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	08/15/2025

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 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** Based on observations and interviews, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in good repair and sanitary conditions for 1 of 2 units([NAME] Wing), an activity office and the Laundry/kitchen areas on 3 of 3 environmental tours.1. On 8/11/25 from 10:00 a.m. to 10:20 a.m., a surveyor and the Facilities Manager toured the laundry room and the [NAME] Wing hallway and observed the following findings:Laundry: - There was a ceiling tile, over the stackable dryers, that was broken and had fallen out of place. - The entire floor was dirty and heavily soiled with dirt. - There were approximately 10 cracked/broken floor tiles throughout the laundry room. - There were three stained ceiling tiles in the soiled area of the laundry room. [NAME] Wing hallway- A laundry cart had a ripped cover and also had tape on it holding some of the cover together.On 8/11/25 at 10:20 a.m., in an interview with a surveyor, the Facilities Manager confirmed the findings. 2. On 8/13/25 from 8:45 a. m. to 8:55 a. m., a surveyor and a Maintenance Worker conducted a tour of the facility and observed the following findings:[NAME] Wing- Resident room [ROOM NUMBER] - The privacy curtain was missing hooks, hanging down and in disrepair.- Resident room [ROOM NUMBER] - The floor was dirty around the base of the toilet. There were two floor tiles, under the bathroom door by the door jamb, that were broken and missing.-The activity office had dead bugs in all three ceiling lights. On 8/13/25 at 8:55 a. m., in an interview with a surveyor, a Maintenance Worker confirmed the findings. 3. On 8/13/25 from 9:40 a.m. to 10:10 a.m., a surveyor and the Environmental Services Laundry/Housekeeping Supervisor conducted a tour of the laundry/kitchen areas and observed the following findings: -The kitchen hallway had two large wall air vents that were heavily soiled with dust. - The kitchen mat drying rack, stored in the kitchen hallway, had large amounts of rust on the base area. - The laundry hallway had wooden chair rails on the walls that had chipped/missing paint that created uncleanable surfaces.- The laundry room had 2 ceiling tiles, in the corner behind the folding table, that had brown stains on them.- The ceiling air vent, over the 3 large dryers, was dusty. - The ceiling air vent, over the stackable dryers, was dusty. On 8/13/25 at 10:10 a.m., in an interview with a surveyor, the Environmental Services Laundry/Housekeeping Supervisor confirmed the 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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review, interview, and facility policy, the facility failed to ensure an Interdisciplinary Meeting was held within 7 days of completed Minimum Data Set (MDS)/ Assessment Reference Date (ARD) for 3 of 14 Residents reviewed (Resident's (7, 19 and 35). 1. Review of facility policy Care Plans-Comprehensive-Preliminary dated 3/1998 states . The resident's/patient's comprehensive care plan is developed within seven (7) days of the completion of the resident's/patient's comprehensive assessment (MDS) . Review of Resident [R]7's Quarterly MDS/ARD dated 7/18/25. Review of R7's clinical record revealed the IDT was held 7/16/25 (2 days prior to MDS/ARD) completion. During an interview on 8/12/25 at 11:21 a.m., the Licensed Social Worker (LSW) stated that she is supposed to schedule IDTs within 7 days of the MDS /ARD date. At this time LSW confirmed R7's IDT was held 2 days prior to MDS/ARD completion date. 2. Review of Resident (R) 35's clinical record revealed a Minimum Data Set (MDS) admission Assessment was completed on 7/30/25. Further review of the clinical record lacked evidence that an interdisciplinary team (IDT) meeting was held within 7 days following the assessment. 3. Review of R19's clinical record revealed an MDS Quarterly Assessment was completed on 5/17/25 and that an IDT meeting was held 5/29/25 (12 days after the assessment). On 8/12/25 at 11:24 a.m., the above findings were discussed with the Licensed Social Worker (LSW). At this time, the LSW stated she tries to hold the IDT meeting within 7 days of the MDS assessments but thought she had up to 14 days to hold the meeting and stated she has not yet scheduled an IDT meeting for Resident #35.

