STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205099	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rumford Community Home	11 John F Kennedy Lane Rumford, ME 04276

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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 0558

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Reasonably accommodate the needs and preferences of each resident.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 51669

Based on interviews and record review, the facility failed to ensure resident preferences were followed for 2 of 3 residents reviewed for bathing (Residents #23 #8).

Findings:

1.Resident #23 and has a Brief Interview for Mental Status (BIMS) of 10 out of 15, indicating he/she is moderately cognitively impaired.

Review of Resident #23's care plan revealed, . requires extensive assist by 1 staff with bathing BID [2 times a day] and as necessary .often refuses care reapproach and offer several times as needed .

Review of East/West Bath Schedule, updated 1/25/25, revealed that Resident #23 is to receive a shower or bed bath on Thursday day shift.

Review of Resident #23's clinical record lacked evidence that he/she was offered/refused a shower or bed bath on 10/10/24, 1/2/25, 1/9/25, 1/16/25, 1/30/25, and 2/6/25.

During an interview on 2/5/25 at 11:33 a.m., Certified Nursing Assistant (CNA) #7 stated Resident #23 primarily receives bed baths but is showered occasionally and sometimes refuses to bathe, though not often.

2. Resident #8 has a BIMS of 15 out of 15, indicating he/she is cognitively intact. Review of Resident #8's Annual Minimum Data Set (MDS) dated [DATE], under Section F- Preferences for Customary Routine and Activities, Interview for Daily Preferences, revealed it is very important for Resident #8 to choose his/her bathing options.

Review of Resident #8's care plan states, .self-care performance deficit r/t [related to] Activity Intolerance, Impaired balance . BATHING/SHOWERING .requires extensive assist by 1 staff for bathing daily and as necessary .

Review of East/West Bath Schedule, updated 1/25/25, revealed that Resident #8 is to receive a shower on Thursday night shift.

(continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205099	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/10/2025
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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/5/25 at 10:00 a.m., Resident #8 stated his/her shower day is Thursday and that he/she is supposed to get a shower but that staff does not want to give him/her one, so they provide a bed bath instead. During a follow-up interview on 2/7/25 at 11:09 a.m., Resident #8 stated that he/she wanted to get a shower last night, but staff did not offer a shower and instead gave him/her a bed bath. Review of Resident #8's Bathing Task, revealed he/she received a shower on 12/12/24. Further review lacked evidence he/she was offered/refused a shower or bed bath on 10/17/24, 10/24/24, 10/31/24, 11/7/24, 11/14/24, 11/21/24, 11/28/24, 12/5/24, 12/19/24, 12/26/24, 1/2/25, and 1/23/25. During an interview on 2/5/25 at 11:33 a.m., CNA #7 stated Resident #8's shower day is Thursday and that he/she requires a Hoyer lift to transfer to a shower chair and is dependent on assistance for bathing. During an interview in the presence of 2 surveyors on 2/7/25 at 11:37 a.m., the Director of Nursing (DON) stated that CNAs know a resident's bathing preference and schedule based on the Electronic Medical Record (EMR) and the bath/shower list in CNA binder at the nurses' desk. At this time, the DON stated it is her expectation that residents receive sponge baths daily and receive a weekly shower, whirlpool bath, or bed bath on their designated bath day. On 2/7/25 at 12:47 p.m., the DON reviewed the clinical records for Residents #8 and #23 and confirmed the above findings.

