STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/07/2025

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ORONO COMMONS	117 BENNOCH RD ORONO, ME 04473

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F 000	INITIAL COMMENTS From 5/4/25 through 5/7/25, unannounced on-site visits were conducted at Orono Commons for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification and to investigate complaints #ME00051419, #ME00051160, #ME00050846, #ME00050375, #ME00050302, #ME00050010, #ME00048860 and #ME00048858. It is determined that Orono Commons is not in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000	Orono Commons provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The Plan of Correction is prepared and executed as evidence of the facility's continued compliance with State and Federal regulations.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 578	The code status for R60 was clarified with the resident and the physician order and advance directive were updated as indicated. The DON or designee will review all residents' code status order and advance directive, where applicable, to ensure they do not conflict and additional identified contradictions will be clarified with the resident and physician orders and advance directives will be updated as indicated. The DON or designee will provide education to licensed nurses on policy OPS422 Code Status Orders. The DON or designee will audit code status orders and advance directives, where applicable, weekly for four weeks then monthly for three months or until resolved to ensure they do not conflict and report findings at the monthly QAPI meeting.	6/9/2025

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

NHA 6/3/2025

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.

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F 578	Continued From page 1 (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a resident's right to formulate an advanced directive regarding code status (cardiopulmonary resuscitation [CPR]) was accurate in the clinical record for (Resident #60 [R60]). Finding: On 5/4/25 at 1:38 p.m., R60's clinical record was reviewed. R60's electronic record indicated "(Advanced Directives) DO NOT RESUSCITATE (DNR)" (Do not perform CPR). R60's paper chart contained a "Physicians Orders for Life Sustaining Treatment" (POLST) form indicating "Attempt Resuscitation/CPR". On 5/6/25 at 12:36 p.m., during an interview with a surveyor and an LPN, R60's electronic and	F 578		

paper charts were reviewed. LPN stated she was		

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F 578	Continued From page 2 unsure which directive was correct. At this time the surveyor confirmed R60's advance directive regarding code status had conflicting information.	F 578		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on the facility's policy, Reportable Incident Form review, and interview, the facility failed to	F 609	The events occurred in the past and cannot be corrected. The NHA or designee will review resident to resident altercations of current residents to ensure the facility policy for Abuse Prohibition was followed and that timely notifications were made to the State Agency and Adult Protective Services. The NHA or designee will provide education to licensed nurses on policy OPS300 Abuse Prohibition. The NHA or designee will audit resident to resident altercations for three months to ensure the facility policy for Abuse Prohibition was followed and that timely notification was made to the State Agency and Adult Protective Services and report findings at the monthly QAPI meeting.	6/9/2025

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F 609	Continued From page 3 notify the State Agencies (Division of Licensing and Certification [DLC]) and Adult Protective Services (APS) timely for an allegation of abuse for 1 of 3 facility reported incidents (9/16/24) reviewed during an annual survey. Finding: The facility's policy, "Abuse Prohibition", last reviewed 10/24/22, directed staff to "Report allegations to the appropriate state and local authority(s) involving neglect, exploitation or mistreatment (including injuries of unknown source), suspected criminal activity, and misappropriation of patient property within 24 hours if the event does not result in serious bodily injury." On 9/16/24, the State Agency - Division of Licensing and Certification (DLC), received a fax from the facility that included a Reportable Incident Form that alleged a resident to resident incident occurred on 9/12/24. The report indicated that the physician and Resident Representatives were notified of the incident on 9/12/24. On 5/5/25 at 12:25 p.m., during an interview with a surveyor, the Administrator stated that she reached out to APS and they have no record of receiving the initial report and she does not have evidence that one was sent to DLC. The surveyor confirmed that the initial report was not sent to the State Agencies timely at this time.	F 609		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination.	F 644	A PASARR screen was re-submitted for R18. The NHA or designee will review all residents for new diagnoses or significant change in conditions related to mental disorder or trauma and resubmit a PASARR screen as indicated. .	6/9/2025

