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	05/14/2026

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to promote care for residents in a manner that maintains each resident's dignity for 2 of 2 sampled residents (Residents #41, #51) on 2 of 4 days of survey (5/11/26, 5/12/26). Finding: 1.Review of Quarterly Minimum Data Set (MDS), dated [DATE] , revealed Resident #41 has a Brief Interview for Mental Status (BIMS) 14 of 15 indicating he/she is cognitively intact. On 5/11/26 at 9:23 a.m., a surveyor observed, from the hallway, CNA #8 assisting Resident #41 get up and dressed for breakfast. Resident #41 was sitting on the edge of his/her bed in only a brief. Privacy was not provided as the bedroom door was open and no privacy curtain was drawn. The surveyor observed residents and staff passing the resident's room at this time. On 5/11/26 at 9:23 a.m., in an observation and interview, the Administrator confirmed the above finding. 2. Resident #51 has diagnoses to include, but not limited to, dementia. A review of Resident #51's most recent Quarterly MDS assessment, completed 4/3/26, revealed that Resident #51 has a BIMS of 0, indicating that he/she is severely cognitively impaired. On 5/11/26 at 9:03 a.m., a surveyor observed Resident #51 wearing a hospital gown with the open part of the gown in the front, exposing Resident #51's bare abdomen and parts of his/her bare chest. Resident #51's roommate was seated on his/her bed at the time of the observation. At this time, the surveyor discussed the observation with CNA #2. During an interview at this time, CNA #2 stated that Resident #51 usually wears a hospital gown to bed and that he/she can sometimes dress him/herself, but that he/she is mainly dependent on staff assistance. CNA #2 then stated that even if staff assist Resident #51 with dressing, he/she will take his/her clothing off and not put it back on properly. CNA #2 then stated she would assist Resident #51 with care now and entered the room. On 5/12/26 at 2:32 p.m., during a repeat observation, Resident #51 was seated on his/her bed, shirtless. Resident #51's door and privacy curtain were open, and facility staff were walking by in the hall. At this time, during an observation and interview, the Director of Nursing Services (DNS) and the [NAME] President (VP) of Clinical Services confirmed the finding, and the surveyor discussed the previous observation with the DNS and VP of Clinical Services.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable environment on 3 of 3 units ([NAME] East, [NAME] and Tuttle) and the laundry room for 1 of 1 facility tour.Findings:On 5/14/26 from 8:45 a.m. to 9:25 a.m., a surveyor conducted an Environmental Tour with the Environmental Services Director and the Housekeeping/Laundry Supervisor in which the following findings were observed and discussed:[NAME] East Unit:- Spa room - The floor and base of the whirlpool had dirty/stained caulking and rust along the outside edge.- Resident room [ROOM NUMBER] - The floor was dirty and stained with brown substance. The base board heater had chipped/missing paint creating an uncleanable surface.- Resident room [ROOM NUMBER] - The room floor was all scuffed up and dirty. [NAME] Unit:- Resident room [ROOM NUMBER] - There was an unlabeled urinal on a sink that was shared by multiple residents.- Resident room [ROOM NUMBER] - The bathroom wall across from the toilet was scuffed and missing paint creating an uncleanable surface. There was a wheelchair footrest lying next to the toilet on the floor. - Resident room [ROOM NUMBER] - There was a stained ceiling tile above the toilet in the bathroom and small stain on a ceiling tile above the bed near the door. Tuttle Unit:- Resident room [ROOM NUMBER] - The privacy curtain was missing hooks, hanging down and in disrepair. - Resident room [ROOM NUMBER]- The left armrest on a wheelchair was ripped/torn. The privacy curtain was missing hooks, hanging down and in disrepair. The baseboard heater had chipped paint and was rusty creating an uncleanable surface. The sink basin was cracked and stained. The wall by the closet and the closet door had black marks. The inside of the bathroom doors had chipped/missing paint. The toilet and the caulking around the base of the toilet was dirty.- Resident room [ROOM NUMBER] - The privacy curtain had missing hooks, hanging down and in disrepair. - Resident room [ROOM NUMBER] - The caulking around the base of the toilet was dirty. - Resident room [ROOM NUMBER] - The base board heater had chipped/missing paint creating an uncleanable surface.- Resident room [ROOM NUMBER] - The floor and caulking around the base of the toilet was dirty. - Resident room [ROOM NUMBER] - The wall was gouged and had exposed sheetrock at the head of the bed. The toilet bowl was dirty and stained. The caulking was dirty around the base of the toilet. The bathroom doors and frames had chipped/missing paint creating uncleanable surfaces. Laundry Room:- The wooden shelf and the exposed wooden wall by the washing machines were untreated creating uncleanable surfaces. - The surface of the cement floor was worn off and untreated creating an uncleanable surface.- There were 15(fifteen) cracked/broken and/or missing floor tiles.- The cove base was coming off the wall by the left dryer. On 5/14/26 at 9:25 a.m., in an interview with a surveyor, the Environmental Services Director and the Housekeeping/Laundry Supervisor confirmed the discussed and observed findings.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews the facility failed to provide written transfer/discharge and bed hold notices to include cost of care, which included appeals rights to 4 of 4 residents reviewed for discharge (Resident #1, #9, #38 & #77). Findings: 1. Resident #1's clinical record revealed the resident was transferred to an acute care hospital on [DATE] and again on 4/17/26 and was subsequently admitted . The clinical record lacked evidence that Resident #1, who was responsible for himself/herself, was provided with written bed hold notices upon transfer. On 5/12/26 at 1:05 p.m., in an interview with 4 surveyors present, Director of Nursing Services confirmed that the resident did not receive written bed hold notices for the two transfers to the hospital. 2. Resident #77's clinical record revealed the resident was transferred to an acute care hospital on 4/2/26. The clinical record lacked evidence that the resident and/or resident representative were provided with a written a transfer/discharge notice and bed hold notice for this transfer to a hospital. On 5/14/25 at 11:56 a.m., in an interview with a surveyor, the [NAME] President of Clinical Services confirmed that the resident and/or resident representative were not given a transfer/discharge notice and bed hold notice in writing for this transfer to a hospital. 3. Review of Resident #38's clinical record revealed that he/she was transferred to an acute care hospital on [DATE] and was subsequently admitted , and that Resident #38 was again transferred to an acute care hospital on 2/18/26. Further review of Resident #38's clinical record lacked evidence that the facility issued a written transfer/discharge notice and bed hold notice to Resident #38 for the above dates. On 5/14/26 at 12:30 p.m., during an interview, the Director of Nursing Services (DNS) confirmed that the facility does not have evidence that Resident #38 received written transfer and bed hold notices for the above dates. 4.Review of Resident #9's clinical record revealed he/she was transferred to an acute care hospital on [DATE]. Review of Bed Hold dated 10/24/25 states: Permission/Agreement There is no documented evidence that Resident #9's representative received notice of bed hold and transfer agreement in writing for this hospital transfer. Review of provided email dated 10/23/25 at 3:47 p.m. states . [the state aide Medicare will hold the bed for 7 days. ---if [he/she]were to need to stay longer than 7 days, [he/she] could come back to [his/her] bed if [he/she] pain $395 a day, or if [he/she] did not have money to hold the bed, [he/she] could come back if we had a bed available. Again, this is not the [cashe], but the regulations state I need to inform you.] Further review of the email provided lacked evidence of right to appeal, ombudsman name, contact and transfer notice. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident #9's clinical record on 5/12/26 at 1:22 p.m. the Director of Nursing confirmed above findings.