STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 5/19/24 through 5/22/24, on-site visits were conducted at Orono Commons for the purpose of completing a staggered weekend entrance for the annual Long Term Care Survey Process for Federal Recertification, facility reported incidents #ME00047088, #ME00044943, #ME00044428, #ME00044390, #ME00043831, and complaints #ME00046250, #ME00046058, #ME00045659, #ME00044850, #ME00043442, #ME00043119. It was determined that Orono Commons was not in compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000	Orono Commons provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed as evidence of the facility's continued compliance with state and federal regulations.	
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550	The events happened in the past and can't be corrected Observations were made to validate that staff offered and provided bathing care to each resident per the residents choice. Observations were made to validate that staff served all residents seated at the same table at the same time in the dining room. Observations were made to validate staff are responding to call bells in a timely manner. The facility answers call bells in a timely manner to meet the needs of each resident. The facility serves all residents seated at the same table at the same time in the dining room. The facility offers and provides bathing care to each resident per the residents choice. Facility nursing and dietary staff will be re-educated to these processes. DON/Designee will complete audits/observations of the dining process, bathing care, and call bell response time to validate residents are being treated with dignity and respect. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	7/6/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Colleen Lesler | TITLE: Int. Admin | (X6) DATE: 6/15/24

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews the facility failed to respond to residents request for assistance in a manner that maintained or enhanced their dignity by not answering the call bells in a timely manner for 3 of 9 residents interviewed (Resident #18 [R18], R9, R4). In addition, the facility failed to provide morning bathing care for 1 of 1 sampled resident (R9) and facility failed to promote care for residents in a manner that maintains each resident's dignity and respect when staff failed to serve all residents seated at the same table at the same time for meal observations on 1 of 2 units (Homestead). Findings: 1. On 5/19/24, R18's clinical record was reviewed. R18 was diagnosed with Cerebral Vascular Accident (CVA) with hemiplegia and hemiparesis, wheelchair dependent, and the care	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 plan indicated R18 requires extensive assist with toileting. On 5/19/24 at 10:35 a.m., in an interview with the surveyor, R18 stated he/she rang the call bell at around 10:00 a.m. because they had to move their bowels and needed the bedpan right away. R18 stated a half an hour had past and no one has answered his/her call bell. R18 stated their anal area was on fire and it hurt. R18's call bell was observed being answered at 10:50 a.m., fifty minutes after R18 stated he/she turned the call bell on. 2. On 5/19/24, R9's clinical record was reviewed. R9 was diagnosed with diabetes, atrial fibrillation, depression, anxiety and R9's Activity of Daily Living Toileting Task indicated R9 requires extensive to total assist with toileting. On 5/19/24 at 10:45 a.m., in an interview with the surveyor, Resident R9 stated that a couple weeks ago, he/she rang his/her call bell and waited for approximately an hour before someone answered it. R9 stated he/she couldn't hold it and was incontinent of bowel. R9 stated there aren't enough staff to answer call bells. R9 stated he/she has had other incontinent accidents waiting for the call bell to be answered. R9 also stated that he/she has not had a morning bath and likes to have a bath before noon and be clean. On 5/19/24 at 1:15 p.m., in an interview with the surveyor, Certified Nurse Assistant #4 (CNA4) stated she has not given R9 a morning bath because she had so much to do and not enough staff to help. She stated she will do the bath after lunch. On 5/20/24 at 8:00 a.m., in an interview with the surveyor, R9 stated he/she did not get a bath on 5/19/24 until after 3:00 p.m.	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 3 3. On 5/20/24 at 10:00 a.m., in an interview with a surveyor, R4 stated that a couple of weeks ago he/she rang his/her call bell and waited for approximately one to two hours before someone answered it, mostly at night. R4 stated it's pretty rough if you gotta pee, have to hold it, and stated this happens a lot. 4. On 5/20/24 8:45 a.m., R168 was observed sitting at table with another resident that was being assisted with eating by staff. R168 did not have his/her food. The CNA assisting the other resident stated that she had been assisting that resident while R168 had been there for 5 to 10 minutes. When asked if R168 was waiting for breakfast the whole time, the CNA stated yes; another CNA stated they were looking for R168's tray. At 8:52 a.m., dietary brought R168's tray up from the kitchen and staff apologized that it was late. On 5/20/24 at 8:57 a.m., during an interview with a surveyor, Homestead Unit Manager (HUM) stated that R168 had been at the table the whole time the other resident was being assisted with eating. R168's tray did not come up on either cart so HUM had to call down to the kitchen to get a breakfast tray. 5. On 5/20/24 at 12:15 p.m., a surveyor observed multiple residents sitting around the bar area of the Homestead Unit eating lunch. A surveyor observed that 2 residents did not have their lunch trays. During an interview with a surveyor, CNA7 stated that they separate the tickets for the residents by where they usually eat and send them to the kitchen that way but they just don't always come up that way. She stated that R57 and R219 typically eat at the bar. All other residents seated at the bar area have their food except R57, and R219, the cart was not here with their trays. At 12:22, R57 received his/her	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 4 tray and 12:26 p.m. , R219 received his/her tray.	F 550		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the facility failed to ensure that a resident's preference for a second serving of the main meal choice for lunch was available on 5/21/24, for 1 of 1 residents	F 561	The events happened in the past and can't be corrected. All residents have the potential of being affected by this practice. The facility provides care and services to each resident per the resident's choice, this includes having sufficient food choices to accommodate the resident's request for additional servings at meal time. Dietary staff will be re-educated to this process. NHA/Designee will make observations during meal times to validate requests for additional servings of the current menu items are being provided by the kitchen. These observations will be weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. Results of these audits/observations will be brought to the monthly QAPI Committee for further review and recommendations.	7/6/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 5 (Resident #37 [R37]) reviewed for weight loss and received an appetite stimulant. Finding: On 5/21/24 a during lunch meal service on Homestead Unit, a surveyor observed that chop suey and salad was part of the main menu choice for lunch. R37 requested seconds because he/she did not get enough. A surveyor observed Certified Nursing Assistant #6 (C.N.A.6) call down to the kitchen and reported to R37 that there wasn't any left. On 5/21/24 at 1:10 p.m., during an interview with surveyors, the Food Service Director (FSD) stated that they ran out of the main meal choice of chop suey and salad. It is the last day before our delivery tomorrow, so we ran out, usually I would run to the store to buy lettuce but I couldn't because I was working as staff. Sometimes we do not have enough of something at the end of a supply period. We have a lot of double portions, we are not compensated double portions. We only made enough chop suey for everyone (one serving), we were unable to offer seconds. When we run out, we offer them off the alternative menu. On 5/22/24 at 8:05 a.m., C.N.A.6 stated that R37 did not want anything else other than the chop suey and salad so R37 did not get anything else to eat. R37's admission weight on 2/27/24 was 117.2 pounds (lbs). On 5/3/24, R37's most recent documented weight was 102.1 lbs, a 15.1 lbs weight loss in 2 months.	F 561		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 6 On 3/22/24, a "nutrition" note was documented that stated "R37's Body Mass Index (BMI) was 21.4, which is considered low for age. Would continue to work with resident to meet food preferences and encourage intake. May at some point need to consider an appetite stimulant. Registered Dietician (RD) to continue to monitor and evaluate as indicated." On 3/29/24, another "nutrition" note was documented, "spoke with Speech Language Provider (SLP) and Provider, because R37 was refusing to eat. The Provider ordered Mirtazapine for appetite stimulant." On 5/21/24, R37's clinical record was reviewed. R37's care plan included a Nutrition care area that indicated, "Resident is at nutritional risk: related to poor intake," which was initiated on 3/4/24 with an intervention to "Honor food preferences within meal plan."	F 561		