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F 644	Continued From page 4 A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the State mental health authority for Pre-Admission Screening and Resident Review (PASRR) was notified after a resident was newly diagnosed and/or experienced symptoms related to a mental disorder or trauma event to determine if a change in level of service was required for 1 of 2 sampled residents reviewed for PASRR (Resident #18 [R18]). Finding: On 5/4/25, R18's clinical record was reviewed. R18's PASARR, completed on 2/15/22, did not require a level II determination. On 8/6/24, R18 was diagnosed with bipolar disorder, but the clinical record lacked evidence that the resident was referred to the State mental health authority	F 644	The NHA or designee will provide education to the social worker on policy SS105 Pre-admission Screening for Mental Disorder and or Intellectual Disability Patients. The NHA or designee will audit residents with new diagnoses and significant change in conditions related to mental disorder or trauma weekly for four weeks then monthly for three months or until resolved to ensure a PASARR screen is resubmitted as indicated as report findings at the monthly QAPI meeting	

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F 644	Continued From page 5 for a new PASARR determination. On 5/7/25 at 8:35 a.m., during an interview with a surveyor, the Administrator stated a new PASARR was submitted for R18 on 5/6/25. At this time a surveyor confirmed the facility failed to refer R18 for a PASARR after a new diagnosis and/or experienced symptoms related to a mental disorder.	F 644		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission.	F 655	The events occurred in the past and cannot be corrected. The DON or designee will review care plans of newly admitted residents and additionally identified missing care plans will be developed and implemented. The DON or designee will provide education to licensed nurses on policy OPS416 Person-Centered Care Plan. The DON or designee will audit care plans for newly admitted residents daily for 4 weeks then weekly for 3 months to ensure a baseline care plan was developed and implemented within 48 hours that includes the minimum healthcare information necessary to care for the resident and report findings at the monthly QAPI meeting.	6/9/2025

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F 655	Continued From page 6 (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical 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 properly care for 5 of 10 sampled residents (Resident #40 [R40], R166, R56, R50, and R60). Findings: 1. On 5/6/25 during a clinical record review for R40, admitted to the facility for skilled care. The clinical record shows that R40's baseline care plan was not implemented or developed to provide the instructions needed to provide minimum healthcare necessary to properly care for R40. On 5/6/25 at 11:30 a.m. during an interview with the Regional Marketing Advisor the surveyor confirmed that R40's baseline care plan was not	F 655		

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F 655	Continued From page 7 developed until 4 days after admission. 2. On 5/6/25 during a clinical record review for R166, admitted to the facility for skilled care. The clinical record shows that R166's baseline care plan was not implemented or developed to provide the instructions needed to provide minimum healthcare necessary to properly care for R166. On 5/6/25 at 3:45 p.m. during an interview with the Administrator the surveyor confirmed that R166's baseline care plan was not developed until 4 days after admission. 3. On 5/4/25, R56's clinical record was reviewed and indicated that R56 was admitted to the facility the last week of February 2025. R56's baseline care plan, which included problems, goals, and interventions, was not started until 3/5/25, greater than 48 hours after admission. On 5/6/25 at 8:23 a.m., during an interview with Market Clinical Advisor, a surveyor confirmed this finding. 4. On 5/6/25, R50's clinical record was reviewed and indicated that R50 was admitted to the facility in February 2025. The clinical record lacked evidence that R50's baseline care plan, which included problems, goals, and interventions, was developed and implemented within 48 hours of admission. On 5/6/25 at 2:13 p.m., during an interview with a surveyor, the Administrator, the Director of Nursing, and the Market Clinical Advisor, R50's clinical record reviewed. At this time a surveyor confirmed R50's baseline care plan was not completed with 48 hours of admission. 5. On 5/6/25, R60's clinical record was reviewed	F 655		

