

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  205143	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/17/2024
NAME OF PROVIDER OR SUPPLIER  Cummings Health Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE  5 Crocker Street Howland, ME 04448	

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)
<p>F 0568</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.</p> <p>35904</p> <p>Based on interviews and record reviews, the facility failed to ensure quarterly statements were provided to the Resident or Resident representative for 1 of 1 Resident with a trust account (Resident #8 [R8]). In addition, the facility failed to ensure quarterly statements were provided to all Residents or Resident representatives with trust accounts.</p> <p>Finding:</p> <p>On 7/15/24 at 12:25 p.m. during a resident interview, R8 stated that he/she did not recall receiving any quarterly statements with an accounting of his/her resident trust account.</p> <p>On 7/17/24 at 8:41 a.m. during an interview with a surveyor, the Accountant stated they were unable to find documentation to support that R8 was sent his/her quarterly statements and that quarterly statements are not sent out to Residents unless a statement is sent with a cost of care statement or their trust account drops to a negative balance. A surveyor confirmed, at this time, with the Accountant that R8 did not receive any quarterly statements, and that quarterly statements are not sent out to Residents or Resident representatives.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0577</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>33242</p> <p>Based on observations and interview, the facility failed to post, in a place readily accessible to residents, family members, and legal representatives, the results of the most recent survey of the facility in 2 of 2 survey folders (located in the dining room and entrance foyer).</p> <p>Findings:</p> <p>On 7/16/24 at 8:15 a.m., a surveyor observed the survey folder located in the dining room, located on a rack on the wall. This folder included the State Survey results, with the most recent results from a survey dated 2/11/20, although the State Agency had completed multiple surveys after that date.</p> <p>On 7/16/24 at 8:20 a.m., during an interview with a surveyor, the Administrator stated there were two survey folders, one in the dining room and one in the entrance foyer area for family members, The Administrator and surveyor observed both survey folders with the most recent survey in the entrance foyer folder was 5/11/23, although the State Agency had completed an additional survey after that date on 3/5/24; the Administrator and surveyor also observed the folder in the dining room with the most recent survey dated 2/11/20. During these observations, the surveyor confirmed that both survey folders did not contain the most recent surveys in them.</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 33242</p> <p>Based on interview and record review, the facility failed to complete a comprehensive Minimum Data Set 3.0 (MDS 3.0) assessment within 14 days after a resident experienced a significant change of condition, when hospice services were discontinued for 1 of 1 sampled residents (Resident #5 [R5]).</p> <p>Finding:</p> <p>On 7/15/23, during a review of R5's clinical record, a surveyor could not find evidence that R5 was receiving hospice services even though the most recent MDS, dated [DATE], indicated under section O110-K1 that R5 was. On 7/15/24 at 1:17 p.m., during an interview with a surveyor, the Director of Nursing (DON) stated that R5 ended hospice services on 6/3/24. The surveyor asked both the DON and MDS Coordinator if a significant change MDS was completed when hospice services ended and both replied no. The surveyor confirmed that when a resident comes off of hospice a significant change MDS needed to be done.</p>		

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<p>F 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 33242</p> <p>Based on record review and interview, the facility failed to ensure that the Annual Minimum Data Set (MDS) 3.0 was coded accurately on two annual MDS assessments to indicate that a resident had a State Level II Preadmission Screening and Resident Review (PASRR) for 1 of 1 sampled residents reviewed for PASRR (Resident #21 [R21]).</p> <p>Finding:</p> <p>On 7/15/24, R21's clinical record was reviewed and included a PASSR, dated 3/4/20, that indicated that R21 qualified for Level II services. Review of R21's annual MDS, dated [DATE], Section: A1500 was coded to indicate that R21 did not have a Level II PASRR and had been coded incorrectly starting with the 8/12/22 annual MDS.</p> <p>On 7/16/24 at 10:12 a.m., during an interview with a surveyor, the MDS Coordinator stated that R21 did have a Level II PASRR and that the MDS was coded inaccurately. The surveyor confirmed this finding during this interview.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>33242</p> <p>Based on record review and interviews, the facility failed to follow their fall protocol for neurological assessments and failed to follow physician orders for 1 of 1 residents reviewed for hospitalization (Resident #22 [R22]).</p> <p>Finding:</p> <p>The facility's policy, Falls Protocol, undated, indicated that staff were to initiate Neuro Checks if a resident sustained a head injury and/or had an unattended fall and directed the licensed nurse to complete a Neurological Evaluation. The Neurological Assessment flowsheet directed staff to complete these every 15 minutes times (x) 4, 30 minutes x 4, 2 hours x 4, and every 4 hours x 4.</p> <p>On 7/16/24, R22's clinical record was reviewed and indicated that R22 had a fall on 6/8/24 at 7:30 a.m., bumped his/her head, and was sent to the hospital later in the day. A review of the Neurological Assessment flowsheet completed for R22 indicated that the assessments were not completed for the 9:45 a.m. and 10:15 a.m. assessment times, but were completed after those times up to 2:15 p.m., thereafter the resident was at the hospital. On 7/16/24 at 11:39 a.m., during an interview with a surveyor, Licensed Practical Nurse #1 (LPN1) stated she missed those assessments because she thought someone else was going to get them.</p> <p>R22's clinical record also included a physician order, dated 6/28/24, for Metoprolol (blood pressure medication) with parameters that directed staff to call the Medical Provider if R22's systolic blood pressure (SBP) was greater than 170. On 7/6/24 for the morning reading, the SBP was documented at 181 and on 7/15/24 for the morning reading, the SBP was documented at 267. The clinical record lacked evidence of the Medical Provider being called. On 7/16/24 at 11:21 a.m. during an interview with the Minimum Data Set (MDS) Coordinator and the Director of Nursing, a surveyor confirmed this finding. They were unable to find evidence that indicted the Medical Provider was notified each time.</p>

