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	1961	A. BUILDING: _____ B. WING _____	05/21/2024

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P 000	Initial Comments On 5/19/24 through 5/21/24, onsite visits were made at Orono Commons, for the purpose of completing the state relicensure survey. It was determined that Orono Commons was not in substantial compliance with 10/144, Chapter 113-Regulations Governing the Licensing and Functioning of Assistive Housing Programs-Level IV, Private Non-Medical Institutions.	P 000		
P 060	3.25.3.6 Licensing The following shall be appended to the contract and made a part thereof: This Regulation is not met as evidenced by: Based on record reviews the facility failed to provide appendices listed in the contract to residents who were admitted to the facility. Finding: On 5/20/24 during record reviews and a review of a provided copy of the contract given to residents on admission. The facility has the following appendices listed on the contract. Appendix A: Admission policy, Appendix B: Your Rights, and Appendix C: Grievance Policy The contracts in the residents clinical record did not have the above appendices attached, the facility was not able to provide those appendices to a surveyor. On 5/20/24 during an interview with the Residential care Director a surveyor confirmed that the contracts did not include the above appendices.	P 060		

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P 304	Continued From page 1	P 304		
P 304	7.1.2 Medications and Treatments No injectable medications may be administered by an unlicensed person, with the exception of bee sting kits and insulin. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that an injectable medication (exclusive of bee sting kits and insulin), was not administered by an unlicensed person, for 1 of 1 resident receiving the medication Trulicity. (Resident #2) Finding: Review of Resident #2's clinical record noted a diagnosis of Diabetes Mellitus. The physician's orders included an order, dated 2/23/24, for Trulicity 0.75 mg/0.5 ml (milligrams per milliliter) subcutaneous every week. The order did not include whether a Certified Residential Medication Aide's (CRMA) could administer the medication nor any additional instructions of when to hold the medication, monitoring of side effects, or symptoms to report to the provider. The manufacturer's prescribing information stated Trulicity (generic name dulaglutide) is a "glucagon-like peptide-1 (GLP-1) receptor agonist used in the treatment of diabetes and stimulates glucose-dependent insulin secretion and reduces glucagon secretion. Trulicity is a non-insulin option that helps the body release the insulin it's already making." On 5/20/24 at approximately 10:00 a.m., in an interview with a surveyor, the CRMA stated they have been administering this medication to Resident #2 because they were told they were	P 304		

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P 304	Continued From page 2 able to administer this medication, review of the medication administration record provides evidence that the CRMA's have been administering this medication	P 304		
P 306	7.1.4 Medications and Treatments Unlicensed assistive personnel must be trained by a registered professional nurse in regard to the management of persons with diabetes. The registered professional nurse must provide in-service training and documentation to include: [Class III] This STANDARD is not met as evidenced by: Based on personnel file reviews and interview, the facility failed to provide documented evidence that 2 of 4 Certified Residential Medication Aide's (CRMA's) received annual diabetes management training (CRMA #2, CRMA #4), Findings: On 5/20/24 during the review of CRMA #2's personnel file, there is no evidence that they received their annual diabetes management training. On 5/20/24 during the review of CRMA #4's personnel file, there is no evidence that they received their annual diabetes management training.	P 306		

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P 306	Continued From page 3 On 5/20/24 at 2:05 p.m., during an interview with the Director of Nursing, the surveyor confirmed that CRMA #2 and #4 have not had their annual diabetes training.	P 306		
P 361	7.14 Medications and Treatments Breathing apparatus. When the facility assists a resident with a hand-held bronchodilator, metered dose nebulizers, intermittent positive pressure breathing machine or oxygen machine, there shall be documentation of the following: This STANDARD is not met as evidenced by: Based on personnel file reviews and interview, the facility failed to provide the necessary training to assist residents in the use of Oxygen therapy and Continuous Positive airway Pressure therapy (CPAP). for 3 of 4 Certified Residential Medication Aide's (CRMA's) (CRMA #1, #3, #4) in addition the facility failed to have complete orders for the use of oxygen and the CPAP for 1 of 3 residents reviewed (Resident #3) Findings: On 5/20/24 during the review of CRMA #1's personnel file, there is no evidence that they received their in-service on how to use any type of breathing apparatus. On 5/20/24 during the review of CRMA #3's personnel file, there is no evidence that they received their in-service on how to use any type of breathing apparatus. On 5/20/24 during the review of CRMA #4's	P 361		

