STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205099	A. Building B. Wing	04/22/2026

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

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 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 interview, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable environment on 2 of 2 units (East and West) and the laundry room for 3 of 3 facility observations/tours. (4/21/26 and 4/22/26)Findings:1. On 4/21/26 at 10:27 a.m., a surveyor observed a specialized gel cushion stored on the floor by the window. At this time, in an interview with a surveyor, Certified Nursing Assistant (CNA #1) confirmed the finding.2. On 4/21/26 at 10:50 a.m., a surveyor observed a wash basin on the bathroom floor in Resident room [ROOM NUMBER]. At this time, in an interview with a surveyor, CNA #1 confirmed the finding.3. On 4/22/26 from 11:30 a.m. to 12:00 p.m., a surveyor conducted an Environmental Tour with the Maintenance Director in which the following findings were discussed and/or observed. East Unit:- Resident room [ROOM NUMBER] - A privacy curtain was missing hooks, hanging down and in disrepair. - Resident room [ROOM NUMBER] - A privacy curtain was missing hooks, hanging down and in disrepair. - Resident room [ROOM NUMBER] - The bathroom had a ceiling tile that had a large brow stain on it. The room wall, above the baseboard heater, had chipped/missing paint creating an uncleanable surface. - The dining room wall, to the right after entering the first door, had dried liquid residue on it. [NAME] Unit:- Resident room [ROOM NUMBER] - There was a wash basin and a clean brief lying on the closet floor.- Resident room [ROOM NUMBER] - A privacy curtain was missing hooks, hanging down and in disrepair. - Resident room [ROOM NUMBER]- A resident dresser had worn/missing surface finish exposing untreated wood like material creating uncleanable surfaces. There the shared bathroom had a graduated cylinder on top of the toilet that was not labeled. - Resident room [ROOM NUMBER] - A resident dresser had worn/missing surface finish exposing untreated wood like material creating uncleanable surfaces. - Resident room [ROOM NUMBER] - There were two stained ceiling tiles in the room. - Resident room [ROOM NUMBER] - There was one stained ceiling tile in the middle of the room. - Whirlpool room - There were two broken ceiling tiles in the room. Laundry Room:- The cement floor behind the washing machines had chipped/missing paint creating an uncleanable surface. Additionally, the floor was covered with lint and trash. - A laundry cart had untreated wood holding the laundry bin to the wheeled unit creating an uncleanable surface.- There was an approximately five feet by five feet section of wall, to the left of the washing machines, that was missing sheetrock and exposing untreated wooden wall studs creating uncleanable surfaces. On 4/22/2026 at 12:00 p.m., in an interview with a surveyor, the Maintenance Director confirmed the discussed and observed findings.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to review and revise the care plan by an interdisciplinary team (IDT) meeting, which included the participation of the resident and resident's representative, after each Minimum Data Set (MDS) 3.0 assessment, for 7 of 14 residents whose care plans were reviewed (Resident #1, #5, #6, #7, #15, #27, #29). Findings: 1. Review of Resident #6's clinical record revealed an MDS Quarterly Assessment was completed on 4/13/26. Further review of Resident #6's clinical record revealed that an IDT meeting was held 4/9/26 (prior to completion of the assessment). 2. Review of Resident #29's clinical record revealed an MDS Quarterly Assessment was completed on 4/2/26. Further review of Resident #29's clinical record revealed that an IDT meeting was held 3/31/26 (prior to completion of the assessment). 3. Review of Resident #7's clinical record revealed an MDS Quarterly Assessment was completed on 3/3/26. Further review of Resident #7's clinical record revealed that an IDT meeting was held 2/26/26 (prior to completion of the assessment). 4. Review of Resident #1's clinical record revealed an MDS Quarterly Assessment was completed on 10/17/25. Further review of Resident #1's clinical record revealed that an IDT meeting was held 10/7/25(prior to completion of the assessment). Review of Resident #1's clinical record revealed an MDS Quarterly Assessment was completed on 1/2/26. Further review of Resident #1's clinical record revealed that an IDT meeting was held 1/27/26 which was not within 7 days of the above MDS assessment. 5. Resident #5's medical record contained a quarterly MDS dated [DATE] and an annual MDS dated [DATE]. The record lacked evidence of an IDT meeting being held within 7 days of the above MDS assessments. 6. Resident #15's medical record contained a quarterly MDS dated [DATE], 9/6/25, and an annual MDS dated [DATE]. The record lacked evidence of an IDT meeting being held within 7 days of the above MDS assessments. 7. Resident #27's medical record contained a quarterly MDS dated [DATE], 1/2/26, 10/1/25, and an annual MDS dated [DATE]. The record lacked evidence of an IDT meeting being held within 7 days of the above MDS assessments. On 4/22/25 at 9:25 a.m. during an interview with 4 surveyors the Director of Social Services stated, we have 14 days to have the IDT meeting, and two surveyors reviewed the federal regulation with her regarding the timing. On 4/22/25 at 9:45 a.m. during an interview with four surveyors The Director of Social Services presented an email from the administrator to him/her that states, I accessed the reg (regulation) through the State Operations Manual, Appendix PP. The Care Plan must be reviewed and revised by (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the IDT after each MDS and show evidence of resident and/or resident representative participation. I am looking through the SOM (State Operation Manual), and it only specifies that the initial IDT needs to be done within 7 days of completion of the MDS, so I think that following the 7-14 days mentioned by your SSD (Social Service Director) would be acceptable. Then the Director of Social Services stated they go by the ARD (assessment reference date) and not the completion date and confirmed the above findings with four surveyors.

