STATEMENT OF DEFICIENCIES & PLAN OF CORRECTION **Biennial Survey**		Date Completed: 11/14/2023
Name of Facility: OSHER INN AT THE CEDARS Administrator: KATHARINE ONEILL ASSISTED LIVING PROGRAM Census: 26 Total Capacity: 30	Address: 650 OCEAN AVE PORTLAND, ME 04103-2704	
Summary Statement of Deficiencies	**Plan of Correction**	**Completion Date**

Osher Inn At The Cedars, an Assisted Living Program, is not in compliance with Regulations Governing the Licensing and Functioning of Assisted Housing Programs: Assisted Living Programs, Part of 10-144, Chapter 113.

The following requirements were not met:

10 CONSUMER RECORDS

10.2 Assessments and reassessments.

10.2.2 Reassessments shall be done at least every six (6) months thereafter, indicating the date of the reassessment and the signature of the assessor.

This has not been met as evidenced by:

Based on a review of resident records, the facility failed to complete reassessments every six (6) months.

Findings:
On 11/14/2023 the Surveyors reviewed three (3) resident files. Three (3) of three (3) resident files had reassessments not completed in a timely manner. The Surveyors determined the following (asterisks indicates gap greater than 6 months):

Resident #1's Assessments:

- 07/27/2023
- 12/06/2023*
- 06/23/2022
- 07/07/2021*

 Signature of Administrator: _____ Date: _____ CLS (Rev 9/2006)
(Signature binding on all 3 Biennial Survey page(s))

- 11/30/2020*

Resident #2's Assessments:

- 09/15/2023
- 03/20/2023
- 07/07/2021*
- 09/28/2020*

Resident #3's Assessments:

- 11/02/2023
- 04/03/2023*
- 06/11/2021*

The Surveyors reviewed the findings with the Nurse Manager and the Administrator during the survey on 11/14/2023.

The Surveyors discussed the findings again during the exit interview on 11/14/2023.

10.3 Service plans. A service plan shall be signed by the consumer or his/her legal representative. The plan authorizes the program to arrange for or to provide services. The service plan must be reviewed and revised as appropriate, but at least every six (6) months, unless changes occur. The plan must describe:

This has not been met as evidenced by:

Based on a review of resident records, the facility failed to complete service plans every six (6) months.

Findings:
On 11/14/2023 the Surveyors reviewed three (3) resident files.
Three (3) of three (3) resident files had service plans not completed

in a timely manner. The Surveyors determined the following (asterisks * indicates gap greater than 6 months):

Resident #1's Service Plans:

- 07/07/2021*
- 12/09/2020*

Resident #2's Service Plans:

- 09/15/2023
- 03/20/2023
- 07/23/2021*
- 03/19/2020*

Resident #3's Service Plans:

- 11/02/2023
- 04/03/2023*
- 06/11/2021*

The Surveyors reviewed the findings with the Nurse Manager and the Administrator during the survey on 11/14/2023.

The Surveyors discussed the findings again during the exit interview on 11/14/2023.