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	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandy River Center	119 Livermore Falls Road Farmington, ME 04938

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record review and interview, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice by failing to follow a physician's orders for daily weights for 1 of 3 residents reviewed during a complaint investigation (Resident #1).Finding:Resident #1 was recently admitted with diagnoses to include congestive heart failure (CHF).Review of Resident #1's physician orders revealed an order for Daily Weight: Notify the provider if: resident has a weight gain > 2 lbs in 1 day, or 5 lb in a week.for CHF Review of Resident #1's October Treatment Administration Record lacked evidence of daily weights being done for 10/18/25, 10/19/25, 10/20/25, and 10/21/25. Further review of the weight summary in the clinical record lacked evidence that daily weights were started until 10/21/25. On 11/25/25 at 12:21 p.m. the above finding was discussed during an interview with the Market Clinical Lead. At this time, the Market Clinical Lead reviewed Resident #1's clinical record and confirmed that daily weights were not done for the above dates.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review, interviews, and facility policy, the facility failed to maintain adequate pharmaceutical services to ensure the receipt and administration of physician ordered medication was available to meet the needs of 1 of 3 residents requiring anti-seizure medication reviewed during a complaint investigation (Resident #1).Findings:1. Resident #1 was recently admitted with diagnoses to include epilepsy.On 11/10/25 the Division of Licensing and Certification received a complaint indicating Resident #1 . did not receive [his/her] prescribed medications including [his/her] seizure medication. supposed to take [his/her] seizure medications twice a day.A review of Resident #1's clinical record revealed a physician order for Phenobarbital Tablet 64.8MG, Give 1 tablet by mouth two times a day for seizures. A review of Resident #1's October 2025 Medication Administration Record (MAR) indicated the phenobarbital was scheduled to be given at 8:00 a.m. and 8:00 p.m. each day. Further review of the MAR revealed Resident #1 did not receive the 8:00 p.m. dose of the medication on 10/16/25 and did not receive the 8:00 a.m. dose or 8:00 p.m. dose on 10/17/25, resulting in three consecutive missed doses.A review of the October MAR nursing progress notes for the missed phenobarbital doses revealed the following:-A progress note dated 10/17/25 at 12:05 a.m. states, .New admission, awaiting for pharmacy delivery-A progress note dated 10/17/25 at 10:50 a.m. states, .Not available. checked pixies [Pyxis- an automated medication storage and dispensing machine] not available. Informed provider. waiting for delivery from pharmacy.A provider progress note dated 10/17/25 states, AFTER HOURS TELEHEALTH CONSULT . The individual has a known seizure disorder and is currently prescribed phenobarbital. The pharmacy contacted the facility after 6:00 PM requesting a prescription as no current script was available for dispensing. necessitating this urgent prescription request to ensure continuity of seizure management. Treatment Plan: Phenobarbital 64.8 milligrams twice daily prescription provided for immediate dispensing.On 11/25/25 at 9:07 a.m. during an interview with 2 surveyors, the Director of Nursing (DON) reviewed Resident #1's clinical record and confirmed he/she did not receive his/her prescribed phenobarbital doses on 10/16/25 and 10/17/25.On 11/25/25 at 11:42 a.m. during an interview with 2 surveyors, the above concerns were discussed with the Market Clinical Lead, and she stated it is her expectation that the pharmacy would have delivered Resident #1's phenobarbital by 10/17/25. At this time, a surveyor reviewed the Sugarloaf Unit controlled substance book with the Market Clinical Lead, which indicated the facility did not receive the phenobarbital delivery from the pharmacy until 3:00 a.m. on 10/18/25.2. Facility policy Ordering and Receiving Controlled Medications, revised January 2023 states, .Refill Requests for CIII-CV.requested from the pharmacy a minimum of 3 days in advance of need to assure an adequate supply is on hand.The facility may be asked to contact the prescriber for a new prescription upon request for a medication with no remaining fills available.A review of Resident #1's November MAR revealed Resident #1 did not receive his/her scheduled 8:00 p.m. phenobarbital [a Schedule IV controlled substance] dose on 11/2/25 and did not receive the scheduled 8:00 a.m. dose on 11/3/25 until 2:26 p.m.A review of the November MAR nursing progress notes for the missed phenobarbital doses revealed the following:-A progress note dated 11/2/25 states, . informed online provider. pharmacy will send the medication tomorrow-A progress note dated 11/3/25 states, .medication not available nurse awareA review of the Sugarloaf Unit controlled substance book indicated that after the 8:00 a.m. dose on 11/2/25, the facility had no remaining doses of Resident #1's phenobarbital on hand. Further review of the controlled substance book revealed the facility did not receive a refill of Resident #1's phenobarbital until 11/3/25 at 2:08 p.m., resulting in the missed 8:00 p.m. dose on 11/2/25 and the late dose on 11/3/25. On 11/25/25 at 12:46 p.m. during an interview with 2 surveyors, the above findings were discussed with the Market Clinical Lead and the DON. At this time, the Market Clinical lead stated the nurse should have notified the provider by 10/31/25 that a script was needed in order to refill Resident #1's phenobarbital before the medication ran out.