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interviews, and record review, the facility failed to ensure a resident's comprehensive care plan was developed and implemented to reflect the current needs of the resident for 5 of 18 residents reviewed for care planning (Residents #17, #38, #25, #61, #85). Findings: 1. Resident #38 was admitted to the facility in 2025 with diagnoses to include Quadriplegia. On 5/11/26 at 10:37 a.m. a surveyor observed Resident #38 sitting in a high-back wheelchair in his/her room. At this time, a Certified Nursing Assistant (CNA) entered the room and refilled Resident #38's water bottle that was part of a hands-free adaptive drinking system with a flexible arm and mouthpiece, located on the back of his/her wheelchair. During an interview, Resident #38 stated that the device allows him/her to drink independently. A review of Resident #38's clinical record revealed physician orders dated 2/9/26 and 5/5/26 for Occupational Therapy that state, Therapeutic Exercise; Therapeutic Activities; Self Care/Home Management Training; Neuro Re-education; Wheelchair Management; Group Therapy. Duration 12 weeks. A review of Resident #38's comprehensive care plan lacked evidence that goals and interventions were developed and implemented related to the occupational therapy services Resident #38 is receiving, including his/her use of adaptive devices. On 5/14/26 at 9:30 a.m. during an interview, the Occupational Therapist (OT) stated that Resident #38 has been receiving occupational therapy services since admission to the facility. On 5/14/26 at 12:30 p.m., the surveyor discussed the above finding with the Director of Nursing (DNS), Assistant Director of Nursing, and the [NAME] President of Clinical Services. During an interview at this time, the DNS stated that the facility has never included goals and interventions related to therapy services on a resident's care plan for any of the facility's residents receiving physical therapy (PT) or OT. 2. On 5/11/26 at 11:05 a.m. a surveyor observed Resident #17 lying in bed in his/her room with his/her call light on. During an interview at this time, Resident #17 stated that he/she had called for a bedpan and that CNA #11 was supposed to go to supply and get another bedpan but never returned. At 11:10 a.m., three staff members entered Resident #17's room to respond to his/her call light and stated that CNA #11 is on break but that they would go find a bedpan. At 11:14 a.m., CNA #11 entered Resident #17's room alone and stated that she had forgotten about Resident #17's bedpan and then proceeded to assist Resident #17 to use the bedpan alone. A review of Resident #17's comprehensive care plan states, .Behavioral Symptoms: [Resident #17] has physical behavioral symptoms directed at others .All care should be provided with 2 staff members. On 5/13/26 at 1:14 p.m. a surveyor observed Resident #17's call light on, and at this time, the Activities Director asked the Social Services Assistant to accompany her to answer the call light. During an interview at this time, the Social Services Assistant stated that for the safety of Resident #17 and the safety of the staff, two staff are to be present for all interactions with Resident #17. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/13/26 at 2:10 p.m. the surveyor discussed the above finding with the Administrator. 3 Review of facility policy, Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property. revised 10/18 states, Prevention . The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as: Verbally aggressive behavior, such as screaming, cursing .Physically aggressive behavior such as hitting, kicking, grabbing .threatening gestures . On 9/8/25 at 2:22 p.m., the Division of Licensing and Certification (DLC) received a facility-reported incident that stated that Resident #61 .rolled from out of [his/her] room after eating lunch, yelled and cursed at [Resident #89] for being in [his/her] way, threatening to run [Resident #89] over in [his/her] wheelchair. The follow-up report submitted to the DLC on 9/15/25 indicated that Resident #61 .used her motorized wheelchair to push [Resident #89] out of [his/her] way and then ran over [Resident #89's] foot rather than wait for staff to move [him/her]. A review of Resident #61's clinical record revealed the following: A progress note dated 3/12/25 that states, It was reported to me by CNA. that Resident backed over another resident's feet in [his/her] wheelchair this morning .Resident is usually grouchy and mean with others. Plan of care ongoing. A progress note dated 7/19/25 that states, Resident was in the lobby area watching TV when another resident tried to get around [him/her] in [his/her] wheelchair. This RN [registered nurse] saw resident kick the other person very hard and started yelling and swearing. A progress note dated 7/29/25 that states, resident became verbally aggressive to another resident and to said nurse. states [he/she] will punch another resident in the face if [he/she] touches [him/her]. redirected resident. A progress note dated 9/5/25 that states, .Resident was sitting in the common area with other residents present when she started yelling and shouting SHUT UP! SHUT UP! to another resident with dementia. Staff separated residents. Writer reported. behaviors to DON/MD [Medical Doctor] for further review of behavior displayed in front of visitors, resident and staff. No further behaviors noted at this time. Care plan continued. A progress note dated 2/9/26 that states, Another resident was rolling [his/her] wheelchair past where this resident was sitting when [he/she] gave the wheelchair a kick. Staff immediately intervened without any further incident. No injury on either resident. This resident was redirected. A review of Resident #61's comprehensive care plan lacked evidence that goals and interventions were developed and implemented for his/her verbal and physical behaviors towards others. On 5/14/26 at 1:28 p.m. during an interview in the presence of 3 surveyors, the DNS stated that Resident #61 has always disliked residents with dementia to be around him/her, so the facility tries to keep an eye out on residents with dementia who are trying to get around near Resident #61 to prevent any incidents from arising. At this time, a surveyor discussed that Resident #61's care plan lacks goals and interventions for his/her history of resident-resident conflicts. At this time, the DNS confirmed that interventions should have been in place on Resident #61's care plan to address his/her behaviors. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4.Resident #85 was admitted 5/2026 for skilled services. Review of Resident #85 orders revealed order with start date of 5/5/26 for PT [Physical Therapy] - Treatment Clarification orders: Therapeutic Exercise: Therapeutic Activities: Gait training: Neuro re-education; wheelchair management. Frequency 60 Duration 12 weeks. Review of Resident #85's care plan created 5/4/26 lacked goals and interventions in the area of therapy services. Interview with Occupational l Therapist (OT) on 5/12/26 11:09 a.m. Confirmed Resident #85 received PT and OT services 5 days a week and stated they have a therapy plan of care for him/her, but it should be transferred into the resident's care plan. 5. Review of Resident #25's clinical record revealed he/she sustained an unwitnessed fall on 5/11/26. Review of his/her care plan for falls revealed an intervention stating, Needs will be met while completing hourly rounding. On 5/14/26 at 7:10 a.m., during an interview with Certified Nursing Assistant #9 stated Resident #25 is on hourly rounding for fall precautions, stating they document this on a rounding sheet kept at the nurse's station. On 5/14/26 at 8:06 a.m., a review of Resident #25's Hourly Rounding Sheets for 5/12/26 and 5/13/26 revealed 14 missing rounds. On 5/14/26 at 8:35 a.m., the above information was reviewed with the Facility Administrator.