STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205031	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orono Commons	117 Bennoch Rd Orono, ME 04473

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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.

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, facility policy review, interviews, and record review, the facility failed to follow it's own policy after a new pressure ulcer was observed, for 1 of 1 resident reviewed (Resident #1 [R1]). On 12/1/25, a pressure ulcer was observed on R1's right big toe but a treatment/monitoring was not started until 12/9/25, 8 days later. Finding: The facility's policy, Skin Integrity and Wound Management, revised 9/15/25, stated the nursing assistant will observe skin daily and report any changes or concerns to the nurse. The licensed nurse will: evaluate any reported or suspected skin changes or wounds; document newly identified skin/wound impairments as a change in condition; document skin/wound findings on the 24-hour report; perform and document skin inspection on all newly admitted /readmitted patients weekly thereafter and with any significant change of condition; and complete wound evaluation upon admission/readmission, new in-house acquired, weekly, with unanticipated decline in wounds, and at planned discharge. On 12/8/25 at 10:07 a.m., during an interview with a surveyor, a family member stated that a wound to the right big toe was observed during a recent visit. On 12/9/25 at 9:45 a.m., a surveyor and a family member observed a wound to the top of R1's right big toe. The family member stated that she showed a nurse this area this morning and it seems that they were unaware of the wound. A cloth heel protector was observed on R1's right foot; the wound did not look infected or have drainage. On 12/9/25, a surveyor reviewed R1's clinical record; skin documentation and/or foot evaluation was completed on 12/2/25 and 12/4/25 with no mention of any type of wound on the right big toe, and there was no current treatment to the right big toe area ordered or being monitored. On 12/9/25 at 10:35 a.m., the Administrator, Director of Nursing, and surveyor observed R1's wound to the right big toe. The Homestead Unit Manager and Charge Nurse both denied being aware of the wound as they passed by R1's room. On 12/9/25 at 11:03 a.m., during an interview with a surveyor, the Administrator stated that staff that took care of R1 observed the right toe area yesterday but thought it was already a known area to nursing since R1 had an area to the left toe that was being treated (laceration). She stated that education will be done with staff to always report, and this communication to nursing was missed. The Administrator stated that they are working on taking photos and documenting at this time for the right big toe wound. On 12/9/25, a treatment was added twice a day to cleanse the right big toe (Stage II pressure) with wound wash and apply skin prep and to document wound status daily. On 12/22/25 at 10:13 a.m., during an interview with a surveyor, Hospice Registered Nurse (RN) stated that she had spoken to a charge nurse but couldn't remember who about the presence of R1's new pressure injury to the right big toe prior to surveyor's visit on 12/9/25 and that the facility was already aware of the right big toe pressure wound on 12/1/25. On 12/22/25 at 2:39 p.m., during an interview with a surveyor, Registered Nurse #2 (RN2) stated that on 12/1/25, she was asked to take photos of R1's right big toe wound with the tablet. RN2 stated that she was the only one that can see the photo on the tablet by signing in to the tablet, it did not cross over into the clinical record. RN2 completed no additional information in R1's clinical record regarding this wound, therefore no treatment or monitoring was started. On 12/22/25 at 4:11 p.m., during an interview with a surveyor, the Administrator stated that the Director of Nursing reviewed the photo that RN2 took, and it was the new pressure injury on the right big toe. The surveyor confirmed that the process was not followed when a new pressure injury was identified on 12/1/25, when nursing was aware of the new pressure injury and only took a photo and the CNAs who provided daily care from 12/1/25, until the surveyors visit on 12/9/25, did not report this new open area to the charge nurses.