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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** 37440 Based on observations and interview, the facility failed to adequately maintain maintenance and housekeeping services necessary to maintain the facility in good repair and sanitary conditions for 2 of 2 units (East and West), a laundry cart, the conference room and the laundry room for 2 of 2 environmental tours (2/5/25 and 2/6/25). Findings: 1. On 2/05/25 at 10:30 a.m., a surveyor and the Administrator observed a laundry cart being used in the East Unit Hallway that had untreated wood holding the laundry bin to the wheeled unit. At this time, in an interview, the Administrator confirmed the wood was not treated and created uncleanable surfaces. 2. On 2/06/25 from 8:35 a.m. to 9:10 a.m., an environmental tour was conducted with the Director of Ancillary Services in which the following findings were observed: Conference Room - There were four(4) ceiling lights that had dirt/debris in them. East Unit - Resident room [ROOM NUMBER] - The baseboard heater was coming apart, hanging down and in a disrepair. The room entrance door had chipped/gouges on the face of the door and had rough edges creating an uncleanable surface. - The wheelchair storage closet, across from resident room [ROOM NUMBER], had chipped/missing paint and gouges on the door creating an uncleanable surface. - Resident room [ROOM NUMBER] - The room entrance door had chipped, gouged and missing paint creating uncleanable surfaces. - Resident room [ROOM NUMBER] - The baseboard heater was broken apart, hanging down and in disrepair. The caulking around the base of the toilet was stained yellowish brown. - Resident room [ROOM NUMBER] - The baseboard heater has chipped/missing paint creating an uncleanable surface. - Resident room [ROOM NUMBER] - The baseboard heater in the bathroom has chipped/missing paint creating an uncleanable surface. The toilet seat was stained yellowish brown. - The base board heater in the dining room had chipped/missing paint creating an uncleanable surface. West Unit - Resident Rooms 7, 8, 10, 11, 12, 13,,15, 16 and 18 had room entrance doors that had chipped, gouged and missing paint creating uncleanable surfaces. - Resident room [ROOM NUMBER] - The room entrance door had chipped, gouged and missing paint creating uncleanable surfaces. The walls had chipped/missing paint and there was a large area of spackled wall near the bathroom door. - The hallway base board heater, near the Rehab room, had chipped/missing paint creating an uncleanable surface. Laundry Room: - The ceiling above the 2 bay sink had a large brown stain on it. - The floor was dirty and stained brown throughout the laundry. On 2/06/25 at 9:10 a.m., in an interview, the Director of Ancillary Services confirmed the findings.

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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 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37440 Based on interviews, record reviews, and facility policy, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours that included the problems, interventions, and initial goals needed to provide minimum healthcare information necessary to properly care for 1 of 15 residents reviewed for baseline care plans. (Resident #15). Findings: Review of policy Baseline Care Plan Policy and Procedure revised 3/17/23 noted: .The baseline care plan must (i) Be developed within 48 hours of a resident's admission ., (ii) include the minimum healthcare information necessary to properly care for a resident including, but not limited to: a. initial goals based on admission orders, b. Physician orders-Code status, c. dietary orders, d. therapy service e. social service-discharge, f. PASRR recommendations (if applicable). On 2/04/25 at 12:54 p.m., a surveyor observed Resident #15 sitting in his/her room in his/her recliner chair with his/her foley catheter bag hanging on his/her walker. The surveyor observed no EBP signage on the resident's door or door frame and did not observe any PPE readily available. Resident #15 was admitted to the facility on [DATE] with order that included Foley care every shift -active 1/23/25. On 2/04/25 at 3:20 p.m., a surveyor and the Director of Nursing (DON) reviewed a list of residents identified to be on Enhanced Barrier Precautions (EBP). The surveyor pointed out that Resident #15 was not on the list and he/she had a foley catheter. The DON stated that he/she had been missed and he/she had not been identified as needing to be on EBP. On 2/4/25 at 3:20 p.m., a surveyor reviewed Residents #15's Base Line Care plan, initiated 1/22/25, and it did not include Problems, Goals, and Interventions for Enhanced Barrier Precautions. At this time, in an interview, the DON confirmed that the base line care plan did not include EBP Surveyor: [NAME], [NAME] 51669 2. Resident #85 was admitted on [DATE] under hospice care and had diagnoses to include heart failure, chronic respiratory failure with oxygen dependence, hearing loss, falls with rib fractures, and anxiety, Review of Resident #85's clinical record revealed the following active orders for February 2024: -Order with a start date of 2/22/24 for Pregabalin Oral Capsule 25 MG [milligrams] * Controlled Drug* Give 1 capsule by mouth one time a day for Pain. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Order with a start date of 2/23/24 for Morphine Sulfate Oral Solution 20MG/5ML [milliliters] (Morphine Sulfate) *Controlled Drug* Give 0.25ml by mouth every 3 hours as needed for Pain for 30 Days. - Order with a start date of 2/23/24 for Lorazepam Oral Tablet 0.5 MG *Controlled Drug* Give 1 tablet by mouth every 4 hours as needed for agitation for 30 Days. -Order with a start date of 2/23/24 for Lasix Oral Tablet 20 MG Give 1 tablet by mouth one time a day for CHF [congestive heart failure] -Order with a start date of 2/23/24 for Cleanse skin tear to right forearm with N/S, apply bacitracin ointment, cover with non-adherent dressing and wrap with gauze . -Order with a start date of 2/24/24 for Fall mat on floor beside bed every shift -Order with a start date of 2/26/24 for Oxygen 2L [liters] continuously via nasal cannula 4-6L for comfort every shift. Review of Resident #85's baseline care plan, initiated 2/23/24, revealed, Focus: Residents/POA [Power of Attorney]/guardians goal is for resident to remain in long term care facility at this time . and Focus: The resident is (SPECIFY: independent/dependent on staff etc.) for meeting emotional, intellectual, physical, and social needs r/t [related to] (if dependent) Disease process (Specify) . but lacked evidence that goals and interventions were put into place for these focus areas. Further review of Resident #85's baseline care plan lacked evidence that goals and interventions were put into place for hospice care, activities of daily living, pain, anxiety, diuretic use, impaired skin integrity, falls, oxygen use, and nutrition. On 2/7/25 at 12:47 p.m., the Director of Nursing (DON) reviewed Resident #85's care plan and confirmed it did not contain goals and interventions for the above concerns.

