STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205158	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gregory Wing of St Andrews Village	145 Emery Lane Boothbay Harbor, ME 04538

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 37440 Based on facility policy, record reviews 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 2 of 6 residents reviewed for advanced directives (Resident's #24 and #26). Findings: Review of facility policy titled Advance Directives effective date 10/1991 states Purpose: To comply with Federal and Critical access hospitals conditions of participation, the Federal Patient Self-Determination Act, the Main Uniform Health Care Decisions Act and to provide the community with a method for healthcare decision making, [NAME] health has adopted this Advance Directive Policy to provide: 1. B. Written information to patients and or their support person concerning their right to make decisions about medical care. C. Documentation of patients declaration of an advanced healthcare directive form. 2.B.1. [NAME] health will provide written information to all adult patients, emancipated minors, persons authorized to make medical decisions on behalf of patients and or the patient support person during every inpatient admission, at time of registration, to outpatients or their representative, to those who are in in emergency department, those undergoing same day surgery, are those who are in observation status. C.4. Any employee or medical staff were receives a copy of Advanced Healthcare Directive form will submit it as part of the patient's medical record . 1. Resident #24 was admitted to the facility on [DATE]. A review of Resident #24's clinical record lacked evidence that the facility provided resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. 2. Resident #26 was admitted to the facility on [DATE]. A review of Resident #26's clinical record lacked evidence that the facility provided resident and/or resident's representative written information concerning the right to accept or refuse medical or surgical treatment and/or formulate an advance directive. On 5/13 24 at 11:50 a.m., during an interview, the Registered Nurse (RN #2) confirmed the above findings.

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: 205158	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 37440 Based on facility policy, record review and interviews, the facility failed to report in a timely manner, an injury of unknown origin with serious injury to the Division of Licensing and Certification (DLC) (State Survey Agency) and to Adult Protective Services (APS) (State Agency) for 1 of 1 residents sampled for injuries/accidents. (#27) Finding: Review of the facility's Abuse. Neglect, and/or Exploitation Reporting Policy # 02-7080-246, effective date: 05/1999, noted in 1. Policy Statement: 2. All personnel who suspect any incident of resident abuse, neglect or exploitation, including injuries of an unknown source or misappropriation of resident property, must promptly report the incident to (the Department of Health and Human Services)DHHS through the Division of Licensing and Regulatory Services(DLRS) within 24 hours of the incident and to Adult Protective Services. Attachment one: 1. All incidents: All incidents must be reported to DHS through the division of licensing and regulatory services DSLRs . Within 24 hours of the incident or the next working day, when the incident occurs or on a holiday or weekend.) . On 3/18/24 at 3:09 p.m., the Division of Licensing and Certification received from the facility a fax which indicated an injury of unknown origin to Resident #27 which was discovered during morning care. A review of Resident #27's clinical record noted a nursing note written by Nursing n 3/15/24 a 10:59 indicating Resident with some right shoulder swelling noted this am during am care/dressing. When sitting on edge of bed, right shoulder is not symmetric, right shoulder appears lower/? dropped compared to left. Resident winces when assisted with dressing. No eventer fall has happened with resident recently. Small rash area noted on right chest and irregular bruise noted on right inner upper arm, non tender. Will try ice and Tylenol and monitor. On 3/15/24 a 2:05p.m., the resident was transported to an acute care hospital emergency room for evaluation. Resident #27 was found to have right humeral head fracture and fracture Compression Thoracic 5, 6,and 7. On 5/13/24 at 10:50 a.m., in an interview, the Director of Nursing stated this injury was discovered on Friday 3/15/24. She went on to state that the facility knew about the serious injury the same evening in a report from the hospital. She further stated that the facility report to the state was not sent in until 3/18/24. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/24 at 12:10 p.m., in an additional interview, the Director of Nursing confirmed that the facility did not send a report timely to the Division of Licensing and Certification (DLC) (State Survey Agency) and to Adult Protective Services (APS) (State Agency) regarding this injury of unknown origin.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37648 Based on interviews and record reviews, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours that included the problems, interventions, and initial goals needed to provide minimum healthcare information necessary to properly care for 1 of 3 residents that were reviewed for new admissions. (#189) Finding: On 5/13/24 at 10:25 a.m., During an interview, Resident #189 stated, he/she has a pacemaker which is checked via his/her phone. Resident #189 was admitted to the facility on [DATE]. The hospital history and physical included information that the resident had a pacemaker placed for tachybradycardia syndrome and heart block. Further review indicates resident #189's code status as Do Not Resuscitate. Review of the clinical record lacked evidence of a baseline care plan completed within 48 hours to include the instructions necessary to properly care for Resident #189's immediate health and safety needs for the above concerns. On 5/14/24 at 10:19 a.m., during an interview, the Registered Nurse Admission Coordinator confirmed the above and stated she will add the presence of a cardiac pacemaker immediately.

