STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 000	INITIAL COMMENTS From 3/3/25 through 3/5/25 on-site visits were conducted at Market Square for the purpose of an annual Recertification Survey and investigating complaints #ME00048175, #ME00047524, #ME00046927, #ME00046122, #ME00045684. It was determined that Market Square was not in substantial compliance with 42 CFR 483, Sub-part B Requirements for Long Term Care Facilities.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure accommodations were made for a resident to include the facility's bathing schedule and resident preferences for 1 of 3 residents reviewed for activities of daily living (Resident #7). Finding: On 3/4/25 at 9:30 a.m., during an interview, Resident #7 stated that he/she wants to and is supposed to get a shower twice a week, on Sundays and Wednesdays. But due to staffing, he/she no longer gets a shower consistently. He/she stated that staff will come in and tell him/her that he/she will be getting a bed bath instead.	F 558		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 558	Continued From page 1 On 3/4/25 at 9:40 a.m., observation of the weekly shower schedule indicated Resident #7 was to receive a shower on Sunday and Wednesday early evenings. On 3/4/25 at 9:48 a.m., in an interview and review of Resident 7's February 2025 bathing documentation, the Quality Improvement Specialist(QIS) confirmed that Resident #7's bathing documentation lacked evidence that he/she received showers on 2/5/25, 2/9/25, 2/12/25, 2/23/25 and 2/26/25. The QIS additionally confirmed that there was no documentation of the resident refusing and full bed baths were given instead of the showers.	F 558		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 584	Continued From page 2 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable environment on 3 of 3 units (Andrews East, Andrews West and Tuttle) for 1 of 1 facility tour. Findings: On 3/5/25 from 8:30 a.m. to 9:15 a.m., a surveyor conducted an Environmental Tour with the Environmental Services Director and the Quality Improvement Specialist, in which the following findings were observed: Andrews East > There was an EZ sit-to-stand patient lift, in the	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 584	Continued From page 3	F 584		

hallway by Room 6, that had food debris and dirt in the foot base area.
> Resident Room 4 - The wall behind bed 2 had chipped/missing paint and was marred with black marks. The base board heater front cover was off at the end of the bed exposing heating elements. Resident #32's grabber/reacher was coated with a thick brown substance on the grabber part and the entire handle.
> Resident Room 7 - The room was very cold and without heat. The base board heater was broken apart and laying on the floor.
> Resident Room 10 - A bedpan was stored on the toilet. There was a foam pad on the shower floor.

Andrews West
> Resident Room 26 - The room entrance door and the bathroom door were gouged/marked gouged and had untreated putty on many areas creating uncleanable surfaces.
> Resident Room 27 - The room entrance door was marred and chipped/gouged creating an uncleanable surface.
> Resident Room 28 - The room entrance door was marred and chipped/gouged creating an uncleanable surface.

Tuttle
> Resident Room 32 - The walls behind the beds were scuffed/marred with black marks and the entire floor was soiled with dirt and debris.
> Resident Room 35 - The privacy curtains had missing hooks, were hanging down and in disrepair. The caulking around the base of the toilet was dirty.
> Resident Room 36 - The caulking around the base of the toilet was dirty. The bathroom exhaust fan was dusty. The inside the bathroom

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 584	Continued From page 4 doors had chipped/missing paint. The privacy curtain was missing hooks, hanging down and in disrepair. The bathrooms walls were marred/marked with black marks. > Resident Room 43 - An EZ sit-to-stand patient lift, stored in Room 43, had food debris and dirt debris in the base area. The privacy curtains were missing hooks, hanging down and in disrepair. The caulking around the base of the toilet was dirty. > Resident Room 44 - The privacy curtains were missing hooks, hanging down and in disrepair. > Resident Room 46 - There was a urine hat on the bathroom floor. On 3/5/25 at 9:15 a.m., in an interview, the Environmental Services Director and the Quality Improvement Specialist confirmed the findings.	F 584		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a	F 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 625	Continued From page 5	F 625		

resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to issue a bed hold notice which included the daily bed hold cost, to a resident, known family member and/or legal representative for 3 of 3 sampled residents who had been transferred to the hospital (Residents #7, #66, and #69).

