STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205168	A. BUILDING _____ B. WING _____	R 02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD PARK REHAB & LIVING	107 ORCHARD ST 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 2/5/25 an unannounced on-site visit was conducted at Orchard Park Rehabilitation and Living Center to follow up on the deficiencies cited at the annual Long Term Care Survey Process for Federal Recertification for 12/11/24. It was determined that Orchard Park Rehabilitation and Living Center was not compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	{F 000}		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	F 580	See attached POC	2/20/2025

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

Pamela Lovell, BSN MSN Administrator for DRS — 2/19/2025

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 580	Continued From page 1 (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that a medical provider and the resident's representative were notified timely of a significant change and/or incident for 1 of 3 residents reviewed for falls (Resident #1). Findings: Resident #1 has a history of lumbar vertebra fracture and a bone density disorder with a most recent Brief Interview for Mental Status score of 6 out of 15 indicating severe cognitive impairment. Review of the facilities incident report stated Resident #1 had fallen on 2/2/25 at 5:00 p.m. and	F 580	See attached POC	2/20/2025

2/19/2025

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F 580	Continued From page 2 the medical provider was notified of the fall on 2/3/25 at 1 p.m. (20 hours after the fall), the incident report lacked any further description, resident assessment or resident representative notification after the fall. Review of the nursing documentation shows a "Post Fall Observation" completed on 2/3/25 at 4:06 p.m., stating the resident obtained a fall in the dining room while ambulating using a walker and there were no abnormalities in his/her neurological status. The report lacked resident representative notification of the fall. In addition, the post fall nursing documentation lacked evidence of the resident representative being notified of the fall. On 2/5/25 at 2:28 p.m., during an interview, the Director of Nursing stated, she notified the family on Monday, the day after the fall.	F 580	See attached for	2/20/2025
{F 684} SS=E	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, interviews and the facility policies, the facility failed to document and adequately monitor a resident after an unwitnessed fall for 3 of 3 residents reviewed for	{F 684}		

2/19/25

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{F 684}	Continued From page 3 falls (#1, #5 and #10). Findings: 1. Resident #1 has a history of lumbar vertebra fracture and bone density disorder with a most recent Brief Interview for Mental Status (BIMS) score of 6 out of 15 indicating severe cognitive impairment. Review of Resident #1's incident report stated he/she had an unwitnessed fall on 2/2/25 at 5 p.m. The incident report lacked any further description and/or resident assessment after the fall. Review of the nursing documentation shows a "Post Fall Observation" completed on 2/3/25 at 4:06 p.m., approx. 23 hours after the fall. Upon further review, the medical record lacked evidence of continued monitoring for neurological changes after the unwitnessed fall. 2. Resident #5 has a history of falls with a most recent BIMS score of 4, indicating severe cognitive impairment. Review of Resident #5's incident report stated he/she had an unwitnessed fall on 1/17/25 at 5:45 a.m. Further review of Resident #5's medical record lacked evidence of the facility completing a post fall observation tool or continued monitoring for neurological changes after the unwitnessed fall. 3. Resident #10 has a most recent BIMS score of 3, indicating severe cognitive impairment. Review of the incident report stated he/she had an unwitnessed fall on 2/1/25 at 6:30 p.m. with a nursing note documented at 11:32 p.m. The	{F 684}	See attached POC	2/20/25

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{F 684}	Continued From page 4 medical record lacked evidence of further nursing follow up until 2/2/25 at 10 p.m., and lacked evidence of the facility completing a post fall observation tool, continued monitoring him/her for further injuries and/or neurological changes after the unwitnessed fall. The facilities "Fall Management Policy", last revised 7/19 subsection D states, "A fall incident report will be completed after a resident has had a fall, whether it is a witnessed or not", subsection E states, "Complete Post Fall Observation tool, following a fall, to help identify if the cause of the fall is related to mental status changes, physical limitations or environmental factors" and subsection F states, "Documentation must be completed in the nurse's note on each shift X3 following the fall". The 'Neurological Assessment Policy", last revised 1/19 states, "Residents with suspected neurological compromise will have a neurological sign monitored and recorded for a minimum of 12 hours". Subsection III Procedures states "A neurological assessment following resident head injury will be completed for all residents sustaining head trauma or suspected head trauma. In EMR: Neuro Checks will be conducted-every 15 minutes x4, every 30 minutes x4, every 1 hr. x4, every 4 hr. x2, and every 8 hr. x1. Frequency of neuro checks after 24 hours is determined by resident's observed signs and symptoms of neurological compromise." On 2/5/25 at 2:28 p.m., during an interview, the Director of Nursing confirmed the facility failed to complete the required documentation and further monitoring of the above unwitnessed falls.	{F 684}	See attached POC	2/20/25

JR for MS 2/19/25

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{F 757}	Continued From page 5	{F 757}		
{F 757} SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to ensure that a resident's drug regimen was free from unnecessary medicaiton by administering a dose of Insulin outside of the physician order parameters for 1 of 1 reviewed for insulin management (#5). Finding: Resident #5's current Physician orders contained an order, dated 9/7/23 for Novolog Insulin 100 unit/mL (milliliter) give 6 units subcutaneous three	{F 757}	See attached POC	2/19/25

2/19/25

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{F 757}	Continued From page 6 times daily for type 2 Diabetes Mellitus with Diabetic Polyneuropathy with Instructions to Hold for Blood sugar less than 110. Review of the Electronic Medication Administration Record (EMAR) for January 2025 states, nursing administered Novolog insulin, 6 units on 1/23/25 with a documented blood sugar of 82. On 2/5/25 at 11 a.m., during an interview, the Director of Nursing and the Clinical Coordinator reviewed the EMAR for January and confirmed nursing failed to follow physician order by administering NovoLog insulin outside of the parameters.	{F 757}	See attached POC	2/20/25
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and	F 867		