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review and interviews, the facility failed to ensure lifesaving medical equipment was restocked and readily available for use in an emergency for 2 of 2 emergency (crash) carts observed ([NAME] East and Tuttle Units).Findings: Review of Emergency Equipment Checklist Policy dated 3/19 states Emergency equipment and supplies will be checked every night on third shift by a licensed, or his/her designee, to assure all emergency equipment and supplies are present, sufficient, and in proper functioning order:Equipment/supplies to be checked include oxygen and oxygen equipment; cardiac board, suction machine and suction equipment; ambu bag- PPE [personal protective equipment]Procedure: Check Oxygen Emergency Tank: verify contents of tank; crank open tank with wrench; assure oxygen flow with regulator; crank oxygen tank shut with wrench; validate presence of ambu-bag and masks; locate cardiac board; validate function of suction machine and presence of tubing and yankauer/catheter; validate presence of PPE packet; sign daily Emergency Equipment Check sheet.Observation of East Wing Crash Cart [DATE] at 2:30 p.m., revealed the crash cart did not have an ambu bag, 02 tank was empty, and there was no yankauer or suction tubing for the suction machine.Review of East Wing: Nursing Binder contained Shift Responsibilities form [undated] states: These things should be included in the packet that will be turned into DNS at the end of day shift: Crash cart check list and template (put out on the 1st of the month).Review of East Daily Code/Crash Cart Equipment Check dated 4/2025 is blank. There was no evidence that the equipment check was completed in 2026.On [DATE] at 2:33 p.m., East Unit Manager ([NAME]) stated the second shift is supposed to be doing crash cart checks and signing off on it, and she is unable to find when the last crash cart check was completed and is unsure what is supposed to be in the crash cart itself.On [DATE] at 2:44 p.m., observation of Tuttle Unit crash cart showed there is no O2 regulator, making the 02 tank not available for use in an emergency. At this time, the above information was confirmed with Tuttle Unit Manager stated she believed the Night nurse was responsible to review/restock the crash cart, and she does not check that its done.Review of Tuttle Daily Code Cart Equipment Check dated 3/26 revealed the equipment was signed off on [3/26], [DATE] and [DATE].Review of Equipment list updated 3/19 states: -Turn on 02 to be sure tank is full and regulator is working. Be sure to shut tank back off with wrench. AED check that pads have not expired and that the battery is working and charged. This is in the Tuttle nurses station and will be checked by the Tuttle nurse.On [DATE] at 3:03 p.m. 2 surveyors observed Nurses station on Tuttle unit, where policy stated AED located. The surveyors were unable to locate the AED and asked LPN#2 is she was aware of its location. LPN#2 did not know where the AED was located. At this time RN3, who was sitting at nurses station stated AED is located on East unit. On [DATE] at 3:09 p.m., 2 surveyors located the AED on the East Unit. The AED Inspection Record sticker on inside panel of device cabinet stated it was last inspected on [DATE]. At this time RN1confirmed that staff do not perform checks on the AED.On [DATE] at 3:10 p.m. the Director of Nursing confirmed the facility is not performing checks on the AED.During an interview on [DATE] at approximately 9:15 a.m., the above was discussed with the Administrator.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, facility policy, and a review of Safety Data Sheets (SDS), the facility failed to ensure that the resident's environment was free of accident hazards by failing to ensure that a patient lift had working safety clips and failing to ensure that chemicals were properly secured for 2 of 2 observations for 2 of 4 days of survey (5/11/26 and 5/12/26). Additionally, the facility failed to ensure that a resident's motorized wheelchair safety screen was completed for 1 of 3 residents reviewed for accidents (Resident #61). Findings: 1. On 5/11/26 at 9:18 a.m., a surveyor observed a patient lift in the hallway by resident room [ROOM NUMBER] which had a broken safety clip on the sling arm that would not safely secure a sling strap when used to lift a resident. On 5/11/26 at 9:23 a.m., in an interview with a surveyor, the Administrator observed and confirmed the broken safety clip on the patient lift. 2. On 5/12/26 at 4:17 p.m., two surveyors observed a 32 fluid ounce bottle of Clorox Urine Remover for Stains and Odors on the bureau next to the door in Resident room [ROOM NUMBER]. At this time, LPN #1 confirmed the finding and removed the bottle of Clorox Urine Remover for Stains and Odors. The Safety Data Sheet(SDS) for Clorox Urine Remover for Stains and Odors noted: Section 4: First Aid Measures Eye contact: If in eyes, hold eye open and rinse slowly and gently with water for 15 to 20 minutes. Remove contact lenses, if present, after the first 5 minutes, then continue rinsing eye. Calling poison Control Center or doctor for treatment advice. Skin contact: Wash off immediately with plenty of water. If skin irritation persists, call a physician. Inhalation: Remove to fresh air. If breathing is difficult, (trained personnel should) give oxygen. Call a physician or poison Control Center immediately. Ingestion: Drink 1 to 2 glasses of water. Do not induce vomiting without medical advice. Call a physician or poison Control Center immediately. On 5/13/26 at 8:00 a.m., in an interview with a surveyor, the Director of Nursing Services(DNS) stated that the facility has residents that have dementia and are confused. They have residents that do wander and ambulate around the facility and also have residents that move through the facility in wheelchairs. 3. Facility policy, Motorized Wheelchair Use Policy, revised 1/19 states, .Residents will be screened upon admission, quarterly, and when a change in the resident's condition occurs regarding ability to safely operate a motorized wheelchair by a Licensed Therapist, or a Registered Nurse. Residents will operate the motorized wheelchair in a safe manner. A safe manner is described as but not limited to; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	speed, maneuvering around people/objects, ability to follow pedestrian rules, recognizing/avoiding unsafe conditions. The speed of the wheelchair will be adjusted as determined by the safety evaluation. On 9/8/25 at 2:22 p.m., the Division of Licensing and Certification (DLC) received a facility-reported incident that stated that Resident #61 .rolled from out of [his/her] room after eating lunch, yelled and cursed at [Resident #89] for being in [his/her] way, threatening to run [Resident #89] over in [his/her] wheelchair. The follow-up report submitted to the DLC on 9/15/25 indicated that Resident #61 .used [his/her] motorized wheelchair to push [Resident #89] out of [his/her] way and then ran over [Resident #89's] foot rather than wait for staff to move [him/her]. On 9/15/25 at 1:20 p.m., the facility submitted its 5-day investigation follow-up report to the DLC that states, .the Administrator has suspended [Resident #61's] motorized wheelchair privileges for 2 months- effective 9/10/2025 and ending on 11/10/2025. A review of Resident #61's clinical record revealed a Motorized Wheelchair Safety Screen dated 3/13/24 that addressed areas to include, but not limited to: Ability to judge the speed of the motorized wheelchair Resident demonstrates ability to judge distances Ability to react quickly for stopping and turning Ability to be patient with other residents Ability to make good judgements in protecting their safety and the safety of others Is the resident able to safely operate the motorized wheelchair indoors? Is the resident able to safely operate the motorized wheelchair outdoors? Further review of Resident #61's clinical record lacked evidence that any Motorized Wheelchair Safety Screens were completed after the 3/13/24 assessment, including prior to the above incident reported 9/8/25. On 5/13/26 at 8:50 a.m. during an interview, the Administrator stated that Resident #61 got his/her motorized chair back as planned in November, but that he/she had functional issues with using the hand control and ran himself/herself into a fence. The Administrator then stated that Resident #61 had three incidents involving the motorized chair within a two-day timespan, so the facility permanently revoked it and that he/she now has a manual wheelchair for locomotion. On 5/14/26 at 3:27 p.m. during an interview, a surveyor discussed the above concerns with Physical Therapist (PT). At this time, the PT confirmed that Resident #61's last Motorized Wheelchair Safety Screen was completed 3/13/24 and that he did not have evidence of any safety screens being completed after that. The PT then confirmed that if a resident uses a power chair, motorized wheelchair safety screens should be completed quarterly. On 5/14/26 at 3:30 p.m., the surveyor discussed the above finding during an interview with the Administrator.