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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 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. Based on observations, record reviews, interviews and facility policy, the facility failed to maintain a sanitary environment to help prevent the development and transmission of disease and infection related to respiratory care for 1 of 2 residents reviewed for respiratory care (Resident [R] 6). Additionally, the facility failed to ensure physician orders were followed for 1 of 2 residents receiving oxygen therapy (R1) and failed to ensure complete and accurate documentation of the assessment and monitoring of the resident's respiratory condition for 2 of 2 residents receiving oxygen therapy (R1, R6). 1. On 8/11/25 at 9:09 a.m. and 11:22 a.m., R1 was observed wearing oxygen (O2) via a nasal cannula (NC) with the concentrator flow rate set at 1.5 liters per minute (L/min). On 8/12/25 at 9:34 a.m. during a follow-up observation, Resident #1 was wearing oxygen via nasal cannula with the concentrator flow rate set at 1L/min. Review of R1's clinical record revealed the following orders: -order with a start date of 6/5/25 for Oxygen 2L/min via NC PRN [as needed] for dyspnea [shortness of breath], comfort, and/or 02 sat [saturation] below 90% as needed . -order with a start date of 8/11/25 for Oxygen 2L/min via NC every shift for dyspnea, comfort. On 8/12/2025 at 11:05 a.m., during an interview, Registered Nurse (RN) #1 stated R1 had been receiving oxygen PRN but recently had aspiration pneumonia and now requires continuous oxygen at 2L/min. RN #1 then stated when she took R 1's vital signs this morning, his/her oxygen saturation was 83%, and she noticed the flow rate on the concentrator was set to 1L, so she adjusted the setting to 2L. RN #1 then stated that R1 should be receiving 2L of continuous oxygen and that there is no physician order to titrate the oxygen flow rate. On 8/12/25 at 11:27 a.m., during an interview in the presence of 4 surveyors, the above finding was discussed with the Nurse Manager. At this time, the Nurse Manager stated there are no standing orders to titrate oxygen and that R1 should be on continuous oxygen at 2L/min per the physician order. 2. Review of R1's clinical record revealed a physician order with a start date of 6/5/25 for Oxygen 2L/min via NC PRN [as needed] for dyspnea [shortness of breath], comfort, and/or 02[oxygen] sat [saturation] below 90% as needed . Review of R1's O2 Sat Summary indicated R1 was wearing oxygen via nasal cannula for all documented O2 sat measurements from 6/5/25 through 8/13/25. Review of R1's June 2025 and July 2025 Treatment Administration Record (TAR) indicated R1 received PRN oxygen on 6/8/25 and lacked evidence that R1 received oxygen on any other dates in June or July 2025. On 8/13/25 at 12:22 p.m., during an interview with 2 surveyors, the above finding was discussed with the Nurse Manager, and she stated R1 had been using PRN oxygen in June and July 2025, and it should have been documented on the TAR. (continued on next page)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Oxygen Therapy policy, last revised 9/2024, stated in Section II. Key Procedural Points, 3. Oxygen in Use, o. Oxygen tubing, masks, should be changed weekly. Section VI. Assessment. 1. The resident's preliminary and comprehensive assessment should address: a) That oxygen therapy is needed. b) How often oxygen is to be administered. e) Other as appropriate and necessary. Section VII. Charting and Documentation. 