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F 655	Continued From page 8 and indicated that R60 was admitted to the facility in April 2025. The clinical record lacked evidence that R60's baseline care plan, which included problems, goals, and interventions, was developed and implemented within 48 hours of admission. On 5/6/25 at 2:13 p.m., during an interview with a surveyor, the Administrator, the Director of Nursing, and the Market Clinical Advisor, R60's clinical record reviewed. At this time a surveyor confirmed R60's baseline care plan was not completed with 48 hours of admission.	F 655		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews and interviews, the facility failed to follow physician orders for 4 of 20 residents reviewed. (Resident #40 [R40], R51, and R172). Findings: 1. On 5/6/25 at 8:00 a.m. during a clinical record review for R40 shows an order for Aspirin 81 milligrams (mg) by mouth twice a day for clot prevention. Review of R40's Medication	F 684	The events occurred in the past and cannot be corrected. All residents have the potential to be affected. The DON or designee will review medication and treatment records for the past 14 days to ensure medications, including insulin, were administered as ordered. Any omissions or insulin doses given outside of physician parameters will be reported to the physician for follow-up and appropriate action.	6/9/2025

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F 684	Continued From page 9 Administration Record (MAR) shows that R40 did not receive his/her bedtime dose as ordered. (this is a stock medication that was available but not given) R40 also had an order for Quetiapine 25 mg at bedtime, review of his/her MAR shows that this medication was not given as ordered. The facility has an Ekit (emergency kit) called Rx now that has medications available for use. This list included the Quetiapine 25 mg dose for R40 On 5/6/25 at 10:15 a.m. during an interview with the Director of Nursing (DON), and the Marketing Advisor the surveyor confirmed that Aspirin is a house stock medication and was not given to R40 as ordered and that the RX Now system had the dose of Quetiapine that was ordered for R40, and that this medication was not given to R40 as ordered. 2. On 5/6/25 at 2:17 p.m., during a clinical record review for R172, shows orders for atorvastatin 80 mg at bedtime, Calcium Carbonate 500 mg twice a day, Docusate 100 mg twice a day, Levetiracetam 500 mg twice a day, metformin 500 mg twice a day, Senna 8.6 mg twice a day, and Warfarin 3 mg at 5:00 p.m. The following medications are stock medications and were available but were not given to R172 as ordered; Calcium Carbonate 500 mg, Docusate 100 mg, Senna 8.6 mg. The following medications were listed on the medications available list for the RX Now and were available and were not given to R172 as ordered, Atorvastatin 80 mg, Levetiracetam 500 mg, metformin 500 mg and Warfarin 1 mg Review of R172's MAR showed that the above	F 684	The DON or designee will provide education to licensed nurse and medication technicians on following physician orders, administration of insulin following physician parameters, utilization of the emergency kit, and reporting medications not available to the physician for appropriate action. The DON or designee will audit medication and treatment administration records, including insulin administration, weekly for four weeks then monthly for three months or until resolved to ensure compliance with physician orders and report findings at the monthly QAPI meeting.	

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F 684	Continued From page 10 medications were on hold until arrival from pharmacy. On 5/06/25 at 2:09 p.m. During an interview with the Office Manager, R172's MARs were reviewed. The surveyor confirmed that the above medications were not given when they were available as stock medications and in the RX Now system. On 5/6/25 at 2:15 p.m. the above findings were reviewed with the DON and the Marketing Advisor, the surveyor, confirmed that the medications were not given to R40 and R172 as ordered when they were available as stock medications and in the RX Now system. 3. 4. On 5/6/25, clinical record review for R268 shows an order for "MS Contin Oral Tablet Extended Release 30 [milligrams (MG)] (Morphine Sulfate) Give 30mg by mouth every 8 hours for pain". Review of the admission assessment indicated R268 had an elevated heart rate and reported a pain level of 10 on a scale of 1 to 10 (1 being little to no pain and 10 is the worst pain imaginable). Review of R268's Medication Administration Record (MAR) shows that R268 did not receive morphine as ordered for pain (this is a stock medication that was available but not given). The facility has an Ekit (emergency kit) called RX Now that has medications available for use. The list of medications available in the Ekit include the Morphine ordered for R268. On 5/6/25 at 2:20 p.m. during an interview with the Director of Nursing (DON), the Marketing Advisor, and the Administrator, a surveyor	F 684		

