Genesis

October 31, 2023

Ms. Celine Donohue, RN, Long Term Care Supervisor

Maine Department of Health and Human Services

Division of Licensing and Certification

11 State House Station

Augusta, Maine 04333-0011

Dear Ms. Donohue:

In follow up to the recent complaint survey at Sandy River Center conducted on October 3, 2023, please find attached for your review our revised Plan of Correction submission. All alleged deficiencies will be corrected by November 15, 2023.

Please do not hesitate to contact me with any follow up questions at 207-779-6591, x 2205.

Sincerely,

Joanne M. Shaw, MSM, LNHA

Administrator, Sandy River Center

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205069	A. BUILDING _____ B. WING _____	C 10/03/2023

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

(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 10/3/23 an on-site visit was conducted at Sandy River Center for the purpose of complaint investigation #ME00045029. It was determined that Sandy River Center is not in substantial compliance with 42 CFR Part 483, Subpart B Requirements for Long Term Care Facilities. ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 000	Sandy River 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 677 SS=D	§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 interviews and record review, the facility failed to provide a resident with care and services (incontinence care/mobility assistance) to promote physical, mental health, and well-being in a timely manner for 1 of 3 residents sampled (Resident #2). Finding: On 10/3/23 at 11:20 a.m., in an interview with a surveyor, Resident #2 stated "I had to wait for 2 and a half hours in my own mess this morning. They said they had to get breakfast over with before they could clean me up." Resident #2 stated this happened at 7:30 a.m. and he/she waited until 10:00 a.m. for assistance. Surveyor asked if this happened often, Resident #2 stated "I've laid here for 3-4 hours before." He/she stated staff brought in the breakfast tray and left it on the overbed table. Resident #2 stated "I couldn't eat it because of the position I was in and eventually they took it and I didn't get anything."	F 677	This event happened in the past and cannot be corrected. Residents were interviewed to determine if their needs were met timely. An audit of resident records and observation was completed to validate that resident incontinence needs were met. The facility validates that Activities of Daily Living (ADLs) are provided in accordance with accepted standards of practice, the care plan, and the patient's choices and preferences, inclusive of: hygiene, mobility, elimination, dining, communication. The facility completed incontinence evaluations of those residents in need of incontinence care to determine the frequency of	11/15/2023

			toileting or frequency of incontinence care. Tasks are developed in the documentation POC for staff to sign off as completed on incontinence care and/or toileting task timely per resident evaluations. CNA staff will be re-educated to this process. Director of Nursing/designee will conduct random resident interviews to validate care needs are met timely, random observation of incontinent care and/or toileting to validate incontinent care/toileting is being completed timely, and documentation of task in POC to validate incontinence/toileting care is recorded followed. This will be weekly x 4 weeks, then biweekly x 4 weeks, then monthly audits x 2 months to ensure compliance with incontinence management. Results of these audits will be submitted to the QAPI committee for further review and recommendation.	

Administrator 10/31/23

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

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.

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F 677	Continued From page 1 Resident #2 stated he/she had been slumped towards the left side and could not right him/herself in bed without staff assistance, and he/she needed to be cleaned before he/she could sit back up due to incontinence. The surveyor asked if he/she had any wounds on his/her bottom. Resident #2 stated "I have little sores on my butt. The last thing I need is to sit here in urine or poop." Resident #2 stated he/she is a double amputee and cannot get out of bed alone. Surveyor asked if staff knew he/she needed help this morning when the tray was brought in, Resident #2 stated, "one came in and said 'yup' and left. The other said I'd have to wait until breakfast was over and she came back at 10:00." On 10/3/23 at 11:35 a.m., in an interview with CNA #1, a surveyor asked if Resident #2 had been incontinent this morning and had to wait to be changed. CNA #1 confirmed he/she had left and came back to change Resident #2 after breakfast. The surveyor asked if Resident #2 had any sores on his/her skin. CNA #1 stated "he/she does have sores. He/she won't offload." The surveyor asked if it always takes 2 staff to reposition Resident #2 in bed. CNA #1 stated, "I can do it, sometimes it can take 2." On 10/3/23 at 11:40 a.m., in an interview with CNA #2, a surveyor asked if Resident #2 had been incontinent this morning and had to wait until after breakfast to be changed. CNA #2 confirmed Resident #2 had been incontinent and was changed after breakfast. CNA #2 comfired resident is impatient and wants it right off. We've been busy going round and round." Resident #2's clinical record noted an admission date of 1/24/23, and diagnoses which included:	F 677		