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P 361	Continued From page 4 personnel file, there is no evidence that they received their in-service on how to use any type of breathing apparatus. On 5/20/24 during a clinical record review for Resident #3 there is no evidence that there is an active order for the use of oxygen. On 5/20/24 at 2:05 p.m., during an interview with the Director of Nursing, the surveyor confirmed that CRMA #1, #3 and #4 have not had their in-service on how to use any type of breathing apparatus and that Resident #3 did not have an active order for the use of oxygen.	P 361		
P 443	11.1.1.12 Administrative and Resident Records Current diagnoses and/or physical or mental disabilities and instructions as to any special care required; This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to have a residents current diagnosis and/or mental disabilities with any special instructions to provide care for 1 of 3 sampled residents (Resident #2) Finding: During a record review for Resident #2, his/her physician orders and summary sheets did not have any diagnosis listed, on the physician order sheet it is documented as diagnosis not specified. On 5/20/24 at approximately 10:00 a.m. during an interview with the Residential Care Director the surveyor confirmed the above finding.	P 443		

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P 454	Continued From page 5	P 454		
P 454	11.1.4 Administrative and Resident Records Administrative and Resident Records Individual records required. Information pertaining to a resident's stay shall be centralized in an individual record, containing the following, where applicable: Written and dated orders signed by a duly authorized licensed practitioner for all treatments, medications and special diets. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to have written orders signed by a duly authorized licensed practitioner for a special diet in the resident's record for 1 of 3 sampled residents (Resident #2). Finding: Resident #2's clinical record contained a physician's order, signed, and dated 2/16/24, that did not include a diet order. A Dietary slip that was on Resident #2's lunch meal tray, has the diet listed as a 2 gram no added salt diet. There was no evidence in the residents clinical record of a written diet order signed by a duly authorized licensed practitioner, for this special diet to be administered. On 5/20/24 at 2:05 p.m., during an interview with the Director of Nursing, the surveyor confirmed Resident #2 did not a physician's order for the 2 gram no added salt diet that was being provided to Resident #2.	P 454		

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P 479	Continued From page 6	P 479		
P 479	12.2 Standards for Resident Care Resident assessment. Residents shall be assessed within thirty (30) calendar days of admission and reassessed annually or if there is a significant change in a resident's condition, using the state approved Resident Assessment Instrument (RAI) or other assessment or assessment process as required by the agency providing the MaineCare funds, to determine their abilities and need for services. The resident and resident's legal representative, as well as staff or other persons approved by the resident or resident's legal representative who are knowledgeable about the resident, shall participate in or be consulted concerning the assessment. The areas identified below are to be assessed. The listing of these areas is not meant to exclude assessment of any other obvious needs which the residents may exhibit. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a Resident Assessment was completed, within thirty calendar days of admission for 1 of 3 sampled residents (Resident #2) and that an annual resident assessment was completed timely for 1 of 3 sampled residents (Resident #1). Finding: Resident #2's "face sheet" indicated the resident had been admitted on 2/16/24. The resident's clinical record lacked evidence that the Resident Assessment was completed within 30 days of admission.	P 479		

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P 479	Continued From page 7 During a clinical record review for Resident #1, his/her annual assessment was due to be completed on 4/22/24. The clinical record lacked evidence that the annual assessment was completed and as of 5/20/24 it is 29 days overdue for completion. On 5/20/24 at 2:05 p.m., during an interview with the Director of Nursing, the surveyor confirmed Resident #2 did not have a completed admission assessment within 30 days of admission and as of this date the assessment is not completed and that the assessment for Resident #1 has not been completed making it late.	P 479		
P 494	12.3 Standards for Resident Care Service plan: A service plan shall be developed and implemented within thirty (30) calendar days of admission for each resident based upon the findings of the resident assessment instrument (RAI). The plan shall address those areas in which the resident needs encouragement, assistance or an intervention strategy. The resident, his/her legal representative (if applicable) and others chosen by the resident shall be actively involved in the development of the service plan, unless he/she is unable or unwilling to participate. There shall be documentation in the resident's record identifying who participated in the development of the service plan. The service plan shall describe strategies and approaches to meet the resident's needs, names of who will arrange and/or deliver services, when and how often services will be provided and goals to improve or maintain the resident's level of functioning. Residents shall be encouraged to be as independent as possible in	P 494		

