STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205097	A. BUILDING _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWAY CENTER FOR HEALTH & REHABILITATION, LLC	29 MARION AVE NORWAY, ME 04268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS From 4/22/25 through 4/24/25, on-site visits were conducted at Norway Center for Health & Rehabilitation for the purpose of the annual Long Term Care Survey Process for Federal Recertification and investigating compliants #ME00048375, #ME00048444, #ME00049730, #ME00051000 and #ME00051215. It was determined that Norway Center for Health & Rehabilitation is not in substantial compliance with 42 CFR 483, Sub-part B Requirements for Long Term Care Facilities.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to provide personal hygiene for 1 of 1 resident reviewed for Activities of Daily Living (ADL) (Resident #26). Findings: On 4/22/25 at 9:32 a.m., 4/23/25 at 12:09 p.m., and 4/23/25 at 2:20 p.m., Resident #26 was observed to have notable buildup on his/her bottom teeth. During an interview with Resident #26 representative stated [Resident #26] bottom teeth have build up on them, and resident can't brush them independently and further stated [Resident #26] used to insist on brushing their teeth when	F 677		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205097	A. BUILDING _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWAY CENTER FOR HEALTH & REHABILITATION, LLC	29 MARION AVE NORWAY, ME 04268

(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 677	Continued From page 1 they were young, and it would bother resident to not have them clean. Review of Resident 26's care plan, updated 3/16/25 states: Personal Hygiene: partial/moderate assistance, helper provides less than half the effort. Oral Hygiene: set up/clean up assistance, helper provides set up/clean up assistance, ..." Review of quarterly Minimum Data Set (MDS) dated 2/18/25 revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of 3 of 15 indicating he/she is not cognitively intact. Review of Resident #26's Activities of Daily Living (ADL)" Oral Hygiene" from 4/1/25 through 4/23/25 lacked evidence that he/she refused any oral hygiene care. During an interview on 4/24/25 at 2:00 p.m., Certified Nursing Assistance (CNA) stated residents should be offered oral hygiene when getting ready in the morning and before bed. CNA further stated that if a resident refuses it should be documented in the chart as a refusal. At this time a surveyor asked about Resident #26's teeth. CNA stated Resident #26 is "not too big on brushing." This surveyor and CNA went into Resident # 26's room and Resident #26 was asked if he/she would like to have his/her teeth brushed and he/she stated that would be very nice. On 4/23/25 at 2:20 p.m., Registered Nurse (RN) observed Resident #26's mouth and confirmed obvious build up . On 4/23/25 at approximately 2:30 p.m., the above was discussed with Director of Nursing and	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205097	A. BUILDING _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWAY CENTER FOR HEALTH & REHABILITATION, LLC	29 MARION AVE NORWAY, ME 04268

(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 677	Continued From page 2 Assistant Director of Nursing.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to obtain provider orders for the maintenance and monitoring of a pacemaker. In addition, the facility failed to initiate goals and interventions necessary for the presence of a pacemaker for 1 of 13 care plans (Resident #34). Findings: Resident #34 was admitted in 2/25 and has a diagnoses to include chronic heart failure, ischemic cardiomyopathy, hypertensive heart disease, and type II diabetes mellitus. Review of Resident #35's clinical record revealed appointment "CM Heart 4/10/25 at 1:00 p.m." Review of Resident #34's clinical record "NSG Admission/Readmission Evaluation" originally dated 2/20/25 section: "Devices and treatments (care profile) is blank in subsection: pacemaker ..."	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205097	A. BUILDING _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWAY CENTER FOR HEALTH & REHABILITATION, LLC	29 MARION AVE NORWAY, ME 04268

(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 3	F 684		

Review of clinical record "[[Hospital] Consultation Note] dated 2/14/25 revealed Resident #35 had a past medical history of "presence of combination internal cardiac defibrillator (ICD) and pacemaker."

Review of Resident #34's signed provider orders for April 2025 lacked evidence that orders regarding maintenance/monitoring of Resident #34's pacemaker.

Review of Resident #34's care plan initiated 2/21/25 lacked evidence of goals and interventions for the presence of a pacemaker.

During an interview on 4/23/25 at 12:04 p.m., Registered Nurse (RN) stated Resident #34 did not go to his/her appointment scheduled for 4/11/25 at CM Heart as resident had a meeting with the care team, and they believed it was something Resident #34 could do once he/she was discharged. At this time RN stated the appointment was for a device check, but she was unsure if Resident #34 had a pacemaker or not and didn't know what kind of device resident has. Review of facility appointment calendar "April 2025" revealed crossed out appointment on 4/11 states "[Resident #35] CM Heart, 300 Main St, Lew [Lewiston] @ 13:00." Further review of residents clinical record lacked evidence Resident #35 went to this appointment.