Findings:

1. Resident #7's clinical record revealed the resident was transferred to an acute care hospital on 5/23/24 and subsequently admitted. The clinical record lacked evidence that Resident #7 and/or the resident representative were provided with a written bed hold notices upon transfer.

2. Resident #69's clinical record revealed the resident was transferred to an acute care hospital on 10/08/24 and subsequently admitted. The clinical record lacked evidence that Resident #69 and/or the resident representative were provided with a written bed hold notices upon transfer.

3. Documentation in Resident #66's clinical record indicated that he/she transferred to an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 625	Continued From page 6 acute care hospital on 1/18/25 and subsequently admitted. The clinical record contained no evidence that the facility issued a bed hold notice to the resident, a family member, or legal representative upon transfer. On 3/3/25 at 4:13 p.m., the above was confirmed with the Director of Social Services.	F 625		
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. (ii) Meets the requirements set forth in paragraph	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 655	Continued From page 7	F 655		

(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 interviews, record review, and facility policy, 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 care for 3 of 25 care plans reviewed (Resident's (R)4, R55, and R67).

Findings:

Review of policy "48 Hour Baseline Care Plan" dated 10/18 states "a baseline care plan will be created within 48 hours of admission. Based on the admission assessment, physician orders and resident preferences a care plan will be created to facilitate a smooth transition of care and to provide effective, person care plan."

1. Resident (R55) was admitted in February of 2023.
Review of R55's admission assessment dated 2/17/25 states: "Smoking Status" If a current

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 655	Continued From page 8 smoker, fill out the NCA LTC Smoking Risk : current every day smoker. Review of R55's baseline care plan, dated 2/24/25, lacked evidence that a care plan was initiated in the area of smoking on admission. During an interview on 3/3/25 at 4:10 pm the above was confirmed with Quality Improvement Specialist. 2. Resident #67 was recently admitted to the facility. A review of the nursing assessments, dated 2/11/25 for "Resident Smoking Screen" and a "Resident Smoking Contract" state he/she can smoke unsupervised. As of 3/3/25 the residents' care plan lacked interventions and goals relating to smoking. On 3/3/25 at 4:01 p.m., the above was discussed with the Quality Improvement Specialists 3. Resident #4 was admitted in February 2025 and has diagnoses to include Stage 4 sacral pressure ulcer. On 3/5/25 between 9:54-10:20 a.m., during an observation, LPN #1 and Certified Nursing Assistant (CNA) #3 placed a wedge pillow under the left and right sides of Resident #4's back and a wedge pillow under his/her bilateral lower extremities. At this time, CNA #3 stated Resident #4 is turned and repositioned every 2 hours and that 3 positioning wedges are used, 1 for his/her ankles and 2 for his/her back.	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 655	Continued From page 9 Review of Resident #4's baseline care plan states, "Impaired skin integrity secondary to pressure ulcer ...Offload pressure points... Apply bolstered pillows to BLE [bilateral lower extremities] to prevent rotating" and lacked evidence of the use of additional positioning wedges. During an interview on 3/4/25 at 2:20 p.m., Licensed Practical Nurse (LPN) # 5 stated Resident #4 is positioned every 2 hours, using 4 to 6 wedge pillows to support her back and legs. During an interview on 3/5/25 at 2:51 p.m., the finding was reviewed with the Administrator and the Regional Quality Improvement Specialist.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 656	Continued From page 10 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record reviews, interviews, and facility policy the facility failed to update/implement goals and interventions for diuretic and anticoagulant medication use for 1 of 1 resident reviewed for (Resident #11). Findings: Review of policy "Comprehensive Person-Centered Care Planning" dated 1/19 states: "The facility must develop and implement	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 656	Continued From page 11 person-centered care plan for each resident, which includes measurable objectives and timeframe's to meet a resident's medical, nursing, ... needs identified in the comprehensive assessment evaluation." Review of Resident #11 (R11) active medication orders, dated March 2025 revealed: - order with start date of 4/27/24 for anticoagulant "Eliquis 5mg tablet two times daily for atrial fibrillation" - order with start date of 11/30/24 for diuretic "Lasix 20 mg tablet 1 time daily for atrial fibrillation." Review of R11's care plan, updated 11/15/24, lacked evidence that goals and interventions were put into place for the use of diuretic and anticoagulant medications. On 3/4/25 10:15 a.m., Dduring a review of R11's care plan with Quality Improvement Specialist (QIP) and 2 surveyors, QIP confirmed R11 care plan lacked goals and interventions for diuretic and anticoagulant use. At this time QIP stated there should definitely be goals and interventions for above medications.	F 656		
F 684 SS=D	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	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 684	Continued From page 12	F 684		

care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and interview, the facility failed to ensure physician orders were followed for 1 of 2 sampled residents for (Resident #67).

