

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205031	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Orono Commons		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on review of Payroll Based Journal Report, facility schedules with census, review of timecards, and interviews, the facility failed to ensure sufficient direct care staff were scheduled and on duty to meet the needs of residents that reside in the facility for 1 of 4 quarters reviewed (2nd quarter). This has the potential to affect all residents needing assistance with Activities of Daily Living (ADL's). Review of Payroll Based Journal staffing report revealed the facility triggered for excessively low weekend staffing during the second quarter of 2026 (January 1 - March 31). On 7/1/26 at approximately 12:45 p.m., during an interview with the Administrator and a surveyor, the staffing schedules, census numbers, and time cards were reviewed for the second quarter of 2026. On Sunday, 3/1/26, the facility had a census of 80 residents, which required 16 direct care staff to be on duty and providing hands-on care during the entire day shift. A review of the daily census and staffing schedules indicated that there were 14 direct care staff on duty for the entire day shift. On Saturday, 3/14/26, the facility had a census of 78 residents, which required 16 direct care staff to be on duty and providing hands-on care during the entire day shift. A review of the daily census and staffing schedules indicated that there were 14 direct care staff on duty for the entire day shift. On Sunday, 3/15/26, the facility had a census of 76 residents, which required 16 direct care staff to be on duty and providing hands-on care during the entire day shift. A review of the daily census and staffing schedules indicated that there were 14 direct care staff on duty for the entire day shift. On Saturday, 3/28/26, the facility had a census of 73 residents, which required 15 direct care staff to be on duty and providing hands-on care during the entire day shift. A review of the daily census and staffing schedules indicated that there were 14 direct care staff on duty for the entire day shift. During this review, the surveyor confirmed the facility did not ensure enough staff were on duty to meet resident needs on the weekends.		

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record reviews and interviews, the facility failed to ensure that residents residing in the facility were free from neglect when residents were denied incontinence care during mealtimes for 4 of 4 residents reviewed/interviewed. Findings: On 8/17/25, a family member completed an online complaint regarding the care of their father/mother. It was stated that R87 was left soiled (incontinent) for 4 hours and that staff had told R87 they would come back to help but did not return. On 7/12/26 at 12:35 p.m., during a tour of the Homestead unit, residents were observed sitting around the area staff called the breakfast bar. A resident was heard asking to use the bathroom, staff did not respond to him/her they stating they were not able to provide personal care during meal service. The resident asked 2 additional times to go to the bathroom, the surveyor asked if anyone was going to assist him/her. With surveyor intervention a CNA then said she can help him/her. On 7/14/26 at 7:30 a.m., during a review of a facility reported incident and the review of the facility's complete investigation for R87, the facility failed to provide incontinence care to R87 during a supper meal. A transcribed statement from R87 states that he/she was incontinent with bowel and staff were busy and short-staffed and was not provided with incontinence care. Written statements from the CNA,s who worked on that day documented that it was during a meal pass (supper meal service starts at 4:30 p.m.) and the CNA assigned to care for R87 mentioned that R87 needed to be changed. The CNA who was assigned to R87 was seen going to assist R87 at approximately 7:00 or 7:30 p.m., almost 3 hours after he/she requested incontinence care. The written statement from the CNA who was assigned to care for R87 wrote that at approximately 5:30 p.m. while giving R87 their supper tray R87 had stated they needed to be changed (provided incontinence care) and the CNA informed R87 that it would be a while before he could assist R87 because he was told he could not perform personal care during mealtimes. R87 waited for assistance while sitting in a brief with a bowel movement from 4:30 until 7:30 p.m., he/she was sitting for 2-3 hours in a soiled brief because they are not allowed to stop meal service for any personal care. On 7/14/26 at 9:00 a.m., during an interview with an anonymous staff, he/she stated if a resident needs help during mealtimes we are