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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. Based on observations, interviews, 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 2 days of survey (4/22/26). Findings:Safety Data SheetsPure Bright Germicidal Ultra Bleach4. First Aid MeasuresEye Contact: Immediately flush with plenty of water. After initial flushing, remove any contact lenses and continue flushing for at least 15 minutes.Skin contact: Wash skin with soap and water.Inhalation: Remove to fresh air.Ingestion: Do not induce vomiting. Clean mouth with water and drink afterwards plenty of water. If symptoms persist, call a physician. Micro-Kill Q3 Concentrated Disinfectant, Cleaner & Deodorizer4. First Aid MeasuresInhalation: Remove person to fresh air and keep comfortable for breathing. If experiencing respiratory symptoms: Call a poison center or a doctor. Causes irritation of the respiratory tract. Dizziness. Headache. Skin contact: Take off immediately all contaminated clothing and wash it before reuse. Rinse skin with water/shower. If skin irritation occurs: Get medical advice/attention. Causes caustic burns/corrosion of the skin. Eye Contact: Rinse cautiously with water for several minutes. Remove contact lenses, if present and easy to do. Continue rinsing. Immediately call a poison control center or doctor/physician. Causes serious eye damage. Corrosion of the eye tissue. Permanent eye damage. Ingestion: Rinse Mouth. Do not induce vomiting. Immediately call a poison control center or doctor/physician. Causes burns to the gastric/intestinal mucosa. Diarrhea. Nausea. Vomiting. Odor Control Spray4. First Aid MeasuresInhalation: If breathing is irregular or stopped, immediately seek medical assistance and start first aid actions. Provide fresh air. Skin Contact: Wash with plenty of soap and water. Eye Contact: Remove contact lenses, if present and easy to do. Continue rinsing. Irrigate copiously with clean, fresh water for at least 10 minutes, holding the eyelids apart. Ingestion: Rinse mouth with water (only if the person is conscious). Do not induce vomiting. Oxivir TB Wipes4. First Aid MeasuresEyes: Rinse with plenty of water. If irritation occurs and persists, get medical attention. Skin: No specific first aid measures are required. Inhalation: No specific first aid measures are requiredIngestion: If swallowed: call a poison center or doctor/physician if you feel unwell.On 4/22/26 at 10:41 a.m., two surveyors observed the clean side laundry room door to be ajar. The door was not shut and locked. The two surveyors entered the laundry room and found numerous hazardous chemicals in the room that would be accessible to residents that ambulate and roam in their wheelchairs. The chemicals found were as followed:- One gallon of Pure Bright Bleach(gallon container)- One 32 ounce spray bottle of Micro Kill Concentrated Disinfectant, Cleaner, and Deodorizer - Two 1.8 lb tubs of Diversey Oxivir Tb Wipes - One 8 oz spray bottle of Medline Simply Fresh Odor Eliminator. - One unlabeled spray bottle containing clear liquidDuring an interview with two surveyors present at this time, a laundry aide confirmed that the door does not always shut when leaving the room. On 4/22/26 at 11:00 a.m., in an interview with two surveyors present, the Administrator confirmed that the chemicals in laundry were not stored safely and appropriately to safe guard residents that are confused and ambulate and move about in their wheelchairs. The Administrator went on to say that the door should be shut and locked at all times.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on record review and interviews the facility failed to ensure annual performance reviews were completed at least once every 12 months for 3 of 5 Certified Nursing Assistants selected for reviews (CNA) (Staff #2, Staff #4 and Staff #5).Findings:1.Staff #2's was hired 11/1/16. Staff #2's personnel file lacked evidence that an annual performance evaluation was reviewed and signed by CNA #2 in 2024 and 2025.2. Staff #4 was hired 6/20/22. Staff #4's personal file lacked evidence that a performance evaluation was reviewed and signed in 2024 and 2025.3. Staff #5 was hired 12/10/97. Staff #5's personnel file lacked evidence that a performance evaluation was reviewed and signed in 2024 and 2025.During an interview with Director of Nursing and Administrator on 4/22/26 at 11:36 a.m., the DON confirmed that only 3 of the 5 annual reviews were signed by staff. Administrator states they are currently changing the process of annual evaluations because they are done online and they can't see when they are completed.During a follow up interview on 4/22/26 at 11:51 a.m. the Administrator stated it is the supervisor's responsibility to ensure the annual reviews are completed. states they are all completed at the same time.