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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. 42531 Based on record reviews, interviews and facility policy, the facility failed to update/implement goals and interventions in the area of antibiotic medication use for 1 of 6 residents reviewed for medications (Resident #15). Findings: Review of facility policy Care Planning/Interdisciplinary Team/Family Participation dated 3/98 states .A comprehensive care plan is developed within seven days of completion of the resident comprehensive assessment (MDS).Reviewing care plans to assure that: They reflect the resident's actual needs . Review of Resident 15's care plan initiated 3/22/23 revealed .Focus: I have a Urinary Tract Infection; Goal: UTI will resolve without complications; Interventions: Administer antibiotic as prescribed by Provider Review of Resident 15's clinical record revealed order with start date of 2/23/24 for Amoxicillin-Pot Clavulanate 875-125 mg tablet. Give 1 tab by mouth twice daily for 7 days for UTI [Urinary Tract Infection]. Further review of Resident #15's clinical record lacked evidence his/her care plan was updated after this medication was completed. On 5/14/23 at 11:26 a.m., during an interview, the Director of Nursing indicated that Resident #15's care plan should have been updated within 7 days of the antibiotic completion and confirmed the above findings.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on interview, record review and facility policy, the facility failed to review and revise the care plan by an interdisciplinary team (IDT) that included, to the extent possible, participation of the resident and/or his/her representative after each assessment for 1 of 7 sampled residents (Resident #17). Findings: Review of facility policy Care Planning/Interdisciplinary Team/Family Participation dated 3/98 states .A comprehensive care plan is developed within seven days of completion of the resident comprehensive assessment (MDS).Reviewing care plans to assure that: They reflect the resident's actual needs . Resident #17 was admitted to the facility on [DATE]. During review of Resident #17's medical record, the surveyor noted quarterly Minimum Data Set (MDS) Assessments dated 2/6/24. The clinical record lacked evidence that a care plan meeting was held by the IDT, resident and/or representative for this assessment. In addition, the last documented IDT meeting was held on 11/14/23. On 5/14/24 at 2:32 p.m., during an interview, the Social Worker reviewed Resident #17's entire clinical record and confirmed there was no evidence that an IDT was held. On 5/14/24 at 2:54 p.m., the above was discussed with Director of Nursing.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 42531 Based on interview and clinical record review, the facility failed to develop a discharge summary which included a recapitulation of the resident's stay for 1 of 1 residents reviewed for discharge (Resident #33). Findings: Resident #33 was admitted to facility on 2/9/24 for skilled services. On 2/24/24 resident #33 was discharged to the community. The clinical record lacked evidence a recapitulation of the resident's stay was completed at discharge. On 5/15/24 at 10:09 a.m., during an interview, the Director of Nursing indicated that she reviewed Resident #33's clinical record and was unable to find evidence that a recapitulation of stay was completed for this resident.

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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 and interview, the facility failed to ensure that the resident's environment was free of accident hazards relating to a commode for 1 of 3 days of survey. (5/13/24) Finding: On 5/13/24 at 10:05 a.m., two surveyors observed a commode over a toilet in Resident room [ROOM NUMBER]'s bathroom. The left armrest had been worn down and the right armrest was broken open with sharp/jagged plastic edges exposed. On 5/13/24 at 10:13 a.m., in an interview with two surveyors, the Director of Nursing confirmed that the sharp/jagged plastic edges on the armrest was an accident hazard.

