STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205099	A. BUILDING _____ B. WING _____	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUMFORD COMMUNITY HOME	11 JOHN F KENNEDY LANE RUMFORD, ME 04276

(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 11/06/23 through 11/08/23, on-site visits were conducted at Rumford Community Home for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification and investigation of complaints #ME00040983, #ME00044001, and #ME00045193. It was determined that Rumford Community Home was not in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary	F 657		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 12/1/23

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 657	Continued From page 1 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to review and revise the care plan to reflect the current needs of a resident in the area of pressure ulcers. (#22) Finding: A review of Resident #22's clinical record noted diagnoses which included: Diabetes Mellitus and past history of stroke with hemiplegia/hemiparesis of the right side. A dietitian's note, dated 10/28/23, indicated Resident #22 had a recently healed Stage II pressure ulcer. Physician's orders, dated 10/5/23, instructed staff to have the resident get up to chair daily in the afternoon for two hours, or as tolerated. In addition, an order dated 10/2/23, instructs staff to apply Barrier ointment to right hip (resolved pressure ulcer area) twice daily for preventive skin care. A review of Resident #22's care plan, last revised on 10/17/23, noted Resident #22 was at risk for pressure ulcer development related to immobility. The section titled "Interventions" was noted to be blank. On 11/7/23 at 11:20 a.m., in an interview with a surveyor, the Director of Nursing confirmed the care plan had not been revised to include interventions for pressure ulcer prevention in a resident at risk for recurrence.	F 657		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		

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F 812	Continued From page 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 observations and interview, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for a baseboard heater, the grease trap, the cement floor, a standing floor fan, the food disposal unit, the large food mixer, the dish machine, and the hood system filters for 1 of 3 days of survey (11/6/23). Additionally, the facility failed to ensure all staff with facial hair were wearing facial hair protectors for 1 of 3 days of survey (11/8/23). Findings: On 11/6/23 from 6:05 a.m. to 6:35 a.m., an initial kitchen tour was conducted with the Cook in which the following findings were observed:	F 812		

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F 812	Continued From page 3 1. > The dish room baseboard heater had chipped/missing paint creating an uncleanable surface. The grease trap cover was rusty on the top and around the edges of the lid. The cement floor portion had chipped/missing paint creating an uncleanable surface. The standing floor fan was dusty/dirty and had dried liquid residue on the blades. > The food disposal unit had dried liquid residue on it. > The large food mixer had dried food particles on the mix arm and the safety guard. > The dish machine was heavily soiled with scale buildup on the inside of the unit and the outside top and outside sides of the unit. > The hood system filters were heavily soiled with dust. 0n 11/6/23 at 6:35 a.m., in an interview, the Cook confirmed the findings. 0n 11/6/23 at 7:40 a.m., in an interview, the surveyor discussed the findings with the Food Service Director. 2. 0n 11/8/23 at 12:25 p.m., a surveyor observed two(2) male kitchen staff with facial hair in the kitchen that were not wearing facial hair protection. 0n 11/8/23 at 12:30 p.m., in an interview, the Food Service Director confirmed the finding.	F 812		
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced	F 814		

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F 814	Continued From page 4 by: Based on observation and interview, the facility failed to maintain a garbage storage area in a sanitary condition to prevent the harborage and feeding of pests for 1 trash dumpster for 1 of 3 days of survey. (11/6/23) Finding: On 11/6/23 at 6:00 a.m., a surveyor observed a trash dumpster with the front right lid open exposing trash. 0n 11/6/23 at 6:35 a.m., in an interview, the Cook confirmed the findings. 0n 11/6/23 at 7:40 a.m., in an interview, the surveyor discussed the findings with the Food Service Director.	F 814		

F657 Care Plan Timing and Revision

Interventions were immediately added to Resident #22's care plan in the area of pressure ulcers on 11/8/23.

Resident care plans were reviewed and revised to reflect the current needs of a resident in the area of pressure ulcers.

Education to be provided to licensed nursing staff related to requirements to review timely and make ongoing revisions to ensure the care plan reflects the current needs of the resident in regards to pressure ulcers.

Nursing Management will review resolved pressure ulcers weekly to ensure interventions are in place to reduce risk of the pressure ulcer returning.

Random audits to be completed by MDS Coordinator or designee to ensure continued compliance with timely revisions of pressure ulcers and to ensure care plans reflect the current needs of the resident until 100% compliance is met.

Patterns and trends of audits will be discussed at QAPI.

Compliance Date: 12/8/2023

F812 Food Procurement, Store/Prepare/Serve- Sanitary

The dish room baseboard heater, grease trap cover and cement floor have been painted to ensure a cleanable surface.

The standing floor fan, food disposal and large food mixer have been cleaned and added to weekly cleaning schedule to ensure continued compliance.

The dish machine has been cleaned and scale buildup on the inside and outside has been removed. Dish Machine cleaning has been added to monthly kitchen/maintenance rounds.

The hood system filters have been cleaned and added to monthly kitchen/maintenance rounds.

All other areas of the kitchen area were reviewed and found to be in compliance.

Education was provided to all dietary staff regarding the requirement to maintain cleanable surfaces, clean equipment and following the beard net requirement.

Food Service Director or designee will audit weekly cleaning schedule and beard net compliance for three months or until compliant. Food Service Director or Cook will be present during monthly kitchen/maintenance rounds to ensure adequate follow up.

Administrator to randomly audit cleaning schedules, beard net compliance and monthly kitchen/maintenance round log forms. Administrator to be present for rounds at least quarterly.

Results of audits will be brought to QAPI meeting.

Compliance Date: 12/8/2023

F814 Dispose Garbage and Refuse Properly

All residents have the potential to be affected.

Education to be provided to dietary staff regarding the requirement to maintain the garbage areas in sanitary conditions to prevent the harboring and feeding of pests.

Food Service Director, Manager on Duty or designee will audit conditions of dumpsters at varying times to ensure continued compliance.

Administrator to randomly audit condition of dumpster and audit forms.

Outcome of audits will be brought to QAPI meeting until 100% compliance is obtained and maintained for a period of three consecutive months.

Compliance Date: 12/8/2023