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	F 584	The tiles in rooms 138, 143, and 144 were replaced. The torn wheelchairs in rooms K2, 161, 167, and R11 were discarded. The torn recliners in room R38 and R52 were discarded. The floors in room 161 and bathrooms 161, 147, and 148 were cleaned. The walls in room 161 and 167, bathroom wall in 172, and heater in room 165 were repainted. The sink countertop in room 161 was replaced. The heater in room 165 was repainted. The toilet paper holder in room 161 was replaced. Room 131 and surrounding corridors and rooms were deep cleaned. The Administrator or designee will review all resident rooms, bathrooms, and corridors for unsanitary conditions, offensive odors, and equipment/furniture in poor condition, and additionally identified areas of concern will be addressed as indicated.	7/6/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 7 the protection of the resident's property from loss or theft. §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 interview, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain an environment free from offensive odors for 2 of 3 days of survey (5/19/24 through 5/21/24) and to maintain the building in good repair and in a sanitary condition for 1 of 1 environmental tour (5/21/24). Findings: On 5/19/24 at 10:30 a.m., a surveyor observed a strong, foul odor of urine in the corridor outside Room 133.	F 584	Continued from Page 7 The Administrator or designee will provide education to all staff on the Code of Federal Regulations part 483.10(i)(1)-(7). The Housekeeping Supervisor or designee will provide education to housekeeping staff on policy ENV201 Cleaning: Resident/Patient Areas and ENV202 Detail Cleaning. The Maintenance supervisor or designee will provide education to all staff on the TELs work order system. The Administrator or designee will audit the resident rooms, bathrooms, and corridors weekly for four weeks then monthly for three months or until resolved to ensure adequate housekeeping and maintenance services are being provided to maintain an environment free of offensive odors and maintain the building in good repair and sanitary condition and report findings at the monthly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 8 On 5/19/24 at 10:45 a.m., in Room 138-1, in an interview with the surveyor, Resident #9 (R9) stated that almost every day a strong urine odor from the hall seeps into his/her room and is very unpleasant. On 5/19/24, between 10:30 a.m. and 1:15 p.m., a surveyor observed a lingering, strong, foul urine odor in the corridor outside Room 133. On 5/20/24 at 7:30 a.m., in the corridor outside Room 133, the strong, foul odor of urine continued and was observed throughout the day until 2:00 p.m. when the observations were stopped. On 05/21/24, between 2:10 p.m. and 2:29 p.m., a surveyor completed an environmental tour with the Director of Nursing, the Administrator, and the Maintenance Supervisor. The following findings were confirmed at the time of observations: At 2:15 p.m. during the tour, in the hallway near Rooms 133, and Room 138 the strong odor of urine was confirmed with the Director of Nursing, the Administrator, and the Maintenance Supervisor. Room 138, the floor tile had a torn section that was patched and had unsealed seams creating an uncleanable surface. Room 143, the threshold has tear in the flooring which is unsealed creating an uncleanable surface.	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 9 Room 144, threshold has unsealed flooring creating an uncleanable surface. A wheelchair (K2-lite) being used on the Homestead unit has a torn armrest on the left side. Room 147, the bathroom was observed to have flooring that was heavily soiled and stained around toilet. Room 148, the bathroom was observed to be dirty and not homelike. Room 161, the wheelchair in the room was observed to have torn armrests on the left and right side creating an uncleanable surface and the floor was noted to be sticky when you walked on it causing your shoes to stick to the floor, in the bathroom the toilet paper holder was missing a piece and was not attached to the wall, the walls had peeling/chipped paint and the sink top was peeling, all creating uncleanable surfaces. Room 165, the baseboard heater was observed with chipped paint and the recliner chair was dirty. Room 167, the bathroom had chipped paint on the walls and the wheelchair in the room had torn armrests on the left and right side creating an uncleanable surface. Room 172, the bathroom walls had chipped paint and the recliner chair in the room had torn armrests. R38's recliner chair had torn armrest on the right and left side creating an uncleanable surface. R52's recliner chair had a torn back handle	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 10 creating an uncleanable surface. R11's wheelchair had a torn armrest on the right side creating an uncleanable surface. In the large dining room on the Homestead unit a table had peeled top creating an uncleanable surface.	F 584		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of	F 623	The events happened in the past and can't be corrected for resident #49. All residents discharged or transferred have the potential of being affected by this practice. The Center informs the patient/resident representative, when there is a decision to transfer or discharge the patient from the Center. The patient and resident representative is notified in writing that includes the reason for the transfer/discharge that is in a language and manner they understand. Facility licensed nursing staff will be re-educated to this process. NHA/Designee will complete audits of discharged/transferred residents weekly x4 weeks, bi-weekly x 4 weeks, and then monthly x3 months to ensure that residents that are discharged or transferred are informed in writing of the reason for discharge. The results of these audits will be brought to the Monthly QAPI Committee for further review and recommendations.	7/6/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 11 this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402,	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 12 codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the resident and/or resident representative in writing for the reason of a transfer/discharge from the facility, for 2 of 3 sampled residents reviewed for hospitalization (Resident #37 [R37], and R24). In addition, the facility failed to notify the Ombudsman of transfer/discharges since January 2024. Findings:	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 13 1. On 5/21/24, R37's clinical record was reviewed and indicated that the resident was transferred to the hospital on 3/8/24 and admitted to the hospital. The clinical record lacked evidence of a written transfer/discharge notice being provided to the resident/resident representative. On 5/21/24 at 10:22 a.m., during an interview with a surveyor, the Market Clinical Advisor stated she was unable to find evidence that a written transfer/discharge notice had been given to the resident and/or representative. 2. On 5/22/24, R24's clinical record was reviewed and indicated that the resident was transferred to the hospital on 12/4/23 and was admitted to the hospital. The clinical record lacked evidence of a written transfer/discharge notice being provided to the resident/resident representative. On 5/22/24 at 11:12 a.m., during an interview with a surveyor, the Senior Director of Nursing stated she was unable to find evidence of a written transfer/discharge notice had been given to the resident and/or representative. On 5/22/24 at 10:45 a.m., during an interview with a surveyor, the Director of Nursing stated the last time the Ombudsman received notification of transfer/discharges was in January.	F 623		
