STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1961	A. BUILDING: _____ B. WING _____	11/04/2025

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ORONO COMMONS	117 BENNOCH RD ORONO, ME 04473

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P 000	Initial Comments On 11/3/25 and 11/4/25, onsite visits were conducted at Orono Commons RCIV, for the purpose of completing the state relicensure survey. It was determined that Orono Commons RCIV is not in substantial compliance with 10/144, Chapter 113-Regulaitons Governing the Licensing and Functioning of Assistive Housing Programs- Level IV, Private Non-Medical institutions.	P 000		
P 367	7.17 Medications and Treatments Whenever employees are provided in service training or are taught procedures, the use of equipment or anything else which impacts resident care, there must be documentation in the employee file. This in service training could be taught by other professionals including a Physician, Registered Nurse, Practitioner, Dietician, Physical Therapist, Occupation Therapist, Speech Therapist, product company representative, or other experts in their field. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that in-service education provided by a Registered Nurse (RN) to unlicensed personnel for wound care, was documented in the employee's record for 2 of 5 personnel records reviewed (Certified Residential Medication Aide [CRMA] #4 and #1). Findings: On 11/3/25 during a clinical record review, it was noted that Resident #1[R1] had a physician order for wound care in the form of a dressing change. Review of R1's Treatment Administration Record (TAR) for October has documentation that shows	P 367		

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P 367	Continued From page 1 CRMA #4 completed dressing changes on October 2,3,4 and 5. During an interview with the Residential Care Director (RCD) and review of CRMA #4's personnel file there is no evidence that she received education that was provided by a Registered Nurse (RN) for wound care/dressing change. The RCD explained that the Home Health person who was coming in to do the dressing changes for R1 was the one who showed CRMA #4 how to do the dressing change. During an interview with the on duty CRMA #1, she stated that she has done the dressing change for R1 and was taught how to do the treatment by CRMA #4. A review of the personnel records for CRMA #4 and #1 the files lacked evidence that the employee had received training for wound care/dressing changes by a Registered Nurse. On 11/3/25 at 2:30 p.m. during an interview with the Administrator the surveyor confirmed that CRMA #4 and #1 have not received any education by a Registered Nurse (RN) for wound care. This provision has changed in the rule effective 9-18-25. See the provision of the rule Section 5.R	P 367		
P 449	11.1.1.16 Administrative and Resident Records Name, address and telephone number of the person to be notified and the procedures to be followed in an emergency to cover the immediate care of the resident and disposition of the body at	P 449		

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P 449	Continued From page 2	P 449		

the time of death.

This STANDARD is not met as evidenced by:
Based on record reviews and interview, the facility failed to ensure that procedures to be followed in an emergency to cover the immediate care of the resident and the disposition of the body at the time of death were in the medical records for 3 of 3 residents reviewed (Resident #1{R1], R2 and R3).

Findings:

1. During a clinical record review for R1 it was noted that he/she was admitted to the facility in July 2024. The resident's medical record lacked procedures to be followed in an emergency to cover the immediate care of the resident and/or the disposition of the body at the time of death. A surveyor discussed this finding with the Administrator, on 11/3/25 at 12:39 p.m.

2. During a clinical record review for R2 it was noted that he/she was admitted to the facility in June 2024. The resident's record lacked procedures to be followed in an emergency to cover the immediate care of the resident and/or the disposition of the body at the time of death. A surveyor discussed this finding with the Administrator, on 11/3/25 at 12:39 p.m.

3. During a clinical record review for R3 it was noted that he/she was admitted to the facility in May 2023. The resident's record lacked procedures to be followed in an emergency to cover the immediate care of the resident and/or the disposition of the body at the time of death. A surveyor discussed this finding with the Administrator, on 11/4/25 at 11:00 a.m.

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P 449	Continued From page 3 This provision has not changed in the rule effective 9/18/25. See new provisions of the rule in Section 8.A.1.o.	P 449		
P 450	11.1.2 Administrative and Resident Records A listing of all personal property of significant value to the resident that includes such things as jewelry, radios, television sets, dentures, appliances and other valuables. Where serial numbers are available, these shall be included as part of the record. The record shall be signed and dated by the resident or his/her legal representative. When significant items of personal property are brought into or removed from the facility, it shall be so noted in the record. It shall be noted in the record if a resident has no personal property of significant value. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that a listing of personal property was completed on admission for 2 of 3 residents records reviewed. (Resident #2[R2] and R3) Findings: 1.On 11/3/25, a review of Resident #2's clinical record lacked evidence of a "Resident Personal Belongings Inventory" completed, signed and dated by the resident or his/her legal representative and was not updated as he/she acquired more belongings. Observation of his/her room indicates he/she has numerous personal belongings that are not listed on R2's personal belongings inventory list.	P 450		