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F 684	Continued From page 11 confirmed that the Morphine ordered for R268 is a house stock medication and was not given to R268 as ordered for pain. 4. On 5/7/25 R51's clinical record review indicated a physician order for "Basaglar KwikPen Subcutaneous Solution Pen-injector 100 UNIT/ [Milliliter (ML)] (Insulin Glargine) Inject 25 unit subcutaneously one time a day for diabetes Hold for [Blood Glucose (BG)] [less than(<)] 110". Review of the Medication Administration Record (MAR) and Treatment Authorization Record (TAR) revealed insulin was administered outside of parameters on 7 out of 30 days in the month of April (4/1/25, 4/3/25, 4/15/25, 4/16/25, 4/17/25, 4/22/25, and 4/25/25). On 5/7/25 at 9:33 a.m., during an interview with a surveyor, the Market Clinical Advisor confirmed with the surveyor that R51 received insulin on 4/1/25, 4/3/25, 4/15/25, 4/16/25, 4/17/25, 4/22/25, and 4/25/25 with a blood glucose result less than 110. At this time the surveyor confirmed that the physician's order to hold insulin for a blood glucose less than 110 was not followed.	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced	F 695	R165 had their respiratory rate, skin color, and breath sounds evaluated. The DON or designee will review residents with physician orders for oxygen therapy to identify those orders that may require supplementary clinical assessment. The DON or designee will provide education to licensed nurses on following physician orders as written, including supplemental clinical assessments related to oxygen therapy.	6/9/2025

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F 695	Continued From page 12 by: Based on record review and interviews, the facility failed to provide respiratory care as order by the Provider for 1of 3 residents that use oxygen. Resident #165 [R165]) Finding: On 5/6/25 during a clinical record review for R165, it was noted that R165 uses oxygen daily and has had an order change dated 5/1/25 for oxygen to be administered by nasal cannula (NC) at 2 liters/min every shift for maintaining peripheral oxygen saturation (SPO2) between 88-93% evaluate HR (heart rate), respiratory rate, pulse oximetry, skin color and breath sounds. R165's clinical record was reviewed and there is no evidence that this order was completed as ordered as there is no documentation showing that his/her respiratory rate, skin color and breath sounds were evaluated as ordered. On 5/06/25 at 2:46 p.m., during a clinical record review for R165 the surveyor confirmed with the Director of Nursing, the Administrator and the Clinical Market Advisor that there is no nursing documented evidence of R165's respiratory rate, skin color and breath sounds being evaluated every shift as ordered.	F 695	The DON or designee will audit the clinical record for residents receiving oxygen therapy weekly for four weeks then monthly for three months or until resolved to ensure that required supplementary clinical assessments are documented and report findings at the monthly QAPI meeting.	
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan,	F 697	The events occurred in the past and cannot be corrected. (DON) or designee will review residents with pain management orders to ensure whether other residents experienced delays in receiving prescribed pain medications.	6/9/2025

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F 697	Continued From page 13 and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide pain management in a timely manner for 2 of 2 residents reviewed for pain management (Resident #40 [R40] and R268). Due to this facility's failure, R268 experienced consistent, unrelieved pain resulting in the resident discharging Against Medical Advice (AMA) to seek pain control from an Emergency Room (ER). Findings: 1. On 5/6/25, a review of the clinical record for R268 revealed the following: -R268 was admitted on 11/19/24 for skilled therapy after a spinal surgery. -Review of the admission orders revealed an order for "MS Contin Oral Tablet Extended Release 30 [milligrams (MG)] (Morphine Sulfate) Give 30mg by mouth every 8 hours for pain", and "acetaminophen Tablet 325 MG (Acetaminophen) Give 2 tablet by mouth every 4 hours as needed for Mild Pain no more than 3 doses in 48 hours, notify physician/ advanced practice provider(APP). Do not exceed 3[grams(g)]/day. (standing order)". -Review of the admission assessment, dated 11/19/24 and completed by the Registered Nurse (RN) at 7:06 p.m., indicated R268 had an elevated heart rate, reported a "Pain score: 10" (on a scale of 1 to 10, with 1 meaning little to no pain and 10 is the worst pain imaginable), "vocal complaints of pain" and "resident unable to tolerate being still due to pain". The admission assessment also indicated "Mood is pleasant, no unwanted behaviors witnessed." The admission	F 697	The DON or designee will provide education to licensed nurses on assessment and timely pain control intervention. policy NSG227 Pain Management. The DON or designee will conduct resident interviews and audit medication administration records for pain management weekly for four weeks then monthly for three months or until resolved to ensure that residents received timely administration of pain management medications and report findings at the monthly QAPI meeting.	