not allowed to stop meal service for any personal care. If they call and want more drinks, they have to wait until all trays are passed and the feeders are helped. On 7/14/26 at 11:05 a.m., during a Resident Council meeting with R47, R43 and R5 in attendance, they stated that they all like to stay dry and fresh and when they are incontinent and have to stay in it for 1 to 2 hours it's not comfortable and it's embarrassing. During meals they have been told they are not allowed to help us change or go to the bathroom until they are done passing meal trays. R5 then stated that he/she had to pee so badly the nurse came in but left to get the CNA, when the CNA came in R5 was so upset and the CNA told him/her she was passing trays first then she came to help him. On 7/14/26 at 12:50 p.m., during an interview with the Administrator and the Clinical Market Lead, they stated the incident occurred during meal service, and we have to serve hot meals, so we need them (staff) to pass trays first. At this time the surveyor confirmed that R87 and other residents are not assisted with incontinence care in a timely manner and that the facility's practice is not to provide personal care/hygiene/incontinence care during meal services.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to follow provider orders and ensure a resident's medical choices in accordance with professional standards for a resident who experienced a medical emergency (Resident #69 [R69]). Additionally, the facility failed to complete neurological assessments after an unwitnessed falls for 1 of 4 residents reviewed for falls (Resident #10 [R10]). Findings: 1. On [DATE] at 11:11 a.m., during an interview with a surveyor, R69 stated he/she has had watery stools for the past couple weeks. On [DATE], review of R69's clinical record indicated the following: -Review of the bowel elimination record (30-day look back from [DATE] through [DATE]) indicated R69 had loose or watery stools for a total of 19 out of 24 days: R69 had loose or watery stools on 13 out of 15 days in June ([DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]). R69 had loose or watery stools on 6 out of 8 days in July ([DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]). R69 was hospitalized from [DATE] through [DATE] (6 days total). -Review of R69's Order Summary included the following orders: Loperamide 2 milligrams (MG) Tablets, dated [DATE], with direction to Give 1 tablet by mouth every 6 hours as needed (prn) for loose stools. Pink Bismuth Suspension 262 MG/15 [milliliters (ML)], dated [DATE], with directions to Give 30 ml by mouth every 4 hours as needed (prn) for diarrhea. -Review of the Medication Administration Record (MAR) indicated: R69 did not receive Loperamide for loose stools in the month of July per order. R69 did not receive Loperamide for 10 out of 13 days that R69 had loose or watery stools in the month of June. R69 did not receive a dose of Pink Bismuth for diarrhea as ordered on the days R69 had loose or watery stools in the month of July. R69 did not receive Pink Bismuth for 12 out of 13 days that R69 had loose or watery stools in the month of June. On [DATE] at 8:04 a.m., during an interview with a surveyor and the Licensed Practical Nurse (LPN) R69's clinical record was reviewed. At this time, the surveyor confirmed that R69 was not provided with prn (as needed) loperamide or Pink Bismuth per provider orders, to treat his loose/watery stools. 2. On [DATE] at 4:02 p.m., the State Department received a complaint alleging that staff were attempting to coerce R69 to sign a Do Not Resuscitate (DNR) while in an impaired mental state after a several minute long loss of unconsciousness. Review of R69's medical record revealed the following: -On [DATE], R69 had an order for FULL CODE (perform cardiopulmonary resuscitation [CPR]). R69 signed a Physicians Orders for Life Sustaining Treatment (POLST) form on [DATE] indicating he/she wants Full Treatment to include CPR, transfer to a hospital if indicated, and intensive care. -On [DATE], review of the transfer discharge notice and bed hold notice indicated R69 transferred to the emergency room by ambulance as the Resident needs cannot be met by the facility. These notices were not signed by R69. -R69's medical record contained, a POLST form indicating DNR, signed by the provider but not R69 and back dated to [DATE], and inaccurate / incomplete records regarding vital signs and transfer information (See F842). On [DATE], the EMS Patient Care Report (PCR) revealed the following: -At 11:31 a.m., EMS arrived at R69's bedside. Staff reported to EMS that R69's baseline was loud, interactive, and his/her own Power of Attorney. Following a syncopal episode [a temporary loss of consciousness and muscle control. It occurs when a sudden drop in blood pressure or heart rate briefly reduces blood flow to the brain], patient was somnolent (feeling sleepy, drowsy, or inclined to fall asleep) and more confused than normal, unable to reliably answer questions. Primary assessment reveals. patient is unable to remember [his/her] age, the year, or how many quarters make a dollar. Deemed unreliable by EMS assessment. staff asks patient if [he/she] would like to change [his/her] DNR status. When handing DNR to EMR to have (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	patient sign, EMS declines as patient is deemed unreliable by EMS assessment and facility report.