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 09/12/2023

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 9/12/23 an on-site visit was conducted at Sandy River Center, for the purpose of complaint investigations #ME00044832, #ME00044833, #ME00044858, and #ME00044864. 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.	F 000		
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 reviews and interviews, the facility failed to complete a medication reconciliation to ensure that correct physician orders were implemented for 1 of 2 sampled residents (Resident #1) admitted from an acute care hospital. Findings: A review of the clinical record for Resident #1 revealed an admission date of 8/25/23 from an acute care hospital. The facility received a hospital discharge summary on 8/25/23, which noted a time of 8:06 a.m. and indicated a co-signature was required. Page 4, stated	F 684		

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 684	Continued From page 1 "Current discharge medication list. Continue these medications which have not changed. Metoprolol tartrate 50 mg (milligrams) by mouth 2 times daily (a short acting beta blocker to treat blood pressure), and Aspirin 81 mg by mouth daily." On 8/25/23, a revised discharge summary, with a time of 1:13 p.m., noted on page 5 the following instructions: "Start taking these medications - Amiodarone (an antiarrhythmic to treat ventricular tachycardia) 200 mg by mouth daily, Metoprolol succinate (an extended release beta-blocker [brand name Toprol XL]) 50 mg by mouth daily, Clopidogrel (an antiplatelet to decrease blood clots [brand name Plavix]) 75 mg by mouth daily, and Omeprazole (used to treat gastroesophageal reflux and stomach ulcers) 20 mg by mouth daily." Page 6 noted: "Stop taking these medications: Metoprolol tartrate 50 mg and aspirin 81 mg." A review of both discharge summaries noted the same language as follows on Page 5 through page 6 of the original discharge summary, and page 7 of the revised discharge summary, "Apixaban (an anticoagulant) and Plavix for 3 months post procedure (through 10/31/23) and then he/she can return to his/her usual aspirin and Apixaban regimen." And, "transition back to maintenance Amiodarone therapy (200 mg daily), Toprol XL daily." On 8/28/23, the physician completed an admission history and physical. The physician's note stated on page 8, under Assessment and Plan: "Apixaban and Clopidogrel through 10/31, then resume apixaban and ASA (aspirin), and continue Amiodarone and metoprolol."	F 684		

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F 684	Continued From page 2 A review of Resident #1's Physician's Order Summary noted that the physician did not reconcile or write orders at the time of the visit on 8/28/23 to discontinue Aspirin and Metoprolol tartrate, or to add Clopidogrel, Metoprolol succinate, and Omeprazole. Amiodarone was not ordered until 9/5/23. On 9/18/23 at 10:05 a.m., in a telephone interview with a surveyor, the Director of Nursing (DON) stated the facility had received incorrect discharge instructions from the hospital prior to Resident #1's admission, and it was not until 9/5/23 when the nurse practitioner accessed the hospital's electronic records that the discrepancy with the Amiodarone order was found. The surveyor stated that on 8/28/23, the physician had seen Resident #1 and had mentioned the correct orders in the progress note but did not write new medication orders. The finding was confirmed during a telephone discussion with the DON and the Administrator on 9/18/23 at 2:39 p.m. A review of the facility's policy, "Medication Reconciliation," with an effective date of 9/1/22, stated, "The patient's medication orders will be reconciled at each transition of care. Medication reconciliation is the process of comparing a patient's existing medication orders to all of the previous medications the patient has been taking. The process involves obtaining and maintaining a complete and accurate list of current medication use across all healthcare settings. Medication reconciliation involves collaboration with the patient/representative and multiple disciplines including admission liaisons, physicians/advanced practice providers (APP), licensed nurses, and pharmacy. 1. Process.	F 684		

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F 684	Continued From page 3 Medication reconciliation will be performed: 1.1. When patients are admitted/readmitted from hospital. 3. For patients admitted from the hospital: 3.1. Obtain and review copies of Medication Administration Records (MARs), Treatment Administration Records (TARs), transfer forms, and Physician's Order Sheets (POS). 3.1.1 Verify MAR/TAR information with transfer forms and POS, if available. 5.3 Clarify medication orders with clinical staff from transferring hospital, when necessary. 5.4 Any discrepancies discovered during reconciliation will be reported to the physician/APP before finalizing the current list of medications. 6. Once reconciled, medication orders will be obtained from the physician and entered electronically into the medical record. 7. A repeat reconciliation will be performed to compare hospital/home care discharge medication listing to current Center medication listing to MAR. On 9/22/23 at 9:54 a.m., in a telephone interview with the surveyor, the Administrator confirmed that the facility had failed to perform a medication reconciliation as per its policy, when Resident #1 was admitted or at the time of the physician's first visit, resulting in the failure of Resident #1 to receive his/her medications as intended.	F 684		