Finding:

On 3/3/25 Resident #67's clinical record was reviewed and included several physician orders for wound care instructing nursing to:

Right shoulder: Cleanse with Vashe solution soaked gauze applied to wound bed and left in place for 5 minutes. Apply skin prep spray to periwound. Apply Kaltostat to high draining areas (center of wound bed). Apply generous amount of Medihoney to rest of wound bed. Cover with fluffed dry gauze to fill the wound cavity. Cover with dry gauze and ABD (abdominal pad). Secure with Hypafix tape Change daily and PRN (as needed).

Anterior neck: Cleanse with Vashe solution soaked gauze applied to wound bed and left in place for 5 minutes. Apply skin prep spray to periwound. Apply Medihoney and moist gauze to wound. Apply dry gauze to cover. Secure with Hypafix tape Change daily and PRN.

Lateral neck: Cleanse with Vashe solution soaked gauze applied to wound bed and left in place for 5 minutes. Apply skin prep spray to periwound. Apply Medihoney and moist gauze to wound. Apply dry gauze to cover. Secure with Hypafix tape Change daily and PRN.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 684	Continued From page 13 The physician orders lack current orders for wound management for the left shoulder wound. On 3/3/25 from 9:36 a.m., through 10:05 a.m., a surveyor observed the Licensed Practical Nurse (LPN #1) perform Resident #67's wound dressing changes. The LPN #1, after cleansing the right shoulder wound, she applied skin prep to the periwound and then medi-honey to the wound bed. She then applied Kaltostat over the medi honey. Next, she applied a gauzed soaked in normal saline over the kaltostat then the ABD(Abdominal) pad and secured with the tape. On the anterior neck, lateral neck and left shoulder wound sites, after cleansing the wound beds on each wound she applied skin prep to the periwounds, with each wound she applied medi-honey to a Mepilix dressing then applied the dressing to the wound. On 3/3/25 at 10:05 a.m., during an interview, the LPN confirmed the failure to follow the providers orders for the right shoulder, anterior and lateral neck wounds and the lack of a wound order for the left shoulder.	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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 695	Continued From page 14	F 695		

by:
Based on observations, record review, and interviews, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to respiratory care for 1 of 1 resident reviewed for respiratory care (Resident #29).

Finding:

Resident #29 has diagnoses to chronic obstructive pulmonary disease (COPD).

On 3/3/25 at 11:31 a.m. and 3/4/25 at 1:49 p.m., a surveyor observed Resident #29's, unbagged nasal cannula tubing, draped on top of the oxygen concentrator located next to the bed, with the nasal cannula prongs in direct contact with the surface of the oxygen concentrator. An empty plastic storage bag was observed tied to the nightstand drawer handle.

Review of Resident #29's clinical record revealed an active order, dated 2/10/25, for "Change tubing one time weekly ...change all oxygen tubing ..." and an active order, dated 2/10/25 for "Clean/store oxygen tubing not in use ...Place in plastic bag when not in use."

Review of Resident #29's care plan, dated 2/10/25, revealed, "Change oxygen tubing weekly; label and date..."

On 3/4/25 at 2:00 p.m., in an interview, the Certified Nursing Assistant (CNA) #1 stated when oxygen tubing is not in use, it is stored in one of the respiratory bags attached to the oxygen concentrator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 695	Continued From page 15 On 3/4/25 at 2:10 p.m., in an interview, Licensed Practical Nurse (LPN) #4 confirmed that Resident #29's unbagged nasal cannula tubing was draped over his/her oxygen concentrator tubing and stated oxygen tubing is supposed to be stored in the storage bag when oxygen not in use. On 3/4/25 at 2:38 p.m., the finding was reviewed with the Regional Quality Improvement Specialist.	F 695		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 755	Continued From page 16	F 755		

reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure that two people who are authorized to administer medications signed the Shift Count page indicating that they counted all controlled substances at the change of shift for 2 of 2 units reviewed for medication storage (East and West Units).

