STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205168	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard Park Rehab & Living Center	107 Orchard Street 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)
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 (Cortland, Northern Spy and [NAME]), the Therapy room, a common area, and the laundry room for 2 of 2 environmental tours (1/20/26 and 1/22/26).Findings: 1. On 1/20/26 at 10:56 a.m., 2 surveyors observed multiple cooking dishes stacked under the therapy room sink next to and below the drainpipe. At this time, in an interview with two surveyors present, a Certified Occupational Therapy Aide (COTA) confirmed the finding. On 1/20/26 at 11:15 a.m., in an interview with a surveyor, the Director of Nursing (DON) confirmed the cupboard contained dishes that were stored and stacked under and near to the therapy room sink drainpipe. 2. On 1/21/26 from 10:35 a.m. to 11:15 a.m., a surveyor conducted an Environmental tour with the Maintenance Director and the Director of Environmental Services in which the following findings were observed: Cortland Unit:- Resident rooms [ROOM NUMBERS] had privacy curtains that were missing hooks, hanging down and in disrepair. - Resident room [ROOM NUMBER] - The bathroom baseboard heater had chipped/missing paint and was rusty creating an uncleanable surface. The bathroom door protective surface was pulled away and coming off the door on the inside and outside of the door and the inside bottom of the door was chipped/gouged exposing unsealed wood. There was a wash basin on the floor the under sink. The toilet water fill line had a rusty escutcheon (the cap that covers the wall opening around the water line entrance). The room baseboard heater had chipped/missing paint and was rusty creating an uncleanable surface. - The hallway floor, at different locations throughout the hallway, had 7 chipped/broken floor tiles. - The Whirlpool room walls with chipped/missing paint and damaged sheetrock creating uncleanable surfaces. The floor linoleum was ripped/missing at the corner of the wall by the toilet and at the sink cabinet. Additionally, the linoleum was ripped/missing around the floor drain and seams in the middle of the floor had split and pulled apart. A ceiling light was rusty and the ceiling grid next to the light was rusty. The whirlpool tub was dirty, stained yellow and cracked throughout the tub. Additionally, the tub's water intake screen and water jets were soiled and stained. Northern Spy: - Resident room [ROOM NUMBER] had privacy curtains that were missing hooks, hanging down and in disrepair. - Resident room [ROOM NUMBER] - The bathroom ceiling tile, around a sprinkler head, was bubbled up and bent out of shape. - The hallway floor, at different locations throughout the hallway, had 32 chipped/broken floor tiles. [NAME] Unit:-6 cracked/broken floor tiles on [NAME] Unit-[NAME] shower room revealed chipped and missing paint on the walls. Common area:- The ceiling, near the nurse's station. had large brown stains on it. - The ramp, going downstairs, had a broken handrail. Laundry room:- The left clothes dryer had Velcro tape holding the bottom lint door on and had tape on the door glass. - A three-shelf laundry cart had ripped and hanging duct tape on the bottom shelf. On 1/21/26 at 11:15 a.m., in an interview with a surveyor, the Maintenance (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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Director and the Director of Environmental Services confirmed the findings.

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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 0628 Level of Harm - Potential for minimal 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 issue a written transfer/discharge notice and a bed hold notice to include cost of care to the legal representative for 2 of 4 sampled residents reviewed for transfer to an acute care hospital (Residents #4, #28).Findings:1. Resident #4 was admitted to the facility in January 2024.A review of Resident #4's clinical record indicated he/she was transported to an acute care hospital on [DATE]. Further review of the clinical record lacked evidence that Resident #4 and his/her representative received a written transfer/discharge notice and a written bed hold notice for the above date.2. Resident #28 was admitted to the facility in October 2022.A review of Resident #28's clinical record indicated he/she was transported to an acute care hospital on 4/2/25. Further review of the clinical record revealed the following nursing progress notes, indicating Resident #28 was again transported to an acute care hospital on 4/4/25 and was subsequently admitted : A nursing progress note dated 4/4/25 that states, Spoke with [Gastroenterologist] in regards to last ED [Emergency Department] visit.Was advised that resident return to ED for another evaluation.Resident is going to ED at [alternate ED] .transported by facility staff.A nursing progress note dated 4/4/25 that states, .left a voicemail that we received a call from [Gastroenterologist] and they wanted [Resident #28] back in the ED. As a team we decided to bring [him/her] to [alternate ED] as resident was just in [original ED] and they did not help [him/her].A nursing progress note dated 4/4/25 that states, Resident admitted to [acute care hospital] with Dx [diagnosis] of intestinal blockage.Additional record review indicated Resident #28 was transported to an acute care hospital on [DATE] and was subsequently admitted .Resident #28's clinical record lacked evidence that R2's representative received a written transfer/discharge notice and a written bed hold notice for the above dates.On 1/22/26 at 11:15 a.m. a surveyor discussed the above findings during an interview with the Licensed Social Worker (LSW). At this time, the LSW confirmed that she does not have evidence that the facility provided a written transfer notice and a written bed hold notice for Resident #4's transfer on 10/19/25 and Resident #28's transfers on 4/2/25, 4/4/25, and 12/4/25. The LSW then stated that Resident #28's transfer to the Emergency Department on 4/4/25 was a scheduled appointment, so the facility was not required to provide a transfer notice or a bed hold notice.