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F 677	Continued From page 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Chronic Pain, Hypertension, and bilateral below the knee amputations. The Minimum Data Set (MDS) 3.0, Quarterly Assessment, completed 7/17/23, noted a BIMS (Brief Interview of Mental Status) score of 14, indicating intact cognition. Resident #2 was coded as requiring extensive, 2-person assistance with bed mobility, transfers, dressing, toileting, and personal hygiene, and was frequently incontinent of urine. A stage III pressure injury was noted that was not present upon admission. Resident #2's care plan, with a revision date of 8/11/23, included Activities of Daily Living, with extensive assistance for toileting, and Skin Integrity/Actual Breakdown. A nursing wound assessment, dated 9/26/23, noted moisture associated skin damage (MASD), and "Wound appears stalled at this time. No symptoms of infection. No complaints of pain. Orders for treatment from wound clinic completed by this nurse. Resident encouraged to reposition and continue to leave brief unsecured to allow the area not to be saturated in moisture and urine." A provider note, dated 8/21/23, stated "Patient seen today for follow up and med review. He/she is in his/her bed waiting to be transferred up for breakfast. He/she reports "my butt hurts". He/she does have transfers by hoyer and is a bilateral lower extremity amputee. He/she is teary eyed today on exam, upon provider arrival in room as he/she is wanting out of bed and has "been waiting an hour". Provider did advise support staff for transfer assist for up to table for a.m. meal." On 10/3/23 at 3:45 p.m., in an interview with the Administrator and the Director of Nursing, the	F 677		

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F 677	Continued From page 3 surveyor discussed that Resident #2 had reported being incontinent this morning and was left in his/her soiled brief through breakfast, which he/she was unable to eat, from 7:30 am until 10:00 am. The surveyor advised that 2 direct care staff had confirmed the finding.	F 677		
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- (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 review and interview, the facility failed to ensure that physician's orders were followed for 1 of 2 residents reviewed for pressure ulcer care (Resident #1). Findings: A review of the clinical record for Resident #1, indicated he/she was admitted to the facility on 8/9/23 from an acute care hospital. The hospital discharge summary, dated 8/9/23, on page 6, described Resident #1's seven (7)	F 686		

	pressure injuries. The area on Resident #1's right heel			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

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F 686	Continued From page 4 was described as a dark purple DTI (Deep Tissue Injury) with intact skin. The periwound is boggy, reddened and blanchable. The recommendations stated to "offload the area, use a Tru-Vue heel boot, apply Skin Prep twice a day to clean and dry affected area and leave open to air." Physician documentation revealed Resident #1 was evaluated by the facility's provider on 8/10/23, who noted "bilateral heels with DTI's." Provider order, dated 8/30/23, stated "Right heel wound: Cleanse with wound wash. Pat dry. Apply Sure Prep to periwound. Apply Maxsorb AG (Silver) to wounds, cover with ABD (abdominal) pads and Kerlix wrap. To be changed every other day and PRN (as needed)." A review of Resident #1's August and September 2023, TAR, noted that wound care for the right heel was not documented as being provided on 8/31/23, 9/2/23, and 9/4/23. On 10/3/23 at 2:45 p.m., in an interview with a surveyor, the Wound Care Nurse confirmed there had been a problem when entering the new orders from 8/30/23 and as a result, the orders were not visible on Resident #1's TAR (Treatment Administration Record). The nurse confirmed that due to this error, wound care had not been provided for the right heel wound from 8/30/23 until 9/6/23. Wound evaluation, dated 9/20/23, for Resident #1's right heel noted the following: "Dressing removed with this writer's initials and date of 9/13/23. Unit manager aware." The wound was described as a Stage III pressure injury.	F 686	This event happened in the past and cannot be corrected. An audit was conducted of the facility's wound treatment orders to ensure they are in place and correctly assigned to the TAR (Treatment Administration Record). The facility validates that physician orders are entered correctly, followed and documentation reflects this. The facility reviews orders entered by licensed staff and/or providers within 24 hr of entering through the 24 hr chart check systems to validate orders are entered correctly in PCC enabling the order to appear on the MAR and/or TAR. The facility also reviews EMAR documentation through AM meeting process to validate that the orders are followed and documented. Staff will be re-educated to this process. Director of Nursing/designee will complete audits of MD treatment orders to validate orders are entered correctly to be visible on the MAR/TAR and staff are documenting completion of treatments. This will be weekly x 4 weeks, then biweekly audits x 4 weeks, then monthly audits x 2 months to ensure physician orders for wound treatments are followed and documented. Results of these audits will be submitted to the	11/15/2023