During an interview in presence of RN on 4/23/25 at 12:25 p.m., Resident #34 used his/her right hand and patted his/her upper left chest and confirmed he/she does have a pacemaker/defibrillator and hasn't gone to the cardiologist for a really long time and doesn't know why. States he/she does have a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205097	A. BUILDING _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWAY CENTER FOR HEALTH & REHABILITATION, LLC	29 MARION AVE NORWAY, ME 04268

(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 4 pacemaker monitor at home. Review of admission Minimum Data Set (MDS) dated 2/26/25 revealed Resident #34 had a Brief Interview for Mental Status (BIMS) of 13 of 15 indicating he/she is cognitively intact. On 4/23/24 at approximately 3:15 p.m., the above was discussed with Director of Nursing and Assistant Director of Nursing.	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, interviews, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to respiratory care for 1of 1 resident reviewed for respiratory care (Resident #34). Findings: On 4/22/25 at 10:24 a.m., and 4/23/35 at 7:35 a.m., observations of Resident #34's nebulizer machine was observed on top of dresser with tubing and mask attached and resting on top of the nebulizer and not in a bag.	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205097	A. BUILDING _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWAY CENTER FOR HEALTH & REHABILITATION, LLC	29 MARION AVE NORWAY, ME 04268

(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 5 Review of Resident #34's orders active for April 2025 revealed order for "Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML3 ml inhale orally every 4 hours as needed for Wheezing or dyspnea; flu Lung sounds pre and post nebulizer treatment: C=Clear, D=Diminished W=Wheeze, bCR=Crackles R=Rhonchib Report abnormal lung sounds to RN for assessment. Document total min spent for nebulizer TX. Document Respiratory Rate before and after TX. Review of Resident #34's TAR dated April 2025 revealed nebulizer was last used 4/9/25. On 4/23/25 at 12:25 p.m., during an observation of Resident #34, Registered Nurse (RN) confirmed the nebulizer tubing was unbagged and stated Resident #34 has not used the nebulizer in a few weeks and it should not still be in there. On 4/23/25 at approximately 4:15 p.m., the above was discussed with Director of Nursing and Assistant Director of Nursing.	F 695		
F 725 SS=F	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 §483.71.	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205097	A. BUILDING _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWAY CENTER FOR HEALTH & REHABILITATION, LLC	**29 MARION AVE NORWAY, ME 04268**

(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 6 §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 record reviews, interviews, and the Payroll Based Journal Report (PPJ), the facility failed to ensure sufficient direct care staff were scheduled and on duty to meet the needs of residents for 1 of 4 quarters reviewed for weekend staffing (9/1/24 through 12/31/24). Findings: Review of Center for Medicare & Medicaid (CMS) PPJ Report revealed the facility triggered for low weekend staffing during the first quarter (10/1/24 through 12/31/24). During a review of first quarter weekend staffing with scheduler on 4/24/25 at 12:05 p.m., the scheduler confirmed the facility was not adequately staffed for 7 of 39 days reviewed. During a review of the daily staffing sheets with the Director of Nursing (DON) on 4/24/25 at 1:05 p.m., the above was confirmed. At this time DON	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205097	A. BUILDING _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWAY CENTER FOR HEALTH & REHABILITATION, LLC	29 MARION AVE NORWAY, ME 04268

(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 7 stated she would have daily punches obtained for the days in question. The daily punches were not obtained by the end of survey.	F 725		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the Culinary Services: Storage of Food & Supplies Policy and Procedure, revised 2/2022, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for a hood, ceiling lights, a ceiling vent, and the walk-in refrigerator door; and failed to ensure foods were labeled and dated in a walk-in freezer for 1 of 1 kitchen tour for 1 of 1 day of survey (4/22/25). Findings:	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205097	A. BUILDING _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWAY CENTER FOR HEALTH & REHABILITATION, LLC	29 MARION AVE NORWAY, ME 04268

(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 8 The facility's Culinary Services: Storage of Food & Supplies Policy and Procedure, revised 2/2022, noted: 2. Labeling and rotating food supply: a. Food products that are opened and not completely used or transferred from its original package to another storage container or prepared at the facility and stored should be labeled as to its contents and used by dates. 4. Food removed from its original container must be labeled with the common name of the food. On 4/22/25 from 9:00 a.m. to 9:30 a.m., an initial kitchen tour was conducted with the Food Service Director in which the following findings were observed: > The hood over the dish washing machine had rust build-up on the inside of it. > There were 3 ceiling lights, over a food preparation area, that had cracked/broken lenses. > There was a ceiling vent, over a food preparation area, that was heavily soiled with dust and had worn/missing paint. > The walk-in refrigerator door had rust build-up on the bottom inside of the door and up about halfway of the door. > The walk-in freezer had 8 bags of what appeared to be cauliflower that was not labeled and dated. On 4/22/25 at 9:30 a.m., in an interview, the Food Service Director confirmed the findings.	F 812		
F 940 SS=E	Training Requirements CFR(s): 483.95 §483.95 Training Requirements A facility must develop, implement, and maintain	F 940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205097	A. BUILDING _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWAY CENTER FOR HEALTH & REHABILITATION, LLC	29 MARION AVE NORWAY, ME 04268