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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. 51669 Based on interviews, observations, and record review, the facility failed to document and adequately monitor a resident after an unwitnessed fall for 1 of 2 residents reviewed for falls (Resident #28). In addition, the facility failed to ensure that physician orders were followed for 1 of 2 residents reviewed. (Resident #8 & (Resident #7) Findings: 1. Review of Resident #28's clinical record indicated that he/she sustained an unwitnessed fall on 1/23/25 at 10:45 p.m. Further review of the clinical record lacked evidence that a fall risk assessment and Post Fall Observation Tool were completed or that neurological checks were initiated following the unwitnessed fall. Review of policy, Falls Management Policy, revised 12/4/24, states, Complete a fall risk assessment upon admission .quarterly .and after a fall .Complete Post Fall Observation Tool, following a fall .If the fall is unwitnessed .neurological checks will be initiated as outlined on the Neurological Assessment Flow Sheet . On 2/10/25 at 10:53 a.m., during an with the Director of Nursing (DON) stated it is her expectation that after an unwitnessed fall, the nurse completes a post-fall observation tool and initiates neuro-checks. At this time, the DON confirmed that the facility failed to complete the required documentation and monitoring for the above unwitnessed fall. 2. Review of Resident #8's clinical record revealed a physician order, with a start date of 1/17/24, for Continuous Oxygen 2L/min [liters per minute] to maintain O2 [oxygen] sat [saturation] >88% On 2/4/25 at 10:49 a.m. and 2/5/25 at 9:59 a.m., Resident #8 was observed lying in bed, receiving continuous oxygen via a nasal cannula, connected to an oxygen concentrator located on the floor next to the bed, out of Resident #8's reach, with the oxygen flow rate set to 2.5 L/min. On 2/5/25 at 10:00 a.m., during an interview, Resident #8 stated that he/she does not adjust his/her oxygen concentrator, and that staff make all adjustments to the oxygen flow rate. On 2/5/25 at 11:50 a.m., the finding was reviewed with the Administrator. 33639 3. On 2/6/25, a review of Resident #7's clinical record was completed. Resident #7 had a Physician order on 12/31/24 to obtain bloodwork (labs) for a Complete Blood Count (CBC) without diff, Comprehensive Metabolic Panel (CMP), Erythrocyte sedimentation rate (ESR) and C-Reactive Protein (CRP) the next lab day. A review of the physicians orders written on the Medication Administration Record (MAR) revealed the resident required labs to be drawn on 12/31/24 for a CBC without diff, CMP, ESR and CRP. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the lab results for Resident #7 revealed the physicians ordered labs were not done until 1/28/25. On 2/6/25 at 9:34 a.m., in an interview, the DON stated that the providers order for labs was missed and she had provided education to nursing staff regarding the process of adding provider orders for lab work to the binder used for the lab.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 33639 37440 Based on observation, interview, and a review of Safety Data Sheets (SDS), the facility failed to ensure that the resident's environment was free of accident hazards relating to the storage of chemicals being properly secured for 1 of 5 days of survey (2/10/25). Findings: . The Safety Data Sheet for Oxivir Tb Wipes(Virucidal - Bactericidal - Fungicidal - Tuberculocidal) Disinfectant Cleaner wipes noted the following: 4. First Aid Measures: Eyes: Rinse with plenty of water. If irritation occurs and persists, get medical attention. Ingestion: IF SWALLOWED: Call a Poison Center or Doctor/Physician if you feel unwell. On 2/10/25 at 8:00 a.m., a surveyor observed a 1.8 pound container of Oxivir Tb Wipes(Virucidal - Bactericidal - Fungicidal - Tuberculocidal) Disinfectant Cleaner wipes in the conference room which had the door open. The chemical was not secured and accessible to confused and vulnerable residents who ambulate and residents who also move about the facility in wheelchairs. On 2/10/25 at 8:35 a.m., in an interview, the Administrator confirmed the wipes were left unsecured in an unlocked room and accessible to confused and vulnerable residents who ambulate and residents who also move about the facility in wheelchairs.

