STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Market Square Health Care Center, LLC	3 Market Square South Paris, ME 04281

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 51669 Based on record review, interviews, and facility policy, the facility failed to ensure a resident's care plan was updated to reflect the resident's current care needs in the area of falls for 1of 3 residents reviewed (Resident #4). Finding: Facility policy, Falls Management Policy, states, Residents' care plan will be updated with all new interventions . Review of Resident #4's clinical record revealed he/she sustained a fall on 10/14/24, 10/16/24, 11/19/24, and 12/1/24. Review of Resident #4's care plan, updated on 11/12/24, revealed, Problems: .requires extensive assistance with self-care .inability to perform ADLs independently . Further review of Resident #4's care plan lacked evidence of goals and interventions for falls. On 12/19/24 at 2:19 p.m., during an interview with 2 surveyors, the Administrator stated it is her expectation that the resident care plan would be updated after a fall. On 12/19/24 at 5:37 p.m., during an interview with 2 surveyors, the Assistant Director of Nursing (ADON) reviewed the entire clinical record and confirmed that Resident #4's care plan was not updated to include goals and interventions for the care area of falls.

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 51669 Based on record review and interviews, the facility failed to ensure that clinical records were complete and contained accurate information for 2 of 3 residents reviewed. (Residents #4 and #5). Findings: Facility policy, Falls Management Policy, revised July 2019, states, .E. Complete the Post Fall Observation Tool, following a fall .F. Documentation must be completed in the nurse's note on each shift x 3 following the fall . 1. Review of Resident #4's clinical record revealed he/she sustained falls on 10/14/24, 10/16/24, 11/19/24, and 12/1/2024. The medical record lacked evidence that the Post Fall Observation Tool was completed for the 10/14/24, 10/16/24, or 12/1/24 falls. Further review of Resident #4's clinical record revealed the following progress notes: -11/29/24 at 8:41 p.m., CNA called this nurse to resident's room. Resident found lying on the floor beside her bed . -12/2/24 at 9:25 a.m., Yelling heard by nursing staff with original origin unknown. Upon arrival of CNA staff resident observed holding self up on opposite bed in room. Resident lowered to floor by CNA staff . The clinical record lacked evidence of a nurse's note each shift for 3 shifts after these falls. 2. Review of Resident #5's Care plan, updated on 9/30/24, revealed, Problems: .history of falls within last month r/t impaired mobility, poor safety awareness, impulse control .Goal: .no increase in the incidence of falls/injuries .Interventions: .non-slick footwear that fits, keep areas free of obstructions .call light within easy reach. Review of Resident #5's clinical record revealed he/she sustained a fall on 11/22/24 and 11/26/24. Further review of Resident #5's clinical record lacked evidence that nursing notes were completed each shift x 3 shifts after these falls. On 12/19/24 at 5:37 p.m., during a review of Resident #4's and Resident #5's entire clinical records with 2 surveyors, Assistant Director of Nursing (ADON) confirmed the clinical records lacked evidence that a nurse's note was completed each shift for 3 shifts following the above falls, and Resident #4's clinical record lacked evidence that a Post Fall Observation Tool was completed after the falls sustained on 10/14/24, 10/16/24, and 12/1/24.

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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 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** 42531 Based on observations, interviews, and facility policy, the facility failed to maintain an Infection Control Program designed to help prevent the development of infection for 1 of 3 sampled residents. (Resident 3) Findings: Review of policy Oxygen Use & Storage Policy dated 10/24 states Respiratory Care: A sanitary environment must be maintained to prevent the transmission of disease. When nebulizer parts are not in use, after [NAME] air dried, the mask and/or hand held devices shold be stored in a plastiv bag to the risk of it becoming contaminated . During observations of room [ROOM NUMBER] on 12/19/24 at 10:13 a.m., and 12:15 p.m., the following was observed: -an unbagged bedpan was observed on the bathroom floor. -an unused catheter bag dated 12/17 was observed in a cardboard box containing pudding cups belonging to Resident 3. -a nebulizer was observed on bedside table. The apparatus was apart and left on top of the bedside table. Nebulizer tubing was observed rolled up and in a pink wash basin containing headbands and hairbrush with a large amount of hair on it. On 12/19/24 at 12:16 p.m., during an interview, Resident 3 indicated he/she was very upset because his/her food is in the box and doesn't understand why someone would leave a catheter bag in the box because that was disgusting. Resident 3 further indicated it's been a while since she/he has used the nebulizer, but uses the bed pan daily. On 12/19/24 at 12:18 p.m., during an observation of room [ROOM NUMBER] and interview with Registered Nurse (RN)1 confirmed the above findings and stated that bedpans should always be bagged, catheter bags should never be placed in with resident personal items and nebulizer tubing should be bagged when not in use. On 12/19/24 at 1:03 p.m., during an interview, the above was discussed with Administrator.