1. When oxygen therapy has been ordered, the staff/charge nurse should record the following data in the resident's medical record: a) the date and time the procedure was ordered. b) the rate of flow, route, and rationale. c) the name of the person administering the oxygen. d) the frequency and duration of the treatment. e) the resident's tolerance to the treatment. f) the reason for prn (as needed) administration. j) All pertinent observations, k) the signature and title of the person recording the data. 3. On 8/11/25 at 10:37 a.m., a surveyor observed an oxygen concentrator in R6's room and noted the label indicating when the tubing was last changed was dated 7/31/25. R6 stated he/she only uses it when need and the last time was a couple of weeks ago. A review of R6's clinical record noted diagnoses that included Chronic obstructive pulmonary disease (COPD), and Congestive heart failure (CHF). The Minimum Data Set (MDS) 3.0, admission Assessment, completed 6/15/25, Section O – Special Treatments, Procedures and Programs, indicated R6 did not receive oxygen therapy. A review of R6's care plan, initiated 6/9/25 and revised 7/29/25, included the focus area: Oxygen therapy related to respiratory illness (COPD), and with interventions that included: Report symptoms of respiratory distress and report to (physician as needed): Respirations, Pulse oximetry, Increased heart rate (Tachycardia), Restlessness, Diaphoresis, Headaches, Lethargy, Confusion, Atelectasis, Hemoptysis, Cough, Pleuritic pain, Accessory muscle usage, Skin color. Provider orders, dated 6/11/25, included Oxygen (O2) as needed for dyspnea/comfort 1-2 liters per minute via nasal cannula. And, Change oxygen tubing weekly. Rinse filter, pat dry and replace. Initial and date orange tubing sticker every day shift every 7 days. A review of R6's Treatment Administration Record (TAR) for June, July, and August, 2025, noted no use of oxygen in July or August. In June, R6 received oxygen at 2 liters on 6/10/25. Documentation on the TAR noted R6's oxygen tubing was last changed on 8/7/25. A review of the vital signs recorded by staff in R6's electronic medical record noted daily oxygen saturations (SpO2) ranging from 86-97%. Staff had documented oxygen use as follows: 6/11/25 at 7:50 a.m., SpO2 at 90% Oxygen via Nasal Cannula 6/12/25 at 7:41 a.m., SpO2 at 93% Oxygen via Nasal Cannula 6/19/25 at 7:26 a.m., SpO2 at 91% Oxygen via Nasal Cannula 6/23/25 at 7:58 a.m., SpO2 at 92% Oxygen via Nasal Cannula 6/23/25 at 7:38 p.m., SpO2 at 96% Oxygen via Nasal Cannula 6/24/25 at 7:50 p.m., SpO2 at 93% Oxygen via Mask (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/25/25 at 9:17 a.m., SpO2 at 89% on Room Air 6/28/25 at 8:04 a.m., SpO2 at 91% Oxygen via Nasal Cannula 6/29/25 at 7:37 a.m., SpO2 at 90% Oxygen via Nasal Cannula 7/5/25 at 8:55 a.m., SpO2 at 92% Oxygen via Nasal Cannula 7/20/25 at 8:14 a.m., SpO2 at 92% Oxygen via Nasal Cannula On 8/13/25 at 11:25 a.m., a surveyor confirmed with Registered Nurse #2 that R6's oxygen tubing was still dated 7/31/25, indicating the date it was last changed. On 8/13/25 at 11:30 a.m., in an interview with a surveyor, RN #3 stated if the oxygen saturation dips to the 80's, the RN will add oxygen and check back within 5-10 minutes to assess the effect. If the oxygen saturation has improved, RN #3 will leave the oxygen on and recheck again later. Asked how this would be documented, RN #3 stated I would put that in a nursing note. On 8/13/25 at 12:20 p.m., in an interview with the Nurse Manager, 2 surveyors discussed the lack of documentation for prn oxygen use, including when oxygen was applied and at what liter flow, and follow up assessment for effectiveness and oxygen saturation. In addition, the oxygen tubing for R6 was observed on two occasions with the date of 7/31/25, and documentation in the TAR indicating the tubing was last changed on 8/7/25. The Nurse Manager confirmed the findings.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, the facility's Storage - Food and Non Food Items policy, the facility's Sanitation-Warewashing-Mechanical/Manual Cleaning/Sanitizing policy, and the facility's Dish machine Temperature and Cleaning Records, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for a grease trap cover, floor drain covers and the walk-in freezer; failed to ensure kitchen staff wore appropriate hair coverings; failed to ensure foods were properly dated, labeled and/or discarded past the manufacturer's best used by date for 1 of 1 kitchen tour.