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F 697	Continued From page 14 assessment provided no indication the facility provided R268 with any pain relieving treatment when R268 complained of severe pain. -Review of R268's Medication Administration Record (MAR) for 11/19/24 shows that R268 did not receive morphine or acetaminophen as ordered for pain (these are stock medications that were available but not given). -Review of nurse notes documented at 8:29 p.m. on 11/19/24, indicated that R268 was verbally angry about uncontrolled pain resulting in R268 signing out AMA to get pain control from the ER. The nursing notes provided no indication the facility provided R268 with any pain relieving treatment when R268 complained of severe pain on 11/19/24. The clinical record lacks evidence that R268 received pain medications as ordered (See F684) or any other interventions for severe pain. Review of the facility's Ekit (emergency kit) titled: RX Now revealed "Morphine Sulfate [extended release (Er)] 15 mg tablets MS Contin" available for use. On 5/06/25 at 2:20 p.m., during an interview with the Administrator, the Market Clinical Advisor, and the Director of Nursing, R268's clinical record was reviewed. The Administrator stated R268 arrived at 4:51 p.m., and left the building at 8:52 p.m., R268 had mistakenly been transported from the hospital to the pharmacy before arriving at the facility which contributed to the resident going so long without pain medication. The Administrator stated they did not have his medications available. The list of available medication in the facility's Ekit (emergency kit) titled: RX Now was reviewed. At this time a	F 697		

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surveyor confirmed the morphine was available in the facility's Ekit but not provided to R268, and there was no evidence that pain relieving interventions (pharmaceutical and non-pharmaceutical) were implemented for R268.

On 5/7/25 at 10:22 a.m., during an interview with a surveyor, a RN stated that the delay in pain medication on admission is a common problem. RN stated he was waiting for the prescriptions to be delivered from the pharmacy and did not know the medication was available in the Ekit stock. RN confirmed the provider was not notified of the uncontrolled pain or elevated heart rate, and was unable to identify non-pharmaceutical interventions implemented to treat R268's pain. At this time the surveyor confirmed with RN there was no evidence that pain relieving interventions (pharmaceutical and non-pharmaceutical) were implemented for R268's severe pain.

2. On 5/4/25 at 11:15 a.m. during an interview with R40, he/she stated their admission date was on 4/10/25 between 5:00 and 6:00 p.m., R40 stated that they were in pain and that no staff came in to see him/her. R40 stated that he/she had to leave their room to find staff late in the night per R40 and ask for pain medication. He/she found the charge nurse and reports that RN told them that there were no written scripts for the pain medications therefore would not be giving R40 any pain medications.

During a clinical record review on 5/4/25 the clinical record revealed that R40 arrived at the facility at 5:22 pm. and reported a pain level of 8 out of 10. The clinical record revealed that the resident was admitted for skilled care after a total hip replacement and had orders for pain

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F 697	Continued From page 16 management using the following medications: Acetaminophen 325 Milligrams (mg) 2 tablets for mild pain every 4 hours as needed, Cyclobenzaprine 10 mg every 8 hours as needed for muscle spasms and Hydromorphone 2 mg 1-2 tablets by mouth every 6 hours as needed for pain with a maximum daily dose of 12 mg. During a review of R40's Medication Administration Record (MAR), there was no documentation to indicate R40 received any pain medication until 11:37 p.m. and at that time R40's pain was documented at a level of 10, with 10 being severe pain. Based on the physician orders and discharge orders the resident was eligible to receive a dose of Acetaminophen 325 mg 2 tablets as needed, the last dose received was on 4/10/25 at 8:49 a.m. and was eligible to receive Hydromorphone 2 mg 1-2 tablets with the last dose received on 4/10/25 at 8:49 a.m. while at the hospital prior to discharge. On 5/6/25 during an interview with the Administrator, she stated that the facility has an Ekit (emergency kit) titled: RX Now. The RX Now list of available medications was not readily available in the nurses station and was found in the Providers office in a folder. Review of the RX Now medication list (Genesis Master Ekit contents list) revealed that the facility's RX Now (machine used in the facility as their emergency medication supply) showed the ordered medications for R40's pain control were available for use. On 5/6/25 at 8:09 a.m. The surveyor confirmed with the Administrator that R40 was admitted at 5:22 p.m. and per documentation on the	F 697		