F 625 SS=B	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	F 625	The events happened in the past and can't be corrected for resident #5 and #49. All resident have the potential to be affected The facility provides required notice of the bed-hold policy before transferring a resident to the hospital. Licensed and administrative staff will be re-educated to this process.	7/6/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 14 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 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 notify the resident and/or the resident's representative in writing of a bed hold notice after a transfer/admission to an acute care hospital for 3 of 4 sampled residents reviewed that were sent to the hospital (Resident #37 [R37], R24, and R71). Findings: 1. On 5/21/24, R37's clinical record was reviewed and indicated that the resident was transferred to the hospital on 3/8/24 and admitted to the hospital. The clinical record lacked evidence of a written bed hold notice being provided to the resident/resident representative.	F 625	Continued from Page 14 NHA/Designee will complete audits of residents who discharge or transfer to the hospital to validate that the appropriate notice of bed-hold policy was provided before transferring a resident. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 15 On 5/21/24 at 10:22 a.m., during an interview with a surveyor, the Market Clinical Advisor stated she was unable to find evidence that a written bed hold notice had been given to the resident and/or representative. 2. On 5/22/24, R24's clinical record was reviewed and indicated that the resident was transferred to the hospital on 12/4/23 and was admitted to the hospital. The clinical record lacked evidence of a written bed hold notice being provided to the resident/resident representative. On 5/22/24 at 11:12 a.m., during an interview with a surveyor, the Senior Director of Nursing stated she was unable to find evidence that a written bed hold notice had been given to the resident and/or representative. 3. On 5/22/24, review of R71's clinical record indicated the resident was transported to the hospital on 6/8/24 and admitted to the hospital. The bed hold notice in the record does not indicate that it was provided to R71's representative. On 5/22/24 at 12:27 p.m., in an interview with the Director of Nursing and the Senior Director of Nursing, the Director of Nursing stated she was unable to find evidence that the bed hold notice was provided to the resident representative. At this time a surveyor confirmed this finding.	F 625		
F 655 SS=B	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	F 655	An audit of resident's baseline care plans were completed to validate care plans are in place that include the minimum healthcare information necessary to properly care for a resident including, but not limited to Initial goals based on admission orders, Physician orders, Dietary orders, Therapy services, Social services, PASRR recommendation, if applicable.	7/6/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 16 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 (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:	F 655	Continued from Page 16 The facility developed baseline care plans within 48 hours of a resident's admission and include the minimum healthcare information necessary to properly care for a resident including, but not limited to Initial goals based on admission orders, Physician orders, Dietary orders, Therapy services, Social services, PASRR recommendation, if applicable. Licensed staff/IDT will be re-educated to this process. DON/Designee will complete audits of resident's CP to validate that they are in place within 48hrs of admission. These audits will be M-F x 14 days, weekly x 4 weeks, then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 17 Based on record reviews and interview, the facility failed to provide the resident and/or their representative with a summary of the baseline care plan for 4 of 5 residents reviewed for baseline care plans (Resident #37 [R37], R168, R63, and R270). Findings: 1. On 5/19/24, R37's clinical record was reviewed which indicated R37 was admitted to the facility on 2/27/24. There was no evidence in R37's clinical record that a copy of the baseline care plan summary was provided to the resident or his/her representative. 2. On 5/21/24, R168's clinical record was reviewed which indicated R168 was admitted to the facility on 5/7/24. There was no evidence in R168's clinical record that a copy of the baseline care plan summary was provided to the resident or his/her representative. On 5/21/24 between 10:25 a.m. and 10:31 a.m., during interviews with a surveyor, the Riverview Unit Manager she stated that during the care plan meetings, she currently does not and did not provide a copy of the baseline care plan to the resident or resident representative. 3. On 5/20/24 record review indicated R63 was admitted on 4/12/24 with Hemiparesis (weakness or the inability to move one side of the body) following cerebral infarction affecting the right dominant side. The baseline care plan was completed on 4/16/24. The care plan identifies the "resident is incontinent with potential for improved control or management of urinary elimination" and includes the intervention "assist	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 18 the resident to the toilet at scheduled times i.e. (that is) upon rising, before meals, at HS (bedtime) and as needed." On 5/20/24 at 7:53 a.m., in an interview with a surveyor, R63 stated it can be hard to get help to the bathroom, by the time someone is able to come help, sometimes it is too late. R63 stated staff only assist R63 to the bathroom when the resident initiates the request. On 5/21/24 at 10:37 a.m., in an interview with a surveyor, the Director of Nursing stated it looks like the care plan was completed on 4/16/24. At this time the surveyor confirmed the care plan was not completed within 48 hours of admission. On 5/21/24 at 2:04 p.m., in an interview with a surveyor, Certified Nursing Assistant #8 (CNA8) stated the toileting schedule is not on R63's Kardex. CNA8 stated he was unaware of that being part of R63's care plan and believes the care plan should be updated as R63 is able to ring the call bell to use the bathroom. CNA8 stated he had not assisted R63 to the bathroom since approximately 10:00 a.m. At this time the surveyor confirmed with CNA8 that the toileting schedule on R63's care plan was not followed. 4. On 5/20/24 record review indicated R270 was admitted on 5/15/24 with Pneumonitis due to inhalation of food and vomit, autistic disorder, and reduced mobility. The baseline care plan was completed on 5/19/24 (4 days after admission). On 05/21/24 at 9:24 a.m., in an interview with the Director of Nursing, a surveyor confirmed that the base line care plan was not completed within 48 hours.	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 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	F 656	An audit of the residents with a diagnosis of PTSD or those residents indicating a history of trauma was completed to validate that the care plan to address this is in place and includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified through assessment. . The facility develops and implements a comprehensive person-centered care plan for each resident based on identified areas on the Comprehensive MDS and 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. Licensed nurses and social services will be re-educated to this process. CNE/Designee will conduct random weekly audits of completed comprehensive MDSs to validate comprehensive person centered care plans are in place as identified through the comprehensive MDS and includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	7/6/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 20 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 review and interview, the facility failed to develop a care plan for the area Post Traumatic Stress Syndrome (PTSD) for 1 of 1 sampled resident with a diagnosis of PTSD (Resident #18 [R18]). Finding: On 5/21/24, a review of R18's care plan, under the care problem of 'Resident/patient exhibits or is at risk for distressed/fluctuating mood symptoms related to: depression, anxiety, PTSD.' There was no documented evidence of a care plan developed to address the issues of PTSD. On 5/22/24 at 9:55 a.m., in an interview with the surveyor, the Director of Nursing (DON) stated she did not find a care plan for PTSD other than it being mentioned as one of the problems under fluctuating mood symptoms in the care plan. The DON stated the Licensed Social Worker (LSW) told the DON an assessment of R18's PTSD was not done. The DON confirmed there was no care plan for PTSD.	F 656		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 21 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 reviews and interviews, the facility failed to complete neurological assessments as directed, failed to follow physician orders for obtaining vital signs, referrals, medication administration, and failed to order urgent/stat diagnostic testing timely for 6 of 10 sampled residents (Resident #37 [R37], R24, R68, R168, R26, and R71). Findings: The facility's policy, Neurological Evaluation, revised 2/1/23, directed staff to completed a neurological evaluation when a resident sustains an injury to the head, or face, and/or has an unwitnessed fall. Evaluations will be performed every 15 minutes for 2 hours, then every 30 minutes for 2 hours, then every 60 minutes for 4 hours, and then every 8 hours until at least 72 hours as elapsed. 