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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. 37440 Based on observations and interviews, the facility failed to maintain respiratory equipment in a sanitary manner to help prevent the development and transmission of disease and infection related to respiratory care for 3 of 4 days of survey. (2/4/25, 2/5/25 and 2/10/25) Findings: 1. On 2/4/25 at 10:40 a.m., a surveyor observed Resident #13's oxygen concentrator tubing and nasal cannula was observed stored on top of resident's bureau on some of his/her personal belongings and not bagged. The resident stated to the surveyor that he/she only wears oxygen at night and it is stored during the day. 2. On 2/5/25 at 8:15 a.m., a surveyor observed Resident #13's oxygen concentrator tubing and nasal cannula was observed stored on top of her concentrator and not bagged. On 2/05/25 at 10:25 a.m., in an interview, the Administrator confirmed that the oxygen tubing and nasal canula should be stored in a bag and not just draped on the resident's belongings on the night stand or coiled up and stored on top of the O2 concentrator. At this time, the surveyor asked for the oxygen/respiratory policy and procedure for storing equipment in the resident. On 2/05/25 at 11:50 a.m., the Administrator reached out to the Regional Director of Clinical Operation-Maine for input and a policy on O2 storage and equipment storage. The Regional Director of Clinical Operation-Maine informed the Administrator that National Health Care Associates Inc. does not have a specific policy on that however, they store tubing in respiratory bags when they are not in use. The facility could not produce a policy and procedure on storing oxygen/respiratory equipment in the resident rooms. 3. On 2/10/25 at 9:25 a.m Resident #13's oxygen concentrator tubing and nasal cannula was observed lying on the floor next to the head of her bed and was not bagged. On 2/10/25 at 9:30 a.m., in an interview, LPN #1 confirmed that Resident #13's oxygen concentrator tubing and nasal cannula was lying on the floor next to the head of her bed and was not stored in a bag.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 33639 Based on record review and interview, the facility failed to show evidence of an attempt of a gradual dose reduction (GDR) and lacked documentation to justify the continued use of an antidepressant medication for 1 of 5 residents reviewed for unnecessary medications (#5.) Finding: Resident #5 has diagnosis of Bipolar Disorder, Major Depressive Disorder. Resident #5's Medication Administration Record (MAR) indicated that Resident #5 had been receiving the antidepressant medication Venlafaxine Extended Release (ER) 225 milligrams (mg) once daily, since 6/15/24. A Pharmacy Report dated 11/20/24 indicated that Resident #5 had been receiving antidepressant Venlafaxine ER 225 mg daily since 6/15/24. Consider gradual dose reduction (GDR) or document contraindication. The clinical record lacked evidence that a GDR was attempted or documented that it was clinically contraindicated for this resident between the dates of 11/20/24 and 2/7/25. The surveyor discussed this finding in an interview with the Administrator on 2/6/25 at 7:45 a.m.

