

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/26/2025
NAME OF PROVIDER OR SUPPLIER Orchard Park Rehab & Living		STREET ADDRESS, CITY, STATE, ZIP CODE 107 Orchard St Farmington, ME 04938	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on record review, interview and review of the facility's internal investigation, the facility failed to ensure that 1 of 1 resident reviewed for dignity was provided care in a manner that maintained and respected his/her dignity. (Resident #1) The Division of Licensing and Certification received the facility reported incident regarding Resident #1 related to mistreatment on 8/4/25. Review of the facilities 5-day follow-up investigation dated 8/7/25 indicated that 8/4/25, Resident #1 was observed seated in a wheelchair wearing johnny pants that had been applied backwards, with the ties positioned in the back and secured in a double knot. The resident was also seated on a sheet that had been tied in front of him/her around the waist and secured in a double knot. On 8/27/25 at approximately 2:18 p.m., during a telephone interview with a surveyor, Certified Nurse's Assistant #6, (CNA) confirmed these actions, stating that he had tied a sheet around Resident #1's waist and secured it in a double knot as he/she was sitting in his/her wheelchair and applied johnny pants backwards, with the ties positioned in the back and secured in a double knot to deter Resident #1 from accessing his/her brief because he was unable to locate a belt. CNA #6 further explained that Resident #1 was noted to shred and remove her brief. CNA #6 confirmed these interventions were not included in Resident 1's plan of care and acknowledged that he had previously received training on abuse, neglect, restraints and resident rights. CNA #6 further stated he did not recognize his actions of applying the johnny pants backwards with the ties positioned in the back in a double knot and secured in a double knot as inappropriate and that this intervention had been explained to him during orientation to prevent the resident from shredding and removing his/her brief. The facilities investigation concluded that CNA #6's actions were considered abuse and use of a restraint even though there were no malicious intent. The facilities internal investigation through interviews and written statements determined that the residents' rights were violated when he/she was inappropriately tied with a sheet in a double knot and johnny pants were put backwards and secured with a double knot which restrained his/her ability to access his/her brief. All of which constituted resident abuse. CNA #6's contract was terminated immediately. The facility also immediately educated all staff on abuse, neglect, restraint, use, dignity and respect. On 8/26/25 at 1:00 p.m., during an exit interview with the Director of Nursing, (DON) the above findings were discussed, including concerns related to dignity, respect, abuse and restraint. The Director of Nursing acknowledged the findings and confirmed understanding of the cited concerns.</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 205168
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on record review, interviews and review of the facility's Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property policy, the facility failed to ensure that 1 of 1 resident reviewed was free from abuse when the resident was found with a sheet double knotted in front of her waist and a pair of johnny pants applied backwards with the ties double knotted behind him/her. (Resident #1) The Division of Licensing and Certification received the facility reported incident regarding Resident #1 related to mistreatment on 8/4/25. The facilities policy, Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property indicates: It is the policy of this facility that each resident will be free from abuse. Abused can include verbal, mental, sexual or physical abuse, misappropriation of resident property and exploitation, corporal punishment, or involuntary seclusion. The resident will also be free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the residents' medical symptoms. Additionally, residents will be protected from abuse, neglect, and harm while they are residing at the facility. A. Abuse is defined as 483.5 as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm pain or mental anguish. Abuse also includes deprivation by an individual, including a caretaker of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being, physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse and mental abuse, including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately not that the individual must have intended to inflict injury or harm. The facility policy further indicates the following: E. Convenience is defined as the result of any action that has the effect of altering a resident's behavior such that the resident requires a lesser amount of effort or care and is not in the resident's best interest. H. Freedom of movement means any change in place or position for the body or any part of the body that the person is physically able to control. N. Manual method means to hold or limit a resident's voluntary movement by using body contact as method of physical restraint. T. Physical restraint is defined as any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria: Is attached or adjacent to the residence body, cannot be removed easily by the resident and restricts the resident's freedom of movement or normal access to his or her body. U. Removes easily means the manual method, physical or mechanical device, equipment or material can be removed intentionally by the resident in the same manner as it was