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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. 37648 Based on observations, record reviews and interviews, the facility failed to ensure that clinical records were complete and contained accurate documentation for 1 of 3 sampled residents reviewed for Oxygen (#189). Finding: On 5/13/24 at 10:25 a.m. and on 5/14/24 at 9:56 a.m., observations of Resident #189 on Oxygen set at 2 Liters Per Minute (LPM) via nasal cannula. Review of the hospital discharge history and physical states the resident has diagnosis of chronic respiratory failure with hypoxia and obstructive sleep apnea and required oxygen at home at 2LPM continuously. The Assessment and Plan states, Patient on continuous home oxygen, 2 LPM via nasal cannula. Review of the Physician order dated 5/7/24 states O2 every day and night shift for ILD (Interstitial Lung Disease), the order lacked the amount of oxygen / LPM to be administered. On 5/14/24 at 10:19 a.m., during an interview, both the surveyor and the Registered Nurse (RN) Admission Coordinator reviewed the admission orders which indicated the 2LPM. The RN stated she will update the orders immediately to reflect the LPM of oxygen.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on record review, interviews and facility policy, the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation, failed to determine that drug records are in order and that an account of all controlled drugs is maintained, failed to ensure that two people who are authorized to administer medications signed the Shift Count page indicating that they counted all controlled substances at the change of shift for 1 of 2 units reviewed for medication storage ([NAME] Wing). Findings: Review of facility policy Controlled Substance Storage dated 5/1/18 states .At each shift change, or when key are transferred, a physical inventory of all controlled substances, including refrigerated items is conducted by two appropriately licensed/certified personnel and is documented . 1. Review of controlled substance logbook labeled [NAME] Wing Book #16 index revealed page 81 was blank. Further review revealed page 81 belonged to Resident #27 for medication Lorazepam 2mg [milligram]/ml [milliliter] concentrate take 0.25ml. (5mg) by mouth every hour as needed for anxiety, agitation, nausea. Give 1mg 1hour prn for severe anxiety/SOB/nausea. 2. Review of controlled substance logbook labeled [NAME] Wing, Book #16, revealed that oncoming licensed staff failed to sign the shift count page on 5/11/24 at 19:00 and failed to sign out on 5/12/24 at 07:00. On 5/13/24 at 11:18 a.m., during an interview, the Certified Medication Technician (CMT) indicated that staff do not use the index when they do shift count and they only need one person to sign controlled medications into the controlled substance book. The CMT further indicated that when she does count, she does not use the index and just matches the page numbers in the book with the actual medication cards. On 5/13/24 at11:28 a.m., during an interview, the Registered Nurse (RN2) indicated that staff should be using the index during the shift count, but they had not been. RN2 further indicated that licensed staff were required to sign the controlled logbook at the beginning and end of each shift and anytime the keys were transferred to another person. RN2 further indicated they have one staff member entering controlled medications into the controlled logbook. On 5/13/24 at 12:10 p.m., during an interview with 2 surveyors, the Director of Nursing (DON) reviewed the controlled book, noted index page 81 was blank. At this time, the DON stated the index is the key to reconciliate the controlled medication count, the page should have been filled out, and licensed staff should be signing at the beginning and end of each shift indicating the controlled medication count is correct, confirming the above concerns.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 42531 Based on record review, interview and facility policy, the facility failed to show evidence of documentation to justify the use of psychotropic medications for 2 of 5 residents reviewed for unnecessary medications (#17 and #28). Findings: Review of facility policy Restraints, Physical/Chemical dated 2/98 states .Psychotropic Medication Implementation: .The facility will follow pharmacy recommendations for indication, gradual dose reduction and monitoring . 1. Resident #17 was admitted to on 10/30/23 with a diagnosis of anxiety. Review of Resident #17's clinical record revealed Pharmacy Review dated 2/28/24 stating Patient has an order for Lorazepam 0.5mg [milligram] tab give 1 tab po [by mouth] as needed. [He/she] uses this medication infrequently. According to the regulations this medication is a psychotropic and requires 2 attempts at a gradual dose reduction in the first year and then every year after. If it is not appropriate to attempt a dose decrease at this time, the provider may wish to document rational for contraindication. [Provider response]: Disagree. Further review of Resident #17's clinical record lacked evidence of a rational for the provider's response. During an interview on 5/14/24 at 3:29 p.m., the Director of Nursing confirmed she had reviewed Resident #17's clinical record and was not able to find any rational for Resident #17's continued use of lorazepam. 37440 2. Resident #28 was admitted to on 11/2/23 with diagnosis of anxiety and depression. Review of Resident #28's clinical record revealed a Pharmacy Review - Note to Attending Physician/Prescriber dated 3/25/24 stating Patient has order for Sertraline 100mg give one tab po qam [every morning]. According to the regulations a gradual dose reduction should be attempted 2 times in the first year and once a year thereafter. Provider might wish to attempt a GDR or document rationale for contraindication at this time. Physician may wish to consider a dosage reduction at this time to ensure patient is on the lowest effective dose. [Provider response]: Disagree. Further review of Resident #28's clinical record lacked evidence of a rational for the provider's response. On 5/15/24 at 10:50 a.m., during an interview, the surveyor discussed the finding with the Administrator and the Director of Nursing at the survey exit meeting.