CNA		

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F 697	Continued From page 17 admission checklist documents that R40's pain was 8/10 and that he/she should have been provided pain medications and that he/she was not provided with any pain medications until 11:37 p.m. almost 6 hours after reported pain at a level	F 697		
F 725 SS=F	of 8 out of 10 when admitted. Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:	F 725	All residents have the potential to be affected The facility ensures that they have staffing patterns in place that are sufficient to assure patient safety and attain or maintain the highest practicable physical,mental, and psychosocial well-being of each patient. This includes the ability to meet the plan of care of each resident, including care needs. Nursing leadership staff will be re-educated to this process. NHA or designee will audit the center staffing plan and complete random resident interviews weekly for four weeks then monthly for three months or until resolved to ensure that sufficient nursing staff is in place to meet the needs of residents and findings will be reported at the monthly QAPI meeting.	6/9/2025

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F 725	Continued From page 18 Based on Payroll Based Journal staffing (PBJ) report and interview, the facility failed to ensure sufficient direct care staff were scheduled and on duty to meet the needs of residents that reside in the facility for weekends of the first quarter 2025 (October 1 - December 31, 2024). Finding: A payroll based journal (PBJ) report for the first quarter of 2025 indicated the facility triggered for low weekend staffing. On 5/6/25 at 1:50 p.m., during an interview with the surveyor, the Administrator confirmed that the facility triggered for low weekend staffing for the first quarter per the PBJ report. The Administrator confirmed this finding and no additional information was provided to indicate that the PBJ information was incorrect which identified low weekend staffing.	F 725		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on interviews, observations, and two lunch meal test trays, the facility failed to serve hot foods at an appetizing and palpable	F 804	The events occurred in the past and cannot be corrected. All residents have the potential to be affected. The Food Service Director (FSD) or designee will provide education to dietary staff on HCSG Policy 006: Food Quality and Palatability.	6/9/2025

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F 804	Continued From page 19 temperature for 1 of 2 lunch trays tested on 5/5/25 and 5/6/25. Findings: On 5/4/25 between 10:15 a.m. and 11:30 a.m., during a facility initial tour, several residents stated to the surveyors that hot foods were served cold. On 05/5/25 at 12:45 p.m., two surveyors tested food temperatures on a lunch test tray at the end of lunch delivery service to the residents on the Riverview Unit. The following food temperatures were: Cubed chicken was 96.4 degrees Fahrenheit and had a taste sensation of cool to cold. Macaroni and cheese was 94.3 degrees Fahrenheit and had a taste sensation of cool to cold. Cubed potatoes were 96.6 degrees Fahrenheit and had a taste sensation of cool. On 5/6/25 at 1:10 p.m., after the second lunch meal tray was tested, in an interview with the surveyor, the District Manager of Health Services Group, confirmed that the hot foods temped on 5/5/25 were not served hot.	F 804	The FSD or designee will audit meal temperatures weekly for four weeks then monthly for three months or until resolved to ensure that hot foods are served at an appetizing and palatable temperature and report findings at the monthly QAPI meeting.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812	The dish machine was serviced to ensure it can reach required wash and rinse temperatures. An air gap was added to the ice machine. The kitchen floor was cleaned. The dented food can in dry storage was discarded. The thawing chicken was stored to prevent dripping and the dough stored underneath the thawed chicken was discarded. Foods not maintained at safe holding levels were discarded. Undated and outdated drinks were discarded.	6/9/2025