Findings:

1. Review of East Wing Med Cart Controlled Substance Log on 3/5/24 at 11:55 a.m., revealed the following:
- No outgoing signature on 3/1/25 at 6:30 a.m., 3/2/25 at 6:30 a.m., 2/14/25, 2/21/24, 1/24/25, 1/20/25, 12/23/24, 12/30/24, at 7:00 a.m., 1/23/25 at 6:30 a.m., 1/18/15 at 5:00 a.m., 1/7/25 at 8:00 a.m., or 12/26/24 unknown time.
- No incoming signature on 2/13/25 at 7:00 a.m., 1/27/24 at 11:30 p.m., or 12/24/24 at 11:15 p.m.,

2. Review of East Wind Treatment Cart Controlled Substance Long on 3/5/25 at 12:30 p.m., revealed:
-no incoming signature on 1/29/25 at 11:00 p.m.
-no outgoing signature on 1/15/25 at 7:15 p.m., 11:00 p.m., 2/2/25 11:00 p.m, 2/7/25 no time noted.

3. Review of West Wing Controlled Substance Log revealed:
-No outgoing signature on 2/20/25 at 11:00 p.m.,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 755	Continued From page 17 2/24/25 at 6:30 a.m., 2/27/25 8:00 a.m., undated at 8:00 a.m., 3/2/25 7:00 a.m., 2/6/25 at 8:00 a.m., 2/8/25 at 8:00 a.m., 2/9/25 at 800 a.m. 2/11/25 at 7:00 a.m., 2/13/25 at 6:30 a.m., 2/14/25 at 7:00 a.m., 2/15/25 7:00 a.m., 2/18/25 at 8:00 p.m. -No incoming signature on 2/19/25 at 9:00 p.m. During an interview on 3/5/25 at 11:58 a.m., Certified Nursing Assistant-Medication Technician (CNA-M)1 stated that she had received education on the importance of signing the controlled substance log at each shift change, but doesn't always make sure the person shes relieving signs it, but will in there future. During an interview on 3/5/25 at 12:30 p.m., CNA-M2 stated that she had received education to include the importance of signing the controlled medication log after count at each shift change and anytime the keys are transferred to another person. During an interview on 2/5/25 at 12:35 p.m. Licensed Practical Nurse (LPN)2 stated that during shift change, and after controlled medication count the incoming and outgoing staff are supposed to sign the count book. During an interview on 3/5/25 at 12:15 p.m. the above was confirmed with Quality Improvement Specialist.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 758	Continued From page 18	F 758		

processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 758	Continued From page 19 §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure an as needed (prn) psychotropic medication met the required 14-day limit for 2 of 6 residents reviewed for psychotropic medications (Resident #4 and #67). Findings: 1. Resident #4's medical record contained a provider order, dated 2/13/25, for Diazepam 5 mg (milligram) tablet PRN(as needed) every 8 hours for muscle spasms, with no stop date. The medical record lacked evidence of clinical rational to continue the medication. On 3/5/25 at 2:17 p.m., the above was confirmed with the Assistant Director of Nursing 2. Resident #67's medical record contained a provider order, dated 2/11/25, for Lorazepam 1 mg (milligram) tablet Oral as Needed One Time for anxiety disorder prior to wound change, with no stop date. The medical record lacked evidence of clinical rational to continue the medication. On 3/5/25 at 1:16 p.m., the above was discussed with the Quality Improvement Specialist.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 761	Continued From page 20 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure medications including treatments were stored properly for 2 of 3 days of survey (3/3/25 and 3/4/25). Additionally, the facility failed to obtain physician orders for medications located at a resident's bedside, for 1 of 1 sampled resident (Resident #322). Findings: Review of Facility Policy "Self-Administration of Medications," dated 5/2018, states, " ...residents	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 761	Continued From page 21	F 761		

who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team [IDT] has determined that the practice would be safe ...and there is a prescriber's order to self-administer ...an assessment is conducted by the IDT ...the results of the IDT assessment ...are recorded ...on the care plan ..."

Review of policy, "Specific Medication Administration Procedures," dated 5/2018, states, "...administer medication and remain with resident while medication is swallowed...Do not leave medications at bedside..."