-At 11:43 a.m., R69's blood pressure was 75/53 mm Hg (millimeters of mercury), indicated R69 was hypotensive (abnormally low blood pressure, typically reading below 90/60 mm Hg, that can cause symptoms like dizziness and fainting when the brain doesn't receive enough blood. In severe cases, it can indicate life-threatening conditions like shock).-At 11:47 a.m., R69's blood pressure was 83/61 mm Hg.-At 11:55 a.m., R69's blood pressure was 80/56 mm Hg.-At 11:57 a.m., EMS departed the facility with R69.On [DATE], a surveyor reviewed the following written, witness statements:-The Director of Nursing (DON)'s witness statement, dated [DATE], stated that on [DATE] a Registered Nurse/Unit Manager (RN/UM) told her that R69 was unresponsive and may need CPR. On arrival to R69's room, the DON stated R69 looked pale and diaphoretic, but the DON did not remain in the room as there were several others attending R69 including the Advance Practice Registered Nurse (APRN). She saw a Licensed Practical Nurse (LPN) walking down the hallway after they called [Emergency Medical Services (EMS)], and heard the resident identify [his/her] name and date of birth . The last thing she heard was staff asking [R69] can you squeeze my fingers.-On [DATE] the APRN signed a late entry progress note for [DATE] at 11:36 a.m. that stated R69's chief complaint was Altered Mental Status (AMS, a broad range of changes in a patient's baseline cognition, awareness, or consciousness). The progress note indicated Code status: FULL CODE. The provider's physical exam stated, General: .sitting upright in [wheelchair (WC)], awake but does not respond to questions. Skin: diaphoretic. Neuro: . Pt awake, eyes open does track, but does not follow directions or answer questions. Psych: not responding to questions. 911 called, by time EMS arrived [patient (pt)] was conversing, but still slightly obtunded [a dulled or reduced level of alertness. An obtunded patient is drowsy and requires repeated verbal or gentle tactile stimulation to awaken. When awake, they may appear confused, have a slowed reaction time, and quickly drift back to sleep]. Writer left room when EMS arrived, per nursing [he/she] initially declined to [emergency room (ER)] transport. RN came to inform this writer, by time got back to room pt had agreed to go ER and EMS was in process of preparing to transport.-Certified Nursing Assistant (CNA2)'s witness statement, undated, stated, When EMS arrived, the patient was responsive. Initially, the patient refused evaluation and transport to the local hospital. As time progressed the patient agreed to be evaluated at the hospital and expressed willingness to sign DNR paperwork. [RN/UM], went to speak with the provider regarding the patient's DNR status. When [RN/UM] returned, the patient remained responsive, alert, and willing to sign the DNR paperwork. At that time one member of the EMS crew stated, .I will not let [R69] sign that.-The Registered Nurse/Unit Manager (RN/UM)'s witness statement, dated [DATE], stated, at [11:24 a.m.] I received a phone call from my charge nurse.[R69] is now clammy, not very responsive with eyes rolling in the back of [his/her] head. I told [the charge nurse] to call 911., RN/UM confirmed in her statement that she discussed changing R69's code status while EMS was at the bed side and brought R69 the DNR documentation to sign. On returning to the room, EMS intervention prevented R69 from signing the document due to R69's altered mental status.On [DATE] at 9:00 a.m., during an interview with a surveyor and the Clinical Market Director, R69's clinical record and the facility's internal investigation were reviewed. At this time, the surveyor confirmed with Clinical Market Director that the medical record contained inaccurate and incomplete documentation (See F842) and that the facility attempted to pressure R69 to change his/her code status when he/she was experiencing a medical emergency and unable to give informed consent.3. On [DATE], R10's clinical record was reviewed for falls. The clinical record indicated that R10 experienced an unwitnessed fall on [DATE], [DATE], [DATE], and [DATE]. The clinical record lacked