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P 450	Continued From page 4 2. On 11/4/25, a review of Resident #3's clinical record lacked evidence of a "Resident Personal Belongings Inventory" being completed and/or updated as he/she acquired more belongings. Observation of his/her room indicates he/she has numerous personal belongings that were not listed on R3's personal belongings inventory list. On 11/4/25 at 11:00 a.m. during an interview with the Administrator the surveyor confirmed these findings. This provision has not changed in the rule effective 9/18/25. See new provisions of the rule in Section 8.A.2.b, 8.A.2.c	P 450		
P 494	12.3 Standards for Resident Care Service plan: A service plan shall be developed and implemented within thirty (30) calendar days of admission for each resident based upon the findings of the resident assessment instrument (RAI). The plan shall address those areas in which the resident needs encouragement, assistance or an intervention strategy. The resident, his/her legal representative (if applicable) and others chosen by the resident shall be actively involved in the development of the service plan, unless he/she is unable or unwilling to participate. There shall be documentation in the resident's record identifying who participated in the development of the service plan. The service plan shall describe strategies and approaches to meet the resident's needs, names of who will arrange and/or deliver services, when and how often services will be provided and goals to improve or maintain the resident's level of functioning. Residents shall be encouraged to be as independent as possible in	P 494		

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P 494	Continued From page 5 their functioning, including ADLs and IADL's if they choose, unless contraindicated by the resident's duly authorized licensed practitioner. The service plan shall be modified, as necessary, based upon identified changes. Residents shall never be required to perform activities specified in the residential service plan or any other activities and cannot be used to replace paid staff. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that the Service Plan was developed and implemented within 30 days of admission and they failed to develop a complete service plan to address the residents current needs for 1 of 3 residents reviewed (Resident #2[R2]), in addition the facility failed to provide evidence that the resident/resident representative's participated in the development of the service plans and was documented in the clinical record for 3 of 3 residents sampled for review (R2,R1 and R3) Findings: 1. On 11/3/25, R2's clinical record was reviewed. R2 was admitted on 6/6/24 documentation indicated that a service plan was developed on 9/10/24 98 days after admission. Since R2's admission his/her service plan has not been updated to address his/her current needs. The service plan was not developed or implemented to address R2's needs for oxygen, Hospice care, the use of a walker and his/her anxiety. Also,	P 494		

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P 494	Continued From page 6 during the clinical record review there was no evidence in the clinical record of the resident or resident representative participating in the development of the service plan. 2. On 11/3/25, R1's clinical record was reviewed. Documentation indicated that a service plan was developed after admission on 7/2/24. There was no evidence in the clinical record of the resident or resident representative participating in the development of the service plan. 3. On 11/3/25, R3's clinical record was reviewed. Documentation indicated that a service plan was developed after admission on 5/23/23. There was no evidence in the clinical record of the resident or resident representative participating in the development of the service plan. On 11/3/25 at 3:04 p.m., During an interview with the Residential Care Director a surveyor confirmed these findings. This provision has changed in the rule effective 9/18/25. See new provisions of the rule in Section 13.C.	P 494		
P 540	13.10 Staffing The pharmacists consultant services. Each facility of more than ten (10) beds shall retain the services of a pharmacist consultant no less than quarterly to: This STANDARD is not met as evidenced by: Based on record reviews and interviews, there was no evidence the Pharmacist visited quarterly and reviewed written policies and procedures for pharmaceutical services, reviewed medication	P 540		

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P 540	Continued From page 7 areas for labeling, storage, temperature, expired medications, locked compartment, access to keys and availability and completeness of a first aid kit, reviewed staff performance in carrying out pharmaceutical policies and procedures, and/or reviewed medication records and initial and date the records when reviewed for 3 of 5 resident records reviewed (Resident #1 [R1], R2, and R3). Findings: 1. On 11/3/25 during a review of R1's clinical record the record lacked evidence that the Medication Regiment Review was completed at a minimum quarterly. 2. On 11/3/25 during a review of R2's clinical record the record lacked evidence that the Medication Regiment Review was completed at a minimum of quarterly. 3. On 11/4/25 during a review of R3's clinical record the record lacked evidence that the Medication Regiment Review was completed at a minimum of quarterly. On 11/3/25 at 12:39 p.m. during an interview and resident record reviews with the Administrator and the Residential Care Director it was stated that the Pharmacist will leave recommendations and those recommendations are put in the residents clinical record if the Pharmacist didn't have any recommendations they did not have any documentation of the review in the record. The facility has moved to using electronic records using Point Click Care partially. The Administrator stated their program has not been set up that allows the Pharmacist to document in the residents clinical records electronically and they	P 540		

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P 540	Continued From page 8 did not sign or date the clinical records. The surveyor confirmed these findings at this time.	P 540		
P 609	15.13 Sanitation/dietary services Second-grade products prohibited. Second-grade products such as unlabeled canned goods, home canned goods, improperly sealed or unsealed containers or packages, outdated food and similar foods are prohibited from use. [Class I/II] This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to remove expired food from the Dining Room cabinet and failed to refrigerate food after opening. Finding: On 11/3/25 at 11:20 a.m. an observation of the Dining Room cabinets showed there were 4 bottled condiments on the top shelf of the bottom cabinet. There was a squeeze condiment bottle of sweet relish that had a best by date of 9/13/25 and was not refrigerated after opening as instructed, a glass bottle of duck sauce that was opened and had directions to refrigerate after opening, a bottle of Zesty Italian dressing with a best when used by date of 4/25/25 with directions to refrigerate after opening and a bottle of steak sauce that had directions to refrigerate after opening. All items were available for use. On 11/3/25 during the observation the surveyor confirmed with the Certified Residential Aide the above findings and the above foods were discarded.	P 609		

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P 609	Continued From page 9 This provision has not changed in the rule effective 9-18-25. See the provision of the rule Section 10.E.6	P 609		