During observations on 3/3/25 at 10:27 a.m. and 3/4/25 at 9:55 a.m., a 0.5 fluid ounce bottle of thera tears lubricant eye drops was observed in a plastic cup on Resident #322's over-the-bed table. Additionally, a 1 fluid ounce bottle of Top Care Nasal Spray (oxymetazoline hydrochloride 0.05% nasal decongestant) and a 0.38 fluid ounce bottle of Fluticasone propionate 50mcg(microgram) per spray nasal spray was observed on Resident #322's tv stand.

Review of Resident #322's clinical record lacked evidence of a physician order for the thera tears, Top Care nasal spray, and the fluticasone nasal spray and lacked evidence of an order to self-administer. Further review of the clinical record lacked evidence of an IDT assessment.

On 3/4/25 at 3:27 p.m., a surveyor and Licensed Practical Nurse #1 observed the thera tears, Top Care nasal spray, and fluticasone nasal spray at Resident #322's bedside. Additionally, a surveyor observed a clear medication cup containing approximately 30ml (milliliter) yellow liquid was on his/her tv stand. At this time, LPN #1 stated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 761	Continued From page 22 liquid was Lactulose given earlier today and that Resident #322 probably refused the medication. At this time, LPN #1 stated medications should not be left at bedside and stated she was not aware Resident #322 had medications in his/her room. On 3/5/25 at 8:36 a.m., the findings were discussed with the Regional Quality Improvement Specialist.	F 761		
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 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 ensure the kitchen was maintained in a clean and sanitary manner for floors, the food disposal unit, a wall mounted fan,	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 23	F 812		

and a plunger. Additionally, the facility failed to ensure foods were sealed, labeled, dated and/or discarded if past use by date in a reach-in freezer, in a walk-in refrigerator, a unit kitchenette refrigerator and in a dry storage room for 2 of 2 kitchen/kitchenette tours for 1 of 1 day of survey (3/3/25).

Findings:

The facility's Food Storage policy and procedure dated 2023 noted: 13. Refrigerated food storage: f. All foods should be covered, labeled and dated and routinely monitored to assure that foods (including leftovers) will be consumed by their use by dates, or frozen(where applicable) or discarded. 14. Frozen foods: c. All foods should be covered, labeled and dated. All foods will be checked to assure that foods will be consumed by their use by dates or discarded.

1. On 3/3/25 from 8:40 a.m. to 9:40 a.m., a surveyor conducted a kitchen tour with the Food Service Director in which the following findings were observed:
> The kitchen floor was dirty with food debris and trash around entire floor and under the equipment and shelving.
> The dish room food disposal unit had dried food and dried liquid residue on it.
> The dish room wall mounted fan was heavily soiled with dust.
> There was a plunger with dried food and liquid residue on it laying on the dish room floor.
> The dry storage room had 7, one liter boxes of Apple Juice Blend base with a best if used by date of February 23, 2025. There was also 19, one quart containers of Med Plus 2.0 Nutritional Drink with a best if used by date of February 28,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 24 2025. There were 5 bags of cornflakes that were not labeled. > The walk-in refrigerator cement floor had food and dirt debris on it and was missing areas of paint/sealant. > The walk-in freezer cement floor had food and dirt debris on it and was missing areas of paint/sealant. There was 1 package of hot dogs and 3 packages of buns that were not dated or labeled. > The storage room cement floor was dirty and was missing areas of paint/sealant. On 3/3/25 at 9:40 a.m.; in an interview, the Food Service Director confirmed the findings. 2. On 3/3/25 at 10:15 a.m., a surveyor observed the refrigerator kitchenette for Andrews East and Andrews West to contain a one liter box of Apple juice blend base with best used by February 23, 2025 and a 1 quart container of Med plus 2.0 butter pecan nutritional drink with best used by February 28, 2025. There was also an undated and unmarked 2 quart container of cereal on top of the refrigerator. On 3/3/25 at 10:21 a.m., in an interview, Registered Nurse,(RN #1) confirmed the findings.	F 812		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 842	Continued From page 25 to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 842	Continued From page 26 (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure that a clinical record contained complete and accurate documentation for 2 of 2 residents reviewed for smoking (Resident's #55 #67), and for 2 of 5 residents reviewed for medication review (Resident #45 and #55). Findings: 1. On 3/3/25 at 9:16 a.m., during an interview, Resident #67, stated he/she smokes cigarettes independently outside approximately 4-5 times a day and he/she stores the lighter and cigarettes in his/her room. A review of the nursing assessment dated 2/11/25 for "Resident Smoking Screen" states, "Resident smoking status based upon above information is: Non-smoker, Supervised smoker or	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 842	Continued From page 27 Unsupervised" neither of the 3 choices listed are checked. The section stating, "Include in nursing care plan & interdisciplinary resident care plan. 30 day assessment: Resident can smoke unsupervised" has "yes" checked. A review of the "Resident Smoking Contract" states, "I have read and understand the resident smoking policy. Please check one of the following: For the safety of myself and others, I agree to keep my cigarettes and lighter at the nurses station. I understand failure to comply could result in loss of smoking privileges and/or discharge from the facility. I am responsible to keep my cigarettes and lighters safe in my room period I understand not all residents are permitted to have lighters and agree not to give cigarettes and/or a lighter to any other resident. I do not agree to follow or abide by the resident smoking policy and wish to be discharged from the facility." Further review showed the resident had initialed all three choices above. On 3/3/25 at 4:01 p.m., the above was discussed with the Quality Improvement Specialists, who confirmed the screening and the contract were not completed accurately. 2. Review of R45's active orders for March 2025 revealed the following: -Order with start date of 11/11/24 for "elopement alarm three times daily: Expiration date: Wander	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 842	Continued From page 28	F 842		