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observations and interviews, the facility failed to provide a sanitary environment to ensure that respiratory equipment was clean to help prevent the development and transmission of disease and infection related to oxygen tubing for 1 of 3 residents reviewed for respiratory care (Resident #11).Findings:On 5/12/26 observations at 6:50 a.m., 7:02 a.m., and 7:10 a.m. of Resident #11 was observed lying in bed, nasal canula tubing is attached to his/her nose but the connector is lying on the floor in front of the oxygen concentrator, and visible from the door.On 5/12/26 at 7:33 a.m., Certified Nursing Assistant (CNA) #3 was observed standing in the doorway resident's room, nasal canula tubing attached to his/her nose but oxygen tubing is noted to be lying on the floor not attached to the oxygen concentrator, and visible from the door.On 5/12/26 at 7:34 a.m., CNA#7 was standing in residents' doorway and saying Good Morning [Resident #11] nasal canula tubing attached to his/her nose but oxygen tubing is noted to be lying on the floor not attached to the oxygen concentrator, and visible from the door.On 5/12/26 at 8:17 a.m., CNA#3 was observed bringing in breakfast for resident and placed it sitting it on the bedside table, she then elevated the residents' head of bed. The residents' nasal canula tubing is attached to his nose but oxygen tubing is noted to be lying on the floor not attached to the oxygen concentrator.5/12/26 9:13 a.m. Resident #11 observed lying in bed, nasal cannula observed in his/her nose, the end of tubing (connector) observed on floor in front of concentrator. Resident states he/she didn't sleep very well and is unsure why. On 5/12/26 at 9:19 a.m. Resident #11 was observed sitting up in bed, nasal cannula observed in his/her nose and the end of tubing connector was observed lying on the floor not attached to concentrator. At this time a surveyor went to the nursing station and asked Licensed Practical Nurse (LPN)#1 how often Resident 11's oxygen saturation is obtained. LPN#1stated that it's done every shift when he/she is on 02. At this time LPN#1 was asked to take Resident 11's 02 level. LPN#1 went into the room and put the pulse oxygen machine on Resident 11' s right index finger and stated he'd be right back and left the room. LPN#1 came back approximately 60 seconds later and 02 read 89%. LPN#1 stated that he will try another finger, at this time a surveyor pointed to the end of the tubbing that is not connected to the concentrator. At this time the above was confirmed. Review of Resident #11's order with start date of 4/9/26 for Supplemental oxygen 1-2 L via nasal cannula as needed to keep 02 sat greater than 90 percent. Review of most recent oxygen saturation dated 5/11/26 at 1:51 a.m., was 98% via ns (nasal cannula) 2-3L. Review of Resident 11's care plan updated 5/4/26 states: Respiratory: unable to maintain oxygen saturation secondary to A-Fib, SOB when lying flat GOAL: will maintain an oxygen saturation greater than 90%; Monitor oxygen saturation every shift and PRN when oxygen is in use.5/12/26 9:28 a.m. the Above was discussed with Administrator with 4 surveyors present.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record reviews and interviews, the facility failed to ensure that two people who are authorized to administer medications signed the Shift Count page indicating that they counted all controlled substances at the change of shift for 2 of 3 units reviewed for medication storage (Tuttle and Andrew's Went Unit's). Findings:1. Review of Tuttle's Med Cart Controlled Substance Log on 5/11/26 revealed the following:- No outgoing signature on 5/25/25 at 0630, 5/28/25 at 0700, 6/12/25 at 2100, 8/13/25 at 0700, 9/10/25 at 0700, 9/19/25 at 1535, 10/6/25 at 2300, 11/28/25 0700, and on 12/10/25 at 0700.- No incoming signature on 9/19/25 at 1900 and on 11/27/25 at 2035.2. Review of Andrew's [NAME] Med Cart Controlled Substance Log on 5/11/26 revealed the following:- No outgoing signature on 3/2/26 at 1900, 3/4/26 at 1500, 2/19/26 at 1500, 3/25/26 at 1500, 3/25/26 at 2300, 3/26/26 at 1900, 4/18/26 at 1900, 4/21/26 at1500, and on 4/30/26 at 1930.- No incoming signature on 1/23/26 at 2300, 3/3/26 at an unknown time, 3/4/26 at 0700, 2/19/26 at 0700, 3/25/26 at 1500, and on 4/10/26 at 0715.On 5/13/26 at 8:20 a.m., the above information was reviewed and confirmed with the Facility Administrator.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on facility policy, record review, observations, and interviews, the facility failed to adequately ensure medications and biologics were stored at appropriate temperatures in 3 of 3 refrigerators observed for 3 of 3 months of medication refrigerator logs reviewed. Additionally, the facility failed to ensure treatments were stored properly for 2 of 4 days of survey. (5/11/26 and 5/12/26) Findings: 1. On 5/11/26 at 11:05 a.m., during an observation of Resident #17's room, a medicine cup containing an unknown white powder was located on Resident #17's over-the-bed table. During an interview at this time, Resident #17 stated the powder is for his/her rash. On 5/12/26 at 12:56 p.m., the surveyor and Licensed Practical Nurse (LPN) #2 observed a medicine cup containing an unknown white powder located on Resident #17's over-the-bed table. During an interview at this time, LPN #2 stated that she asks the Certified Nursing Assistants (CNAs) which residents need Nystatin powder, and then she gives it to the CNAs to provide the treatments to the residents. The surveyor and LPN #2 then reviewed Resident #17's clinical record, and LPN #2 confirmed that Resident #17 has an active physician order for Nystatin twice daily and stated that on 5/11/26, she documented the medication as administered at 8:13 a.m. and on 5/12/26, she documented the medication as administered at 9:14 a.m. The surveyor then discussed that LPN #2 was documenting the medication as administered prior to it being administered and asked LPN #2 how she knows if the CNA administered the treatment. The LPN then stated that if the CNA says they provided the treatment, they usually get it done. On 5/12/26 at 1:20 p.m., the surveyor discussed the above finding with the Director of Nursing (DNS). During an interview at this time, the DNS stated that the medication should not be left at the bedside and that the nurse should be providing the treatments, not CNAs. 2. Review of the facility policy Medication Storage in the Facility states Medications requiring refrigeration are kept in a refrigerator at temperatures between 36 degrees Fahrenheit and 46 degrees Fahrenheit. -On 5/12/26 at 1:00 p.m., observation of the Andrew's [NAME] Unit medication refrigerator, which contained Insulin's Glargine, Aspart, and Novolog. Additionally, medication refrigerator also contained Tuberculin Purified Protein, and Ativan. A review of the medication refrigerator temperature logs from March 1, 2026 through March 31, 2026 showed 9 out of range readings. A review of the medication refrigerator temperature logs from April 1, 2026 through April 28, 2026 showed 5 out of range readings. -On 5/12/26 at 1:25 p.m., observation of Andrew's East Unit medication refrigerator, which contained Insulins Lantus and Novolog. A review of the medication refrigerator temperature logs from April 1, 2026 through April 30, 2026 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showed 1 out of range reading. -On 1/12/26 at 1:35 p.m., observation of the Tuttle Unit medication refrigerator, which contained Tuberculin Purified Protein, Shingrix, Spikevax, and Prevnar vaccinations, and Insulins Lispro and Lantus. A review of the medication refrigerator temperature logs from February 1, 2026 through February 28, 2026 showed 23 out of range readings. A review of the medication refrigerator temperature logs from March 1, 2026 through March 31, 2026 showed 16 out of range readings. On 5/12/26 at 1:00 p.m., during an interview with Licensed Practical Nurse #1 (LPN), who states if there are any out of range temperature readings, he would call maintenance. On 5/12/26 at 1:25 p.m., during an interview with LPN #3 who states if there were any out of range temperatures, he would call maintenance and document on the medication temperature log what he did. On 5/12/26 at 1:45 p.m., during an interview with the Director of Nursing Services (DNS), who states it is the expectation of the nursing staff to address the out of range temperatures by contacting maintenance and document on the temperature log what they have done. At this time, the above information was reviewed and confirmed. On 5/12/26 at 2 p.m., during an interview with 2 surveyors present, Maintenance Assistant #1, stated there have not been any recent maintenance slips within the past few months regarding medication refrigerator temperatures being out of range.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interview, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for a food mixer, food storage bins, the ceiling, the hood system, a door, and floors; failed to ensure foods were sealed, labeled and/or dated on kitchen carts and in a walk-in freezer for 2 of 2 kitchen/kitchenette tours for 1of 4 days of survey (5/11/26); and failed to ensure Daily High-Temp Ware Wash temperatures, the Freezer and Refrigerator Temperatures, and Sink/Bucket Sanitizer and 3-Bay parts per million(PPM) were monitored/documented for 1 of 4 days of survey. (5/12/26) Additionally, the facility failed to serve food in in sanitary manor for 1 of 4 days of survey. (5/11/26)Findings: Food Storage policy and procedure dated 2023 noted: Procedure: 8. All containers or storage bags must be legible and accurately labeled and dated. 12. Leftover food should be stored in covered containers or wrapped carefully and securely and clearly labeled and dated before being refrigerated. 