(8/11/25)The facility's Sanitation-Ware washing-Mechanical/Manual Cleaning/Sanitizing policy effective date: 04/20/12 noted: Procedure: d) Check temperatures. Record daily the wear washing machines temperatures of both the wash and the rinse cycles on the dishwasher temperature record form. Temperatures shall be maintained in accordance with the manufacturer's instructions.The facility's Storage - Food and Non Food Items policy effective date: 04/20/12 noted: Procedure: 1) General Storage Information- b) Expiration dates must be checked on a regular basis. 2) Refrigerator Storage- d) Food items will be properly labeled and dated as appropriate when placed under refrigeration. 3) Freezer Storage- d) All items to be frozen must be properly wrapped, labeled and dated.On 8/11/25, a surveyor did an Initial Kitchen Tour with [NAME], RD. from 9:30 a.m. to 10:10 a.m. in which the following findings were observed: > The grease trap cover was dirty and rusty. > A male kitchen worker, with a facial hair, did not have a facial hair covering on. > There were 3 floor drain covers that were dirty and had chipped/missing paint creating uncleanable surfaces. > Reach-in refrigerator #5 had one 8-ounce container of fat free milk with a best used by date of July 7, 2025. > The walk-in freezer had 3 packages of a white substance and two large bags of french fries that were not labeled and dated. Additionally, there was a bag of french fries and a bag of [NAME], under the freezer compressor, that had chunks of ice buildup on them. On 8/11/25 at 10:10 a.m., in an interview with a surveyor, the Registered Dietician confirmed the findings.On 8/12/25 at 2:30 p.m., the Administrator provided kitchen documentation to the surveyor that had been requested. The Dish Machine and Cleaning Records Temperature check sheet show that the dinner time dish machine temperatures were not monitored and documented for the following dates: May 2025= 1,2,3-6, 8-31. June 2025= 2-9, 11-17, 19-30. July 2025= 4-6, 9, 12-14, 16, 17, 18-21, 23, 27,28, 31. At this time in an interview with a surveyor, the Administrator 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. 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 (8/11/25, 8/12/25 and 8/13/25).1. On 8/11/25 at 8:30 a.m., two surveyors observed one of two dumpsters with the front right lid open exposing trash. There was also trash on the ground around the two dumpsters. Additionally, two surveyors observed a trash storage area, outside the maintenance shop area, that had trash piled in and on 3 large, uncovered trash receptacles. On 8/11/2025 at 9:12 a.m., in an interview with a surveyor, the Administrator confirmed the finding. 2. On 8/11/25 at 8:30 a.m., a surveyor and the Facilities Manager observation of trash storage area outside the maintenance shop area. 1 of 3 large, uncovered trash receptacles had trash in it. At this time, in an interview with a surveyor, the Facilities Manager confirmed that the staff puts trash in the bins daily to take to the dumpsters at the end of the day and the bins are not covered. 3. On 8/12/25 at 8:15 a.m., a surveyor and the observed trash on the ground around the two dumpsters. The surveyor also observed trash in 2 of the 3 large, wheeled uncovered trash receptacles outside the maintenance shop area. On 8/12/25 at 8:30 a.m., in an observation and interview with a surveyor, the Facilities Manager confirmed the findings.4. On 8/13/25 at 8:15 a.m., two surveyors observed one trash dumpster with the right side slide door open exposing trash. Also, there was a trash bag on the ground in front of the other dumpster. On 8/13/25 at 8:30 a.m., in an interview with a surveyor, the Facilities Manager confirmed the findings.