Guard Placement" Review of clinical record revealed:
"3/1/25: Nurse Day Shit: Wander Guard Placement: "LW" There is no documentation as to where the wander guard is placed. Nurse Evening Shift: "KL" Wander Guard Placement: "KL" There is no documentation as to where the wander guard I placed. Nurse Evening Shift: "CB" Expiration Date: 3012025; Wander Guard Placement: "CB" There is no evidence as to where the wander guard is placed.

-3/2/25: Nurse Day Shit: Wander Guard Placement: "LW" There is no documentation as to where the wander guard is placed. Nurse Evening Shift "KL." There is no documentation as to where the wander guard is placed; Nurse Night Shift: Wander Guard Placement: "EF" There is no documentation as to where the wander guard is placed. Expiration Date: 627.

-3/3/25: Nurse Day Shift: Wander Guard Placement: "BR" There is no documented evidence as to where the wander guard is placed. Nurse Evening shift: Wander Guard Placement: "BR" There is no documented evidence as to where the wander guard is placed. Nurse Night Shift: Wander Guard Placement: "CB" Expiration Date: 3032025.

-3/4/25: Nurse Day Shift: Wander Guard Placement: "BR" There is no documented evidence as to where the wander guard is placed. Nurse Evening shift: "BR" There is no documented evidence as to where the wander guard is placed. Nurse Night shift: Wander Guard placement: "AT" Expiration Date: 2026."

During an interview on 3/5/25 at 4:45 p.m., the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 842	Continued From page 29	F 842		

Director of Nursing and Assistant Director of Nursing confirmed the facility was not appropriately documenting the monitoring of R45's wander guard.

3. Review of Resident (R)45 active orders for March 2025 revealed:

-Order with start date of 8/5/24 for constipation medication "Miralax 17 gram oral powder packet (1 packet) powder in packet (EA) oral. One time daily for repeated falls."
-Order with start date of 3/2/25 for constipation medication "senna 8.6 mg tablet (1 tab) oral one time daily for repeated falls."
-Order with start date of 2/8/25 for sleep medication "melatonin 3 mg tablet (1 tab) Oral one time daily for diagnosis exempt."
-Order with start date of 2/8/25 for "Muscle Rub 15%-10% topical cream (1) cream (gram) topical two times daily for diagnoses exempt."

During a review of R45's clinical record on 3/4/25 at 1:49 p.m., with Quality Improvement Specialist, the above was confirmed.

4.. R55 was admitted with diagnoses to include COPD.