13. Refrigerated food storage: f. All foods should be covered, labeled and dated and routinely monitored to assure that foods will be consumed by their use by dates, or frozen or discarded. 14. Frozen Foods: c. All foods should be covered, labeled and dated. All foods will be checked to assure that foods will be consumed by their use by dates or discarded. Dish Machine Temperature Log policy and procedure dated 2023 noted: Policy: Dishwashing staff will monitor and record dish machine temperatures to ensure proper sanitizing of dishes. 2. Staff will Record dish machine temperatures for the wash and rinse cycles after each meal. The director of food and nutrition services will spot check this log to assume temperatures are appropriate and staff is correctly monitoring dish machine temperatures. 1. On 5/11/26 from 8:10 a.m. to 8:50 a.m., a surveyor conducted an initial kitchen tour with a cook and the Food Service Director(FSD) in which the following findings were discussed and observed: - The food mixer had dried food particles and dried liquid residue on the shroud, cage and base. Additionally, the mix arm had chipped/missing paint creating an uncleanable surface. - There was a large bin of cereal that was not date and labeled. - There was a large bin of sugar and a large bin of flour that were not dated. - The ceiling over food preparation areas had dried food and liquid residue spattered on it. - The hood system was missing filters and the exhaust area was dusty/dirty. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- There was a bag of bread products, on a cart by the coffee maker, that was not labeled and dated. - There were six bags of bread products, on a cart labeled first-in first-out, that were not labeled and dated. - The dish room door and frame, that exits to a hallway, was rusty and had chipped/missing paint creating uncleanable surfaces. - The food disposal had dried liquid residue on it. - The walk-in refrigerator had a cement floor that had worn off/missing paint and was not sealed creating an uncleanable surface. - The walk-in freezer had a bag of carrots, a bag of French fries and a box of chicken patties that were previously opened and left open to the air and not secured. Additionally, there was a large bag of tater tots that was not labeled and dated. On 5/11/26 at 8:50 a.m., in an interview with a surveyor, both the cook and the FSD confirmed the findings. 2. On 5/11/26 at 12:00 p.m., a surveyor observed the refrigerator, in the main dining room, had spilled liquid residue on the unit shelving. On 5/11/26 at 12:05 p.m., in an interview with a surveyor, a kitchen worker observed and confirmed the finding. 3. On 5/12/26 at 3:00 p.m., a surveyor reviewed the kitchen dish washer logs, the sanitation bucket logs and the kitchen/kitchenette refrigerator/freezer temperature logs and found dates that were not monitored/documented and were missing in February, March and April of 2026. Daily High-Temp Ware Wash checklist: 2026–Missing dates February- no evidence of documentation March 30th and 31st for lunch Freezer and Refrigerator Temperatures Form: 2026 –Missing dates March Dining room freezer: 29th, 30th. East/West Unit: p.m.-29th, 30th. April Tuttle Unit: a.m.- 26th, 30th; p.m.-25th, 26th, 27th, 30th. East/West Unit: a.m.- 22nd, 23rd, 30th.; p.m.-22nd, 23rd, 25th, 26th, 27th, 30th. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dining Room: a.m.-30th,; p.m.-22nd, 23rd, 25th, 26th, 27th, 30th. Kitchen Freezer: a.m.-30th. Kitchen Walk-in: a.m.-30th. Sink/Bucket Sanitizer: Kitchen 2026–Missing dates February - early morning-27th, 28th.; mid-morning-27th, 28th.; afternoon- 26th, 27th, 28th.; evening-26th, 27th, 28th.; March: early morning-28th-31st.; early morning-27th-31st.; afternoon- 4th-30th,; evening- 4th-30th. April: no evidence of documentation Bucket Sanitizer: Kitchen 2026–Missing dates February - early morning-27th, 28th.; mid-morning-27th, 28th. March: no evidence of documentation April: no evidence of documentation On 5/12/26 at 3:10 p.m., a surveyor discussed the findings with the Administrator. 4. On 5/11/26 observation of breakfast meal tray pass showed the following at 8:23 a.m., CNA #5 (Certified Nursing Assistant) carrying a tray containing uncovered food down the hall to room [ROOM NUMBER]. At 8:28 a.m., CNA #4 carrying a tray containing uncovered foods down the hall to room [ROOM NUMBER]. At 8:30 a.m., CNA #5 carrying a tray containing uncovered foods down the hall to room [ROOM NUMBER]. At 8:31 a.m., CNA #3 carrying a tray containing uncovered foods down the hall to room [ROOM NUMBER]. At 8:34 a.m., CNA #3 carrying a tray containing uncovered foods down the hall to room [ROOM NUMBER]. On 5/11/26 at 8:36 a.m., during an interview with Dietary Aid #1, he discussed the process of prepping trays prior to bringing them down the hall to resident's rooms, stating all food items are supposed to be covered or packaged. At this time, he confirmed he has not been covering all the food on the resident's meal trays. On 5/11/26 at 8:38 a.m., in an interview with the Director of Nursing Services, the above information was discussed and confirmed.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on observations, record review, and interviews, the facility's Quality Assurance Committee failed to ensure that the Plan of Correction for identified deficiencies from the Annual Long Term Care Survey Process for Federal Recertification, dated 5/14/26, were effective. The Federal citations F584 and F812 were cited again for the same concerns during the follow-up survey completed on 7/7/26.At the annual recertification survey completed on 5/14/26, deficiencies F584 and F812 were cited. During the follow up survey on 7/7/26, it was determined that F584 and F812 would be recited for the same concerns: 1. F584: Safe/clean/comfortable/homelike environment: Observation of laundry room on 7/7/26 revealed the surface of the cement floor was worn off and untreated creating an uncleanable surface. There were 15 (fifteen) cracked/broken and/or missing floor tiles. The cove base was missing from the bottom of the wall to the left of the dryers. Review of facility plan of correction, signed 6/11/26, with completion date of 6/26/26 states: The cement floor has been repainted; the cracked tiles have been replaced, and the cove base has been secured to the wall. During interview with 2 surveyors on 7/7/26 at 9:35 a.m., the Maintenance Director states he was aware the above concerns needed to be completed, they do have the cove base in house, however, just hasn't replaced it. 2. F812: Food Procurement, Store/Prepare/Serve-Sanitary: A review of the facility's Plan of Correction, dated 6/11/26, states, . Dish room door and frame were painted.Walk in freezer floor has been sealed/painted. and indicated a completion date of 6/26/26. On 7/7/26 from 8:32 a.m.-8:45 a.m. during the follow-up survey, a surveyor conducted a kitchen tour with the Food Service Director (FSD) and observed and discussed the following: The cement floor in the walk-in refrigerator/freezer had worn off/missing paint and was not sealed, creating an uncleanable surface. The back of the dish room door had chipped/missing paint, and the door frame had a significantly rusted/rotted area at the bottom of the frame, creating uncleanable surfaces. On 7/7/26 at 10:15 a.m., during an interview with 2 surveyors, the Maintenance Director confirmed that he had not painted the back of the dish room door and stated that the bottom of the frame is rotted and needs replacement. The Maintenance Director then confirmed that he did not paint floor and stated that facility has been looking into a different solution. On 7/7/26 at 11:10 a.m., 2 surveyors discussed the above findings during an interview with the Administrator.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and facility policy, the facility failed to maintain an Infection Control Program designed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to the use of Personal Protective Equipment (PPE) while providing care for a resident on Enhanced Barrier Precautions (EBP), sanitizing glucometers, linen handling, hand hygiene during resident care, and applying transmission based precaution for 3 of 4 days of survey (5/11/26, 5/12/26, 5/13/26). Additionally, the facility failed to conduct an annual review of its Infection Prevention and Control Program (IPCP). Findings: 1.Observation of Enhanced Barrier Precautions (EBP) room [ROOM NUMBER] on 5/13/25 at 9:50 a.m., Certified Nursing Assistant (CNA)#7 was observed opening the door with her ungloved, left hand, and holding a full trash bag in her ungloved right hand. CNA#7 was not wearing a gown. At this time a surveyor asked CNA#7 if she had been wearing the required Personal Protective Equipment while caring for the resident in the room. CNA#7 replied that they wore gloves, but not the gown. CNA#7 was able to state why the resident was on EBP precautions and what precautions she was supposed to wear. Observation inside the room revealed second CNA#12 at residents' bedside ungowned, ungloved and using her bare hands to place soiled linen into a plastic bag. Observation of sign hanging outside of room [ROOM NUMBER] states: Enhanced barrier Precautions: Everyone Must: clean their hands, including before entering and when leaving the room; Providers and staff must also: wear gloves and a gown for the following High contact Resident care activities: Dressing, bathing/showering; transferring; changing linens; providing hygiene; changing briefs or assisting with toileting: Device care or use: central line, urinary catheter, feeding tube, tracheostomy; wound care: any skin opening requiring a dressing. On 5/13/26 at 10:13 a.m., the above was discussed with Administrator. 