STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205146	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastport Memorial Nursing Home	23 Boynton Street Eastport, ME 04631

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49635 Based on record review and interview, the facility failed to complete an annual Comprehensive Minimum Data Set 3.0 (MDS 3.0) assessment timely for 1 of 1 residents reviewed for hospice (Resident #23 [R23]) Finding: On 1/28/25, a review of R23's clinical record was completed. R23 was admitted on [DATE]. An admission Comprehensive MDS assessment was completed and submitted on 6/17/23. Quarterly MDS assessments were completed on 9/15/23, 12/14/23, 3/15/24, 6/16/24, 9/15/24 and 12/16/24. The record lacked evidence that an annual Comprehensive MDS assessment was completed. On 1/29/25 at 10:05 a.m., during an interview with a surveyor, The Interim Director of Nursing reviewed her records and stated the MDS completed on 6/16/24 should have been an annual Comprehensive MDS assessment. At the time of the interview, it was 592 days since R23's last Comprehensive assessment. At this time a surveyor confirmed the above finding.

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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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49635 Based on interview and record review, the facility failed to complete a significant change in status Minimum Data Set 3.0 (MDS 3.0) assessment within 14 days of a resident's admission to hospice services, for 1 of 1 sampled residents (Resident #23 [R23]). Finding: On 1/28/25, a review of R23's clinical record was completed. R23 was admitted on [DATE]. An Admission MDS was completed and submitted on 6/17/23. On 7/29/24, R23 transitioned to hospice level of care. The record lacked evidence that a significant change in status MDS was completed after R23 transitioned to hospice level of care. On 1/29/25 at 10:05 a.m., during an interview with a surveyor, The Interim Director of Nursing reviewed her records and stated she had not completed a change in condition when R23 transitioned to hospice. At this time a surveyor confirmed the above finding.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49635 Based on record review and interview, the facility failed to develop a care plan to address the physical needs of a resident for 1 of 5 residents reviewed for unnecessary medication (Resident #9 [R9]). Finding: On 1/28/25, a record review of R9's clinical record was completed. R9 was admitted on [DATE] with diagnoses including heart failure and atrial fibrillation (afib). The care plan did not address the management of heart failure, afib or the use of an anticoagulant medication (a medication used to prevent blood clots). On 1/28/25 at 2:12 p.m., during an interview with the Interim Director of Nursing, a surveyor confirmed the care plan did not address monitoring and management of heart failure including daily weight monitoring as ordered by the provider, and/or the monitoring and management of afib including the use of anticoagulant medication.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. 35904 Based on interviews, the facility failed to employ a qualified Activity Director (AD) to manage resident centered activities for all residents (24 residents). Finding: On 1/27/25 at 10:45 a.m. in an interview with a surveyor, the Administrator stated that the AD has not completed a State-approved program to become qualified as an AD. On 1/29/25 at 11:02 a.m., in an interview with a surveyor, the AD stated she hasn't completed the State-approved program to take the exam to become an Activity Professional, and does not have other requirements to ensure the activities program is directed by a qualified professional. The surveyor confirmed at this time that the AD has not completed the State-approved program and is not qualified to be the AD. The Administrator and AD state the AD is enrolled in the program and is in the process of completing a State-approved program to become qualified as an AD.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49635 Based on record review and interview the facility failed to follow a doctors order for daily weights for a resident with heart failure for 1 of 5 residents reviewed for unnecessary medications [Resident #9 (R9]. and the facility failed to have a provider appropriately addresss a pharmacist reocmmendation regarding a psychotropic medication for 1 of 5 residents reviewed for unnecessary medications (R1). Finding: 1. On 1/28/25, clinical record review indicated R9 was admitted on [DATE] with a diagnosis of heart failure. A provider order dated 1/16/25 stated, Start Daily weight checks. Notify provider of weight gain greater than 3 pounds in one day or 5 pounds in one Week. The record lacked evidence that daily weights were obtained as ordered. On 1/28/25 at 1:54 p.m., during an interview, provider orders and daily weight documentation were reviewed by the Interim Director of Nursing and a surveyor. At this time the surveyor confirmed the provider order for daily weights were not followed. 