evidence that Neurological Assessments were completed.On [DATE] at 9:56 a.m., during an interview with a (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure that clinical records contained accurate and complete information in the areas of neurological assessments, transfer forms, resident falls, vital signs, Physician's Orders for Life Sustaining Treatment (POLST) forms, documentation regarding provider ordered medications, documentation for treatments provided, documentation for meal intake, and Bed Hold Notice Forms for 5 of 22 sampled residents (Resident #10 [R10], R69, R4, R24, and R43). Findings: 1. The Falls Management Policy, last revised [DATE], states under the Post-Fall Management: 5.3 Any patient who sustains an injury to the head from a fall and/or has a fall unwitnessed by staff will be observed for neurological abnormalities by performing neurological check, per policy. Neurological Assessments (Neuros) on the Neurological Evaluation Flow Sheet evaluate: Level of Consciousness (Alert, Drowsy, Stuporous, or Comatose), Orientation (person, place, time), Follows Simple Commands (yes or no), Sensation / Response to Pain (normal, unusual, or no response), Pupils response to light, Motor function (able to move limbs equally), Vital Signs (Temperature, Pulse, Respirations, and Blood Pressure), and Change from Resident's Baseline (yes or no). These assessments are to be completed every 15 minutes for First 2 Hours after the initial evaluation, then every 30 minutes for 2 hours, then every hour for 4 hours, and then every 8 hours for at least 64 additional hours. On [DATE], review of R10's clinical record indicated the following: -On [DATE] at 1:00 a.m., a progress note stating, nurse reporting unwitnessed fall, no injury but [patient(pt) complaint of (c/o)] low [back] pain. Pt has full [range of motion (ROM)], no head strike. Second call: Nurse reporting unwitnessed fall this morning with internal rotation left leg with hip pain. Lumbar xray was previously ordered. This visit was conducted on [DATE] [at] 05:09 a.m. Second call visit was conducted on: 6/626 [at] 9:20 [a.m.]. The time of the progress note (1:00 a.m.) occurs prior to the time of the reported first call (5:09 a.m.) and the second call (9:20 a.m.). It was unclear if the second call was for a second fall or a follow up to the initial fall. -Review of R10's Neurological Evaluation Flow Sheet indicated that on [DATE] at 4:45 p.m., R10 had an unwitnessed fall. Neuros initiated at 4:45 a.m. were incomplete (pulse and respirations not documented). All neuro assessments required for the first 2 hours were missing documentation of pulse and respirations. Additionally, all 30-minute neuros were missing documentation of all vital signs. Neuros completed at 8:15 a.m., and 8:45 a.m., indicated that R10 had a change from baseline but the clinical record lacks evidence of what the change from baseline was. At 9:00 a.m. the flow sheet states, Sent to [emergency room (ER)] for eval. -Review of the [Skilled Nursing Facility (SNF)/Nursing Facility (NF)] Transfer Form for transfer on (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE] indicates the transfer vitals were taken at 9:13 a.m. on [DATE], and that the date of R10's transfer to the ER was [DATE] 02:48 [a.m.]. The nurse-to-nurse report for the transfer occurred [DATE] 10:29 [a.m.]. -On [DATE] at 9:51 a.m., a Transfer Note states, Note: [R10] was transferred to Sent to: [hospital] Date:[DATE] 2:48 Sent From: [facility] for Transfer: Fall. The clinical record contained incomplete documentation regarding post fall assessments, and inaccurate documentation regarding when the resident was transferred to the hospital following the unwitnessed fall on [DATE]. -On [DATE] at 12:58 a.m., a Change in Condition Evaluation stated that R10 had a fall on [DATE], vital signs were obtained at 12:36 a.m. on [DATE] following the fall, and that R10 was experiencing back pain. The Change in Condition Evaluation states family / resident representative was notified on 06/0326 at 01:20 [a.m.] (7 days before the fall). -Review of the neurological evaluation flow sheet indicated that R10 had an unwitnessed fall on [DATE] at 12:30 a.m., and neuros initiated at that time. Neurological Evaluations following the initial assessment were incomplete for 7 out of 8 of the 15-minute reassessments (missing vital signs and change from baseline assessment documentation), all 4 of the 30-minute reassessments were missing vital signs and change from baseline documentation, all 4 of the hourly reassessments were missing vital signs and change from baseline documentation. -On [DATE] at 8:45 p.m., R10 had an unwitnessed fall. Review of the neurological evaluation flow sheet indicated that neuros were restarted at that time. Neurological Evaluations