STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205072	A. BUILDING _____ B. WING _____	08/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MARSHWOOD CENTER	**33 ROGER STREET LEWISTON, ME 04240**

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 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** Based on interviews and record review, the facility failed to review and revise the care plan by an interdisciplinary team (IDT), that included, to the extent possible, participation of resident and/or his/her representative to review and revise the care plan after each assessment for 2 of 7 residents. (#5, #7) Findings: 1. On 8/17/2020 at 11:04 a.m., during an interview with an anonymous complainant, he/she said stated that there was zero communication between the facility and the family representative and a care plan meeting never occurred during his loved one's rehabilitation stating, we were supposed to have a family meeting, there was supposed to be a phone conference between the Doctor and the nurses to find out what's going on. They said we will meet and I never got a phone call. On 8/19/2020 during a review of Resident #5's medical record, which included the review of the Admission Minimum Data Set (MDS) assessment dated [DATE]. The medical record lacked evidence that a care plan meeting was held by the IDT that included, to the extent possible, participation of Resident #5 and/or his/her representative to review and revise the care plan. On 8/19/2020 at 11:59 a.m., in an interview with the Social Worker, she confirmed the IDT should've been completed stating, She (resident #5) was supposed to have one, I must have overlooked it. 2. On 8/19/2020 at 11:58 a.m., during a review of Resident #7's medical record, which included the review of MDS dated [DATE] . The medical record lacked evidence that a care plan meeting was held by the the IDT that included, to the extent possible participation Resident #7 and his/her representative to review and receives the care plan. On 8/20/2020 at 12:23 p.m., during a telephone conversation with the Administrator, a surveyor discussed lack of IDT meetings.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Observations, Interviews and Record Review the facility failed to implement the United States Centers for Disease Control's (CDC) and Centers for Medicare and Medicaid Services' (CMS) COVID-19 Long-Term Care (LTC) Facility guidelines related to screening of everyone entering the healthcare facility, failed to follow professional standards of practice with usage of Personal Protective Equipment (PPE) , failed to follow the facilities COVID-19 policy and procedures for active sreening of employees and visitors and failed to follow the facilities procedure on staff movement from COVID-Positive to COVID-Nave centers. This has the potential to affect all 69 residents in the facility. Findings: The United States Centers for Disease Control and Prevention (US CDC)'s Interim Infection Prevention and Control Recommendation for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 7/15/2020, indicated all facilities screen everyone (patients, HCP (Health Care Personnel), visitors) entering the healthcare facility for symptoms consistent with COVID-19 or exposure to others with [DIAGNOSES REDACTED]-CoV-2 infection and ensure they are [MEDICATION NAME] source control and actively take their temperature and document absence of symptoms consistent with COVID-19. Fever is either measured temperature 100.0F or subjective fever. Facilities Active screening process for all visitors, employees and medically necessary personnel. Effective July 21, 2020. Section: Review of screening logs for both visitors and employees. Page 12, #4 indicates The Center Executive Director will retain the daily screening forms for visitors and employees by month (i.e., in a binder or folder) until further notice. and Section: Staff movement from COVID-Positive to COVID-Nave centers. page 16, 2 indicates, All staff must wear facemask and eye protection at all times in the center, including non-patient-care areas. 1. On 8/18/2020 during a COVID-19 Focused Survey, the facility was unable to provide COVID-19 screening logs for visitors, employees or medically necessary personnel from 7/28/2020 through 8/15/2020. On 8/18/2020 at 10:48 a.m., in an interview with the Center Executive Director, she confirmed she had been shredding the screening records stating, I was reviewing them and make sure we had no issues with them and then getting rid of them. I had a huge stack and I guess maybe I needed to keep them. At this time she confirmed the facility had no documentation of the facility screening staff of COIVD-19 symptoms prior to working prior to 8/15/2020. 2. Facility Policy: Screening of Visitors and Employees, Return to work Guidance for Employees, and Employee Workers Comp Procedures dated July 20, 2020. Page 16, #2 All staff must wear facemask and eye protection at all times in the center, including in non-patient care areas. Facility Lobby Entrance Posting: Staff Must #2: Wear a mask & eye protection at all times. On 8/19/2020 at 1:35 p.m., Dietary staff #2 was observed, not wearing eye protection while sanitizing a dietary cart on the [MEDICAL CONDITION] Disease (COVID) unit. After surveyor intervention, she confirmed: I have to wear goggles and a mask at all times, I forget them, I do it all the time. However, without stopping she continued to spray down the dietary cart, once completed proceeded to pushed the dietary cart down the hall to the kitchen area. On 8/19/2020 at 1:59 p.m., a surveyor discussed dietary staff was not wearing appropriate PPE in the building with Center Executive Director

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.