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>17282</p> <p>Based on monthly schedule reviews and interviews, the facility failed to use the services of a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week for 6 days of 2 months reviewed for staffing (January and February 2024).</p> <p>Findings:</p> <p>On 7/17/24 at 8:20 a.m., a surveyor, Office Manager and Administrator, reviewed the schedules for January and February 2024. The following were confirmed:</p> <ol style="list-style-type: none"> <li>1. For January, on 1/9/24, 1/11/24 and 1/29/24, the facility failed to ensure that an RN was working for 8 consecutive hours.</li> <li>2. For February, on 2/9/24, 2/10/24 and 2/22/24, the facility failed to ensure that an RN was working for 8 consecutive hours.</li> </ol>

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>17282</p> <p>Based on review of Employee Job Performance Evaluations and interview, the facility failed to complete an annual performance evaluation at least every 12 months, for 2 of 5 sampled Certified Nursing Assistants (C. N.A.) employed greater than 1 year (Certified Nurse Assistant #2 [C.N.A.2] and Certified Nurse Assistant-Medications [C.N.A.-M]).</p> <p>Findings:</p> <p>On 7/17/24 at 10:00 a.m., a surveyor and Administrator reviewed C.N.A.2 and C.N.A.-M's employee files with the following confirmed:</p> <ol style="list-style-type: none"> <li>1. C.N.A.2 was hired on 5/9/2018. The annual evaluation was due by 5/9/2024. There was no evidence that the evaluation had been completed as of 7/17/2024.</li> <li>2. C.N.A.-M was hired on 8/17/2009. The annual evaluation was due by 5/9/2023. There was no evidence that the evaluation had been completed as of 7/17/2024.</li> </ol>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>35904</p> <p>Based on observations and interview, the facility failed to store food in a sanitary manner on 1 of 3 survey days, and the facility failed to keep accurate and complete temperature logs of the walk-in refrigerator, walk-in freezer, and refrigerator/freezer in the kitchen (7/15/24).</p> <p>Findings:</p> <p>On 7/15/24 from 10:35 a.m. through 11:10 a.m. during the initial observation of the kitchen with the Food Safety Supervisor (FSS), it was observed:</p> <ol style="list-style-type: none"> <li>1. Thirty chocolate Hormel Magic dessert cups and thirty-five vanilla Hormel Magic dessert cups in the freezer portion of the refrigerator/freezer had a thick buildup of ice crystals around them, and one chocolate Hormel Magic dessert cup was open. Approximately half of the dessert cups were affected by the thick buildup of ice crystals.</li> <li>2. Two large bins/containers of white dry substances (flour and sugar per interview during observation with the FSS) not labeled or dated in kitchen to the left of the oven.</li> <li>3. One bag of confectioner sugar open and not dated, and one large open box of chocolate chips in an open bag inside the box, not sealed, and not dated in the dry goods storage room.</li> <li>4. Walk-in freezer temperatures were missing from the temperature log sheet posted on the walk-in freezer for 7/13/24, 7/14/24, and 7/15/24.</li> <li>5. Walk-in refrigerator temperatures were missing from the temperature log sheet posted on the walk-in refrigerator for 7/13/24, 7/14/24, and 7/15/24.</li> <li>6. Refrigerator/freezer temperatures were missing from the temperature log sheet posted on the refrigerator/freezer for 7/13/24, 7/14/24, and 7/15/24.</li> </ol> <p>In an interview with the FSS at time of observation, a surveyor confirmed the above findings. The FSS states the temperatures were last done on 7/12/24, and it is supposed to be done by the cook.</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dispose of garbage and refuse properly.</p> <p>35904</p> <p>Based on observation and interview, the facility failed to maintain a garbage storage area in a sanitary condition to prevent the harborage and feeding of pests for one trash dumpster for 1 of 3 days of survey (7/17/24).</p> <p>Finding:</p> <p>On 7/17/24 at 7:40 a.m., a surveyor observed a trash dumpster with the top right lid open with two black bags on top of the dumpster exposing trash.</p> <p>On 7/17/24 at 7:44 a.m., in an interview and observation of the trash dumpster with the Administrator, a surveyor confirmed the above finding.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>49635</p> <p>Based on record review and interviews, the facility failed to develop a water management program to prevent the growth and spread of legionella and other water-borne pathogens, and the facility failed to develop policy and procedures for enhanced barrier precautions to reduce the transmission of multidrug-resistant organisms.</p> <p>Findings:</p> <p>1. On 7/16/24 at 1:36 p.m., a surveyor and the facility's Director of Nursing (DON) reviewed the facility's infection control policies. The DON stated there is not a policy for enhanced barrier precautions. The surveyor confirmed at this time that the facility did not have policy and procedures for enhanced barrier precautions to reduce the transmission of multidrug-resistant organisms</p> <p>2. On 7/16/24 at 1:36 p.m., in an interview with a surveyor, the DON stated not knowing of a water management policy for legionella and directed the surveyor to the Administrator.</p> <p>On 7/17/24 at 8:27 a.m., in an interview with a surveyor, the Maintenance Technician stated he did not know of a program that identifies where standing water would be and referred to the Administrator.</p> <p>On 7/17/24 at 8:49 a.m., in an interview with the Administrator, the surveyor confirmed the facility has not completed a risk assessment to determine potential areas of microbial growth, and there is not a policy or procedure for Legionella and other water-borne pathogens.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49635</p> <p>Based on record review, facility policy review, and interview, the facility failed to offer Pneumococcal Vaccinations (Pnevnar 20) to 3 of 5 residents reviewed (Resident #10 [R10], R28, and R32).</p> <p>Findings:</p> <p>On 7/16/24 at 9:02 a.m., clinical record review indicated:</p> <ol style="list-style-type: none"> <li>1. R10 was admitted on [DATE]. There was no evidence R10 had received, been offered, or refused the Pnevnr 20 vaccination.</li> <li>2. R28 was admitted on [DATE]. There was no evidence R28 had received, been offered, or refused the Pnevnr 20 vaccination.</li> <li>3. R32 was admitted on [DATE]. There was no evidence R32 had received, been offered, or refused the Pnevnr 20 vaccination.</li> </ol> <p>On 7/16/24 at 1:45 p.m., review of the Influenza, Pneumococcal, and COVID-19 Immunization Policy indicated, each resident is offered a pneumococcal immunization unless the immunization is medically contraindicated, or the resident has already been immunized.</p> <p>On 7/17/24 at 8:23 a.m., in an interview with the DON, a surveyor confirmed the Pnevnr 20 vaccine was not offered to R10, R28, and R32.</p>