			QAPI committee for further review and recommendation.	

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F 686	Continued From page 5 On 10/6/23 at 3:08 p.m., in a telephone interview with the Administrator and the Director of Nursing, the surveyor discussed that the wound evaluation indicated the right heel dressing had not been changed from 9/13/23 until 9/20/23. The National Pressure Ulcer Advisory Panel (NPUAP) classifies pressure ulcers according to depth. The stages are as follows: Stage I: The skin is intact with the presence of non-blanchable erythema. Stage II: There is partial-thickness skin loss involving the epidermis and dermis. Stage III: There is a full-thickness loss of skin that extends to the subcutaneous tissue but does not cross the fascia beneath it. Deep Tissue Pressure Injury (DTI): Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue,	F 686		
F 842 SS=E	subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury. Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is	F 842		

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F 842	Continued From page 6 resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.	F 842		

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F 842	Continued From page 7 §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that clinical records were complete and contained accurate information for 2 of 3 residents reviewed for pressure ulcer care (#1, #2). Findings: 1. A review of medication and treatment administration records (MAR/TARs) for Resident #1 noted multiple days of incomplete, and/or lack of documentation, in August and September, 2023, as follows: August 2023: Documentation of Pain Assessment - Day shift:	F 842	This event happened in the past and cannot be corrected. An audit was conducted of MAR/TAR (Medication Administration Record/Treatment Administration Record) and POC (Point of Care) documentation to validate physician orders are followed and documented, this includes documentation of ADL care provided. The facility follows physician orders and documents in the MAR/TAR that these orders are followed. The nursing staff documents care delivery to the resident in POC. Nursing staff will be re-educated to this process. Director of Nursing/designee will complete weekly audits x 4 weeks, then biweekly audits x 4 weeks, then monthly audits x 2 months to ensure MAR/TAR and POC completion. Results of these audits will be submitted to the QAPI committee for further review and recommendation.	11/15/20 23

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F 842	Continued From page 8 8/17/23, 8/22/23, 8/27/23 Hydromorphone 2 milligrams by mouth every 8 hours for pain - midnight dose: 8/18/23 Nonpharmacological interventions for pain - Day shift: 8/17/23, 8/22/23, 8/27/23 Nystatin Suspension 100,000 units/ml (milliliter) give 5 ml po 4 times daily for thrush - 5:00 p.m. dose: 8/17/23, 8/22/23, 8/24/23 Protein liquid twice daily for impaired skin - 5:00 p.m. dose: 8/22/23, 8/24/23 Daily vital signs - Day shift: 8/17/23, 8/22/23, 8/24/23, 8/27/23 Weekly weight - Day shift: 8/21/23 Left dorsal foot wound: Cleanse with wound wash. Pat dry. Apply sure prep to periwound. Paint wounds with betadine, cover with kerlix wrap. To be changed every other day and as needed. Day shift: 8/26/23 Left lateral lower leg wound: Cleanse with wound wash. Pat dry. Apply sure prep to periwound. Apply xeroform to wounds, cover with optifoam silicone dressing. To be changed every other day and as needed. Day Shift: 8/26/23 Left lower quadrant wound: Cleanse with wound wash. Pat dry. Apply sure prep to periwound. Apply xeroform to wounds, cover with Optifoam. To be changed every other day and as needed. Day shift: 8/26/23 Right and left heel wounds: Cleanse with wound cleanser. Apply skin prep twice a day to affected area and leave open to air two times a day - 5:00 p.m.: 8/22/23 Right and left heel wounds: Cleanse with wound wash. Pat dry. Apply sure prep to periwound. Apply xeroform to wounds, cover with ABD pads and kerlix wrap. To be changed every other day and as needed. Day shift: 8/26/23 Right dorsal aspect of foot: Cleanse with wound wash. Pat dry. Apply skin prep to area two times	F 842		