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P 494	Continued From page 8 their functioning, including ADLs and IADL's if they choose, unless contraindicated by the resident's duly authorized licensed practitioner. The service plan shall be modified, as necessary, based upon identified changes. Residents shall never be required to perform activities specified in the residential service plan or any other activities and cannot be used to replace paid staff. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the Service Plans were updated and complete to reflect the residents current needs. For 3 of 3 residents reviewed (Resident #1, #2 and #3) Findings: During an Observation and interview with Resident #1, he/she was in their room and a Continuous Positive airway pressure machine (CPAP) was observed on his/her bedside table. When Resident #1 was asked about their CPAP he/she stated they use it every night. Documentation in Resident#1's clinical record did not indicate they used a CPAP, and their service plan did not reflect the use of the CPAP. During record review for Resident #2 their service plan was not complete. The service plan did not include strategies and approaches to meet the residents' needs, names of who will arrange and or deliver services, when and how often services will be provided and goals to improve or maintain the resident's level of functioning.	P 494		

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P 494	Continued From page 9 During an observation and interview with Resident #3, he/she was observed using an oxygen concentrator with a setting of 2 liters per minute using a nasal cannula. He/she stated they use oxygen all the time and when he/she leaves their room and goes to dialysis three times a week they use a portable oxygen tank. Upon review of the service plan the service plan did not include strategies and approaches to meet the resident's needs, names of who will arrange and or deliver services, when and how often services will be provided and goals to improve or maintain the resident's level of functioning. Resident #3 always uses oxygen and goes to dialysis outside of the facility three times a week and this is not addressed in the service plan. On 5/20/24 at 2:05 p.m., during an interview with the Director of Nursing, the surveyor confirmed the above findings.	P 494		
P 521	13.5 Staffing Employee records. Facilities must maintain individual records on all related and unrelated employees. Records shall contain the initial date of employment, date of birth, home address and telephone number, experience and qualifications, social security number, copy of current occupational license (if applicable), references and reference check information, job description, record of participation in in-service, orientation or other training programs, results of annual personnel evaluations, disciplinary actions, illness and injury records and date of and reason for termination. Records may be computerized.	P 521		

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P 521	Continued From page 10 This STANDARD is not met as evidenced by: Based on review of annual evaluations and interview, the facility failed to complete an annual performance evaluation for nurse aides at least every 12 months for 2 of 4 sampled Certified Residential Medication Aide's (CRMA) employed greater than a year (CRMA #1, #2 and #3) Findings: On 5/20/24 personnel files were reviewed CRMA #1 was hired on 7/23/2019, There was no evidence that an annual performance evaluation was completed. CRMA #2 was hired on 8/11/1997, the last evaluation was completed on 11/2/21. There was no evidence that an annual performance evaluation was completed. CRMA #3 was hired on 9/14/1999, the last evaluation was completed on 11/15/21. There was no evidence that an annual performance evaluation was completed. On 5/20/24 at 2:05 p.m., during an interview with the surveyor, the Director of Nursing (DON) stated she was unable to find any annual performance evaluations completed for the above-mentioned CRMA'S.	P 521		
P 532	13.9 Staffing Registered nurse services. Each facility shall retain a registered nurse, either on staff (other	P 532		

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P 532	Continued From page 11 than the Administrator) or on a contractual basis, to provide the following services: This STANDARD is not met as evidenced by: Based on record reviews and interview the facility failed to provide Registered Nurse Services to observe residents signs and symptoms, review resident records for completeness and accuracy, to review medication records, review medication administration practices and procedures, review therapeutic diets and to recommend staff trainings as required in the regulation 13.9. Finding: During clinical record review for Resident #1, #2 and #3 there was no documentation that a Registered Nurse was reviewing Sections 13.9.1 through 13.9.7 of this regulation on a quarterly basis as required by this regulation. On 5/20/24 at approximately 2:00 p.m. during an interview with the Nurse Manager/Residential care director who spoke with the Director of Nursing, the facility has not had a Registered Nurse (RN) Consultant in a long while. They were not able to tell this surveyor when the last RN consultant reports or reviews were completed. The surveyor confirmed this finding at the time of the interview.	P 532		