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F 812	Continued From page 20 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, and interviews, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety by not restraining hair with a hair net for 1 of 4 days of survey (5/4/25), ensuring the dishes were sanitized with regular monitoring of the dishwasher for 2 of 4 days of survey (5/4/25 and 5/5/25), not ensuring that plumbing fixtures were properly installed to prevent backflow as required by the Maine State Plumbing Code for 2 of 4 days of survey (5/4/25 and 5/5/25), not maintaining food temperatures to prevent food borne illness prior to serving residents for 1 of 4 days of survey (5/5/25), and not storing dishes in a sanitary manner for 2 of 4 days of survey (5/5/25 and 5/6/25), In addition, the facility failed to ensure that beverages were removed when outdated or failed to include an open date in 2 of 2 unit refrigerators (Homestead and Riverview). This has the potential to effect all residents in the facility. Findings:	F 812	The FSD or designee will review food preparation areas for cleanliness, dry storage for dented cans, and kitchen and unit refrigerators for undated/dated food and drink. The FSD or designee will provide education to dietary staff on HCSG policies: 016 Food Preparation, 017 Receiving, 019 Food Storage Cold Food, 022 Warewashing, 024 Staff Attire, and 028 Environment. The FSD or designee will audit dish washing temperatures, kitchen cleanliness, food storage, use of hair nets, holding temperatures for hot foods, and labeling and dating of food and drink weekly for four weeks then monthly for three months or until resolved to ensure adherence to applicable regulations and policies and report findings at the monthly QAPI meeting.	

1. On 5/4/25 at 10:20 a.m., during an initial tour of		

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F 812 Continued From page 21 F 812

the kitchen a surveyor observed Dietary Aide #1 (DA1) working within the kitchen without a hair restraint. DA1 sent several trays of dishes through the low temperature dishwasher. A surveyor and DA1 observed the wash cycle temperature was 95 degrees Fahrenheit (F), and the rinse cycle temperature was observed to be 100 degrees F (the minimum wash temperature should be 120 degrees F). DA1 stated he is not trained on how to test or monitor the dishwasher; he was only trained on how to change out the chemicals when they run low. A surveyor and DA1 reviewed the dishwasher logs. The dishwasher monitoring log had not been completed to ensure sanitation of resident's dishes for 8 out of 10 meals cycles (breakfast 5/1/25, 5/2/25, 5/3/25, and 5/4/25; lunch 5/2/25 and 5/3/25; dinner 5/2/25and 5/3/25). These findings were observed and confirmed with DA1 at the time of the observations.

On 5/425 at 10:45 a.m., during an initial tour of the kitchen, a surveyor observed and confirmed the following with Cook1 at the time of the observations:
-the air gap under the ice machine was less than 1 inch, in violation of the 10-114 State of Maine Rules Chapter 226, definition Section A, which defines an Air-Gap Separation - A physical separation between the free-flowing discharge end of a potable water supply pipeline and an open or non-pressure receiving vessel. An
air-gap separation shall be at least twice the diameter of the supply pipe measured vertically above the overflow rim of the vessel - in no case less than one inch (2.54 cm).

- Cook1 was working in the kitchen, and a hair restraint was not used to restrain his facial hair.

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F 812	Continued From page 22 -The kitchen floor was observed to be soiled with accumulations of food debris not associated with the current meal preparation. Cook1 stated they monitor temperatures of food, refrigerators and freezers, and chemical levels of cleaning solutions but do not have a cleaning schedule currently established. -Observation of the dry food storage revealed a 4 pound can of Light Tuna in water chunks, salt added, dented in on the top seal, on the shelf and available for use. On 5/4/25 at 11:00 a.m., a surveyor observed in the walk-in refrigerator, bags of thawing cooked chicken stored on a large tray. The bags extended beyond the ends of the tray allowing the runoff from the bags to drip onto the tray below. On the tray below the thawing chicken were large round balls of dough with plastic wrap partially covering the dough. At this time a surveyor observed and confirmed with Cook2 that thawing chicken was stacked in a manner that allowed runoff to drip onto the dough below. On 5/4/25 at 11:05 a.m., a surveyor observed 2 Dietary Aides entered the kitchen wearing hats (baseball cap style); both aides had facial hair and large amounts of hair protruded out from under their hats unrestrained by a hair restraint. This observation was observed and confirmed by a surveyor with Dietary Aide #2 and Dietary Aide #3 at the time of the observation. A surveyor also confirmed this finding with Cook #1 at 11:08a. On 5/5/25 at 8:02 a.m., a surveyor observed and confirmed the following with the District Manager for Health Services Group (DM): -the air gap under the ice machine was less than 1 inch, in violation of the 10-114 State of Maine	F 812		