1. On 5/20/24, R37's clinical record was reviewed and included documentation that on 3/28/24 R37 was observed sitting on floor in-between the bed and nightstand and had a small bruise noted to forehead. On 5/20/24 at 10:18 a.m., during an interview with the Homestead Unit Manager, a surveyor confirmed that the Neurological Evaluation Flowsheet was not completed as directed for a resident who had a fall and hit their	F 684	The events happened in the past and can't be corrected. All residents have the potential to be affected. The facility ensures that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This includes completing neurologic assessments as indicated and following MD orders inclusive of parameters for med administration, obtaining orthostatic B/P, arranging consults, completing diagnostic tests. Licensed staff will be re-educated to this process. DON/Designee will complete audits of the following: -Completing neurologic assessments as indicated (Unwitnessed falls, observed fall with head strike, and per the MD orders) -Following MD orders for medications with parameters -Obtaining orthostatic B/P as ordered -Coordinating consults and diagnostics as ordered These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	7/6/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 22 head. 2. On 5/22/24, R24's clinical record was reviewed and included documentation that on 5/1/24, R24 had a fall and was found by staff on floor in the bathroom. R24 reported that he/she hit his/her head on the toilet. A surveyor reviewed the Neurological Evaluation Flowsheet and found that neuro checks were not completed as directed. On 5/22/24 at 11:00 a.m., during an interview with the Director of Nursing-Center Nurse Executive (DON), a surveyor confirmed this finding. 3. On 5/20/24, R24's clinical record was reviewed and contained a physician order, dated 3/29/24, to administer Atenolol, a blood pressure medication, daily and to hold if systolic blood pressure is less than 110 or the heart rate is less than 60. On 5/21/24 at 8:50 a.m., a surveyor reviewed the clinical record with the Homestead Unit Manager (HUM) and was unable to find evidence that the vitals were taken daily, prior to the administration of the medication. The HUM stated the way the order was entered into the electronic system lacked evidence of a place to record the vitals prior to the administration of the medication. The surveyor confirmed this finding during this review. 4. On 5/20/24, R24's clinical record was reviewed and contained a hand written order by the Medical Provider, dated 4/4/24, to complete orthostatic vital signs in the morning and to notify the provider if positive. This order was entered by staff into the electronic orders with the directions to take Blood Pressure while lying and take Blood Pressure while standing (which was not the way the Medical Provider wrote it). On 5/20/24 at 10:39 a.m., a surveyor and the HUM reviewed	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 23 R24's documentation and the HUM stated that the orthostatic vital signs were not completed correctly. The HUM stated that vital signs should have been completed while R24 was lying and while sitting as R24 is unable to stand. The surveyor confirmed that the orthostatics were not completed correctly during this review. 5. On 5/21/24, R68's clinical record was reviewed and included a physician order, dated 10/31/23, for both an "urgent wound clinic referral" for progressive wounds with poor healing, and an order for an "urgent vascular consult". The surveyor was only able to find a vascular clinic referral and visit which addressed the vascular wound concerns and not a wound clinic referral or visit for the non-vascular wounds (multiple pressure, moisture related and abrasions). On 5/22/24 at 8:31 a.m., during an interview with a surveyor, the DON stated she was unable to find where a wound consult was obtained other than the vascular consult. 6. On 5/21/24, R168's clinical record was reviewed and included a physician order, dated 5/7/24, for Acetaminophen (analgesic pain reliever) Tablet 325 milligrams (mg), give 2 tablets every 4 hours as needed (PRN) for mild pain and if more than 3 doses in 48 hours to notify the provider. Do not exceed 3 grams (3000 mg) a day. On 5/9/24, a physician order was received that directed staff to administer 500 mg, give 2 tablets of Acetaminophen twice a day, at 9:00 a.m. and 5:00 p.m. A review of the clinical record indicated that on 5/10/24, R168 received the following Acetaminophen doses:	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 24 1 dose of 325 mg x 2 tabs PRN at 2:13 a.m. = 650 mg 1 dose of 500 mg x 2 tabs scheduled at 9:00 a.m. = 1000 mg 1 dose of 325 mg x 2 tabs PRN at 2:45 p.m. = 650 mg 1 dose of 500 mg x 2 tabs scheduled at 5:00 p.m. = 1000 mg On 5/21/24 at 11:03 a.m., during an interview with the DON, a surveyor confirmed that R168 received greater than 3000 mg of Acetaminophen in a 24 hour period. 7. On 5/22/24, R26's clinical record was reviewed and contained information that on 4/9/24 R26 was standing at the table and then fell to the ground and landed on his/her right side. R26 complained of discomfort in his/her right arm and right leg. On 4/11/24 at 11:21 a.m. R26's electronic record contained an order by the Medical Provider to have an urgent/stat diagnostic CAT Scan of the right hip. The order summary stated, recent fall, x-rays of right hip in ED (emergency department) were negative for fracture but significant pain with hip flexion. Concern for occult hip fracture. The diagnostic CAT Scan was not ordered by the facility until 4/15/24, 4 days after the urgent/stat order. On 5/22/24 at 2:17 p.m., during an interview with the DON, a surveyor confirmed that the facility failed to follow the Medical Provider's order timely for an urgent/stat order for diagnostic CAT Scan right hip. The DON stated the facility staff did not see the order until 4/15/24, 4 days after the order was written by the provider. 8. On 5/22/24, R26's clinical record was reviewed and included a physician order, dated 4/11/24, to	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 25 give 5 units Novolog (insulin) SQ (subcutaneous) if glucose (blood sugar [BS]) greater than 300, before meals and at bedtime for DM (Diabetes Mellitus). On 4/13/24 at 7:00 a.m. BS was 288, Novolog 5 units SQ was given, at 11:00 a.m. BS was 245, Novolog 5 units SQ was given, and at 4:00 p.m. BS was 213, Novolog 5 units SQ was given. Novolog 5 units was given on 4/13/24 at 7:00 a.m., 11:00 a.m., and 4:00 p.m. when not needed. On 5/22/24 at 2:50 p.m., during an interview with the Minimum Data Set Coordinator, and the Senior Director of Nursing, a surveyor confirmed that R26 received three doses of insulin when not needed/ordered. 9. On 5/22/24, review of R71's clinical record indicated an unwitnessed fall on 6/6/23. R71 was observed on the floor between the beds laying on R71's left side. The resident was unable to tell the staff what happened. Nurse notes indicated neurological evaluation were recommended by the provider and initiated. On 5/22/24 at 12:27 p.m., in an interview with the DON and the Senior Director of Nursing, a surveyor confirmed that the Neurological Evaluation Flowsheet was not completed as directed for R71, who had an unwitnessed fall.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-	F 686	Resident #15 and #31 Pressure ulcers are being assessed, evaluated, and documented weekly. Both residents' plans of care for treatment of pressure ulcers are being followed. An audit of residents with pressure ulcers was completed to validate weekly assessments and evaluations are being documented and the pressure ulcer plan of care is being followed.	7/6/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 26 (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record reviews, observation, and interviews, the facility failed to ensure that weekly pressure ulcer assessment documentation, used to monitor the healing progress of the wounds, were completed, failed to follow physician orders in obtaining a wound clinic referral, and failed to follow a care plan for 3 of 4 residents reviewed with pressure ulcers (Resident #15 [R15], R68, and R31). Findings: 1. On 5/22/24, R15 clinical record was reviewed. Pressure wound documentation for wound #7, left gluteus; #8 right gluteus; and #9 left gluteus, were reviewed with the Riverview Unit Manager. The "Wound Evaluation" documentation in the clinical record lacked evidence of weekly assessments/evaluations for the week of 3/31/24-4/6/24 and 4/28/24-5/4/24. On 5/22/24 at 10:01 a.m., in an interview with the Riverview Unit Manager, a surveyor confirmed weekly pressure ulcer "wound evaluation" assessment/measurements for R15 were not done for the week of 3/31/24-4/6/24, and 4/28/24-5/4/24.	