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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. Based on observations, interviews, 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 a hood system, floors, a small reach-in standing freezer, a grease trap and a large walk-in freezer; and failed to ensure foods were labeled and dated in a walk-in freezer for 1 of 1 kitchen tour for 1 of 2 days of survey. (4/21/26)Findings:The facility's Food Storage policy, dated 2013 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 foods should be covered, labeled and dated .15. Frozen Foods-c. All foods should be covered, labeled and datedOn 4/21/26 from 9:00 a.m. to 9:30 a.m., a surveyor completed an initial kitchen tour with a cook in which the following findings were observed:- The cook stove hood system was dusty/dirty. - The small reach-in standing freezer had dried food particles and dried liquid residue on the unit shelving and door shelving. - There was trash and food debris around the entire kitchen floor, under the equipment and under the shelving. - The large walk-in freezer had nine packages of rolls and a tray of hamburger patties that that were not labeled and dated. Additionally, the floor was visibly dirty and had trash on it. - The dish room grease trap cover was rusty around the top edges creating an uncleanable surface. On 4/21/26 at 9:30 a.m., in an interview with a surveyor, the cook confirmed the findings. On 4/21/26 at 9:40 a.m., a surveyor discussed the findings with the Administrator.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on observations and interviews, the facility failed to promote care for resident in a manner that maintains the resident's dignity by allowing an uncovered colostomy bag to be seen by passersby for 1 of 2 residents (Resident #1) observed for dignity related to urinary/colostomy bags during 1 of 2 days of survey (4/21/26). Findings:On 4/21/26 at 10:30 a.m., a surveyor observed Resident #1's colostomy bag hanging on the side of the bed, containing brownish/reddish waste, visible from the hallway. At this time, in an interview with a surveyor, Resident #1 indicated he/she would like to have it covered and would be embarrassed if people could see it from the hallway. On 4/21/26 at 10:46 a.m., in an interview with a surveyor, Certified Nursing Assistant (CNA #1) confirmed that Resident #1's colostomy bag containing brownish/reddish waste was visible to passersby in the hallway.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to notify a provider when a resident verbalized desire to self-harm for 1 of 14 residents reviewed during the survey process (Resident [R]#16).Findings: Resident #16 was admitted in 2019 and has diagnoses to include multiple sclerosis, and major depressive disorder. Review of Minimum Data Set (MDS) dated [DATE] revealed Resident #16 had a Brief Interview for Mental Status (BIMS) of 14 of 15 indicating he/she is cognitively intact. Review of Resident #16's clinical record revealed progress note dated 4/14/26 at 8:06 a.m. Behavior Note stating: ?Resident in the dining room for breakfast and was noted to be talking very loudly on the phone. [He/she] was yelling that [he/she] wanted to kill [himself/herself] and that [he/she] did not want to be in this facility anymore. When the cook asked [him/her] if [he/she] needed anything else before [he/she] left the dining room the resident responded, a gun. Per the CNA after this nurse left the dining room [he/she] continued to say[he/she] wanted to kill [himself/herself] . Further review of R#16's clinical record lacked evidence the nurse notified provider/management was notified of [his/her] statement. During an interview on 4/22/26 at 8:00 a.m., Licensed Practical Nurse (LPN) stated that day Resident #16 was very angry speaking with someone on the phone. {He/she} was getting upset with the other residents in the room. [He/she] stated [he/she] wanted to kill [himself/herself]. [He/she] was removed from the situation and once he/she was in the TV room, he was de-escalated. He/she did not have a plan. It was very short-lived and didn't mention it again. He did say he didn't want to be here and i told him/her that the SW could help him find a new place if that's what he wanted to do. She did notify SW and DON in morning meeting at 8:30 but did not document it. States definitely informed SW and DON because it was part of the same conversation about him wanting to leave and it was all in the same note. During an interview on 4/22/26 at 8:10 a.m., Certified Nursing Assistant (CNA) stated she was made aware of Resident #16's self-harm statement when she arrived for report at 2:00 p.m., When this happens staff are made aware, and they make sure to check on the resident regularly. States he/she used to make the statement regularly a while ago when he/she was angry/mad but has not made the statement in a long time. During an interview on 4/22/26 at 9:01, in presence of three surveyors the Director of Nursing (DON) stated she remembered that day but does not recall nurse stating he/she wanted to harm himself like that. DON states Resident #16 used to make that statement a lot when [he/she] was mad/angry, but it's been a while.