STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205069	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY RIVER CENTER	**119 LIVERMORE FALLS RD FARMINGTON, ME 04938**

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F 000	INITIAL COMMENTS On 7/10/23, 7/11/23, and 7/20/23, unannounced visits were conducted at Sandy River Center for the purpose of completing the investigation for complaints #ME00044087 and #ME00044270. It was determined that Sandy River Center was not in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
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 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to administer physician ordered medications to 1 of 2 sampled residents (Resident #2). Finding: On 7/10/23 and 7/11/23, Resident #2's clinical record was reviewed which included Medication/Treatment Administration Records and Nursing Progress notes for May and June 2023. The following were observed: On 5/3/23 at 08:21 a.m., it was documented that an anti-depressant medication, Duloxetine HCl	F 684		

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

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F 684	Continued From page 1 Oral Capsule Delayed Release Particles 40 milligrams (MG) was not given because the medication was on order. On 5/4/23 at 5:31 p.m., it was documented that an anti-depressant medication, Duloxetine HCl Oral Capsule Delayed Release Particles 40 MG was not given because the medication was not available. On 5/6/23 at 10:40 a.m., it was documented that an anti-depressant medication, Duloxetine HCl Oral Capsule Delayed Release Particles 40 MG was not given because the medication was on order from pharmacy. On 5/8/23 at 8:59 a.m., it was documented that an anti-depressant medication, Duloxetine HCl Oral Capsule Delayed Release Particles 40 MG was not given because the medication was on order. On 5/26/23 at 3:56 p.m., it was documented that a anticoagulant medication used to prevent strokes or blood clots, Apixaban (Eliquis) 5 MG was not given because it was on order. On 5/26/23 at 3:58 p.m., it was documented that a medication used to treat high cholesterol, Atorvastatin 80 MG was not given because it was on order. On 6/11/23 at 3:28 p.m., it was documented that an anti-psychotic medication, Seroquel (Quetiapine Fumarate) 25 MG was not given because it was on order. On 6/15/23 at 8:50 a.m., it was documented that an anti-depressant medication, Duloxetine HCl	F 684		

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F 684	Continued From page 2 Oral Capsule Delayed Release Particles 40 MG was not given because it was on order. On 6/16/23 at 9:42 a.m., it was documented that an anti-depressant medication, Duloxetine HCl Oral Capsule Delayed Release Particles 40 MG was not given because it was on order. On 6/16//23 at 5:02 p.m., it was documented that a medication used to treat high cholesterol, Atorvastatin 80 MG was not given because it was on order. On 6/19/23 at 8:12 p.m., it was documented that a medication used to treat diabetes, Basaglar KwickPen Solution insulin (Lantus) was not given because it was on order. On 7/11/23 between 11:30 a.m. - 12:00 p.m., during an interview with a surveyor, the Director of Nursing stated that some of those medications are included in the Emergency Stock (OMNIcell) Inventory and should have been gotten from there. A list was provided to the surveyor and upon review the following medications listed above were included in the Emergency stock: Lantus insulin, Eliquis 5 MG, Quetiapine Fumarate 25 MG and Atorvastatin 80 MG. The Consultant Pharmacist was also present and information was provided that indicated that a delivery of Duloxetine 20 MG was received on 4/24/23. The surveyor confirmed that medications were not administered as ordered by the physician.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		

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F 689	Continued From page 3 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to re-evaluate a resident for an elopement risk and removed a physician ordered wander guard bracelet for 1 of 1 residents reviewed that attempted elopement (Resident #2). Finding: On 7/10/23, a surveyor reviewed Resident #2's clinical record. The electronic record included a progress note, dated 5/14/23 at 10:54 a.m. written by Licensed Practical Nurse (LPN) #1 that indicated, "at around 7:30 a.m., pt (resident) attempted to elope from facility stating he/she was going home. Per previous shift nurse, Resident has not been taking medications in the evenings for a few days. Wander guard placed for safety." LPN #1 left notification for the Medical Provider. Included in the paper chart was a "Provider Notification" for Resident #2 with a message "attempting to elope.....please eval." It was also written by LPN #1 that a "wander guard" was placed and family was notified. This was signed by the Family Nurse Practitioner (FNP) on 5/15/23, with the response "OK".	F 689		

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F 689	Continued From page 4 On 7/11/23 at 7:30 a.m., during an interview with a surveyor regarding Resident #2's attempted elopement May 14th (Sunday), the Family Nurse Practitioner (FNP) stated that the window was open in the common area and Resident #2 was at it. Staff redirected Resident #2 and then the resident kept rolling up to the front door. A wander guard was placed on him/her at that time and notified the family regarding his/her behaviors. The FNP stated that she did some medication adjustments also. On 7/11/23 at approximately 8:00 a.m., the surveyor asked the Director of Nursing (DON) about an elopement care plan or an elopement assessment after this incident, neither of which the surveyor could find. The surveyor showed the DON the "Provider Notification" that indicated that the wander guard had been placed after Resident #2 attempted to leave. The DON stated that there was a wander (guard) bracelet placed on Resident but she talked about it with others on (5/15/23) Monday and removed it because she felt she wasn't an elopement risk. The surveyor explained to the DON that there were no notes/assessment completed that indicated that Resident #2 was not an elopement risk after this incident and no order to discontinue the wander guard order that the FNP just signed on that day. The DON stated she didn't write any notes about the removal of the wander guard and she didn't realize that there was an order for the wander guard signed by the FNP. On 7/11/23 at approximately 1:30 p.m., the surveyor reviewed the Skilled Nursing Facility (SNF)/Nursing Facility (NF) to Hospital Transfer Form and the eINTERACT Transfer Form V5 for a hospital transfer for Resident #2 on 6/20/23.	F 689		

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F 689	Continued From page 5 These forms were completed by LPN #2. The following was noted: SNF/NF to Hospital Transfer Form - Risk Alerts: "May attempt to exit" was checked and on the eINTERACT Transfer Form V5 section 5-13: Are there any additional risks present? It was noted that the box for e. was checked for "May attempt exit". On 7/11/23 at 1:35 p.m., surveyor confirmed with the DON that in addition to the physician order for the use of the wander guard that was signed on 5/15/23, that on 6/20/23, staff documented on the transfer forms that Resident #2 was an elopement risk when they indicated that the resident "may attempt to exit."	F 689		