safety data sheet to the doctor in attendance. Eye contact: Rinse thoroughly with water as necessary. Get medical attention if irritation develops and persists. Skin contact: Wash skin with soap and water. Give medical attention if irritation develops and persists. Inhalation: If symptoms develop move victim to fresh air. If breathing is difficult, [trained personnel should] give oxygen. If symptoms persist, call a physician. Ingestion: Drink 1 to 2 glasses of water. Get medical attention if symptoms occur. On 11/12/24 at 10:38 a.m., during an observation of Resident room [ROOM NUMBER] bathroom, a surveyor observed an open 1lb, 8.8 ounce container of Clorox Healthcare Hydrogen Peroxide disinfectant wipes, with a wipe sticking out of the open top. On 11/13/24 at 9:58 a.m., a surveyor and the Director of Nursing [DON] observed the open 1lb, 8.8 ounce container of Clorox Healthcare Hydrogen Peroxide disinfectant wipes, with a wipe sticking out of the open top in Resident room [ROOM NUMBER] bathroom. At this time, the DON confirmed that the wipes were not secured in a locked cabinet and were accessible.

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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. 51331 Based on observations and interviews, the facility failed to maintain a sanitary environment to help prevent the development and transmission of disease and infection related to respiratory care for 5 of 5 residents reviewed for respiratory care (Resident # 5, #23, #49, #3, #13). Findings: 1. On 11/12/24 at 9:15 a.m. and on 11/13/24 at 7:42 a.m., Observation of Resident #5's nebulizer mask unlabled and stored on their bedside table. 2. On 11/12/24 at 10:00 a.m. and on 11/13/24 at 9:00 a.m., observation of Resident #23's nasal cannula tubing unlabeled and stored on their bedside table. 3. On 11/13/24 at 8:20 a.m., 2 surveyors observed Resident #49 nasal cannula tubing unlabeled and stored on a wheelchair in the hallway. On 11/13/24 at 9:12 a.m., the above was confirmed by the Director of Nursing. 37440 4. On 11/12/24 at 11:28 a.m., during an observation of Resident 3's bathroom, 2 surveyors noted a currently being used oxygen concentrator with the oxygen tubing for the concentrator taped to the floor across the room that had two (2) filters that were heavily built up with dust. On 11/13/24 at 9:17 a.m., in an interview, the the Director of Nursing[DON] confirmed the finding. 5. On 11/13/24 at 9:58 a.m., during an observation of Resident 13's bathroom, a surveyor and the DON noted a mask and oxygen tubing attached to a nebulizer machine resting on a chest of drawers. The mask and tubing were not covered. At this time, the DON confirmed the mask and oxygen tubing was not stored properly.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 51331 Based on interviews and record reviews, the facility failed to ensure sufficient direct care staff were scheduled and on duty to meet the needs of residents that reside on the Long Term Care Unit. This has the potential to affect all residents needing assistance with Activities of Daily Living (ADL)'s. (Resident #4, #45, and #87). Findings: 1.On 11/12/24 at 10:13 a.m., Resident #4 stated, staff take between 30 mintues to 1 hours for staff to answer his/her call bell. In an attitional interview on 11/13/24 at 1:20 p.m. Resident #4 stated that he/she believed waiting over 20 minutes for staff to respond to a call bell is too long. Review of quarterly Minimum Data Set (MDS) revealed Resident #4 had a Brief Interview for Mental Status (BIMS) of 15 of 15, indicating he/she is cognitively intact. Record review of the Individual Account Report from 11/5/24 through 11/12/24 states Resident #4 waited approximately 25 minutes to 1 hour and 18 minutes 10 times. 2. On 11/12/24 at 8:51 a.m., Resident #45 states the unit is often short staffed, taking up to 1 hour for staff to answer his/her call bell, resulting in him/her having incontinent episodes while waiting for the call bell to be answered. Review of quarterly MDS revealed Resident #45 had a BIMS of 15 of 15, indicating he/she is cognitively intact. Record review of the Individual Account Report from 11/5/24 through 11/12/24. Show Resident #45 having to wait approximately 27 minutes to 1 hour and 26 minutes 5 times. 3. On 11/12/24 at 10:13 a.m., Resident #87 states that the unit is often short staffed and it can take anywhere from 30 minutes to 1 hours for his/her call bell to be answered. Review of quarterly MDS revealed Resident #87 had a BIMS of 10 of 15, indicating he/she is cognitively intact. Record review of the Individual Account Report from 11/5/24 through 11/12/24. Showed Resident #87 having to wait approximately 25 minutes to 1 hour and 18 minutes 10 times. On 11/13/24 at 3:25 p.m., during an interview, CNA #1 stated there are times where they are unable to answer call bells within a appropriate amount of time due to limited staff. On 11/13/24 at 3:40 p.m., during an interview, CNA #2 stated some days are difficult and they are unable to answer call bells in a decent amount of time. On 11/13/24 at 4:00 p.m., the above information was confirmed with the Director of Nursing.

