STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205095	A. Building B. Wing	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kennebunk Center for Health & Rehabilitation, LLC	158 Ross Rd Kennebunk, ME 04043

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 48648 Based on closed record review and interview, the facility failed to ensure the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (Form CMS -10055) (SNFABN) were provided to 1 out of 2 residents reviewed whose Medicare Part A services were discontinued. (Resident #267) Finding: On 10/19/23 at 10:45 a.m. a surveyor reviewed Resident #267's medical record. Resident #267 received Medicare Part A services that ended on 6/16/23. The Medical record lacked evidence that the required Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN) was provided to the resident so that he/she could make an informed decision to continue receiving the skilled services that may not be paid for by Medicare and assume financial responsibility. On 10/19/23 at 11:15 a.m. a surveyor met with the Business Office Manager and confirmed this notice was not issued prior to the end of Medicare Part A services.

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 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** 44049 Based on observations and interviews, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in good repair and in a sanitary condition, on 2 of 4 units (Sagamore and [NAME]) for 1 of 1 environmental tour. Findings: 1. [NAME] wing - room [ROOM NUMBER] - resident by the door, arm of wheel chair is cracked with open areas creating an uncleanable surface. 2. Sagamore wing - room [ROOM NUMBER], the wall to the left of the door upon entry has deep gouges in wall door frame. 3. Sagamore wing - room [ROOM NUMBER] - wall between dresser and bathroom has gouges in the lower portion of the wall. 4. Sagamore wing - room [ROOM NUMBER]'s bathroom - Ceiling vent full of dust and cobwebs. On 10/19/23, at 2:20 p.m the above finding was confirmed with the Administrator.

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48648 Based on closed record reviews and interviews, the facility failed to permit a resident's return to facility for 1 out of 1 resident reviewed for facility-initiated discharge to the hospital (Resident #270). Findings: On 5/16/23 at 9:16 a.m., Division of Licensing and Certification received a complaint indicating on 5/15/23 the facility transferred a resident to the hospital and failed to accept return of the resident. On 10/17/23 at 9:30 a.m., a closed record review of Resident #270's showed Resident #270 was admitted to the facility on [DATE] with a complicated medical history. The hospital discharge summary included follow up appointments scheduled for 5/2/23 and 5/3/23 involving out of state providers. Resident #270 was transferred on 4/15/23 to the facility by ambulance due to their inability to tolerate sitting upright for the duration of the ride. On 10/17/23 at 11:00 a.m., in an interview with the Admission Coordinator, stated that transportation was a known problem prior to admitting Resident #270. The facility reports they were told it was no longer possible to transfer resident's out of state. It was reported that the facility expected resident's family would provide transportation to medical appointments. On 10/18/23 at 2:15 p.m., during review of the facility Admission Packet that is provided to all admissions, it states on the first page Except in emergency, the facility will arrange for the transfer of the resident to a hospital or other health care facility when any such transfer is ordered by the attending physician or a substitute physician as specified in Section I, Paragraph 1 of this agreement. On 10/18/23 at 3:45 p.m., during review of the provider notes, dated 5/2/23, it was stated the facility was unable to provide transportation to the follow up appointments on 5/2/23 and 5/3/23 and those appointments were missed. On 10/18/23 at 4:00 p.m., during review of the provider notes dated 5/15/23, it was stated Resident #270 was transferred to the hospital on 5/15/23 for further evaluation and stated The transfer or discharge is necessary to meet the resident's welfare or medical needs and the resident's welfare or medical needs cannot be met in the facility. This form remains unsigned by the resident. Unable to locate confirmation the resident received it. On 10/18/23 at 4:30 p.m., in an interview with the Director of Nursing, stated Resident #270 never should have been admitted due to the complexity of the out of state medical care along with the known transportation issues that the facility has, that left them unable to meet resident's medical needs.