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interviews, the facility failed to ensure that a clinical record contained accurate and complete information for Resident #1 (R1) in the area of level of eating assistance provided for 14 of 24 meals documented between December 1 - 8, 2025. Finding:On 12/9/25, R1's clinical record was reviewed. The care plan included a FOCUS (dated 6/28/24) of: Resident requires/is dependent for Activities of Daily Living (ADL) and the INTERVENTION indicated that R1 was a total assist in the area of eating (last revised on 7/26/24).A surveyor reviewed the meal documentation for December 1st - 8th, 2025 and noted that 14 of the 24 meal opportunities reflected inaccurate or incomplete documentation based on the care plan focus/intervention as follows: (5) meals were blank, (2) meals were documented as supervision, (4) meals were documented as independent, (2) meals were documented as setup, and (1) meal was documented as substantial assist.On 12/9/25 at 1:50 p.m., during an interview with a surveyor, Certified Nursing Assistant stated that R1 was a total assist for eating.On 12/22/25 at 10:17 a.m., during an interview with a surveyor, the Administrator stated that staff know that R1 was a total assist but have documented incorrectly.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to maintain an infection prevention and control program to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable disease and infections in the area of Enhanced Barrier Precautions (EBP) and linen handling for 1 of 1 day of survey (12/9/25).Findings:1. The facility's policy, Enhanced Barrier Precautions, revised on 11/14/25, indicated that in addition to Standard Precautions, Enhanced Barrier Precautions (EBP) will be used (when Contact Precautions do not otherwise apply) for novel or targeted multi-drug resistant organisms (MDROs). EBP expands on the use of gown and gloves beyond anticipated blood and body fluid exposures, focusing on use of gown and gloves only during high contact patient care activities that have been demonstrated to result in transfer of MDROs to hands and clothing of healthcare personnel, even if blood and body exposure is not anticipated.The facility's procedure, Enhanced Barrier Precautions, indicated to follow the Centers for Disease Control (CDC) guidance as indicated per the table in the document. Enhanced Barrier Precautions (EBP) are to be used for any patient with a chronic wound during high contact patient care activities that included: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assist with toileting, and device care or use. Personal protective equipment (PPE) to be used included gown and gloves prior to high contact care activity. On 12/9/25, a review of Resident #1's (R1) clinical record was completed and indicated that the resident had current pressure injuries that were being treated. R1's care plan included a FOCUS of: Patient is at risk of chronic infections related to multiple wounds and chronic skin issues and included an intervention of Enhanced Barrier Precautions to be utilized when performing high contact activities that was added on 12/8/25. On 12/9/25 at 11:03 a.m., during an interview with a surveyor while standing in the hallway, outside of R1's closed door to their room, the Administrator stated that staff were working on taking photos and documenting R1's new pressure wound at this time. A sign was observed placed inside of a [NAME] on the door that indicated EBP was needed for someone in this room and the Administrator noted the PPE cart that had been moved down the hallway, probably by another resident that liked to push things. At this time, a Certified Nursing Assistant (CNA) exited the room and went to get some clean linens. The CNA then returned to R1's room, knocked on and opened the door; the Administrator directed the CNA to look at the sign on the door. Additional staff observed at R1's bedside were not wearing the required EBP PPE; after being directed to put on PPE by the Administrator, two CNAs walked down the hallway and put on gowns and brought an additional one back to the room for the other staff member who was not wearing one. 2. The facility's policy, Linen Handling, last reviewed 5/1/25, indicated that all used linen should be handled using standard precautions and treated as potentially contaminated. Used or soiled linen should be collected at bedside (or point of use) and placed in a bag or directly placed in a lined and covered receptacle at the location where removing linen. On 12/9/25 at 11:45 a.m., a surveyor observed a staff member carrying soiled, loose clothing with a strong smell of urine down the Riverview hallway and then returned to the room empty handed. On 12/9/25 at 11:53 a.m., the Director of Nursing (DON) and surveyor observed the unbagged, soiled clothing in a room where the dirty linen cart was kept; at 11:55 a.m., the DON asked Registered Nurse #1 (RN1) if she carried unbagged clothing to the dirty linen cart and RN1 stated that she didn't have any bags to but the dirty linen in.