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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. 48648 Based on observations, record reviews and interviews, the facility failed to properly store medications and biologicals in medication refrigerators, treatment carts and medication carts for 3 out of 3 units surveyed for medication storage. Findings: 1. Record review of the facility policy #PHARM903 states: All drugs shall be stored at appropriate temperatures that do not exceed manufacturer's recommendations or warnings. Refrigerator: A cold place in which the temperature is held between 36F and 46F. On 11/13/24 at 10:02 a.m. a surveyor observed the medication room for the long-term care unit with the Administrator and found the following: The refrigerator was a dorm style unit with a freezer compartment which is inappropriate for storing medications due to temperature fluctuations. Thermometers located under the freezer and in the lower drawer showed a 10 degree Farenheit difference in temperatures. Significant ice buildup in the freezer and pools of water on the top shelf with 3 medications in the water including a plastic bag containing a Spice Vax vaccination. Two boxes with sealed medications were saturated with the pooled water. A review of the temperature record for this refrigerator showed 12 months of temperatures not in the recommended range of 36-46 degrees with no follow up. On 11/14/24 at 10:30 a.m. a surveyor observed the medication refrigerator located in the Skilled Nursing unit medication room with the unit manager. Several boxes of 2024/2025 Influenza vaccinations were visible through the glass door of the refrigerator. There was no documentation for regular temperature checks for the past year. The Unit Manager confirmed temperatures were not checked. 51331 2. On 11/13/24 at 8:54 a.m. two surveyors observed an unlocked and unattended medication cart in the Skilled Unit hallway for approximately 5 minutes. Observation of Certified Nursing Assistants and residents walking nearby. At 8:59 a.m. through a surveyor intervention, the Licensed Practical Nurse (LPN) #2 was made aware of the unlocked medicaiton cart. On 11/13/24 at 9:12 a.m. the above information was discussed with the Director of Nursing (DON). 3. On 11/13/24 at 2:00 p.m. a surveyor observed two (2) treatment carts containing insulin and ointments unlocked and unattended in the Long Term Care Unit hallway. Observation of residents nearby. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/13/24 at 2:00 p.m. the above was confirmed and observed with the LPN #1 through surveyor intervention. On 11/13/24 at 2:10 p.m. the above was discussed the the Facility Administrator. 4. On 11/14/24 11:00 a.m. a surveyor observed an unlocked and unattended medication cart in the Memory Care Unit nurses station by the door for approximately 3 minutes. Observation of residents and a Hospice Certified Nurses Aid nearby. On 11/14/24 at 11:03 a.m. the above was confirmed and observed with Certified Medicaiton Technician #1 through surveyor intervention. On 11/14/24 at 11:10a.m. the above was disucssed with the Facility Administrator.

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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 and interviews, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for fans, ceiling vents, and ceiling lights and failed to ensure that the kitchen ice machine and the skilled unit ice machine were plumbed in accordance with code requirements to prevent food contamination for 2 of 2 tours. Findings: This direct connection of waste water and potable water was in violation of the 10-114 State of Maine Rules Chapter 226, definition Section A, which defines an Air-Gap Separation - A physical separation between the free-flowing discharge end of a potable water supply pipeline and an open or non-pressure receiving vessel. An air-gap separation shall be at least twice the diameter of the supply pipe measured vertically above the overflow rim of the vessel - in no case less than one inch (2.54 cm) and the Code of Federal Regulation, Title 21, Part 1250, Section 1250, 30 (d) states all plumbing shall be so designed, installed, and maintained as to prevent contamination of the water supply, food, and food utensils. 1. On 11/12/24 from 8:40 a.m. to 9:30 a.m. a surveyor completed a tour of the kitchen with the Food Service Director[FSD] in which the following findings were observed: > The dish room had two wall mounted fans that were dusty/dirty. > There were two wall ceiling vents, over food preparation areas in the kitchen, that were dusty/dirty. > There were five ceiling lights in the kitchen that were heavily soiled with dust and debris. > The kitchen ice machine air gap was not plumbed in accordance with code requirements to prevent food contamination. 2. On 11/12/24 at 11:10 a.m. two surveyors observed the ice machine in the dining area on the skilled unit. The ice machine air gap was not plumbed in accordance with code requirements to prevent food contamination. On 11/13/24 at 8:25 a.m., in an interview, the FSD confirmed the finding.