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F 812	Continued From page 23 Rules Chapter 226, definition Section A, which defines an Air-Gap Separation - A physical separation between the free-flowing discharge end of a potable water supply pipeline and an open or non-pressure receiving vessel. An air-gap separation shall be at least twice the diameter of the supply pipe measured vertically above the overflow rim of the vessel - in no case less than one inch (2.54 cm). The DM was able to manipulate the pipe into the correct position and stated the support was missing a screw. -the dishwasher wash cycle was observed to be 85 degrees F, the rinse cycle was observed to be 90 degrees F. The interior water temperature was 90 degrees F. The water was lukewarm to touch. -the floor by dishwasher was observed to have standing water and exposed concrete creating an uncleanable surface. On 5/5/25 at 11:20 a.m., a surveyor observed wet stacking of serving pans next to the steam table, and serving spoons stored in uncovered bins next to the steam table. The bins containing the serving spoons were observed to have food debris accumulated within the bins. These findings were observed and confirmed with DM at the time of the observation. On 5/5/25 at 11:34 a.m., a surveyor observed Cook 2 check holding temperatures on the steam table. The chicken was 120 degrees F (Minimum safe holding temperature for hot foods is 135 degrees Fahrenheit), Cook 2 turned up the temperature on the first bay of the steam table. The diced potato was 128 degrees F, at that time the second bay of the steam table was observed to be off, Cook 2 turned on the second bay of the steam table. At this time a surveyor confirmed	F 812		

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F 812	Continued From page 24 with Cook 2 that the chicken and potatoes were not maintained at a safe holding temperature. On 5/6/25 at 9:47 a.m., during an interview with the DM, a surveyor observed in the walk-in refrigerator, a 75 count box of Mighty Shakes, approximately 1/2 full of vanilla flavored shake containers. The box was dated "4/23". The DM stated 4/23 is the date the facility received the box, but DM is unable to determined when the box was placed in the refrigerator (Mighty Shakes are good for 7 days after thawing). A second box of Mighty Shales was observed unopened and undated, DM stated the second box was moved from the freezer to refrigerator this morning (5/6/25). 2. On 5/4/25 at 12:00 p.m., a surveyor observed in the Homestead Unit Refrigerator the following: 3 cartons of thickened beverage with directions to discard 7 days after opening. The dates written on the cartons were older than 7 days from 5/4/25; 1 individual glass of poured juice with a date of 4/27 on the cover; 2 individual glasses of poured juice with a date of 4/28 on the cover; and 2 pitchers of juice with a date of 4/26/25. On 5/4/25 at 12:20 p.m., during an interview with a surveyor, Cook stated that the individual poured glasses of juice were good for 3 days. Cook also stated that the dates written on the cartons were the dates that the kitchen received the item and was not the date the product was opened. The surveyor confirmed that these were either not dated or were expired but were in the refrigerator, available for use. Cook removed the items.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORONO COMMONS	117 BENNOCH RD ORONO, ME 04473

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 812 Continued From page 25

On 5/5/25 at 9:35 a.m., a surveyor observed an open carton of Thickened Orange Juice with no open date in the Homestead Unit Refrigerator.

On 5/05/25 at 11:45 a.m., a surveyor observed a Mighty Shake that was thawed with no written date in the Riverview Unit Refrigerator. The directions on the carton are to use within 14 days of thawing. On 12:55 p.m., during an interview with the District Manager of Health Services Group, a surveyor reviewed yesterday's observations that the cartons of thickened beverages are not being dated when opened, and that the thickened beverages are only good for 7 days after opening. She stated that the practice is to date them when they are received by the kitchen. She also stated that the juices in cups are good for 3 days. The surveyor also reported that there was a Mighty Shake currently in the Riverview Unit Refrigerator that was thawed with no date with directions to discard 14 days after thawing. On 5/05/25 1:08 p.m., the surveyor observed the Mighty Shake was still in the Riverview Unit Refrigerator and confirmed with Certified Nursing Assistant that the mighty shake was thawed with no open date and he discarded the carton.

F 812