2. On 5/11/26 at 12:34 p.m., observation of LPN #3 (Licensed Practical Nurse) walking out of Resident #24's room with a glucometer. He is then observed putting the glucometer in the treatment cart and locking the drawer. Upon interview with LPN #3, he states he just checked Resident #24's blood sugar. When asked how often glucometers are cleaned, he stated after each use. Upon further interview, LPN #3 stated he did not clean the glucometer after using it on Resident #24. LPN #3 is then observed taking the glucometer out of the treatment cart and cleaning it. On 5/11/26 at 1 p.m., the above information was discussed with the Director of Nursing Services and the Facility Administrator. 3. Facility policy Hand Hygiene Policy and Procedure dated 11/2025 states, .Indications for Handwashing and Hand Rubbing. Handwashing may also be used for routinely decontaminating hands in the following clinical situations but not limited to. Before having direct contact with patients.After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient.After removing gloves. Gloves and Hand Hygiene. the use of gloves does not eliminate the need for hand hygiene. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before caring for another patient. Decontaminate hands after removing gloves. On 5/11/26 at 12:20 p.m., a surveyor observed CNA #1 enter Resident #23's room and don (put on (continued on next page)

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Market Square Health Care Center, LLC	3 Market Square South Paris, ME 04281

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gloves). CNA #1 then removed Resident #23's fall mat located on the floor next to his/her bed and proceeded to fold the mat and place it against a cabinet. Then, without doffing (removing) her gloves or sanitizing her hands, CNA #1 assisted CNA #2 to transfer Resident #23 from his/her bed to his/her wheelchair. CNA #1 then positioned Resident #23's wheelchair in front of his/her over-the bed table and without doffing the gloves or sanitizing his/her hands, began to lift the cover from Resident #23's meal plate. At this time, the surveyor intervened. During an interview at this time, CNA #1 stated that Resident #23 is usually already in his/her wheelchair so she does not have to sanitize her hands and that they want us to pass the trays as quickly as possible, so she did not sanitize her hands. At this time, the surveyor requested that CNA #1 sanitize her hands, and CNA #1 proceeded to doff her gloves and sanitize her hands. On 5/11/26 at 12:48 p.m., the surveyor discussed the finding with the [NAME] Unit Manager (UM). On 5/11/26 at 1:08 p.m., the surveyor discussed the finding with the Administrator. 4. Facility policy, Linen Handling Policy, developed February 23, 2021, states, .Soiled linen is considered to be potentially contaminated and standard precautions will be used when being handled. Gloves will be worn when handling soiled linens. Linens will be bagged (a pillow case may be used) at the point of collection (resident room) and then soiled linens are transported to laundry bins. Soiled linen should not be held against employee clothing . Transporting laundry: When transporting soiled laundry, measures will be taken in order to prevent cross-contamination. Contaminated linens and laundry bags will not be held close to the body . Bagging/containing contaminated linen where it's collected . On 5/12/26 at 3:06 p.m., two surveyors observed CNA #10 transport a shower chair containing a pile of unbagged soiled linens and 2 bags of trash out of a resident's room on the [NAME] unit to the Whirlpool Room. CNA #10 then wheeled the chair into the shower room, gathered the trash bags and soiled linens, and started the shower to rinse the chair. CNA #10 proceeded to exit the shower room and walk to the Soiled Utility room with the unbagged soiled linens held against her body. CNA #10 then discarded the linens in the bin and after sanitizing her hands, exited the Soiled Utility room. During an interview at this time, the surveyors discussed the above observation with CNA #10. CNA #10 stated, I know the rule and confirmed that she held unbagged soiled linens against her body and stated that she would change her shirt. On 5/12/26 at 3:10 p.m., the surveyors discussed the above finding with the DNS. 5. On 5/11/26 at 8:50 a.m. a surveyor observed a Stop sign hanging on Resident #51's door frame, and a cart containing PPE was located outside of his/her room. The reverse side of the Stop sign indicated EBP. The PPE cart lacked any additional signage. On 5/11/26 at 8:57 a.m. during an interview, LPN #1 stated that Resident #51 has an ESBL (Extended Spectrum Beta Lactamase- a type of antibiotic-resistant bacteria) Urinary Tract Infection (UTI). When the surveyor asked what type of precautions were in place, LPN #1 stated that Resident #51 is on contact precautions and then stated that he wanted to clarify that. LPN #1 then asked the [NAME] UM, and she stated that Resident #51 is on EBP. A review of Resident #51's clinical record revealed the following active physician orders: An order with a start date of 5/6/26 for doxycycline hyclate 100 mg capsule 2 Times Daily for 5 Days (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for Urinary Tract Infection An order with a start date of 3/17/26 for Cephalexin 250 mg capsule 1 Time Daily for history of UTI Resident #51's nursing progress note, dated 5/8/26 states, .continues with PO [oral] ABT [antibiotic therapy] Doxycycline related to UTI. A review of Resident #51's laboratory sensitivity results dated 5/6/26 states Escherichia coli ESBL and were acknowledged by the physician's signature on 5/7/26. Further review of Resident #51's clinical record, including his/her care plan and active physician orders lacked evidence that Resident #51 was on contact precautions or EBP. On 5/12/26 at 2:18 p.m. during an interview, the DNS confirmed that Resident #51 has an ESBL UTI and is currently being treated for with Doxycycline and that the cephalexin order is prophylactic treatment for recurrent UTIs. The DNS then stated that Resident #51 should have been placed on contact precautions from the date the UTI was diagnosed. On 5/13/26 at 3:27 p.m. during an interview with the Infection Preventionist (IP), the surveyor discussed the above finding. At this time, the IP stated that she had reached out to the doctor and called the lab and that nothing on Resident #51's preliminary results indicated ESBL and that EBP was in place until yesterday when Resident #51 was placed on contact precautions. The IP then stated that someone must have known that Resident #51 was on contact precautions because PPE carts outside of resident rooms are designated for residents on contact precautions. 6. On 5/12/26, initial review of the facility's infection control policies included the following: Facility policy, Infection Control Immunizations- Influenza, Pneumococcal, Covid Policy, developed April 2007, last revised 12/24 Facility policy, Infection Control: Core Elements of Antibiotic Stewardship Policy, developed April 2007, last revised 8/24 Facility policy Hand Hygiene Policy and Procedure, developed 11/2025, lacks review or revision date Facility policy, Infection Control/Management of Clostridium Difficile Resident Policy, dated April 2007, revised 10/24 Facility policy, Linen Handling Policy, developed February 23, 2021, lacks review or revision date Facility Policy, Infection Control/Exposure Control Plan, developed April 2007, revised 5/14/24, and states under Program Evaluation The effectiveness of the Infection Prevention and Control Program is reviewed no less than annually . On 5/13/26 at 4:36 p.m. during an interview with the IP and in the presence of the [NAME] President (VP) of Clinical Services and another surveyor, a surveyor discussed that the above IPCP policies lacked evidence of annual review. At this time, the VP of Clinical Services stated that all IPCP policies are reviewed annually but that the review date may not necessarily be reflected on the policy unless it was revised. At this time, the surveyor requested evidence of the facility's annual review of (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	its IPCP. On 5/14/26 at 3:01 p.m. during an interview in the presence of 2 surveyors, the Administrator confirmed that the facility's IPCP was last reviewed 1/29/25 at the Quality Assurance and Performance Improvement (QAPI) meeting and that the IPCP was supposed to be reviewed at the beginning of 2026, but there were conflicts with the pharmacist consultant and the medical director not being in attendance together. The Administrator stated that the IPCP was then scheduled to be reviewed at April's meeting, but that due to all QAPI members not attending at the same time, it was again delayed and confirmed that the facility's IPCP has not been reviewed yet for 2026.