(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 940	Continued From page 9 an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.71. Training topics must include but are not limited to- This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to implement and maintain an effective training program for nursing staff contracted through the Clipboard Application (App), and NURSA App in the areas of dementia care, resident rights, neglect training by failing to ensure contracted Clipboard/NURSA Professionals (Users) completed training prior to independently providing services to residents for 3 of 3 contracted staff reviewed during a complaint investigation.(Staff #1,# 2, & # 4). Findings: Review of the Clipboard app "Terms of Service Agreement" last updated 10/9/23" states, "Clipboard operates an online, marketplace, accessed through the Site, that allows third-party clients (each, a "Client") to post open shifts at facilities (each, a "Facility"), and allows independent contractor professionals (each, a "Professional") to view and sign up to work such shifts if they so choose." Under the subheading "2.1 CLIPBOARD'S ROLE AS A MARKETPLACE" states, "Clipboard merely makes the Site and Services available to enable Professionals and Clients to find and transact directly with each other ... Users alone are responsible for evaluating and determining the suitability of any	F 940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205097	A. BUILDING _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWAY CENTER FOR HEALTH & REHABILITATION, LLC	29 MARION AVE NORWAY, ME 04268

(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 940	Continued From page 10	F 940		

shift, Client or Professional."

Review of the NURSA app "Terms of Service Agreement" dated "3/26/25" states, "The NURSA Platform is a software platform whereby Facilities and Clinicians may connect for posting, viewing, requesting, and acceptance of Shifts." Subsection 7. ADDITIONAL TERMS APPLICABLE TO CLINITIANS: 7.2 Independent contractor status: ...Clinicians utilizing the Nursa Platform do so only as independent contractors ..."

Review of "National Health Care Agency Orientation Packet" undated lacked evidence of Neglect, Resident Rights, and dementia training for agency/contracted staff.

Review of facility provided "Contracted Staff List" revealed the following:
Staff#1 first shift on 12/12/24 through staffing app (Clipboard) and has worked a total of 2 shifts. Review of Staff #3's education file lacked evidence she received education in the areas of dementia care, resident rights, neglect training.
Staff #2's first shift was on 10/28/24 through the staffing app (Clipboard) and has worked 11 shifts. Review of Staff#2's education file lacked evidence she received education in the areas of dementia care, resident rights, neglect training.
Staff #3 first shift was on 11/14/24 through the staffing app (NURSA) and has worked 2 shifts. Review of Staff #3's education file lacked evidence she received education in the areas of dementia care, resident rights, neglect training.

During an interview on 4/23/25 at 12:05 p.m., the Scheduler stated that if there is a call out or no show for a shift the Scheduler or the Director of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205097	A. BUILDING _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORWAY CENTER FOR HEALTH & REHABILITATION, LLC	29 MARION AVE NORWAY, ME 04268

(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 940	Continued From page 11	F 940		

Nursing (DON) will be notified. The shift will be posted on the Clipboard App with a fee rate. A Clipboard User will accept the shift and an email from Clipboard will be sent to the Scheduler and the DON notifying them the shift has been filled. If the User cancels the shift, the shift will automatically repost. Users who don't show up for their shift are automatically blocked. At this time scheduler stated that they currently do have access/use of the Clipboard app but have not used it since 12/25/24 because there were too many weekend" no call, no shows." During a follow up interview on 4/23/25 at 12:14 p.m., the Scheduler stated the facility also uses the NURSA app for staffing needs but has not used them since 4/13/25. At this time the Scheduler and a surveyor reviewed "Agency Report 01/01/2025-04/22/2025." The Scheduler confirmed NURSA staff normally only work in Residential Care, but they did use them in Long Term Care on 12/26/24 for an 8 hour shift.

During an interview on 4/24/25 at 8:50 a.m., with 2 surveyors, the Director of Nursing stated agency and contracted staff from Clipboard and NURSA apps have to complete an online orientation packet prior to the first shift worked, which includes abuse, neglect and misappropriation, and the charge nurse does an agency walk around for emergency exits, and there is a sign off sheet that is completed. DON further stated the staff hired through Clipboard and NURSA apps receive dementia training through their app and the facility does not track it. At this time a surveyor asked for evidence of "sign off sheets." For Clipboard and NURSA staff. These were not provided by the end of survey.