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interview the facility failed to update a care plan to include goals and interventions in the area of suicidal ideation for 1 of 14 sampled residents (Resident (R)#16).Findings: Resident #16 was admitted in 2019 and has diagnoses to include multiple sclerosis, and major depressive disorder.Review of Resident #16's clinical record revealed progress note dated 4/14/26 at 8:06 a.m. Behavior Note stating: ?Resident in the dining room for breakfast and was noted to be talking very loudly on the phone. [He/she] was yelling that [he/she] wanted to kill [himself/herself] and that [he/she] did not want to be in this facility anymore. When the cook asked [him/her] if [he/she] needed anything else before [he/she] left the dining room the resident responded, a gun. Per the CNA after this nurse left the dining room [he/she] continued to say[he/she] wanted to kill [himself/herself] . Review of R#16's care plan reviewed 3/16/26 [R #16] has a behavior problem (occasionally refuses to eat, verbal outburst to staff, emotional distress by disease process r/t paraplegia, morbid obesity, secondary to progression of Multiple sclerosis goal: [R#16] will have fewer episodes of meal refusals, negative statements weekly by review date INTERVENTIONS: Intervene as necessary to protect the rights and safety of others. Approach. speak in a calm manner Divert attentions. Remove from situation and take to alternative location as needed. Monitor each shift for sad or angry affect and notify MD of any changes in behaviors. Further review of R#16's care plan lacked evidence that it contained goals and interventions in the area of suicidal Ideation.During an interview on 4/22/26 at 9:01 a.m., in presence of three surveyors the Director of Nursing (DON) states R#16 used to make self-harm statements in the past but had not made them for a while. At this time a surveyor reviewed R#16's care plan with DON who confirmed it does not contain goals and interventions in the area of suicidal ideation.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observations and interview, the facility failed to maintain a garbage storage area in a sanitary condition to prevent the harborage and feeding of pests for 1 of 2 trash dumpsters for 1 of 2 days of survey (4/21/26).Findings:On 4/21/26 at 8:30 a.m., three surveyors observed the top right lid of 1 of 2 dumpsters to be open exposing trash. On 4/21/26 at 8:35 a.m., in an interview with a surveyor, the Administrator confirmed the finding.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on record review and interviews, the facility failed to conduct an annual review of its Infection Prevention and Control Program (IPCP). Finding:On 4/22/26, initial review of the facility's infection control policies lacked evidence that the facility had developed and implemented written policies and procedures for their IPCP in the areas of hand hygiene and standard and transmission-based precautions.On 4/22/26 at 12:40 p.m. the surveyor discussed the above concern during an interview with the Director of Nursing (DON). At this time, the DON was unable to provide the above policies to the surveyor and stated that she was not sure if the facility had these policies, but that she would look.On 4/22/26 at 1:33 p.m. the DON provided the requested policies, and surveyor review of the policies revealed the following:Facility policy, Hand Hygiene, dated 12/20/2017, last reviewed 7/22/24Facility policy, Standard Precautions Used for All Patients, dated 3/31/23, lacked evidence that the policy has been reviewed and/or revised.Facility policy, Droplet Precautions, dated 3/31/23, lacked evidence that the policy has been reviewed and/or revised.Facility policy, Precautions to Prevent Infection, last reviewed 6/2024.On 4/22/26 at 1:56 p.m., the surveyor discussed the finding during a follow-up interview with the DON, and at this time the DON confirmed that the facility had not conducted an annual review of its IPCP.