F 686	Continued from page 26 The facility completes a comprehensive initial and ongoing nursing assessment of intrinsic and extrinsic factors that influence skin health, skin/wound impairment, and the ability of a wound to heal is performed. The plan of care for the patient will be reflective of assessment findings from the comprehensive patient assessment and wound evaluation. Staff will continually observe and monitor patients for changes and implement revisions to the plan of care as needed. Pressure ulcers are evaluated and assessments are documented weekly. Licensed staff will be re-educated to this process. DON/Designee will complete audits on residents with pressure ulcers to validate documentation of the resident wound assessment is completed weekly and the plan of care for the treatment of pressure ulcers are followed. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 27 2. On 5/21/24, R68's clinical record was reviewed and included a physician order, dated 10/31/23, for an "urgent wound clinic referral" for progressive wounds with poor healing. As of 10/31/23, the facility was treating multiple pressure wounds that included an unstageable on the coccyx, unstageable on the left lower back, a stage 2 in the genital region, and a deep tissue injury on the left heel. On 5/22/24 at 8:31 a.m., during an interview with a surveyor, the Director of Nursing (DON) stated she was unable to find where a wound clinic consult was obtained for R68's multiple pressure injuries. 3. On 5/22/24, R31's clinical record was reviewed which indicated that R31 had a current stage II pressure injury to the left buttock that was first observed on 4/24/24. The surveyor was unable to find weekly (assessment) documentation for the week of 5/5/24 - 5/11/24. On 12:06 p.m. during an interview with the Senior Director of Nursing (SDN), a surveyor confirmed this finding. The SDN stated that it is the facility's practice to complete weekly assessments (which include measurements to monitor healing). In addition, R31's current careplan indicated that R31 should have had a redistribution cushion to his/her chair. On 5/22/24 at 12:28 p.m., during an observation of R31 seated in his/her chair and interview with the Homestead Unit Manager (HUM), a surveyor confirmed that R31 did not have a redistribution cushion in his/her chair. At 12:39 p.m., the HUM stated that R31 used to have a cushion but that the resident kept sliding and they sent the cushion for adjustment and no one knows where it went. The surveyor confirmed this finding.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 28	F 695		
F 695 SS=E	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 by: Based on observations, record review, and interviews, the facility failed to follow its own policy for oxygen use and humidification, failed to ensure physician orders were followed for oxygen administration, failed to ensure that oxygen tubing was changed weekly, and failed to ensure that respiratory equipment was maintained in a clean manner for 4 of 4 days of survey (5/19/24-5/22/24) for Resident #168 (R168). Findings: The facility's policy and procedure for Oxygen:Nasal Cannula, revised 8/7/23, indicated the following: - Verify order, -Determine if humidification is needed by using the table - 2 liters of oxygen per minute does not indicate the use for humidification, -Nasal cannula labeled with date of initial set-up, - If humidifier is used, label with date, - Replace disposable set-up every seven days, date and store in a treatment bag when not in use.	F 695	Resident #168 orders for oxygen are being followed. The resident's humidified water bottle is dated, and the nasal cannula is dated and stored in a treatment bag when not in use. An audit of residents utilizing oxygen was completed to validate MD orders are followed for oxygen, humidification is used accordingly, oxygen tubing is dated and replaced every 7 days, and tubing not in use is stored in a treatment bag appropriately. The facility ensures those residents utilizing oxygen via nasal cannula follow the MD order for oxygen, utilize humidification for use of oxygen over 2 lpm, if not contraindicated. The facility ensures the nasal cannula is labeled with date of initial set-up, If humidifier is used, ensure it is labeled with date. The facility replaces disposable set-up every seven days, indicating with a date and stores in a treatment bag when not in use. Licensed staff will be re-educated to this process. DON/Designee will complete audits of residents with oxygen to ensure MD orders for oxygen are being followed, humidification is used as indicated, nasal cannula/mask are stored in a treatment bag when not in use, tubing and humidified bottles are labeled and set up changed out at least every 7 days. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	7/6/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 29 R168 was admitted to the facility on 5/7/24. The physician orders contained an order, dated 5/7/24, to administer oxygen at 2 liters per minute. The clinical record lacked evidence of orders/treatments to use humidification, clean the concentrator, or change the tubings. 1. On 5/19/24 at 12:14 p.m., a surveyor observed R168 sitting in a wheelchair and using portable oxygen. The oxygen tank regulator was set on 3 liters of oxygen per minute. 2. On 5/19/24 at 12:35 p.m., two surveyors observed the filter on R168's concentrator dusty and the oxygen tubing extension connector touching the floor. The surveyors also noted that there was a humidifier bottle attached to the concentrator that was not dated nor was the oxygen tubing extension dated. 3. On 5/19/24 at 2:34 p.m., during an interview with a surveyor, Licensed Practical Nurse #1 (LPN1) stated that she brought R168 back to his/her room and hooked up the nasal cannula tubing from the portable oxygen tank to the extension tubing that has hooked to the concentrator. LPN1 stated that she did not notice that the extension tubing connector had been on the floor and she did not use an alcohol wipe prior to connecting the extension to the tubing. LPN1 was not sure if housekeeping had been in the room prior to bringing R168 back to his/her room (surveyor noticed the room had been cleaned between observations). The surveyor confirmed with LPN1 that the tubing had been observed laying on the floor and had not been cleaned or changed prior to connecting to the nasal cannula. 4. On 5/20/24 at 8:46 a.m., a surveyor observed	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 30 R168 sitting in a wheelchair and using portable oxygen. The oxygen tank regulator was set on 3 liters of oxygen per minute. 5. On 5/20/24 at 10:49 a.m., a surveyor and the Homestead Unit Manager observed R168's portable oxygen regulator was set on 3 liters of oxygen per minute and not the physician ordered 2 liters per minute. The surveyor also confirmed that the concentrator filter was dusty and humidifier bottle that was connected to the concentrator, was not dated. 6. On 5/21/24 at 11:25 a.m., during an interview with the Market Clinical Advisor, a surveyor confirmed there was no evidence of R168's oxygen tubing being changed weekly and that there was no order for the use of the humidifier bottle that was not dated. The facility's policy and procedure that was provided to the surveyor did not indicate the use of humidification based on R168's physician order for 2 liters per minute of oxygen. 7. On 5/22/24 at 2:32 p.m., a surveyor observed the undated humidifier bottle still attached to R168's oxygen concentrator. The clinical record still lacked evidence of an order to use humidified oxygen.	F 695		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in	F 699	The care plan for Residents #18 has been updated to reflect the past history of trauma, accounting for the resident's experience to mitigate or eliminate triggers that may cause re-traumatization. To identify others at risk, interviewable residents and family members of non-interviewable residents were interviewed about a history of trauma along with triggers and needs.	7/6/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 699	Continued From page 31 order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to identify a resident's current diagnosis of Post-Traumatic Stress Disorder (PTSD)/trauma to determine what trigger(s) might cause re-traumatization for 1 of 1 sampled resident reviewed with a current diagnosis of PTSD (Resident #18 [R18]). Finding: On 5/21/24, a review of R18's clinical record, in the Minimum Data Set (MDS) 3.0, Section I, Active Diagnoses, Psychiatric/Mood Disorder, I6100 was coded to indicate R18 had an active diagnosis for Post Traumatic Stress Syndrome (PTSD). The surveyor was unable to find information in the clinical record that indicated what R18's PTSD was caused by or what events might cause re-traumatization. On 5/22/24 at 9:55 a.m., in an interview with the surveyor, the Director of Nursing (DON) stated she did not find a care plan (goal and trauma interventions) for PTSD other than it being mentioned as one of the problems under fluctuating mood symptoms in the care plan. The DON confirmed the Licensed Social Worker (LSW) did not assess Resident #18's PTSD.	