35904 2. Review of pharmacist recommendation dated 1/2/25 for R1 indicated that olanzapine (a psychotropic medication) 15 milligrams (m.g) at 1300 (1:00 p.m.) and 5 m.g in evening should be reviewed per discussion with staff the patient (R1) is awake much of the evening there was questions if R1 could benefit from the large dose of olanzapine 15 m.g in the evening with 5 m.g during the day. The Psychiatric Mental Health Nurse Practitioner (PMHNP) declined the pharmacist recommendation to change the timing of the doses for olanzapine stating that R1 stable on current medication regimen and any reduction could destabilize presentation, maintain medications as prescribed and will continue to assess for potential reductions. On 1/29/25 at 11:05 a.m. during a telephone call with a Licensed Practical Nurse (LPN)-Charge Nurse, the PMHNP stated she sees a lot of recommendations pertaining to GDR's (gradual dose reductions) and was not aware that the pharmacists recommendation was to change the timing of the doses, and not a GDR request. The PMHNP gave a new telephone order to adjust olanzapine 15 m.g to be given in the evening and 5 m.g in the a.m. for R1. On 1/29/25 at 11:06 a.m. during an interview with the LPN, a surveyor confirmed that the pharmacist recommendation response from the PMHNP dated 1/2/25 for R1 was not fully assessed, and the facility failed to clarify the providers response to the pharmacist recommendation.

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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** 35904 Based on record review, review of the facility incident report, and interviews, the facility failed to monitor an unlocked and/or non-alarmed door to prevent a resident identified as an elopement risk from leaving the building unnoticed. A staff member, who was on the third floor, looked out the window and saw a resident outside, unattended. The failure to have monitoring of unlocked, and/or non-alarmed doors, resulted in an avoidable elopement for 1 of 1 resident reviewed for elopement risk (Resident # 15 [R15]). Finding: R15 was admitted to the facility on [DATE] with diagnoses to include Schizophrenia, Major Depressive Disorder, and Alzheimer's disease. R15 was identified as an elopement risk and wears a wander guard alert (a safety device that alarms if resident wanders too close to a door). Review of R15's Reportable Incident Form dated 12/10/24 indicates that on 12/10/24 at approximately 10:25 a.m., R15 was outside for three minutes and he/she was standing at the edge of our property near the sidewalk. Our Social Worker (SW) saw him/her outside .R15 was wearing a wander guard, but the doors unlocked due to an alarm test and the fire doors closed . with the charge nurse, med tech [Certified Nursing Assistant - Medications], and at least one CNA [Certified Nursing Assistant] on the other side of the doors. On 1/28/25 at 1:21 p.m. in an interview with a surveyor, the SW states that on 12/10/24 she observed R15 outside with bare feet, the SW alerted other staff, and ran to bring R15 inside, and nursing staff checked his/her feet. On 1/28/25 at 1:38 p.m. in an interview with a surveyor, the Interim Director of Nursing (IDON) states the facility was able to determine through video surveillance footage that R15 exited the building from the day room door during a fire alarm (a fire alarm disables the wander guards from alarming the doors) and was returned to the facility on [DATE] approximately three minutes after elopement. R15 was outside with bare feet on a day when it snowed that morning. R15 was assessed, treated (salt and gravel removed from R15's feet), and monitored, there were no lasting effects to R15. During this interview a surveyor confirmed that R15 had elopement unnoticed by staff. On 1/29/25 at 10:44 a.m. in an interview with a surveyor, a Licensed Practical Nurse (LPN) states she was in a resident room doing wound care when R15 went outside and when she came out of the resident room, the IDON and the SW were with R15 in the day room. The LPN states staff will make sure to go and get to the door in the day room (monitor the door) if a fire alarm goes off in the future.