STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2555	A. BUILDING: _____ B. WING _____	C 12/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFIELD REHAB & LIVING CENTER	95 MAIN STREET HARTLAND, ME 04943

(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) COMPLETE DATE
P 000	Initial Comments On 12/9/24, an unannounced on-site visit was made at Sanfield Rehabilitation & Living Center, Residential Care, for the purpose of complaint investigation #ME00049771. It was determined that Sanfield Rehabilitation & Living Center, Residential Care, is not in substantial compliance with 10/144, Chapter 113- Regulations Governing the Licensing and Functioning of Assistive Housing Programs-Level IV, Private Non-Medical Institutions.	P 000		
P 302	7.1 Medications and Treatments Use of safe and acceptable procedures. The administrator shall ensure that all persons administering medications and treatments (except residents who self-administer) use safe and acceptable methods and procedures for ordering, receiving, storing, administering, documentation, packaging, discontinuing, returning for credit and/or destroying of medications and biologicals. All employees must practice proper hand washing and aseptic techniques. A hand-washing sink shall be available for staff administering medications. [Classes I/II/III] This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that staff ordered and administered medication for 1 of 1 residents reviewed. Finding: On 11/27/24, the Division of Licensing and Certification received a facility reported incident	P 302		

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P 302	Continued From page 1	P 302		

alleging staff had not followed order entry procedures and did not seek assistance resulting in a delay in treatment for a Resident experiencing chest pain.

A review of Resident #1's clinical record revealed that on 11/22/24, Resident #1 complained of chest pain and difficulty breathing. The physician evaluated Resident #1 that evening and ordered Nitroglycerin 0.4 mg (milligrams) under the tongue every 5 minutes, if still having chest pain after 3 doses, call 911.

A review of the facility's follow-up investigation noted that when the medication was not delivered by the pharmacy, staff on duty did not request the medication from the emergency drug kit, available on the adjacent skilled/long term care unit. The medication did not arrive until the afternoon of 11/23/24.

On 11/25/24 at approximately 5:30 a.m., Resident #1 reported sternal chest pain. The staff on duty did not recognize the symptoms of a possible heart attack and administered Tylenol, an over the counter pain medication. The staff did not seek assistance from the licensed nurses on the nursing unit. At approximately 7:00 a.m., day shift staff did seek assistance from a licensed nurse. Resident #1 was transferred to the hospital via ambulance and was diagnosed with a heart attack.

On 12/9/24 at approximately 11:00 a.m., in an interview with a surveyor, the Administrator discussed the investigation and stated that while staff on duty were able to identify the steps needed to process a physician's order, and how to seek assistance from appropriate resources, they had not done so. The Administrator

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P 302	Continued From page 2 confirmed the facility had no written policy or procedures for processing provider orders.	P 302		
P 501	12.10 Standards for Resident Care Medical and health care. The facility is responsible for promptly coordinating and assisting in accessing appropriate services for residents. The health care of every resident shall be under the supervision of a duly authorized licensed practitioner. Each resident shall have an annual physical, unless otherwise specified by the licensed medical professional. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to promptly coordinate and assist in obtaining medical services for 1 of 1 residents reviewed. Finding: A review of Resident #1's clinical record revealed that on 11/22/24, Resident #1 complained of chest pain. That same day, the physician examined Resident #1 and ordered a chest xray to rule out possible pneumonia. On 11/25/24, Resident #1 complained of chest pain again, and was transported by ambulance to the emergency department for evaluation. On 11/27/24, the facility reported the incident. A review of the facility's investigation revealed that staff on duty from 11/22/24 through 11/24/24 either did know how to enter the order in the electronic medical record, or did not seek assistance to complete the order. On 12/9/24, in an interview with a surveyor, the	P 501		

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P 501	Continued From page 3 Administrator confirmed that the facility did not have a policy and procedures for order entry, and that staff had failed to communicate and follow-through to ensure Resident #1's xray was obtained.	P 501		