F 699	Continued from page 31 Any new information regarding the history of trauma was added to the documentation and comprehensive care plan. The facility assures that trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences to eliminate or mitigate triggers that may cause re-trauma. The NPE or designee will educate the nurses and social services on the evaluation of trauma and ensure a comprehensive, person-centered care plan is in place to eliminate or mitigate triggers for anyone with a history of trauma. The DON/Designee will review documentation and care plans to ensure trauma survivors have a comprehensive, person-centered care plan that addresses preferences to eliminate or mitigate triggers. This audit will validate that trauma-informed care is addressed in the care plan for trauma survivors. These audits will be conducted weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must-	F 711	Resident #15 had a regulatory visit on 5/3/24 and on 6/3/24 the provider signed and dated all orders. An audit of resident records was completed to validate the physician reviewed the resident's total program of care, including medications and treatments, at each visit.	7/6/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 711	Continued From page 32 §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the physician reviewed the resident's total program of care, which included signing orders for medications and treatments listed on the Physician Orders (block orders) in a timely manner for 1 of 8 sampled residents (Residents #15 [R15]). Finding: Documentation in R15's clinical record stated that the Physician signed the Physician Orders (block orders) on 2/12/24. These orders were in effect for 60 days. The next Physician Orders (block orders), including a 10-day grace period, needed review and the Physician's signature by 4/22/24. The medical record lacked evidence that Physician reviewed and signed orders on or around 4/22/24. Documentation in R15's clinical record stated that the Physician signed the Physician Orders (block orders) on 5/21/24, 29 days late, including the 10-day grace period. On 5/22/24 at 1:13 p.m. in an interview with the	F 711	Continued from page 32 This includes writing, dating, and signing progress notes, signing and dating all orders with the exception of influenza/pneumococcal vaccines as this can be administered per physician approved facility policy. The resident physician/Designee completes required visits that include review of the resident's total program of care, including medications and treatments, at each visit. This includes writing, dating, and signing progress notes and signing and dating all orders with the exception of influenza/pneumococcal vaccines as this can be administered per physician approved facility policy. Physicians, APP, NHA, and Nursing Leadership will be re-educated to this process. NHA/Designee will complete audits of new admissions and residents due for required MD/Designee visits to ensure this process is followed. These audits will be weekly x 4 weeks, bi-weekly times 4 weeks, then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 711	Continued From page 33 Senior Director of Nursing, a surveyor confirmed the above finding.	F 711		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure sufficient direct care staff were scheduled and on duty to meet the needs of all 73 residents that reside on	F 725	The facility currently has staffing patterns in place, based on census and acuity, that are sufficient to assure patient safety and attain or maintain the highest practicable physical,mental, and psychosocial well-being of each patient. This includes the ability to meet the plan of care of each resident. All residents have the potential to be affected. The facility ensures they have sufficient nursing staff, including nurse aides in accordance with state and federal regulations, with the appropriate competencies and skills sets to provide nursing and related services to assure patient safety and attain or maintain the highest practicable physical,mental, and psychosocial well-being of each patient. This includes direct care staff to resident ratios are followed at a minimum of Days 1:5, Evenings 1:10, Nights 1:15. Facility NHA and nursing leadership will be re-educated to this process. NHA/Designee will validate that the facility has sufficient nursing staff to meet the needs of the facility, this includes validation that direct care staff to resident ratios are followed at a minimum of Days 1:5, Evenings 1:10, Nights 1:15. These audits will be daily x 30 days, weekly x 4 weeks, then bi weekly x 2 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	7/6/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 34 the Homestead and Riverview units. This has the potential to affect all residents that need assistance with Activities of Daily Living (ADL). Findings: 1. On 5/19/24, R18's clinical record was reviewed. R18 was diagnosed with a Cerebral Vascular Accident (CVA) with hemiplegia and hemiparesis, wheelchair dependent, and the care plan indicated R18 requires extensive assist with toileting. On 5/19/24 at 10:35 a.m., in an interview with the surveyor, R18 stated he/she rang the call bell at around 10:00 a.m. because they had to move their bowels and needed the bedpan right away. R18 stated a half an hour had past and no one has answered his/her call bell. R18 stated their anal area was on fire and it hurt. R18's call bell was observed being answered at 10:50 a.m., fifty minutes after R18 stated he/she turned the call bell on. 2. On 5/19/24, R9's clinical record was reviewed. R9 was diagnosed with diabetes, atrial fibrillation, depression, anxiety and R9's Activity of Daily Living Toileting Task indicated R9 requires extensive to total assist with toileting. On 5/19/24 at 10:45 a.m., in an interview with the surveyor, R9 stated that a couple weeks ago, she rang her call bell and waited for approximately an hour before someone answered it. R9 stated he/she couldn't hold it and was incontinent of bowel. R9 stated there aren't enough staff to answer call bells. R9 stated he/she has had other incontinent accidents waiting for the call bell to be answered. R9 also stated that he/she has not had a morning bath and likes to be clean and have a bath before	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 35 noon. On 5/19/24 at 1:15 p.m., in an interview with the surveyor, Certified Nurse Assistant #4 (CNA4) stated she has not given R9 a morning bath because she had so much to do and not enough staff to help. She stated she will do the bath after lunch. On 5/20/24 at 8:00 a.m., in an interview with the surveyor, R9 stated he/she did not get a morning bath on 5/19/24 until after 3:00 p.m. 3. On 5/21/24 at 9:15 a.m., in an interview with CNA4, she stated that there are days when she just barely gets her work done. CNA5 stated sometimes she skips her break to get things done. She stated on this past Friday, May seventeenth, there were two CNA's for forty residents. She stated bath were barely done and R9 did not get a bath the way she usually likes to have it done. 4. On 5/20/24 at 9:10 a.m., a surveyor observed CNA6 assisting R27 with breakfast. CNA7 needed to get a straw for R27's beverage and noticed R37's call light on. She went into R37's room who wanted his/her eggs warmed up. CNA6 proceeded to warm R37's eggs up and then another resident wanted their eggs warmed up too, so CNA6 did that too. CNA6 then returned back to R27 and apologized for being gone for so long and placed the straw in the beverage. During an interview with a surveyor, CNA6 stated that there was no one else available to do it and she needed to assist the others at the same time and not make them wait. 5. On 5/21/24 at 10:44 a.m. during a resident	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 36 council meeting R4 stated there are not enough staff. He/she knows this because they are supposed to be up before breakfast and he/she is not getting up before 10:00 a.m., this happens at least 1-2 times a week and it's because they don't have enough staff. R4 does have a care plan intervention that documents that it is important for him/her to engage in daily routines that are meaningful to him/her. One of the listed interventions it that he/she likes to get up in the morning between 7:00 a.m. and 9:00 a.m. 6. On 5/21/24 at 10:46 during a resident council meeting R5 stated that there is not enough staff. They don't go without, but they must wait almost 1.5 hours to use the bathroom and that is not ok. It has become a regular thing to be shorthanded almost daily. 7. On 5/20/24 at 10:00 a.m., in an interview with a surveyor, R4 stated that a couple of weeks ago he/she rang his/her call bell and waited for approximately one to two hours before someone answered it, and it happens mostly at night. R4 stated it's pretty rough if you gotta pee, have to hold it, and stated this happens a lot.	F 725		