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 17282 Based on observations, record reviews, and interviews, the facility failed to maintain a physician ordered oxygen setting on an air concentrator, and failed to maintain respiratory equipment in a sanitary manner to help prevent the development and transmission of disease and infection related to respiratory care for 2 of 3 residents reviewed for respiratory care (Resident #20 [R20], and R8). Findings: 1. On 1/27/25 at 11:00 a.m., during an intial tour, a surveyor observed that the oxygen regulator on R20's oxygen concentrator was set at 3.5 milliliters per minute (LPM). Also observed that the concentrator was soiled with dried liquid and dust and the oxygen concentrator air intake filter located on the back on the concentrator was heavily soiled with dust. On 1/28/25, a review of R20's clinical record was completed. R20 had a physician order for continuous oxygen at 2 LPM. On 1/28/25 between 10:15 a.m. and 11:15 a.m., in an interview with the Licensed Practical Nurse (LPN)-Charge Nurse, she confirmed that the oxygen concentrator and air filter were soiled/dusty and that the oxygen setting should be at 2 LPM not 3.5 LPM. The LPN corrected the air setting immediately. 35904 2. On 1/27/25 at 1:15 p.m., during an initial tour, a surveyor observed R8 wearing oxygen via nasal cannula attached to an oxygen concentrator. The oxygen concentrator air intake filter located on the back of the concentrator was heavily soiled with dust. On 1/28/25 at 11:02 a.m., during an observation, a surveyor observed R8 wearing oxygen via nasal cannula attached to an oxygen concentrator. The oxygen concentrator air intake filter located on the back of the concentrator was heavily soiled with dust. On 1/28/25 at 11:05 a.m. in an interview with the LPN, a surveyor confirmed R8's oxygen concentrator air intake filter located on the back of the concentrator was heavily soiled with dust.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35904 Based on observations and interviews, the facility failed to remove an expired medication from the supply available for use in 1 of 2 locations where medications are stored (medication storage room). Findings: On [DATE] at 7:30 a.m., a surveyor and a Licensed Practical Nurse (LPN) observed an opened vial (bottle) of Novolog (insulin, medication used to treat diabetes, high blood sugar) for Resident #9 (R9) that was in the medication storage room with an open date of [DATE]. The LPN states the Novolog is good for 28 days once opened according to manufacturers directions. In an interview with the LPN, a surveyor confirmed that the Novolog vial was labeled with an opened date of [DATE] and is still being used 16 days after the insulin should have been discarded. The LPN discarded the Novolog vial for R9 at time of finding and replaced it with a new Novolog vial.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 49635 Based on observations, record review, and interviews, the facility's quality assurance committee failed to ensure that the Plan of Correction (PoC) for identified deficiencies from the Recertification Survey, dated 1/29/25, were implemented / effective. The facility lacked evidence that the PoC for deficiencies F636 (Comprehensive Assessments & Timing), F637 (Comprehensive Assessments After Significant Change), F656 (Develop/Implement Comprehensive Care Plan), F684 (Quality of Care), and F689 (Free of Accident Hazards/Supervision/Devices) was implemented in order to prevent repeat deficient practice. The deficiencies F695 (Respiratory Care), and F761 (Label/Store Drugs and Biologicals) were again identified during the re-visit survey on 3/18/25. Findings: 1. The facility's accepted PoC for F636, signed on 2/14/25, indicated the facility would print weekly MDS reports to identify residents needing assessments, the MDS coordinator would receive education on the process, and a monitor would be completed to ensure all residents have a Comprehensive Minimum Data Set (MDS) assessment timely. On 3/18/25 at 11:15 a.m., during an interview with the Administrator and the Director of Nursing, a surveyor confirmed the facility lacked evidence the PoC was implemented, that education was provided, that education was received by the MDS coordinator, or that a monitor was completed weekly. 2. The facility's accepted PoC for F637, signed on 2/14/25, indicated the Director of Nursing would monitor nursing documentation of resident significant change and MDS assessment submission, the MDS coordinator would receive education on the process, and a monitor would be completed to ensure all residents with a significant change in status have a Comprehensive Minimum Data Set (MDS) assessment timely. The PoC indicated an anticipated date of compliance of 3/5/25. The facility lacked evidence that education was provided, that education was received by the MDS coordinator, or that a monitor was completed weekly. On 3/18/25 at 11:15 a.m., during an interview with the Administrator and the Director of Nursing, a surveyor confirmed the facility lacked evidence that the PoC was implemented, that education was provided, that education was received by the MDS coordinator, that a monitor was completed weekly, and deficient practice was identified after the PoC's anticipated date of compliance. 