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37015 Based on record review and interview, the facility failed to revise a care plan to reflect the current needs for 3 of 27 residents reviewed in the areas of transmission-based precautions and respiratory care (#51, #173, #176); and failed to revise the care plan after each assessment for 1 out of 3 sampled residents (#39) receiving in-house therapy services. Findings: 1. On 10/16/23 at 11:16 a.m., a surveyor observed a personal protective equipment (PPE) station with signage advising of the need for transmission-based precautions (TBP) outside of Resident #51's room. A review of Resident #51's clinical record revealed a history and physical, dated 6/25/23, which noted the diagnosis of Vancomycin Resistant Enterococcus (VRE) in the resident's urine. A review of Resident #51's care plan noted the last revision was completed on 9/2/23 and did not include the need to use TBP when providing care for the resident. On 10/18/23 at 12:15 p.m., in an interview with a surveyor, the Director of Nursing confirmed that Resident #51 required TBP and was not included on the care plan. 2. On 10/16/23 at 3:04 p.m., a surveyor observed Resident #173 was using oxygen. A review of the clinical record noted a diagnosis of Chronic Obstructive Pulmonary Disease and a physician's order, dated 10/4/23, which stated O2 (oxygen) via nasal cannula, titrate to keep O2 saturations greater than 90% every shift. A review of Resident #173's care plan, dated 9/28/23, did not include the resident's need for oxygen. On 10/18/23 at 10:15 a.m., in an interview with a surveyor, the Director of Nursing confirmed that the care plan did not include Resident #173's oxygen therapy. 3. On 10/19/23 at 10:00 a.m., a surveyor observed a PPE station with signage advising of the need for TBP outside of Resident #176's room. A review of Resident #176's clinical record revealed the results of a urine culture, dated 10/16/23, were VRE. A review of Resident #176's care plan, last revised on 10/10/23, had not been updated to include the need for TBP when providing care. On 10/19/23 at 12:38 p.m., in an interview with a surveyor, the Director of Nursing confirmed that Resident #176 required TBP and was not included on the care plan. 48648 4. On 10/17/23 at 8:34 a.m. in an interview with Resident #39, discovered they had fallen during a transfer and had broken both legs. Record review of Resident #39 progress notes in the Electronic Medical Record (EMR) found the fall occurred on 7/9/23. 5. On 10/17/23 at 9:04 a.m. this surveyor reviewed Resident #39's care plan that was active on 7/9/23 and found Transfer extensive assist with stand lift, (a partial mechanical lift), from bed to wheelchair. Use Hoyer (a total mechanical lift) if unsafe to use stand lift. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. On 10/17/23 at 2:18 p.m. this surveyor met with the Director of Nursing about the incident and confirmed a stand lift was not used during the transfer on 7/9/23 but therapy had cleared resident to transfer with 2 people assisting for quite a while at that point. 7. On 10/17/23 at 4:00 p.m. this surveyor reviewed the original Rehab Department Recommendations form for Resident #39 to Nursing dated 3/7/23 that stated, Extensive Assist with 2 staff. Minimum assist from wheelchair. Limited assist from bed. Stand lift was no longer checked. 8. On 10/18/23 at 10:35 a.m. this surveyor reviewed provider note located in Resident #39's EMR dated 3/21/23 that documented resident able to transfer with minimal assistance/contact guard Another Provider note dated 4/11/23 documented transfers improved today. PT attributes inconsistent transfers likely to post dialysis weakness. 9. On 10/18/23 at 10:45 a.m. this surveyor reviewed the care plan, including revisions since 3/7/23, and failed to locate any changes in transfer orders for Resident #39 making it unclear to staff on 7/9/23, if resident transfers should continue to utilize a stand lift or take post-dialysis weakness into consideration and use a Hoyer lift. Met with [NAME] Unit Manager and they were also unable to locate documentation that the care plan had been updated following the physical therapy assessment and recommendation on 3/7/23 or after. On 10/18/23 at 1:43 p.m. this surveyor met with the Director of Nursing and confirmed that the care plan had not been updated to reflect the changed recommendation from Therapy on or after 3/7/23.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48648 Based on record reviews, observations and interviews, the facility failed to develop and implement a safe discharge plan that focused on a resident's discharge goals, preparation, and effective transition of care for 5 out of 6 sampled residents discharged from the facility. (#25, #168, #268, #269 and #271) Findings: 1. On 10/16/23 at 9:30 a.m. a surveyor reviewed closed records for Resident #171 in response to a complaint received at the Department of Licensing and Certification on 8/3/22. Review found Resident #271 was admitted on [DATE] and discharged to home on 7/30/22. Discharge orders included orders for home health services. The medical record lacked evidence that home health services was located. Resident #271 was readmitted to acute care on 8/1/22 with sepsis. 2. On 10/16/23 at 9:50 a.m., a surveyor reviewed closed records for Resident #269 in response to a complaint received at the Department of Licensing Certification on 10/18/22. Review found Resident #269 was admitted on [DATE] and discharged to home on 10/3/22. Discharge orders included an order for home health services. The medical record lacked evidence that home health services were confirmed. Resident #259 medical record stated that on 10/2/22, Resident #269 refused to leave the facility when transportation arrived. Provider Note, dated 10/3/22, states Patient anxious about d/c (discharge) and unsure how (they) will do at home. And Pt (Patient) will need extensive help at home. Resident #269 was readmitted to acute care 10/3/22 following a fall at home. 3. On 10/16/23 at 10:12 a.m., a surveyor reviewed closed records for Resident #268 in response to a complaint received at the Department of Licensing and Certification on 1/12/23. Review found Resident #268 was admitted to facility on 12/15/22. Provider notes from the Emergency Department (ED) on 12/28/22 showed Resident #268 had a new vertebral compression fracture with increased pain limiting mobility. The facility failed to reevaluate the discharge plan following this new diagnosis and change in Resident #268's condition as requested by the family. The family initiated a discharge to the ED on 1/8/23 rather than follow the facility planned discharge to home. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 10/16/23 at 11:30 a.m., a surveyor observed Resident #168 sitting on the edge of the bed in room [ROOM NUMBER]. The residents had their belongings in a plastic bag and was wearing slipper socks and no shoes. In an interview, the resident stated that insurance ran out on Sunday (10/15/23) and they were ready to go home today. An Uber had been arranged for resident. The resident was observed being discharged into the rain with no shoes. When a surveyor brought this to the attention of the Administrator, a pair of slippers was provided to the resident. A surveyor observed the LPN reading the discharge plan to resident at the inside front entrance of facility as resident was leaving. After completion of discharge teaching, this surveyor asked the resident for confirmation that they understood what medications were ordered or what they needed to do once they got home. Resident stated no at which point the LPN lifted the rolling walker seat and reminded resident the list of medications was there and to call when they got home if they needed any new prescriptions. Spoke with facility Social Services following this discharge and Social Services confirmed home health services had been verified for this resident and Adult Protective Services would be notified because they did not consider this a safe discharge. 5. A surveyor observed notice that Resident #25 was listed on the dry erase board as a planned discharge to home on 10/18/23 with a neighbor providing transportation. On 10/18/23 at 10:55 a.m., a surveyor interviewed Resident #25 who stated that therapy thought they should stay but insurance said they were ready to go home. Resident #25 confirmed they live alone but have a neighbor who helps. Review of Resident #25's hospital discharge paperwork indicated that prior to admission at the facility, an assessment at the hospital found Resident #25 deemed unsafe to return home. On 10/18/23 at 11:23 a.m., a surveyor interviewed Social Services and confirmed that home health services were verified for Resident #25. When asked about the hospital documentation indicating it was unsafe for this resident to return home, I was told that Adult Protective Services would be notified. On 10/19/23 9:00 a.m., in an interview with the Director of Nursing regarding the discharges reviewed in response to complaints and the three discharges observed during survey; confirmed the facility was unable to provide documentation that these residents had a safe discharge.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48648 Based on record reviews and interviews, the facility failed to follow doctor's orders and their own Weight Policy & Procedure to document weights for 4 out of 4 residents (#6, #13, #26 and #53) with daily or weekly weight orders. Findings: 1. On 10/19/23 at 11:00 a.m a surveyor reviewed Resident #6 physician orders located in the Electronic Medical Record (EMR) and found an order dated 4/15/23 to obtain Daily Weights for a diagnosis of Congestive Heart Failure (CHF). Daily weights were not recorded for sampled months of 9/23 and 10/23. No documentation found with an explanation for the missing weights. 2. On 10/19/23 at 11:30 am a surveyor reviewed Resident #13 physician orders located in the EMR and found an order dated 4/19/23 one-time weekly weight, do every Monday for CHF. Weights were not recorded weekly for the months of 5/23, 6/23, 7/23 and 8/23. No documentation found with an explanation for the missing weights. 3. On 10/19/23 at 11:40 a.m., a surveyor reviewed Resident #53 orders located in the EMR and found an order dated 6/22/23 for weekly weights. Weekly weights were not done for sampled months of 8/23, 9/23 and 10/23. No documentation found with an explanation for the missing weights. 4. On 10/19/23 at 11:49 a.m., a surveyor reviewed Resident #26 care plan located in the EMR, dated 8/25/23 said to obtain weights per facility protocol. Review of facility Weight Policy & Procedure issued 06/2008 and revised 1/2023, states in Procedure #2. After initial weight, new admissions will be weighed weekly for the first 4 weeks. Procedure #5 Significant weight changes will have verification of weight for accuracy and documentation purposes. Review of Resident #26 documented weights in the EMR are: 8/16/23 - 95 pounds (Discharge Weight from [NAME] Hospital) 8/24/23 - 111.6 pounds (Admission weight at facility) 9/18/23-87.6 pounds 9/20/23-89.6 pounds 10/3/23-93.2 pounds No documentation found that showed the facility verified the admission weight when it was 16.6 pounds different from the discharge weight. No documentation that facility documented weekly weights for the first 4 weeks. No documentation in resident's EMR with an explanation for refusals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/19/23 at 12:14 p.m., in an interview with RN#1, surveyor and RN#1 were unable to locate ordered weights for Resident #6, #13 and #26. RN #1 stated that a CNA comes in at 6:00 a.m. to get the days weights and the nurse let's them know who needs a weight if it's not a normal monthly weight. They showed me the location of