



March 25, 2024

Ms. Celine Donohue, RN, Long Term Care Supervisor  
Maine Department of Health and Human Services  
Division of Licensing and Certification  
11 State House Station  
Augusta, Maine 04333-0011

Dear Ms. Donohue:

In follow up to the recent complaint survey at Sandy River Center conducted on March 4, 2024, please accept the attached Plan of Correction submission. All alleged deficiencies will be corrected by April 10, 2024.

Please do not hesitate to contact me with any follow up questions at 207-779-6591 x 2205.

Sincerely,



Joanne M. Shaw, LNHA  
Administrator, Sandy River Center

Department of Health and Human Services

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|-----------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>205069</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>03/04/2024</b> |
|-----------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**SANDY RIVER CENTER**

**119 LIVERMORE FALLS RD  
FARMINGTON, ME 04938**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X5)<br>COMPLETE<br>DATE |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|
| T 001                    | <b>Initial Comments</b><br><br>On 3/4/24, an unannounced on-site visit was conducted at Sandy River Center for the purpose of complaint investigation #ME00046565 and #ME00046580. It was determined that Sandy River Center is not in substantial compliance with 10-144 Chapter 110-Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | T 001               | Sandy River 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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4/10/24                  |
| T 222                    | <b>9.A.4. Minimum Staffing Rules</b><br><br>The nursing staff-to-resident ratio is the number of nursing staff to the number of occupied beds. Nursing assistants in training shall not be counted in the ratios.<br><br>The minimum nursing staff-to-resident ratio shall not be less than the following:<br><br>a. On the day shift, one direct-care provider for every 5 residents;<br>b. On the evening shift, one direct-care provider for every 10 residents; and<br>c. On the night shift, one direct-care provider for every 15 residents<br><br>The definition of direct care providers and direct care is found in Chapter 1 of these Regulations.<br><br><br><br><br><br><br><br><br><br>This Regulation is not met as evidenced by: Based on review of staffing schedules, the resident census, and interviews, the facility failed to assure staffing minimums were met on all units | T 222               | The facility will continue to schedule direct care staff to meet the care needs of the residents. This includes meeting the State of Maine staffing ratio minimums (Day Shift 1 staff:5 residents, Evening Shift 1staff:10 residents. Night Shift 1 staff: 15 residents). The days that staff call out sick, on-call nursing staff will be available to cover direct care staff shifts to meet the needs of the facility while meeting the staff-to-resident ratios outlined for State of Maine minimum staffing requirements. The facility will also utilize non nursing staff, including Activities, Ancillary, and Managerial, to assist in tasks that are within their scope of practice, to adjunct the needs of residents.<br><br><br><br><br><br><br><br><br><br>The facility secures sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related |                          |

Department of Health and Human Services

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

38GJ11

If continuation sheet 1 of 2

Department of Health and Human Services

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>205069</b>                      | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>03/04/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SANDY RIVER CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>119 LIVERMORE FALLS RD<br/>FARMINGTON, ME 04938</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                    |
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| T 222                                                         | <p>Continued From page 1</p> <p>in accordance with the "State of Maine Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities," Chapter 9.A.4.A., between 2/18/24 through 3/2/24, 5 of 14 days reviewed for staffing.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>On 2/18/24, the facility census was 80 which would require 16 direct care staff on duty during the day shift. The facility had 14 direct care staff on the floor for the dayshift.</li> <li>On 2/19/24, the facility census was 80 which would require 16 direct care staff on duty during the day shift. The facility had 15 direct care staff on the floor for the day shift.</li> <li>On 2/25/24, the facility census was 79 which would require 16 direct care staff on duty during the day shift. The facility had 14 direct care staff on the floor for the day shift.</li> <li>On 2/27/24, the facility census was 82 which would require 17 direct care staff on duty during the day shift. The facility had 15 direct care staff on the floor for the day shift.</li> <li>On 3/2/24, the facility census was 81 which would require 17 direct care staff on duty during the day shift. The facility had 15 direct care staff on the floor for the day shift.</li> </ol> <p>On 3/5/24 at 2:00 p.m., a surveyor confirmed the above findings with the Director of Nursing, that certain shifts on 5 out of 14 days were not staffed correctly to meet state minimum staffing ratios.</p> | T 222                                                                                           | <p>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. The minimum nursing staff-to-resident ratio shall not be less than the following:</p> <p>On the day shift, one direct-care provider for every 5 residents, on the evening shift, one direct-care provider for every 10 residents, and on the night shift, one direct-care provider for every 15 residents.</p> <p>The DON/Designee will audit staffing sheets daily to validate sufficient direct care staff are scheduled to meet the needs of the residents and the State of Maine minimum nursing staff-to-resident ratios. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.</p> |                                                                    |