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and facility policy the facility implements, and maintain an effective training program for all staff. Appropriately trained staff can improve resident safety, create a more person-centered environment, and reduce the number of adverse events or other resident complications. This has the potential to affect all three units.Findings:Review of facility policy Orientation Program dated 5/12/08 states It is the policy of North Country Associated is to provide all new staff members with a comprehensive orientation resulting in an in-depth knowledge of our established policies and procedures. The Administrator will ensure that each new staff member receives and follows the facility's Orientation Program: Objectives: to familiarize the new staff member with the entire facility; To introduce the new staff to the specific policies and procedures of the facility; to assure that the new staff member is able to perform all necessary functions relating to his/her respective job description. WITHOUT EXCEPTION, no employee will begin working in the assigned position until he/she has completed the Business Office portion of the program and any other components of the program which are required to be completed by regulation/policy before the individual is given his/her assignment.Certified Nursing Assistant (CNA)#11 was originally hired on 11/7/25. Review of CNA #11's employee file lacked evidence she received a formal orientation to include what to do in case of an emergency. During an interview on 5/11/26 at 4:05 p.m., Certified Nursing Assistant CNA# 11 stated he/she was hired 11/25 and has not received any education regarding what to do in case of an emergency. CNA#11 further states there was a fire last week and it was chaotic because she didn't know where to go or what to do so she just stood there.RN#1 was hired on 4/9/26. Review of RN#1's employee files lacked evidence she received education/training in case of an emergency. Review of RN #1's New Orientation Schedule lacked evidence she was educated/orientated in the areas of fire extinguisher and alarm pull box-location. Building maps and room evacuation tags. Using telephone system, emergency paging, transferring calls. During an interview on 5/11/26 at 2:25 p.m., with 2 surveyors present, Registered Nurse (RN)1stated she was hired on 4/9/26 and received a packet that she had to sign off on that contained abuse, neglect and misappropriation information and was put right on the floor. RN#1 stated she had not received any other formal education, was never told where to find the crash carts, or what supplies needed to be on them. RN#1 further stated she has no idea what the policies/procedures are in case of an emergency and would have no idea what to do in case of a fire.Registered Nurse RN 2 was hired 3/4/26. Review of RN #2's New Orientation Schedule lacked evidence she was educated/orientated in the areas of fire extinguisher and alarm pull box-location. Building maps and room evacuation tags. Using telephone system, emergency paging, transferring calls. During an interview on 5/12/26 with 2 surveyors, RN#2 stated on her first day she received a packet and had to sign off on abuse, neglect and misappropriation. She has not received any further orientation and does not know what to do in case of an emergency and only knows where the crash carts were because she and another nurse asked where they were recently. Review of RN#2's orienting documents revealed abuse, neglect and misappropriation documents signed 3/4/26. There is no evidence RN#2 received any other orientation/education.During [NAME] interview on 5/11/26 at 2:20 p.m., in an interview with Licensed Practical Nurse (LPN)#1 with 2 surveyors present, he is unable to locate fire extinguishers and fire alarms. He states he is unsure how he would evacuate residents safely if there were to be a fire. LPN1 was hired on 1/26/26.During an interview on 5/12/26 at 1:43 p.m., Business Office Manager stated that new staff receive a brief orient with her that includes abuse, neglect, misappropriation and they put them on the floor. They have a formal orient withing 30 days after that that includes fire safety.During an interview on 5/14/26 at approximately 9:12 a.m. the above concerns were discussed with the Administrator.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observations and interviews, the facility failed to ensure a resident's call bell was within reach for 2 of 2 sampled residents (Residents #5, #51) for 2 of 4 days of survey (5/11/26, 5/12/26).Findings:1. On 5/11/26 at 9:28 a.m., a surveyor observed Resident #5 asleep in his/her bed with his/her call bell hanging between the top of his/her mattress and headboard, extending to the floor and not within Resident #5's reach.A review of Resident #5's care plan states, .High risk for falls r/t [related to] balance issues, history of falls . Call bell in reach at all times .On 5/12/26 at 9:09 a.m., during a repeat observation, Resident #5 was lying in bed with his/her call light hanging behind his/her bed, extending down to the floor, out of Resident #5's reach.2. On 5/11/26 at 8:50 a.m., a surveyor observed Resident #51 sitting on the side of his/her bed, with call light cord tucked between the mattress and the wall. The surveyor could not locate the call bell itself.A review of Resident #51's care plan states, . Fall History: At risk for falls . Call light within reach, instruct resident to ring for assistance .On 5/12/26 at 8:51 a.m., during a repeat observation, Resident #51's call bell cord was tucked between the mattress and the wall.On 5/12/26 at 9:13 a.m., the surveyor confirmed the above findings during observations with the [NAME] Unit Manager.On 5/12/26 at 9:30 a.m., the surveyor discussed the above findings during an interview with the Administrator.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observations and interviews, the facility failed to ensure the confidentiality of protected health information for 1 of 70 residents during 1 of 4 days of survey. (Resident #38)Findings:On 5/12/26 from 2:41 p.m. to 2:43 p.m., 2 surveyors observed an open computer screen showing Resident #38's personal medical information on an unattended treatment cart on the Tuttle Unit. It was visible and easily accessible to residents, visitors, and unauthorized personnel. Upon surveyor intervention, the Tuttle Unit Manager walked over to the treatment cart and closed the computer screen at 2:43 p.m On 5/13/26 at 8:20 a.m., the above information was confirmed with the Facility Administrator.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review, interviews, and facility policy, the facility failed to thoroughly investigate a resident's injury of unknown origin for 1 of 3 facility-reported incidents (Resident #27).Finding:Facility policy Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property, revised 10/18 states, under section E. Investigation, .Procedure: The designated facility personnel will begin the investigation immediately. A root cause investigation and analysis will be completed. The information gathered is given to administration. Investigation of injuries of Unknown Origin or Suspicious injuries: The facility may initially evaluate an occurrence to determine whether it meets the definition of an ?alleged violation'. upon discovery of an injury, the facility must immediately take steps to evaluate whether the injury meets the definition of an injury of unknown source.On 2/21/26 at 1:10 p.m., the State of Maine's Division of Licensing and Certification (DLC) received a facility-reported incident that indicated that staff was providing care to Resident #27 and noticed that he/she had a small bruise on the inside of his/her left thigh. The initial report indicated that Resident #27 could not recall how he/she got the bruise. The DLC did not receive a follow-up report.A review of Resident #27's clinical record revealed a nursing progress note dated 2/20/26 that states, CNA [Certified Nursing Assistant] during rounds and PM [evening] care CNA reported unknown source of injury. Writer observed resident in bed with discolored skin to left inner thigh noted. Resident unable to answer question of what happened.Resident remains safe in bed at this time, and no reports noted from previous shift of fall/incident. Administration/on call nurse notified of findings.A nursing progress note, dated 3/4/26 states, Resident was noted to fall back onto the arm of [his/her] recliner landing on [his/her] left thigh assisted resident to sit on recliner correctly.On 5/12/26 at 1:16 p.m. during an interview with the Director of Nursing (DNS), a surveyor discussed the lack of evidence that the facility had conducted an investigation for Resident #27's injury of unknown origin. At this time, the DNS stated that she could provide the incident report and clinical notes and confirmed that the facility did not submit a follow-up report to the DLC. On 5/13/26 at 2:55 p.m., the surveyor discussed the above finding with the Administrator. During an interview at this time, the Administrator stated that she was not even aware the above incident had been submitted to the DLC and confirmed that the facility did not complete an investigation for Resident #27's injury of unknown origin. The Administrator then stated that an investigation was not conducted because the facility had already determined how Resident #27 was injuring him/herself. The surveyor then discussed that the nursing progress note indicating how Resident #27 was injuring him/herself was not dated until 3/4/26, 12 days after his/her initial injury of unknown origin.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) Version 3.0 Assessments were accurately coded in the area of therapy services for 1 of 20 sampled residents (Resident #38).Finding:Review of Resident #38's clinical record revealed a physician order with a start date of 2/9/26 for OT (Occupational Therapy) for a duration of 12 weeks.Resident #38's Quarterly Minimum Data Set (MDS) Version 3.0 assessment, dated 2/24/26, Section O - Special Treatments, Procedures, and Programs, under O0390 Therapy Services indicated None of the above.On 5/14/26 at 12:32 p.m. a surveyor discussed the finding with the MDS Coordinator. At this time, the MDS Coordinator reviewed Resident #38's clinical record and confirmed that Resident #38 was receiving OT services at the time of the 2/24/26 quarterly assessment and confirmed that the assessment was not accurately coded.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on observation, record review and interview, the facility failed to ensure that a care plan was developed in the area of quality of care and accurate for opioid therapy for 1 of 1 resident reviewed. (#77) Findings:Review of Resident #77's medical record stated he/she was admitted in April 2026 with a diagnosis of displaced trimalleolar fracture of right lower leg, fracture of unspecified metatarsal bone(s) left foot and encounter for other orthopedic aftercare. On 4/1/26, the nurse to nurse report between the facility and the hospital noted under admitting diagnosis to include Displaced trimalleolar fracture of right lower leg, Fracture of unspecified metatarsal bone(s) left foot and Encounter for other orthopedic aftercare.On 4/1/26, Resident #77 signed an Informed Acknowledgement and Agreement for Opioid Therapy form on 4/1/26 declining the use of Opioid Therapy.On review of the Resident #77's base line care plan, the care plan lacked evidence of the problem, goals and interventions for the resident's diagnosis of fractures/breaks. Additionally, Resident #77 had been care planned for the use of Opioids which the resident had declined. On 5/14/26 at 11:56 a.m., in an interview with a surveyor, the [NAME] President of Clinical Services confirmed that the base line care plan should have had the problem, goals and interventions for the resident's foot/leg fractures/breaks and that because the resident refused opioid therapy that the care plan should not have included Opioid therapy.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure the clinical record was accurate and complete for 1 of 2 residents reviewed for therapy services (Resident #85) and 1 of 2 residents reviewed for Activities of Daily Living (ADL) (Resident #17).Findings: 1. Resident #85 was admitted 5/26 for skilled care services. Review of Resident #85 active orders revealed order with start date of 5/5/26 for PT- Treatment Clarification orders: Therapeutic Exercise: Therapeutic Activities: Gait training: Neuro re-education; wheelchair management. Frequency 60 Duration 12 weeks order with start date of 5/5/26 for PT: Evaluate and Treat were both unsigned. During an interview on 5/12/26 at 11:09 a.m., the Occupational Therapist (OT) confirmed Resident #85 has been receiving physical Therapy (PT) and Occupational Therapy (OT) services 5 days a week, and they have a restorative aide on weekends. At this time OT reviewed Resident #85's clinical record and confirmed the orders were not signed by a provider. During a follow up discussion in presence of 3 surveyors on 5/12/26 at 11:25 a.m., OT stated she just asked the provider to sign the PT and OT orders for Resident #85. The above concerns were discussed with Administrator on 5/14/26 at 8:04 a.m. 2. Resident #17 was recently admitted with diagnoses to include, but not limited to, fracture of the left lower leg and chronic pain with long term use of opiate analgesic (a type of pain medication with a common side effect of constipation). Review of Resident #17's care plan revealed the following: .requires extensive assistance with self-care secondary to left bimalleolar fracture, NWB [non-weightbearing] status, chronic pain. inability to perform ADLs independently . .Impaired elimination secondary to urinary incontinence. Assist/encourage [Resident #17] to toilet before and after meals, after rest periods, before bed, and as requested. Check for incontinence. Wash skin with mild soap and water.after each episode of incontinence. .at risk for constipation. will have a bowel movement at least 3x [3 times] weekly. A review of Resident #17's ADL documentation lacked evidence of Bladder Documentation for the following dates: Day shift: 4/21/26, 4/24/26, 4/30/26, 5/6/26, 5/7/26, and 5/8/26 Evening shift: 4/17/26, 4/18/26, 4/19/26, 4/20/26, 4/21/26, 4/22/26, 4/23/26, 4/24/26, 4/26/26, 4/28/26, 4/29/26, 4/30/26, 5/2/26, 5/3/26, 5/4/26, 5/6/26, 5/7/26, 5/8/26, 5/5/9/26, 5/10/26, and 5/11/26 Night shift: 4/20/26, 4/24/26, 4/27/26, 4/29/26, 5/3/26, 5/4/26, 5/5/26, 5/9/26, 5/10/26, 5/11/26, (continued on next page)

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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	5/12/26, and 5/13/26 A review of Resident #17's ADL documentation lacked evidence of Bowel Documentation, including whether Resident #17 had a bowel movement, for the following dates: Day shift: 4/21/26, 4/24/26, 4/27/26, 5/6/26, 5/7/26, 5/8/26, and 5/11/26 Evening shift: 4/17/26, 4/18/26, 4/19/26, 4/20/26, 4/22/26, 4/23/26, 4/26/26, 4/28/26, 4/29/26, 5/2/26, 5/3/26, 5/4/26, 5/6/26, 5/7/26, 5/8/26, 5/9/26, and 5/10/26 Night shift: 4/20/26. 4/24/26, 4/27/26, 5/3/26, 5/9/26, 5/10/26, and 5/13/26 On 5/14/26 at 12:30 p.m., a surveyor discussed the above missing documentation with the Director of Nursing (DNS), Assistant Director of Nursing, and the [NAME] President of Clinical Services. During an interview at this time, the DNS stated that ADL documentation should be completed at the point of care, but if that is not possible, documentation is expected to be done every shift, at a minimum. The DNS then stated that Resident #17 was hospitalized on [DATE]. Further review of Resident #17's clinical record revealed a nursing progress note dated 4/21/26 at 6:39 p.m. that indicated that Resident #17 had returned to the facility from his/her orthopedic appointment. Further review of Resident #17's bladder documentation indicated that on 4/20/26 at 1:31 p.m., he/she was continent and used a bedpan. The bladder documentation lacked evidence of Resident #17 voiding after that until 4/22/26 at 5:46 a.m. (over 40 hours after the 4/20/26 entry).

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	05/14/2026

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on Certified Nursing Assistant (CNA) employee education review and interview, the facility failed to monitor and ensure that the CNA attended the required 12 hours of annual in-service education training for 1 of 5 randomly selected CNAs employed greater than 1 year. (CNA #1)Finding:CNA #1 was hired in February of 2025. Review of CNA #1 Employee In-service/attendance records lacked evidence of the required 12 hours of continuing education from 2/2025 to 2/2026. On 5/14/26 at 2:36 p.m., during an interview with the Facility Administrator, the above information was confirmed.