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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, interview and the facility's Storage - Food and Non Food Items policy effective date: 04/20/12, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for a grease trap base, floor drains, ceiling vents, lights and ceiling tiles; failed to ensure facial hair protection was worn; and failed to ensure foods in the walk-in freezer were dated and/or labeled. Findings: On 5/13/24 from 9:10 a.m. to 9:35 a.m., an initial kitchen tour was conducted with the Food Service Director in which the following findings were observed: > The cement base under the grease trap had chipped/missing paint creating an uncleanable surface. > There were 3 floor drain grates that had chipped/missing paint creating uncleanable surfaces. > There were 3 ceiling vents, above food preparation areas, and surrounding ceiling tiles that were moderately soiled with dust. > The dry storage room had a ceiling vent and a light that were moderately soiled with dust. > There was a male kitchen worker with facial hair that was not wearing facial hair protection while preparing food in the kitchen. > The walk-in freezer had an unlabeled and undated bag of bread and also had a package of unlabeled bacon bits. > The dry storage room had a ceiling vent and a ceiling light that were moderately soiled with dust. On 5/13/24 at 9:35 a.m., in an interview, the Food Service Director confirmed the findings.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 37440 Based on observations and interviews, the facility failed to ensure garbage was properly disposed of and contained to prevent the harborage and feeding of pests for 3 of 3 days of survey (5/13/24, 5/14/24 and 5/15/24). Findings: 1. On 5/13/24 at 9:00 a.m., a surveyor observed loose, unbagged trash on the ground around the dumpsters. 2. On 5/14/24 at 8:15 a.m., a surveyor observed loose, unbagged trash on the ground around the dumpsters. 3. On 5/15/24 at 8:15 a.m., a surveyor observed loose, unbagged trash on the ground around the dumpsters. On 5/15/24 at 10:50 a.m., in an interview, the surveyor discussed the findings with the Administrator and the Director of Nursing at the survey Exit meeting.

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F 0868 Level of Harm - Potential for minimal harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 37648 Based on review of the quarterly Quality Patient Resident Safety Committee meeting attendance sheets and interview, the facility failed to ensure that the Infection Preventionists attended 4 of 4 quarterly meetings. Finding: A review of the quarterly Quality Patient Resident Safety Committee meeting attendance sheets indicate that the Infection Preventionists did not attend the 5/24/23, 8/23/23, 11/15/23 and 2/28/24 quarterly meetings. In addition, the facilities Senior Living Performance Improvement & Safety Plan for 2023/2024 under section Program Organization states, The Senior Living Performance Improvement Committee is a Board Committee . Membership of the Committee shall consist of representation from the following constituents: Administration, Board of Trustees, Quality and Safety, Medical Director and/or designee if unable to attend, Pharmacist, Risk Management, Director of Nursing Services and/or designee if unable to attend and three others members of the facility staff. The improvement plan lacks the federally required Infection Preventionists as a committee member. On 5/15/24 at 8:19 a.m., during an interview, the Infection Preventionist stated she has not attended a Quality Patient Resident Safety Committee meeting recently and that she usually does not attend but the Director of Nursing will present her information. On 5/15/24 at 8:25 a.m., during an interview, the Director of Nursing confirmed the infection preventionists has not attended any of the meetings. In addition, the DON stated she does not have the infection prevention education as the infection preventionist has. On 5/15/24 at 9:27 a.m., during an interview with the Administrator the surveyor confirmed the above finding.

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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. 37440 Based on interviews, the facility failed to conduct regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment for 37 of 37 beds. Findings: On 5/14/24 at 11:42 a.m., a surveyor met with the Director of Facilities and asked for the bed gap measurements and side rail gap measurement documentation. The Director of Facilities stated that he had never heard of those before and he would check with the other maintenance men. He came back and stated that they had never heard of them either. At this time, the Director of Facilities confirmed that the facility had never completed bed gap measurements and/or side rail gap measurements at the facility for any of the resident's beds. On 5/14/24 at 11:50 a.m., in an interview with the Administrator and the Director of Facilities, the Administrator stated that she had never heard of bed gap measurements or side rail gap measurements. At this time, the Administrator confirmed that the facility had never completed bed gap measurements and/or side rail gap measurements at the facility for any of the resident's beds. The surveyor asked for the facility's Bed Safety and Bed Rails policy and procedure. On 5/14/24 at 1:30 a.m., in an interview with the Administrator, she stated that she can't locate any Bed Safety and Bed Rails policy and procedure documentation and can't provide any to the surveyor.