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49635</p> <p>Based on record review, facility policy review, Centers for Disease Control and Prevention (CDC) recommendations, and interview, the facility failed to offer the updated 2023-2024 Coronavirus (COVID-19) vaccine for 1 of 5 residents reviewed (Resident #28 [R28]).</p> <p>Finding:</p> <p>On 7/16/24 at 9:02 a.m., clinical record review indicated R28 was admitted on [DATE] and is currently [AGE] years old. R28's last documented COVID-19 vaccination was on 4/28/22. There was no evidence R28 had received, been offered, or refused the COVID-19 vaccination.</p> <p>On 7/16/24 at 1:45 p.m., review of the Influenza, Pneumococcal, and COVID-19 Immunization Policy indicated each resident is offered a COVID-19 immunization unless the immunization is medically contraindicated, or the resident has already been immunized.</p> <p>On 7/16/24 at 1:36 p.m., in an interview with a surveyor, the Director of Nursing (DON) stated she uses the CDC website as a resource. Review of the CDC website, Stay Up to Date with COVID-19 Vaccines   CDC, indicated that CDC recommends the 2023-2024 updated COVID-19 vaccines: Pfizer-BioNTech, Moderna, or Novavax, to protect against serious illness from COVID-19 and that people aged [AGE] years and older who received 1 dose of any updated 2023-2024 COVID-19 vaccine (Pfizer-BioNTech, Moderna or Novavax) should receive 1 additional dose of an updated COVID-19 vaccine at least 4 months after the previous updated dose, and that you are up to date when you have received 2 updated 2023-2024 COVID-19 vaccine doses.</p> <p>On 7/17/24 at 8:23 a.m., in an interview with the DON, a surveyor confirmed the COVID-19 vaccine was not offered to R28.</p>

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>17282</p> <p>Based on employee file reviews and interviews, the facility failed to ensure that a Certified Nursing Assistant (C.N.A.) received at a minimum 12 hours of annual in-service training that included abuse prevention, resident rights and dementia for 1 of 5 Certified Nursing Assistants (C.N.A.s) reviewed (Certified Nurse Assistant #1 [C.N.A.1]).</p> <p>Finding:</p> <p>On 7/17/24 at 9:45 a.m., a surveyor, the Office Manager and Administrator reviewed C.N.A.1's employee file for in-service training during C.N.A.1's annual evaluation period from 2/21/23 to 2/21/24. There was no evidence that C.N.A.1 completed abuse training, resident rights or dementia in-servicing for her annual evaluation period.</p> <p>The Office Manager and Administrator confirmed this finding at the time of review.</p>		