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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 Based on record review and interview, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours that included the instructions needed to provide minimum healthcare information necessary to care for 1 of 11 residents reviewed for baseline care plans (Resident #19 (R19).R19 was admitted in February 2025. Review of R19's clinical record lacked evidence that a baseline care plan, including goals and interventions, was developed and implemented within 48 hours of admission. On 8/12/25 at 4:00 p.m. during an interview, the Nurse Manager reviewed R19's baseline care plan and confirmed it was not developed and implemented until 4 days after admission.

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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. Based on observation, interview, and record review, the facility failed to ensure a resident's care plan was developed in the area of oxygen use for 1of 2 residents reviewed for respiratory care (Resident [R] 1).On 8/11/2025 at 9:09 a.m. and 8/12/25 at 9:00 a.m., R1 was observed wearing oxygen via a nasal cannula.Review of R1's clinical record indicated he/she has diagnoses to include Chronic Obstructive Pulmonary Disease (COPD) and aspiration pneumonia. Review of R1's Quarterly Minimum Data Set assessment, dated 6/9/25, indicated oxygen therapy while a resident. Review of R1's physician orders revealed the following:-order with a start date of 6/5/25 for Oxygen 2L/min [2 liters per minute] via NC [nasal cannula] PRN [as needed] for dyspnea [shortness of breath], comfort, and/or 02 [oxygen] sat [saturation] below 90% .-order with a start date of 8/11/25 for Oxygen 2L/min via NC every shift for dyspnea, comfort.Review of R1's care plan lacked evidence that goals/interventions for oxygen were implemented until after the start of the survey (8/11/25).On 8/12/2025 at 4:00 p.m. during an interview, the Nurse Manager reviewed R1's care plan and confirmed that a comprehensive care plan had not been developed or implemented for R1's oxygen use.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on review of performance evaluations and interviews, the facility failed to complete annual performance evaluations timely, at least once every 12 months, for 2 of 5 Certified Nursing Assistants (CNA's 1 & 2).1.Review of CNA1's 2024 Annual Performance Appraisal initiated by Nurse Manager on 10/10/24 states Impersonation Mode You are currently impersonating another user. To stop impersonating, click on the user menu and select Stop Impersonating. I understand that my electronic signature carries the same legal weight and authority as my written signature. Name [CNA1] date 8/12/25. sign: is blank. This evaluation lacks evidence that it was reviewed/or signed by CNA1.During an interview on 8/13/25 at 10:55 a.m., CNA1 reviewed 2024 Annual Performance Appraisal dated 8/12/24 and stated she did not receive or sign an evaluation yesterday (8/12/25), and she was working all day and never went onto a computer all day long.2. Review of CNA2's 2024 Annual Performance Appraisal initiated by Nurse Manager on 10/28/24 states . I understand that my electronic signature carries the same legal weight and authority as my written signature. Name [CNA2] date 8/12/25. sign: is blank. This evaluation lacks evidence that it was reviewed/or signed by CNA2.During an interview on 8/13/25 at 11:03 a.m., Nurse Manger confirmed that would have been something signed by Human Recourses (HR). CNA1 CNA2 did not sign the evaluations. During an interview on 8/13/25 at 11:31 a.m., in presence of 4 surveyors the Administrator stated she had spoken with HR and was told that an employee does not have to sign an evaluation. A surveyor asked if an employee doesn't sign the evaluation, how is there proof that they received the evaluation and were made aware of any concerns that were noted on the evaluation. Administrator replied, That is a good question.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on Certified Nurse's Aide (CNA) employee education reviews and interview, the facility failed to monitor and ensure that a CNA attended the required 12 hours of annual in-service education, for 1 of 5 randomly selected CNA's employed greater than 1 year. (CNA1).Certified Nursing Assistant (CNA1) was hired on 4/11/16.CNA1 ?s yearly Inservice education records from 4/11/24 through 4/11/25 state she received 7.09 hours of Inservice hour education and not the required 12 hours. During a review of CNA1's in-service hours on 8/13/25 at 11:03 a.m., Nurse Manager confirming CNA1 did not receive the required 12 hours of in-service education.