2/19/25

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F 867	Continued From page 7 information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness	F 867	See attached POC	2/20/25

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F 867	Continued From page 8 of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's	F 867	See attached POC	2/21/25

2/19/25

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F 867	Continued From page 9 governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility's Quality Assurance Committee failed to ensure that the Plan of Correction for identified deficiencies from the Annual Long Term Care Survey Process for Federal Recertification dated 12/11/24, were effective. The Federal citations F684, and F757 were cited again during the re-visit to the annual Long Term Care Recertification Survey, dated 2/5/25. Finding: 1. During the follow-up survey on 2/5/25, it was determined that F684 and F757 would be recited for the same reasons: F684 for failure to document and adequately monitor a resident after an unwitnessed fall and F757 for failure to ensure that a resident's drug regimen was free from unnecessary medications (see F684 and F747). On 2/5/25 at 3:20 p.m., during and interview, the above was confirmed with the Vice President of Quality Improvement and Nursing Services and the Director of Nursing.	F 867	See attached for	2/20/25

2/19/25

ORCHARD PARK REHABILITATION & LIVING CENTER
REVISIT SURVEY on February 5, 2025
PLAN OF CORRECTION

Please note the filing of this plan of correction does not constitute an admission of the allegations set forth in the statement of deficiencies. The facility is filing this plan of correction in accordance with applicable law.

F580 – 483.10(g)(14)(i)-(v)(15) Notify of Changes
Finding #1

- Resident #1 has a BIMS score of 13 out of 15 (SOD states BIMS score of 6, in error); a post fall nurses' note at the time of the fall indicates the resident reported no injury and requested that staff did not notify the responsible party of the fall. No resident injury was noted in the nurses notes for three shifts subsequent to the fall, and the resident's preference not to notify the responsible party was honored.
- No other allegations or findings of this nature were identified.
- Staff Education was provided on February 13th, 2025 regarding fall documentation/physician notification following a resident fall per policy. The Falls Management Policy has been updated.
- The Director of Nursing Services, and/or designee(s) will conduct audits weekly x 4 weeks, and then monthly x 3 months to ensure clinical records reflect timely physician notification following a fall, which may include notification via the use of a SBAR if the fall is without injury. The results of the audits will be reported to the facility's Quality Assurance Committee for 3 months, as indicated.
- **Date of Completion: February 20, 2025**

F684 - 483.25 Quality of Care
Findings #1-3

- Resident #1 has a BIMS score of 13 out of 15 (SOD states BIMS score of 6, in error); a post fall nurses' note at the time of the fall indicates the resident reported no injury and requested that staff did not notify the responsible party of the fall. No resident injury was noted in the nurses notes for three shifts subsequent to the fall. The resident's preference not to notify the responsible party was honored.
- Res #5's clinical record did not contain a post fall observation tool or a neurological assessment; time has lapsed for being able to complete the post fall observation tool or a neurological assessment.
- Resident #10's clinical record contains a post fall observation tool and clinical notes following the fall of 2/1/25; the neurological assessment was not completed and time has lapsed for being able to complete the neurological assessment.
- Other residents have the potential to be affected by this alleged deficient practice. There were no other allegations or findings such as this observed.
- Staff Education was provided on February 13th, 2025 regarding completing the required documentation and monitoring of a resident after sustaining a fall. The Falls Management Policy has been updated.

2/19/25

- The Director of Nursing Services, and/or designee(s) will conduct audits weekly x 4 weeks, and then monthly x 3 months to ensure clinical records of a resident who sustains a fall contain the required documentation and monitoring per the Falls Management Policy. The results of the audits will be reported to the facility's Quality Assurance Committee for 3 months, as indicated.
- **Date of Completion: February 20, 2025**

F757 – Drug Regimen is Free from Unnecessary Drugs 483.45 (d) (1)-(6)
Finding #1

- Resident #5 received Novolog Insulin outside of the parameters for administration per MD orders.
- No other findings of this nature were observed.
- Staff education was provided on February 13th, 2025 to verify parameters of when to hold insulin based on blood sugar result(s) per MD orders. The contract for the nurse administering insulin outside of parameters was terminated on February 5th, 2025.
- The Director of Nursing, and/or designee(s), will conduct audits weekly x 4 weeks then monthly x 3 months to ensure insulin is being held appropriately based on the parameters of the physician order. The results of the audits will be reported to the facility's Quality Assurance Committee for 3 months, as indicated.
- **Date of Completion: February 20, 2025**

F867 – 483.75 (c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities
Finding #'s 1-2

1) F684: a POC has been written to ensure staff are appropriately Notifying Physicians, completing Post Fall Observation Tools and Neurological Assessments in accordance with the Falls Management Policy.
2) F757: a POC has been written to ensure staff are not administering Novolog Insulin outside of the parameters for administration per MD Orders.
   - Residents have the potential to be affected by this finding.
   - Staff education has been provided on February 13th, 2025, regarding the findings of F684 and F757.
   - The Director of Nursing, and/or their designee will conduct audits weekly x 4 weeks, and then monthly x 3 months to ensure the areas cited remain in compliance. The facility is conducting routine Safety/QAPI meetings and will report the results of the audits at these meetings and to the facility's Quality Assurance Committee for 3 months, as indicated.
   - **Date of Completion: February 20, 2025**

2/19/25