F 730 SS=B	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by:	F 730	CNA #1 and #2 have had an annual performance review. An audit of annual performance reviews for all current CNAs has been conducted. The facility ensures that all CNAs receive a performance appraisal at least once every twelve months. Leadership staff will be re-educated to this process.	7/6/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 730	Continued From page 37 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 Nurse Assistants (CNA) employed greater than a year (CNA1, and CNA2). Findings: On 5/22/24 surveyors reviewed the employee files: 1. CNA1 was hired on 2/1/20. There was no evidence that an annual performance evaluation was completed by 2/1/24. On 5/22/24 at 2:00 p.m., in an interview with the surveyor, the Director of Nursing (DON) stated she was unable to find any annual performance evaluations completed after 2022. She confirmed that CNA1 had not had an annual performance evaluation. 2. CNA2 was hired on 8/14/17. There was no evidence that an annual performance evaluation was completed by 8/14/23. On 5/22/24 at 2:00 p.m., in an interview with the surveyor, the DON stated she was unable to find any annual performance evaluations completed after 2022. She confirmed that CNA2 had not had an annual performance evaluation.	F 730	Continued from page 37 DON/Designee will complete weekly audits x 4 weeks, then monthly audits x 3 months to ensure annual performance appraisals are administered to CNAs. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendation. The events happened in the past and can't be corrected.	7/6/24
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date.	F 732	Nurse staff information is currently being posted on a daily basis. The facility post nurse staffing information daily that includes, the facility name, the date, the facility census, and the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	7/6/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 38 (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to post the nurse staffing information in a prominent place, readily accessible and visible to all residents, for 3 of 4 days of survey (5/19/24, 5/20/24, 5/21/24). Finding:	F 732	Continued from page 38 Registered nurses, Licensed practical nurses or licensed vocational nurses (as defined under State law), and certified nurse aides. DON, NHA, and scheduling and payroll manager will be re-educated to this process. NHA/designee will audit posting 5 times per week x 2 weeks, weekly x 4 weeks, then monthly times 3 months to validate posting is current. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 39 On 5/19/24 through 5/21/24, surveyors observed that the nurse staffing information was not posted in a prominent place readily accessible and visible to residents. Surveyors observed the staff posting placed on a table in a room between the entrance door to the facility and an exit door out of the this room to the outdoors. This entrance door to this area was noted to be locked at times and staff had to use a code to allow visitors in or out of the building; a resident would have to be able to exit the entrance door in order to observe the posting that was placed on a table. On 5/21/24 at 3:00 p.m., during an interview with the Director of Nursing, a surveyor confirmed that the staff posting was not accessible to residents for reviewing.	F 732		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §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	F 761	The insulin was discarded and a new supply was labeled with open and discard dates. The expired medication in the two identified medications rooms were discarded. An audit of med rooms and medication carts was completed to validate labeling of drugs and biologicals is being met, including removal of expired medications. The facility follows policy and procedures of Labeling of Drugs and Biologicals in accordance with current accepted professional principles, and include the appropriate accessory and cautionary instructions, and expiration date when applicable. Licensed staff will be re-educated to this process. DON/Designee will complete an audit of medication carts and medication rooms to validate Labeling of Drugs and Biologicals are being completed in accordance with current accepted professional principles, and include the appropriate accessory and cautionary instructions, and expiration date when applicable.	7/6/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 40 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 and interviews, the facility failed to ensure opened insulin was labeled with an open date in 1 of 2 treatment carts (Homestead unit) and failed to remove expired medications from the supply available for use in 2 of 2 medication storage rooms (Homestead and Riverview units) Findings: On 5/19/24 at 11:16 a.m., a surveyor and a Licensed Practical Nurse (LPN1) observed a Basaglar KwikPen (Lantus) for Resident #35 that was in the treatment cart that did not have an open or discard date (Lantus is good for 28 days once opened and at room temperature). On 5/19/24 at 11:26 a.m. a surveyor and LPN1 observed the medication storage room on the Homestead Unit and found the following expired medications available for use: 2 bottles of Stool Softener 100 milligram with expiration date of 4/2024. On 5/19/24 at 11:32 a surveyor and LPN2 observed the medication storage room on the Riverview Unit and found the following expired medications:	F 761	Continued from page 40 These audits will be weekly x 4 weeks, bi-weekly times 4 weeks, then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 41 2 bottles of Aspirin 325 milligram with an expiration date of 4/2024 These findings were confirmed by the surveyor at the time of the observations.	F 761		
F 802 SS=E	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to provide adequate dietary staff to ensure the dietary needs of residents were met timely for 3 of 4 days of survey (5/19/24, 5/20/24, and 5/21/24). Findings:	F 802		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 802	Continued From page 42 Review of the posted meal times for Homestead dining room indicated breakfast is served at 8:00 a.m., lunch is served at 12:00 p.m., and dinner is served at 5:00 p.m. On 5/19/24 at 12:30 p.m., observation of lunch services in the Homestead dining room revealed residents in the dining room were served lunch one-half hour late. Meal trays were delivered to resident rooms up to 1:45 p.m., one and three quarter hours late. On 5/20/24 at 8:32 a.m., a surveyor observed breakfast trays arrived to the Homestead dining room one-half hour late. On 5/20/24 at 8:35 a.m., in an interview with surveyor, a resident stated, "they are always late during the week, they are usually early on weekends." On 5/20/24 at 12:30 p.m., a surveyor observed lunch trays arriving to the Homestead dining room one-half hour late. On 5/21/24 at 8:32 a.m., a surveyor observed the breakfast trays arriving to the Homestead dining room one half hour late. On 5/21/24 at 12:35 p.m., a surveyor observed residents and nursing staff requesting more salad as not all residents received a salad. The Account Manager informed them it was all gone. On 5/21/24 at 12:55 p.m., in an interview with a surveyor, the Account Manager stated we are down 2 people today, the open part-time position, and a chef called out. She stated nursing staff have complained about meals not	F 802	Dietary manager and the District manager will review the schedule prior to posting to ensure there is sufficient Dietary Support Personnel scheduled daily to provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. The District Manager or Manager will be notified of any changes in the schedule for immediate follow up.	7/6/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 802	Continued From page 43 being on time as it makes it hard to plan morning care for residents; it can depend on who is working, we have one staff member who tends to slow things down. The Account Manager also stated they ran out of salad because she was unable go to the store for more ingredients; she was working as kitchen staff to replace the Chef that called out. At this time the surveyor confirmed there were not enough staff to ensure the dietary needs of residents were met timely.	F 802		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on interviews and observations, the facility failed to serve hot foods hot and cold food cold on 1 of 4 days of survey (5/21/24). Findings: On 5/19/24 at 11:36 a.m., during a resident interview they stated concerns regarding the temperature of meals. On 5/19/24 at 12:30 p.m., observation of lunch service revealed residents in the Homestead dining room were served one-half hour late. Meal trays were delivered to resident rooms up to 1:45	F 804	Manager/DM will do pre-meal service checks with the cooks to ensure accuracy and timeliness of meal service. Test trays will be completed daily x3 weeks, weekly x3 months for accuracy and temperature control. Re-Educate, In service staff and conduct competencies (initial/as needed).	7/6/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 44 p.m., one and three quarter hours late. On 5/20/24 at 8:29 a.m., during a resident interview they stated meals are always late during the week, hot foods are not always hot. On 05/20/24 11:56 a.m., during a resident interview they stated the food is not always warm. On 5/21/24 at 12:55 p.m., two surveyors received test trays with American Chop Suey and Pineapple Crisp (cold dessert) with whipped topping. The temperature of the chop suey was 116.9 degrees Fahrenheit, and 116.8 degrees Fahrenheit. The temperature of the Pineapple Crisp for both trays was 66.8 degrees Fahrenheit. The hot and cold foods on the test trays were found not to be palatable at those temperatures by both surveyors. These findings were observed and confirmed with the Account Manager at the time of the findings.	F 804		