the monthly weight binder at the nurse's station. On 10/19/23 at 1:00 p.m., in an interview with RN #2, stated the weights can be entered by the CNA or the nurse. On 10/19/23 at 1:10 p.m., in an interview with Nurse Practioner #1 (NP#1) stated when asked that they sometimes must find the nurse to learn a resident's weight for daily or weekly weights. On 10/19/23 at 1:15 p.m., in an interview with Certified Nurse Aide (CNA #1) stated that CNAs get the weights, usually on night shift, and give them to the nurse who usually enters the weight into the EMR. On 10/19/23 at 2:14 p.m., in an interview with Director of Nursing stated she was surprised there was an issue with the weights. The faciliyt spoke with the CNA that comes in early to do weights and learned they did not know the CNA should document the weight beyond giving it to the nurse.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 37015 Based on observations, record reviews, and interviews, the facility failed to provide respiratory services as directed by physician orders related to oxygen use and monitoring for 2 of 2 residents reviewed for oxygen therapy (#51, #173). Findings: 1. On 10/16/23 at 11:16 a.m., a surveyor observed an oxygen concentrator set at 3 liters/minute in use next to Resident #51's bed. A review of the clinical record revealed a physician's order, dated 9/22/23, which stated Oxygen 2-5 liters per minute via nasal cannula as needed for shortness of breath. Indicate O2 (oxygen) saturation. A review of Resident #51's medication and treatment administration records found no documentation of when oxygen was in use or what the saturation levels were. 2. On 10/16/23 at 3:04 p.m., a surveyor observed an oxygen concentrator set at 1 liter/minute and in use next to Resident #173's bed. A review of the clinical record revealed a physician's order, dated 10/4/23, which stated Oxygen via nasal cannula, titrate to keep O2 saturation greater than 90% every shift. A review of Resident #173's medication and treatment administration records found no documentation of when oxygen was in use, what the saturation levels were, or when oxygen tubing was to be changed. On 10/18/23 at 10:15 a.m., in an interview with a surveyor, the Director of Nursing confirmed the findings.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48648 Based on observations, record reviews and interviews, the facility failed to provide food that accommodated resident preferences for 2 out of 3 residents (#3 and #13) sampled about the food choices available. Findings: On 10/17/23 at 11:30 a.m., in an interview with Resident #13, stated he/she has repeatedly asked for ice cream as a snack and hamburgers as a meal alternative and has not received them. Resident #13 stated their goal is to gain weight because they have lost a lot of weight and that is why they are at the facility. Resident #13 would like more sugar snacks like ice cream and cookies, but they never get them. Dessert is frequently fruit cocktail. On 10/17/23 at 12:00 p.m., a surveyor observed Resident #13 ask the [NAME] Unit Helper for some ice cream. This surveyor walked with the [NAME] Unit Helper to get some ice cream and met the Head Chef in the hallway. The [NAME] Unit Helper asked for ice cream for Resident #13 and was told ice cream is no longer stocked and they would have to go buy some at the store. At this time, a surveyor asked the Head Chef if a resident would be able to order a hamburger as a meal replacement. They stated yes, but not right away and it would be after meal service was finished. On 10/17/23 at 12:30 pm, in an interview with Resident #3 about the food and snacks they enjoy. Resident #3 stated ice cream and cakes. Resident #3 stated she did not enjoy the food at this facility. Resident #3 was unaware that ice cream was no longer available from the facility but stated they weren't surprised. At this time, a surveyor observed Resident #3 send her lunch back and ask for one of her soup cups to be warmed up instead. On 10/19/23 at 10:00 a.m., during an interview with Activity Director stated that residents complain about the snacks available. Oreos were given as an example of a snack that was no longer purchased but residents enjoy. The activities department purchases snacks for residents when they can and tries to offer beverages on the hydration cart that are not usually available. They stated food is very important to these residents and they try to offer activities around making and eating food. They were unaware that ice cream was no longer stocked for residents. On 10/19/23 at 10:14 a.m., a surveyor observed the resident freezer at the central nurse's station and found 9 personal tubs of ice cream that were labeled with residents name but no facility provided ice cream for resident's who do not have anyone to bring them outside food. On 10/19/23 at 2:45 p.m., in an interview with the Administrator about observations of a resident not being able to procure ice cream for a snack, the Administrator agreed this was a reasonable snack and they do provide ice cream but was unable to explain why the Head Chef stated there was no ice cream anymore, why no one went to buy the resident ice cream, or why they were not offered an alternative snack. The Administrator then stated they were trying to minimize the snacks so residents would eat their meals which would be a healthier option. The quality of the snacks and food in general has been a known issue and the facility meets with residents about the food and snacks available.