3. The facility's accepted PoC for F656, signed on 2/14/25, indicated nursing staff would receive education on how to add a diagnosis to a resident's diagnosis list and update the care plan to correspond with the diagnosis, and the Director of Nursing would monitor all physician's notes after visits and ensure any new diagnoses were updated. On 3/18/25 at 11:15 a.m., during an interview with the Administrator and the Director of Nursing, a surveyor confirmed the facility lacked evidence that the PoC was implemented, that education was provided, that education was received by nursing staff, or that monitoring was completed. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. The facility's accepted PoC for F684, signed on 2/14/25, indicated staff would receive education, and the Director of Nursing would monitor all orders and Gradual Dose Reduction (GDR) recommendations for 6 months. On 3/18/25 at 11:15 a.m., during an interview with the Administrator and the Director of Nursing, a surveyor confirmed the facility lacked evidence that the PoC was implemented, that education was provided to staff, that education was received by staff, or that monitoring was completed for GDR recommendations. 5. On 2/14/25, the facility signed a Plan of Correction (PoC) indicating an Elopement/Wandering policy would be established by 3/15/24, staff would be educated on the new policy, drill would be conducted at randomly selected times, and a monitor of staff response to the drills would be completed. The PoC indicated the anticipated date of compliance as 3/5/25. The facility lacked evidence that the policy was established, education was provided to staff, received by staff, drills completed, and/or a monitor of staff response was completed. On 3/18/25 at 10:15 a.m., during an interview with a surveyor and the Director of Nursing, the Elopement and Wandering Policy draft was reviewed. The DON indicated staff had not received education as this policy has not been approved by the board of directors. At this time the surveyor confirmed the Plan of Correction had not been implemented to prevent a resident identified as an elopement risk from leaving the building unnoticed. 6. The facility's accepted PoC for F695, signed on 2/14/25, concentrators will be cleaned, weekly walking rounds would be completed to residents with oxygen orders, staff would receive education, and monitored results would be documented. The PoC identified 3/5/25 as the anticipated date of compliance. On 3/18/25 at 11:15 a.m., during an interview with the Administrator and the Director of Nursing, a surveyor confirmed the facility lacked evidence that the PoC was fully implemented, that education was provided to staff, that education was received by staff, that weekly walking rounds and/or monitoring were completed / documented. Deficient practice was identified at the time of the revisit, after the PoC's anticipated date of compliance. 7. The facility's accepted PoC for F761, signed on 2/14/25, indicated staff would receive education on dating insulin vials / pens, discarding insulin after the expiration date, and weekly monitors would be conducted for 6 months. On 3/18/25 at 11:15 a.m., during an interview with the Administrator and the Director of Nursing, a surveyor confirmed the facility lacked evidence that the PoC was fully implemented, that education was provided to staff, that education was received by staff, or that weekly audits were completed. Deficient practice was identified at the time of the revisit, after the PoC's anticipated date of compliance.

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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. 17282 Based on review of the facility's Water Management Program/Legionella and interview, the facility failed to fully develop/implement a water management program to prevent the growth and spread of legionella and other water-borne pathogens in the area of testing protocols. Finding: On 1/28/25, a review of the facility's Water Management Program/Legionella (revised on 5/24/22) was completed. There was no evidence of testing protocols in the Water Management Program if water testing was necessary. There was no evidence of testing protocols for control measures, acceptable ranges, how this would be monitored and what interventions would be used if water tests positive for Legionella or other opportunistic waterborne pathogens. On 1/28/25 at 1:57 p.m., in an interview with a surveyor, the Maintenance Supervisor stated he could not show evidence of a plan or protocol in place for Legionella/water pathogen testing, acceptable test ranges or monitoring of the water for potential Legionella or other opportunistic waterborne pathogens.