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	F 812	A monitoring procedure will be implemented by 6/17/24 to ensure that all specific deficiencies are maintained by dietary staff auditing each facility refrigerator for proper storage of food /use-by-dates and/or discard and expiration dates at a minimum 2xs per day during stocking and storage. Dietary staff will discard any unlabeled/expired food during each audit and document that the audit was completed. A "refrigerator audit log" will be posted on each facility refrigerator for dietary staff to complete during each individual audit. The Director of Dining Services and/or Dining Supervisors will spot check each facility refrigerator log at least 4xs weekly and maintain a binder of all completed audit logs. This auditing process will be implemented no later than 6/17/24. All audits will be reported to the Administrator weekly and monthly at the Quality Assurance and Performance Improvement meeting.	7/6/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 45 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 monitor food temperatures to prevent food borne illness prior to serving residents for 1 of 4 days of survey (5/19/24), failed to store, prepare, and serve food in accordance with professional standards for food service safety by not storing food in a sanitary manner for 2 of 4 days of survey (5/19/24, and 5/20/24) and failed to ensure that plumbing fixtures were properly installed to prevent backflow as required by the Maine State Plumbing Code on 4 of 4 days of survey (5/19/24, 5/20/24, 5/21/24, and 5/22/24). This has the potential to effect all residents in the facility. Findings: On 5/19/24 at 10:10 a.m., during the initial tour of the kitchen, a surveyor observed on the shelf and available for use in the dry storage: 1 package- Lays Classic chips, opened and undated. 1 package- white powder, open, unlabeled, and undated. The package was resting on the shelf with biscuit mix and pancake mix. Staff were unable to determined what was in the package. 1 package - 4 pounds (lbs) Jello Cheesecake Filling mix, open and undated. 3 condiment containers - contained a dark liquid substance later identified as syrup, unlabeled and undated. 1 container- 5 lbs peanut butter, observed laying	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 46 on its side, peanut butter residue on the outside of the container, lid not sealed. The floor in the dry storage was sticky with dark residue in the doorway. The Manager in Training stated, "I think we just switched out the juice boxes". Next to the doorway was a juice pump system. The nozzle for a juice container was laying on the floor with a thick sticky substance covering the nozzle and tubing. A dark residual substance was visible inside the tubing in dependent locations. The tubing leading off the nozzle was attached to the same pump as 3 other juice containers. Observation of the walk-in refrigerator revealed on the shelf and available for use: 1 package - 5lbs Casa Angelo Grated Parmesan Cheese, facility sticker label on the package reads opened on 5/9 and labeled discard by 5/16. 1 container- 16 ounces (oz) liquid egg whites, undated and open to the environment. Observation of the walk-in freezer revealed on the shelf and available for use: 1- unlabeled and unidentified previously cooked meat wrapped in plastic wrap. The date "4/7" was written on the plastic wrap. Staff were unable to determine if 4/7 was the date it was cooked, the date it was placed in the freezer, or the date it should be discarded. 1- package later determined to be hash browns, open and undated. 1- package Italian Sausages open and undated. Observation of the stand-up freezer revealed: 1 metal container- staff identified as ice cream, unlabeled and undated. 1 package- Rich's pre-sheeted pizza dough, undated and open to the environment.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 47 The above findings were confirmed with the Account Manager at the time of the observations. On 5/19/24 at 11:00 a.m., a surveyor observed improper air gaps on the drain line of a sink used for food preparation and the ice machine. This direct connection of wastewater and potable water was in violation of the 10-114 State of Maine Rules Chapter 226, definition Section A, which defines an Air-Gap Separation - A physical separation between the free-flowing discharge end of a potable water supply pipeline and an open or non-pressure receiving vessel. An air-gap separation shall be at least twice the diameter of the supply pipe measured vertically above the overflow rim of the vessel - in no case less than one inch (2.54 cm). The above was observed and confirmed with the Account Manager at the time of the finding. On 5/19/24 at 11:15 a.m., observation of Disaster Food Storage revealed on the shelf and available for use: 12- 46 fluid (fl) oz bottles, Thick and Easy Clear Hydrolyte Honey Consistency, Use by Date 12/19/20 2- 46 fl oz bottles, Thick and Easy Clear Hydrolyte Honey Consistency, Use by Date 9/2/23 6- 46 fl oz bottles, Thick and Easy Clear Hydrolyte Honey Consistency, Use by Date 10/28/23 2- 46 fl oz bottles, Thick and Easy Clear Hydrolyte Honey Consistency, Use by Date 7/19/23 9- 15oz can, Thick-it Beef Stew Puree, Expiration date 3/16/23	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 48 The above was observed and confirmed with the Account Manager at the time of the finding. On 05/19/24 at 12:10 p.m., a surveyor observed the Cook plating meals. The Cook stated he forgot to check food temperatures prior to serving. Observation of the temperature binder with the Account Manager revealed the last recorded food temperatures were taken on 5/2/24, seventeen days ago. On 5/19/24 at 12:50 p.m., in an interview with a surveyor, the Cook stated, "I have not done them every day." I have done them most of the days, but I won't lie and say I've done it every day. At this time the surveyor confirmed that food temperatures were not taken consistently to prevent food borne illness prior to serving resident. On 5/20/24 at 7:15 a.m., a surveyor observed improper air gaps on the drain line of a sink used for food preparation and the ice machine, this was confirmed on observation with the Account Manager. On 05/20/24 at 7:20 a.m., A surveyor observed: 1 package- sub rolls, open and undated 1 package- of hamburger buns, open and undated 1 package- unidentified white powder in the dry storage on shelf available for use open, unlabeled, and undated. On 5/20/24 at 7:25 a.m., in an interview with a surveyor, the Account Manager stated they should be dating the packages. At this time the surveyor confirmed the above findings.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 49 On 5/21/24 at 8:18 a.m., a surveyor observed improper air gaps on the drain line of a sink used for food preparation and the ice machine, this finding was confirmed with the Account Manager. On 5/22/24 at 9:00 a.m., a surveyor observed improper air gaps on the drain line of a sink used for food preparation and the ice machine, this finding was confirmed with the Account Manager.	F 812		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on employee file reviews and interview, the facility failed to implement and maintain an effective training program which includes, at a	F 947	CNA #3 has received documented education on abuse. An audit of employee files was completed to validate that all CNAs have received their required mandatory education. The facility ensures that CNAs receive no less than 12 hours of annual training that is inclusive of dementia management and resident abuse prevention. Facility leadership and CNAs will be re-educated to this process. DON/Designee will complete audits of CNA mandatory education completion weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	7/6/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. BUILDING _____ B. WING _____	05/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 947	Continued From page 50 minimum, training on abuse for 1 of 4 Certified Nursing Assistants (CNA) reviewed (CNA3). Finding: On 5/22/24, the following employee record was reviewed: CNA3 was hired on 1/29/24. There was no documented abuse training completed by CNA3 in the employee file. On 5/22/24 at 3:09 p.m., in an interview with the surveyor, the Director of Nursing confirmed that she was unable to locate documentation indicating CNA3 completed her abuse training.	F 947		