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F 0868 Level of Harm - Potential for minimal harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 33639 Based on review of the quarterly Quality Assurance Committee meeting attendance sheets and interview, the facility failed to ensure that the Medical Director attended 3 of 3 quarterly meetings. Finding: A review of the Quarterly Assurance Committee meeting attendance sheets indicated that the Medical Director did not attend the 1/17/24, 4/17/24 & 7/24/24 quarterly meeting. On 11/14/24 at 11:09 a.m., during an interview with the Administrator, the surveyor confirmed the finding above.

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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** 37440 48648 51669 Based on observations and interviews, the facility failed to follow appropriate infection control procedures related to hand hygiene during 1 of 2 medication pass observations. Review of Policy/Procedure #31-202, Hand Hygiene Program for Northern Light Member Organizations that Provide Clinical Patient Care, states, .Hand Hygiene is to occur: 1. Before touching a patient .The use of gloves does not replace Hand Hygiene .Hand Hygiene shall occur prior to donning gloves and after doffing gloves . During a medication pass observation on the Memory Lane unit on 11/14/24 between 11:30 a.m. and 11:38 a.m., Registered Nurse (RN) #2 was observed in room [ROOM NUMBER], checking Resident #61's blood sugar, with gloved hands. RN #2 was observed exiting room [ROOM NUMBER] with gloved hands and walking to the medication cart located outside of room [ROOM NUMBER]. RN #2 doffed (removed) her gloves and placed them in the trash bin hanging on the side of the medication cart. Without using the hand sanitizer observed on top of the medication cart, RN #2 then used her right hand to pick up a pen from the top of the medication cart and proceeded to record Resident #61's blood sugar on a sheet of paper and then returned the pen to the medication cart. RN #2 then placed her right hand in her right pocket and removed a set of keys, proceeded to unlock the medication cart drawer, and removed a multi-dose vial containing insulin and placed it on top of the medication cart. RN #2 then donned (put on) a new pair of gloves without sanitizing, and using both hands proceeded to open an alcohol swab, swabbed the top of the insulin vial, and drew up insulin in a syringe. At this time, Resident #61 self-propelled his/her wheelchair into the hall just outside of room [ROOM NUMBER]. RN #2 then used her right hand to wipe Resident #61's abdomen with the alcohol pad and proceeded to administer the insulin. RN #2 then doffed and discarded the gloves and alcohol pad in the trash bin on the side of the medication cart, without performing hand hygiene and immediately donned a new pair of gloves. RN #2 then notified Resident #12, who was observed in a wheelchair next to the medication cart, that she was going to check his/her blood sugar. RN #2 then used her gloved hands to remove a glucometer test strip from its container and inserted it into the glucometer. At this time, a surveyor intervened and asked RN #2 if she was aware of the facility's hand hygiene policy. RN #2 replied that she forgot to sanitize and further indicated that she should sanitize between residents and when donning and doffing gloves. RN #2 then confirmed that she received education regarding hand hygiene and stated that if she sanitizes prior to donning gloves that she cannot put on the new pair of gloves because her hands will be sticky but that she will sanitize after providing care to Resident #12. At this time, a surveyor again intervened, and RN #2 doffed the gloves and used the hand sanitizer and then donned a new pair of gloves. During an interview on 11/14/24 at 11:46 a.m., the Director of Nursing (DON) confirmed that RN #2 has received education regarding the facility's hand hygiene policy and that it was his/her expectation that hands would be sanitized according to the policy. At this time, the above findings were discussed with the DON.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 37648 Based on observations and interviews, the facility failed to ensure that a call bell was functional for 1 of 20 sampled residents (#37). Finding; On 11/12/24 at 9:10 a.m. during an interview, Resident #37 stated his/her call bell has not been working and they said they fixed it. At this time, the surveyor pushed the call bell, the light above the door did not illuminate. The surveyor then went to the nurse's station and checked the call bell screen and asked the Registered Nurse (RN#3) if the call bell screen shows active call bells. RN#3 stated if it's highlighted red is an active call bell. Resident #37's room had no indication of the call bell being activated. Both the Surveyor and RN #3 went to resident #37's room. A Certified Nurses Aid also entered the room and stated the call bell was not working. At this time the Minimum Data Set project manager came to the door stating she would grab a hand bell for resident #37 to use. RN#3 attempted to put call bell on and it did not work. At this time RN #3 wiggles the call bell box and the light illuminated, then shut off. RN #3 stated, it might be a battery. At 9:15 a.m., a hand bell was brought in for Resident #37. RN #3 stated he is having maintenance check the call bell. Resident #37 the then stated, he said he fixed it recently. On 11/12/24 at 3:25 p.m., the above was discussed with the Director of Nursing who confirmed the call bell was now in working order.