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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. 37440 Based on observations, interviews, review of the Dish Machine Temperature Logs (dated 2013), and review of the Food Storage policy (dated 2013), the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for ceiling tiles, floors, and a wall mounted fan; failed to ensure foods were sealed, labeled and dated in a reach-in freezer and in a walk-in refrigerator; failed to ensure that the kitchen ice machine was plumbed in accordance with code requirements to prevent food contamination and failed to ensure that the dish machine was monitored for proper wash and rinse temperatures to ensure clean and sanitized utensils and dishes, all for 1 of 1 kitchen tour for 1 of 1 day of survey (2/4/25). Findings: 1. On 2/4/25 from 9:10 a.m. to 10:00 a.m., a surveyor conducted a kitchen tour with the Food Service Director in which the following findings were observed: - There were three ceiling tiles above a food preparation area that had brown stains on them. - There was trash and food debris on the floor under the equipment and around the edges of the floor. - The dish room had a wall mounted fan that was dusty/dirty and a base board heater that had chipped/missing paint creating an uncleanable surface. - There was an unlabeled and undated plastic container of cereal on a food preparation table. - There was a large bin of flour that was unlabeled and undated. - The walk-in refrigerator had one pie crust wrap that was unlabeled and undated. Also, there was a container of peeled eggs that was not securely shut/sealed and open to the air. - The walk-in freezer had one large package of meatballs, one package of stuffed shells, one package of chicken patties and two packages of pancakes that were unlabeled and undated. - The kitchen ice machine air gap was not plumbed in accordance with code requirements to prevent food contamination. The facility's Food Storage policy noted: Procedure: 13. Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. 14. Refrigerated food storage: F. All food should be covered, labeled and dated. 16. Frozen foods: All food should be covered, labeled and dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This direct connection of waste water and potable water was in violation of the 10-114 State of Maine Rules Chapter 226, definition Section A, which defines an Air-Gap Separation - A physical separation between the free-flowing discharge end of a potable water supply pipeline and an open or non-pressure receiving vessel. An air-gap separation shall be at least twice the diameter of the supply pipe measured vertically above the overflow rim of the vessel - in no case less than one inch (2.54 cm) and the Code of Federal Regulation, Title 21, Part 1250, Section 1250, 30 (d) states all plumbing shall be so designed, installed, and maintained as to prevent contamination of the water supply, food, and food utensils. On 2/4/25 at 10:00 a.m., in an interview, the Food Service Director (FSD) confirmed the findings. 2. Upon review of the Dish Machine Temperature Logs, the surveyor found the following missing dates of monitoring/documentation. November 2024: Breakfast - 2, 3, 8, 15, 16, 17 and 19. Lunch - 16, 18, 24, 27 and 28. Dinner - 22, 27 and 28. December 2024: Breakfast - 1, 6, 10, 19, 2 and 30. Lunch - 1, 5, 19, 20 and 25. January 2025: Breakfast - 7, 21, 30 and 31. Lunch - 5, 8, 12, 13, 14, 16, 22 and 23. Dinner - 1, 2, 3, 5, 8, 12-16, 21 and 22. The facility's Dish Machine Temperature Log noted: Policy: Dishwashing staff will monitor and record dish machine temperatures to assure proper sanitizing of dishes. 3. Staff will be trained to record dish machine temperatures for the wash and rinse cycles at each meal. a. The food service manager will spot check this log to assure temperatures are appropriate and staff is actually monitoring dish machine temperatures. On 2/5/25 at 2:00 p.m., in an interview, the FSD confirmed there were missing dates of monitoring/documentation of the dish machine temperatures for November 2024, December 2024 and January 2025.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205099	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/10/2025
NAME OF PROVIDER OR SUPPLIER Rumford Community Home		STREET ADDRESS, CITY, STATE, ZIP CODE 11 John F Kennedy Lane Rumford, ME 04276	