applied. Review of the facilities 5-day follow-up investigation dated 8/7/25 indicated that 8/4/25, Resident #1 was observed seated in a wheelchair wearing johnny pants that had been applied backwards, with the ties positioned in the back and secured in a double knot. The resident was also seated on a sheet that had been tied in front of him/her around the waist and secured in a double knot. On 8/27/25 at approximately 2:18 p.m., during a telephone interview with a surveyor, Certified Nurse's Assistant #6, (CNA) confirmed these actions, stating that he had tied a sheet around Resident #1's waist and secured it in a double knot as he/she was sitting in his/her wheelchair and applied johnny pants backwards, with the ties positioned in the back and secured in a double knot to deter Resident #1 from accessing his/her brief because he was unable to locate a belt. CNA #6 further explained that Resident #1 was noted to shred and remove her brief. CNA #6 confirmed these interventions were not included in Resident 1's plan of care and acknowledged that he had previously received training on abuse, neglect, restraints and resident rights. CNA #6 further stated he did not recognize his actions of applying the johnny pants backwards with the ties positioned in the back in a double knot and secured in a double knot as inappropriate and that this intervention had been explained to him during orientation to prevent the resident from shredding and removing his/her brief. The facilities investigation concluded that CNA #6's actions were considered abuse and use of a restraint even though there were no malicious intent. The facilities internal investigation through interviews and written statements determined that the residents' rights were violated when he/she was inappropriately tied with a sheet in a double knot and johnny pants were put backwards and secured with a double knot which restrained his/her ability to access his/her brief. All of which constituted resident abuse. CNA #6's contract was terminated immediately. The facility also immediately educated all staff on abuse, neglect, restraint, use, dignity and respect. On 8/26/25 at 1:00 p.m., during an exit interview with the Director of Nursing, (DON) the above findings were discussed, including concerns related to dignity, respect, abuse and restraint. The Director of Nursing acknowledged the findings and confirmed understanding of the cited concerns.</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>Based on record review, interview, facility's internal investigation and Restraint Policy, the facility failed to ensure that 1 of 1 resident was free from the use of restraints. (Resident #1 The Division of Licensing and Certification received the facility reported incident regarding Resident #1 related to mistreatment on 8/4/25. Review of the facilities 5-day follow-up investigation dated 8/7/25 indicated that 8/4/25, Resident #1 was observed seated in a wheelchair wearing johnny pants that had been applied backwards, with the ties positioned in the back and secured in a double knot. The resident was also seated on a sheet that had been tied in front of him/her around the waist and secured in a double knot. The facilities restraint use policy indicates: The facility must ensure the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and are not required to treat the residents' medical symptoms. II. Procedure Examples of facility practices and meeting the definition of a physical restraint include but are not limited to: C. Tucking in a sheet tightly so the resident cannot get out of bed or fastening fabric or clothing, so a resident's freedom of movement is restricted. On 8/27/25 at approximately 2:18 p.m., during a telephone interview with a surveyor, Certified Nurse's Assistant #6, (CNA) confirmed these actions, stating that he had tied a sheet around Resident #1's waist and secured it in a double knot as he/she was sitting in his/her wheelchair and applied johnny pants backwards, with the ties positioned in the back and secured in a double knot to deter Resident #1 from accessing his/her brief because he was unable to locate a belt. CNA #6 further explained that Resident #1 was noted to shred and remove her brief. CNA #6 confirmed these interventions were not included in Resident 1's plan of care and acknowledged that he had previously received training on abuse, neglect, restraints and resident rights. CNA #6 further stated he did not recognize his actions of applying the johnny pants backwards with the ties positioned in the back in a double knot and secured in a double knot as inappropriate and that this intervention had been explained to him during orientation to prevent the resident from shredding and removing his/her brief. The facilities investigation concluded that CNA #6's actions were considered abuse and use of a restraint even though there were no malicious intent. The facilities internal investigation through interviews and written statements determined that the residents' rights were violated when he/she was inappropriately tied with a sheet in a double knot and johnny pants were put backwards and secured with a double knot which restrained his/her ability to access his/her brief. All of which constituted resident abuse. CNA #6's contract was terminated immediately. The facility also immediately educated all staff on abuse, neglect, restraint, use, dignity and respect. On 8/26/25 at 1:00 p.m., during an exit interview with the Director of Nursing, (DON) the above findings were discussed, including concerns related to dignity, respect, abuse and restraint. The Director of Nursing acknowledged the findings and confirmed understanding of the cited concerns.</p>		