Review of R55 active orders for March 2025 revealed order with start date of 3/3/325 for "oxygen-see notes 1 time weekly: change oxygen tubing weekly." Further review of R55's clinical record lacked evidence that an order was obtained for oxygen use.
During an interview on 3/3/25 at 3:55 p.m., the above was confirmed with the Quality Improvement Specialist.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 842	Continued From page 30	F 842		

5. During an interview on 3/3/25 at 12:20 p.m., Resident #55 stated that she is a long time smoker and smokes at least 2 cigarettes per day, and smokes independently.

Review of R55's clinical record revealed Resident Smoking Screen: Market Square Health Care Center: dated 2/17/25, Resident Smoking contract dated 2/17/25 states: Please check on the following: For the safety of myself and others, I agree to keep my cigarettes' and lighter.

Review of R55's admission Minimum Data Set (MDS) dated 5/14/25; section J1300: Current tobacco use: Yes
A review of the "Resident Smoking Contract" dated 2/17/25 states, "I have read and understand the resident smoking policy. Please check one of the following:

For the safety of myself and others, I agree to keep my cigarettes and lighter at the nurse's station. I understand failure to comply could result in loss of smoking privileges and/or discharge from the facility.

I am responsible for keeping my cigarettes and lighters safe in my room period. I understand not all residents are permitted to have lighters and agree not to give cigarettes and/or a lighter to any other resident.

I do not agree to follow or abide by the resident smoking policy and wish to be discharged from the facility."
Further review showed the resident had initialed all three choices above.

On 3/3/25 at 4:01 p.m., the above was discussed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 842	Continued From page 31 with the Quality Improvement Specialists, who confirmed the screening, and the contract were not completed accurately.	F 842		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 880	Continued From page 32 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain an Infection Control Program designed to help prevent the development and transmission of disease and infection relating to Legionella and failed to implement the elements of the Legionella Water Management Program.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 880	Continued From page 33	F 880		

This has the potential to affect all 68 residents.
Findings:

1. The facility's Legionella Water Management Program revised on 1/9/25, under "Control Measures" states, "Various control measures are in place to ensure a healthy water management program. Please refer to Appendix A of the water management program for a description of where controls are located." "Monitoring" states, monitoring provides data for determining whether a water system is operating within the parameters needed to control the growth of Legionella. Please refer to Appendix A of the water management program for the description of how monitoring will be conducted. Market Square receives its water from Maine Water ... Maine Water uses a Total Chlorine system so the facility will use a Total Chlorine testing kit to take water samples. The following equipment will be part of the preventative maintenance schedule. Ice machine and Floor scrubbing machine." "Appendix C: Preventative Maintenance Schedule to see a schedule of equipment that will be serviced as part of the preventative maintenance program."

Review of the entire "Legionella Water Management Program" lacked evidence of an Appendix A or Appendix C. In addition, Review of the "Appendix B: Water Management Monitoring Spreadsheet" lacks evidence of either the Ice machine or the Floor scrubbing machine monitoring and/or samples.

On 3/5/25 at 8:10 a.m., during an interview, the Quality Improvement Specialists confirmed the facility is not following its own Legionella Water Management policy, by not having measures in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. BUILDING _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET SQUARE HEALTH CARE CENTER, LLC	3 MARKET SQUARE SOUTH PARIS, ME 04281

(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 880	Continued From page 34 place to control the introduction of, assess and monitor areas where Legionella and opportunist waterborne pathogen can grow and spread and a diagram where these measures are applied. 2. During an observation on 3/4/25 at 9:00 a.m, Certified Nursing Assistant-Medication Tech (CNA-M) #2 took Resident #121's blood pressure with a reusable wrist cuff. CNA-M # 2 then used a manual blood pressure cuff and stethoscope to take Resident #121's blood pressure on his/her left arm, and after removing the manual cuff, CNA-M #2 draped the blood pressure cuff and stethoscope around her neck. At 9:05 a.m., CNA-M#2 exited the room and placed the wrist cuff in the top drawer of the medication cart without sanitizing it and hung the manual cuff and stethoscope off the back of the medication cart, without sanitizing it. At this time, CNA-M #2 stated the blood pressure cuffs and stethoscope are for multi-patient use and that she should have wiped the equipment down before placing it in the medication cart and that she should not have placed the manual cuff and stethoscope around her neck. On 3/4/25 at 10:15 a.m., the above findings were discussed with the Regional Quality Improvement Specialist.	F 880		