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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. 33639 Based on record review and interview, the facility failed to conduct an annual review of it's Infection Prevention and Control Program (IPCP). Finding: On 2/6/25, during a review of the facility's IPCP policy and procedures, a surveyor noted various policies within the program lacked dates indicating a review and/or revision was completed. Policies included: Infection Control/Exposure Control Plan Review Policy revised 9/2018, North Country Associates: Infection Control Immunizations - Influenza, Pneumococcal Policy revised 9/2018, COVID-19 (Vaccine Policy revised 5/2/23 and National: Clinical Services Infection Prevention & Control Policy dated 6/1/23. On 2/6/25 at 10:07 a.m., the Administrator confirmed that the IPCP policies and procedures had not been reviewed on annually. 37440

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NAME OF PROVIDER OR SUPPLIER Rumford Community Home		STREET ADDRESS, CITY, STATE, ZIP CODE 11 John F Kennedy Lane Rumford, ME 04276	

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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 33639 Based on interview and policy review, the facility failed to designate a qualified staff member to function as the Infection Preventionist, who is responsible for the facility's Infection Control Program since 12/4/22. Finding: On 2/4/25 at approximately 9:37 a.m., during an interview with the Director of Nursing (DON), the surveyor inquired who was responsible for the facilities infection control program. The DON stated that she had been the facilities Infection Preventionist until she transitioned to the DON position on 12/4/22 and a new acting IP and (Assistant Director of Nursing) ADON was hired in January 2024. As of today, the new acting IP has not completed the infection control training for the IP role. A review of the Infection Prevention & Control Policy indicates under Roles and Responsibilities: Administration: Designate one or more individual(s) as the Infection Preventionist(s) who is responsible for the facility's IPCP. The IP will: i. Have primary professional training in nursing, medical technology, microbiology, epidemiology, or another related field. ii. Be qualified by education, training experience, or certification. iii. Work at least part-time at the facility. iiii. Have completed specialized training in infection prevention and control. Be an active member of the facility's quality assessment and assurance committee and reports to the committe on a regular basis. On 2/4/25 at 3:00 p.m. a surveyor confirmed with the Administrator that the facility did not have a designated and qualified IP since 12/4/22.

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	205099	A. Building B. Wing	02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rumford Community Home	11 John F Kennedy Lane Rumford, ME 04276

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33639 Based on immunization record review, review of the facility's immunization policy and interview, the facility failed to implement their Influenza, Pneumococcal, COVID policy for 1 of 5 residents whose immunization records were reviewed. (#19) Finding: The facility's Infection Prevention & Control Policy revised 6/1/23 indicated under Immunizations- Influenza: It is the policy of this facility that every fall, residents will be offered immunization against influenza. The time for immunization will follow the recommendations of the Centers for Disease Control and Prevention (CDC) and the state department of health. Residents or their responsible party will be educated about the risk/benefit of the vaccine. Resident #19's clinical record indicated that the resident was admitted to the facility on ,d+[DATE]. Resident #19's immunization records lacked evidence that the resident's Influenza Vaccination was administered as directed by the facility's Infection Prevention & Control Policy. On 2/6/25 at 8:30 a.m., the Director of Nursing (DON) stated that Resident #19's consent for the Influenza Vaccination was obtained from the Power of Attorney (POA) in October 2024. At that time, Resident #19 had refused the vaccination, and staff had planned on reapproaching the resident. Since then, she had lost site of the vaccines. Resident #19 received the Influenza vaccine on 2/5/25.