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F 842	Continued From page 9 a day. Evening treatment: 8/22/23 Right flank extending down to sacral spine: Cleanse with wound cleanser. Apply skin prep twice a day to affected area and leave open to air. Evening treatment: 8/22/23 September, 2023: Daily vital signs - day shift: 9/15/23 Cleanse abdominal folds every shift due to erythema - day shift: 9/8/23, 9/17/23; night shift: 9/13/23, 9/14/23, 9/15/23 Coccyx wound: Cleanse with wound wash. Pat dry. Apply sure prep to periwound. Hydroferra blue to wound bed, cover with optifoam sacral dressing. To be changed every other day and as needed. Day Shift: 9/1/23, 9/17/23 Left dorsal foot wound: Cleanse with wound wash. Pat dry. Apply sure prep to periwound. Paint wounds with betadine, cover with kerlix wrap. To be changed every other day and as needed. Day shift: 9/1/23 Left lateral lower leg wound: Cleanse with wound wash. Pat dry. Apply sure prep to periwound. Apply xeroform to wounds, cover with optifoam silicone dressing. To be changed every other day and as needed. Day shift: 9/1/23 Left lower quadrant wound: Cleanse with wound wash. Pat dry. Apply sure prep to periwound. Apply xeroform to wounds, cover with Optifoam. To be changed every other day and as needed. Day shift: 9/1/23 Low air-loss mattress to bed every day and night. Check settings and functions every shift. Night shift: 9/13/23, 9/14/23, 9/15/23 2. A review of Resident #2's, Certified Nursing Assistant (CNA) documentation of activities of daily living (ADLs) for September and October 1-2, 2023, revealed multiple days lacking	F 842		

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F 842	Continued From page 10 documentation on multiple shifts as follows: September, 2023: Bathing: 17 out of 30 days Bed Mobility: 18 out of 30 days Dressing: 18 out of 30 days Drinks/snacks other than meals: 18 out of 30 days Locomotion off unit - 20 out of 30 days Locomotion on unit - 21 out of 30 days Mouth care - 17 out of 30 days Personal hygiene - 18 out of 30 days Preventive skin care, including heel/elbow protectors, lotions/creams, pressure redistribution mattress for bed/cusion for chair - 19 ot of 30 days Toileting - 18 out of 30 days Transfers - 19 out of 30 days Meals - 15 out of 30 days October 1-2, 2023: Bathing: 2 out of 2 days Bed Mobility: 2 out of 2 days Dressing: 2 out of 2 days Drink/snack other than meals: 2 out of 2 days Locomotion off unit: 2 out of 2 days Locomotion on unit: 2 out of 2 days Mouth care: 1 out of 2 days Personal hygiene: 2 out of 2 days Preventive skin care including heel/elbow protectors, lotions/creams, pressure redistribution mattress for bed/cushion for chair: 2 out of 2 days Toileting: 2 out of 2 days Transfers: 2 out of 2 days Meals: 1 out of 2 days On 10/6/23 at 3:08 p.m., in a telephone interview with the Administrator and the Director of Nursing, the surveyor discussed the multiple days of	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205069	A. BUILDING _____ B. WING _____	C 10/03/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 11 incomplete documentation of treatments for Resident #1, and of ADL care and assistance provided for Resident #2.	F 842		

October 31, 2023

Ms. Celine Donohue, RN, Long Term Care Supervisor

Maine Department of Health and Human Services

Division of Licensing and Certification

11 State House Station

Augusta, Maine 04333-0011

Dear Ms. Donohue:

In follow up to the recent complaint survey at Sandy River Center conducted on October 3, 2023, please find attached for your review our revised Plan of Correction submission. All alleged deficiencies will be corrected by November 15, 2023.

Please do not hesitate to contact me with any follow up questions at 207-779-6591, x 2205.

Sincerely,

Joanne M. Shaw, MSM, LNHA

Administrator, Sandy River Center