following the initial assessment were incomplete for 5 out of 8 of the 15-minute reassessments (missing Vital Signs), 2 out of 4 the 30-minute reassessments were incomplete (missing Vital Signs), 3 out of the 4 hourly reassessments were incomplete (missing Vital Signs), and 3 out of 8 of the 8-hour neuro reassessments were incomplete (missing Vital Signs). -On [DATE] at 8:45 p.m., R10 had an unwitnessed fall. Review of the neurological evaluation flow sheet indicated that neuros were initiated at that time. 2 out of the total 25 required neuro reassessments were incomplete. The initial assessment was inaccurately documented as a 15-minute reassessment, and the 8-hour reassessment due on [DATE] at 4:15 p.m., was not completed. On [DATE], review of Fall Incidents on the facility Incident by Incident Type indicated R10 had a fall on [DATE] at 4:45 a.m., [DATE] at 8:45 p.m., and [DATE] at 3:30 p.m. The facility report did not capture the fall on [DATE]. On [DATE] at 9:56 a.m., during an interview with a surveyor and the Licensed Practical Nurse (LPN), R10's clinical record was reviewed. The LPN stated, this makes no sense. LPN was unable to determine when R10 fell on [DATE] or if there was more than one fall, the circumstances around the fall, or what time R10 transferred to the hospital on [DATE]. Additionally, the surveyor confirmed with the LPN that the neuros were not completed after unwitnessed falls and stated that neuros must (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	restart with each unwitnessed fall. On [DATE] at 10:23 a.m., during an interview with a surveyor and the Market Clinical Lead, R10's clinical record was reviewed. At this time the surveyor confirmed the clinical record contained inaccurate and incomplete information regarding R10's unwitnessed falls, R10's transfer to the hospital, and follow up neurological assessments. The Market Clinical Lead stated they had identified that neuros were a problem and made a Performance Improvement Plan, but it has not been implemented yet. 2. On [DATE], review of R69's clinical record indicated the following: -On [DATE], R69 was transferred to the emergency room. The Bed Hold Notice dated [DATE] was incomplete (did not identify how long the bed would be held for) and was unsigned by the Resident/Resident Representative. -Review of the Transfer Form indicated that R69 transferred to the hospital on [DATE] at 11:50 a.m. for Altered Mental Status, the Transfer Form vital signs are documented as taken at 2:58 p.m. (3 hours after the resident left the facility). Additionally, the vital signs are inconsistent with vital signs obtained and documented by the Emergency Medical Services at the time of transfer. -Review of R69's Medication Administration Record and Treatment Administration Record indicated that R69 did not receive medications as ordered for loose / watery stools (See F684). There was no documentation in the clinical record for why the medications were not administered as ordered. -On [DATE], a surveyor observed in R69's paper chart, a POLST form signed by R69 on [DATE] indicating he/she wants Full Treatment to include cardiopulmonary resuscitation (CPR), transfer to a hospital if indicated, and intensive care. Additionally, R69's medical record contained an incomplete POLST form indicating do not resuscitate (DNR), signed by the provider but not R69 and dated [DATE] (See F684). On [DATE] at 9:00 a.m., during an interview with a surveyor and the Clinical Market Director, R69's clinical record was reviewed. At this time, the surveyor confirmed with Clinical Market Director that the medical record contained inaccurate and incomplete documentation. 3. On [DATE], R4's clinical record was reviewed. The Treatment Administration Record (TAR) for July lacked evidence of documentation for 9 treatments completed or attempted by Licensed staff for [DATE]rd day shift. On [DATE] at 7:40 a.m., during a review of the TAR with the Director of Nursing (DON), a surveyor confirmed this finding. 4. On [DATE], R43's clinical record was reviewed for a nutrition concern because R43 was experiencing some weight loss. The surveyor observed that meal intake documentation was missing for 12 out of 99 of June meals and 6 of 52 meals July thru the 14th. On [DATE] at 10:24 a.m., during an interview with the DON, a surveyor confirmed the missing intake documentation. 5. On [DATE], R24's clinical record was reviewed for a nutrition concern because R24 was (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	experiencing some weight loss. The surveyor observed that meal intake documentation was missing for 8 out of 46 of June meals and 2 of 24 meals for July thru the 14th. On [DATE] at 10:24 a.m., during an interview with the DON, a surveyor confirmed the missing intake documentation.		