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NAME OF PROVIDER OR SUPPLIER: Rumford Community Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 11 John F Kennedy Lane Rumford, ME 04276	

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33639 Based on immunization record review, review of the facility's immunization policy and interview, the facility failed to implement their Infection Prevention & Control Policy for 1 of 5 residents whose immunization records were reviewed. (#19) Finding: The facility's Infection Prevention & Control Policy revised 6/1/23 indicated under Immunizations - COVID: The facility will offer the COVID-19 vaccine series to all eligible residents as per recommendations of the Center for Disease Control and Prevention. (CDC) Vaccines are offered by the facility or through an arrangement with a pharmacy partner, local health department or other appropriate health entity. Residents and/or healthcare representative (s) will be provided with education by a physician or licensed nurse regarding COVID-19 immunization using the Emergency Authorization Use (EAU) Fact Sheet for Recipients and Caregivers. Any new vaccine information will be dispersed as they become available. Resident #19's clinical record indicated that the resident was admitted to the facility on [DATE]. Resident #19's immunization records lacked evidence that the resident's Covid-19 immunization was administered as directed by the facility's Infection Prevention & Control Policy. On 2/6/25 at 8:30 a.m., the Director of Nursing (DON) stated that Resident #19's consent for the COVID-19 immunization was obtained from the Power of Attorney (POA) in October 2024. At that time, Resident #19 had refused the vaccination, and staff had planned on reapproaching the resident. Since then, she had lost site of the vaccines. Resident #19 received the Covid-19 vaccine on 2/5/25.

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NAME OF PROVIDER OR SUPPLIER Rumford Community Home		STREET ADDRESS, CITY, STATE, ZIP CODE 11 John F Kennedy Lane Rumford, ME 04276	

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. 33639 37440 Based on interviews, the facility failed to conduct regular inspection of all bed frames, mattresses, and bed rails as part of a regular maintenance program to identify areas of possible entrapment for 32 of 32 beds. This has the potential to affect the safety of all residents. Finding: On 2/10/25 at 11:30 a.m., a surveyor asked the Administrator for the bed gap measurements and side rail gap measurement documentation. A surveyor received and reviewed the documentation with the Administrator and she confirmed that the bed gap measurements and side rail gap measurements had not been completed since February 2023. On 2/10/25 at 12:05 a.m., a surveyor and the Director of Ancillary Services reviewed the bed gap measurements and side rail gap measurement documentation. At this time, in an interview, the Director of Ancillary Services confirmed that regular inspection of all bed frames, mattresses, and bed rails as part of a regular maintenance program to identify areas of possible entrapment and bed gap measurements and side rail gap measurements have not been completed since February 2023.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 37440 Based on Certified Nursing Assistant (CNA) employee education record review and interview, the facility failed to monitor and ensure that the Certified Nursing Assistants (CNAs) received the required 12 hours of annual in-service education training for 5 of 5 randomly selected CNAs employed greater than 1 year (CNA #1, CNA #2, CNA #3, CNA #4, and CNA #5). Findings On 2/6/25, a surveyor reviewed the following employee education files: 1. CNA #1 was hired 3/27/23. A review of CNA #1's education records revealed they had not received the required 12 hours of education/in-service training including Resident Rights, Dementia, Quality Assurance and Performance Improvement Program (QAPI), and Infection Control in 2024. 2. CNA #2 was hired 4/10/23. A review of CNA #2's education records revealed they had not received the required 12 hours of education/in-service training including Resident Rights, QAPI, and Infection Control in 2024. 3. CNA #3 was hired 1/8/24. A review of CNA #3's education records revealed they had not received the required 12 hours of education/in-service training including Dementia, QAPI, and Infection Control in 2024. 4. CNA #4 was hired 9/13/1994. A review of CNA #4's education records revealed they had not received the required 12 hours of education/in-service training including QAPI and Infection Control in 2024. 5. CNA #5 was hired 11/1/2016. A review of CNA #5's education records revealed they had not received the required 12 hours of education/in-service training including Resident Rights, QAPI and Infection Control in 2024. On 2/06/25 at 11:19 a.m., in an interview, the Administrator confirmed that all 5 CNAs had not received the required 12 hours, including certain mandatory education and in-service training in 2024.