| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 205168 | A. Building<br>B. Wing | 06/25/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Orchard Park Rehab & Living Center | 107 Orchard Street<br>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 0557<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.<br><br>Based on observations and interviews the facility failed to ensure a resident was treated with dignity and respect for 1 of 3 residents reviewed during a complaint investigation (Resident #3).Findings: Observation of Resident #3 on 6/25/26 at 9:06 a.m., and 11:31 a.m., a urinary catheter was observed hanging from bedframe visible from door containing a yellow liquid. At this time Resident #3 stated he's/she's had a Foley on and off for a long time. When asked if it concerns him/her that the foley is visible from the door, resident stated wouldn't it concern you? During an observation of Resident #3 with Director of Nursing on 6/25/26 at 9:31 a.m., Director of Nursing confirmed Foley catheter uncovered, observed from door. Confirmed the foley bag should have been covered. |

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 |
|---|---|---|---|
| | 205168 | A. Building<br>B. Wing | 06/25/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Orchard Park Rehab & Living Center | 107 Orchard Street<br>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 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>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 3 residents reviewed during a complaint investigation (Resident #1).Findings:Review of policy 48 Hour Baseline Care Plan dated 10/18 sates .A baseline care plan will be created within 48 hours of admission ., the Care Plan will contain the following 6 key elements: initial goals based on admission orders, all physician orders, including medications and administration schedule; dietary orders, therapy services to be provided; social service needs' PASRR recommendations (if any).Resident #1 was admitted 4/26 and diagnosis to include atrial fibrillation. Heart failure and morbid obesity, which made him/her dependent on staff to meet his/her ADL needs.Review of Resident #1 active orders revealed order with start date of 4/14/26 for antiplatelet medication Eliquis 5 mg tablet 2 times daily.Review of Resident #1's care plan updated 5/13/26 lacked goals and interventions for the use of anticoagulant medications.Further review of Care plan states ADL: [Resident #1] requires (Specify): extensive/limited/supervision) assistance with self-care secondary to (Specify): __ AEB [Resident #1] inability to perform ADL's independently. GOAL: [Resident #1] will accept/receive assistance to complete daily tasks over the next 90 days. INTERVENTIONS: Mobility: [Specify]: (extensive/limited/supervision) assistance required with mobility: (Specify: Hoyer lift, 2 assist for transfers, etc.). Bathing/Grooming (Specify: extensive/limited/supervision) assistance required with bathing and grooming: (Specify: 1 person assist, 2 person assist, set up etc.). Dressing (Specify: extensive/limited/supervision) assistance required with dressing: (Specify: 1 person assist, 2 person assist, setup, etc.).Further review of Resident #1's care plan lacked goals and interventions in the areas of ADL were completed for this resident.During an interview on 6/25/26 at 12:31 p.m., the Director of Nursing (DON) stated that she completed and updated care plans. At this time DON reviewed Resident #1's care plan and confirmed it lacked goals and interventions for the use of anticoagulants, and ADLs. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 205168 | A. Building<br>B. Wing | 06/25/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Orchard Park Rehab & Living Center | 107 Orchard Street<br>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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews, and facility policy the facility failed to update/implement goals and interventions for use of foley catheter for 1 of 3 care plans reviewed during a complaint investigation (Resident #3).Findings: Review of facility policy Comprehensive Person-Centered Care Planning dated 1/19 states The facility must develop and implement a .care plan for each resident, which includes measurable objectives and timeframes to meet a resident's medical, nursing, and [NAME]/psychosocial needs Resident #3 was admitted 11/25. Observations of Resident #3 on 6/25/26 revealed he/she required use of a foley catheter, which was observed hooked to the bedframe and visible from the door. At this time Resident #3 states he/she has had a foley for quite some time. Review of Care plan, updated 6/9/26, lacked evidence that goals and interventions were put into place for the use of a foley catheter. During a review of Resident #3's care plan with Director of Nursing on 6/25/26 at 9:35 a.m. Director of Nursing confirmed above concerns. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 205168 | A. Building<br>B. Wing | 06/25/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Orchard Park Rehab & Living Center | 107 Orchard Street<br>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 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident?s drug regimen must be free from unnecessary drugs.<br><br>Based on record review, interviews, and facility policy, the facility failed to monitor side effects of psychotropic medications for 1 of 3 residents reviewed during a complaint investigation (Resident #1).Findings:Review of facility policy Psychoactive Medication Use Policy dated 9/18 states A psychoactive drug is any medication affecting brain activity associated with mental processes and behavior. These include, but are not limited to, drugs in the following categories: anti-psychotic; anti-depressant, anti-anxiety, hypnotic. Target behavior documentation will be collected and documented on a daily basis; Side effect monitoring and documentation will be collected and documented on a daily basis. Psychoactive medications will only be used in conjunction with the Individual Care Plan . Resident #1 was admitted 4/16 for skilled care services and had diagnoses to include depression, bipolar disorder, and attention deficit hyperactive disorder.Review of Resident #1 clinical record revealed the following:-Order with start date of 4/14/26 for antidepressant Mirtazapine 30 mg tablet, one time daily.-Order with start date of 4/14/26 for antipsychotic Aripiprazole 15mg tablet, one time daily.-Order with start date 4/14/26 for antidepressant Trazodone 100 mg, one time daily. Review of Resident #1's entire clinical record lacked evidence he/she was being monitored for side effects or behaviors for use of these medications.During an interview on 6/25/26 at 10:25 a.m., Licensed Practical Nurse (LPN)#1 stated any resident on a psychotropic medication should be monitored for side effects and behaviors and it would be documented in the Electronic Clinical Record.During a review of Resident #1's clinical record on 6/25/26 at 12:31 p.m., The Director of Nursing stated that the facility should be monitoring for behaviors and side effects of psychotropic medications and at this time confirmed the above findings. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 205168 | A. Building<br>B. Wing | 06/25/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Orchard Park Rehab & Living Center | 107 Orchard Street<br>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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews, and facility policy, the facility failed to ensure that clinical records were complete and contained accurate information for 1 of 3 sampled residents reviewed during a complaint investigation (Resident's #1).Findings: Review of facility policy CNA Documentation dated 1/19 states Resident care will be documents in an accurate and efficient manner by CNA's as a means of reviewing resident status and progress toward identified goals The CNA Daily flow sheet will be completed each shift by the CNA assigned to the resident. Using the codes provided on the form, the CNA is to indicate the care provided . Review of Resident #1's admission Minimum Data Set (MDS) dated [DATE] revealed Resident #1 was dependent of facility staff for toileting transfers, hygiene and mobility.Review of Activity of Daily Living (ADL) charting from 4/14/26 through 5/30/36 (47 days) lacked evidence Resident #1 received toileting/hygiene assistance on 4/14/26,4/15/26, 4/17/26, 4/18/26, 4/23/26, 4/25/26, 4/27/26, 4/28/26, 4/29/26, 5/6/26, 5/7/26, 5/15/26, 5/16/26. During the day shift 4/16/26, 4/19/26, 4/20/26, 4/22/26, 4/24/26, 4/29/26, 4/30/36, 5/1/26, 5/2/26, 5/3/26, 5/8/26, 5/9/26, 5/10/26, 5/13/26, 5/17/26, 5/18/26, 5/20/26, 5/21/26, 5/22/26, 5/24/26. During the evening shift 4/16/26, 4/19/26, 4/20/26, 4/21/26, 4/22/26, 4/26/26, 4/29/26, 4/20/26, 5/1/26, 5/3/26, 5/4/26, 5/11/26, 5/12/26, 5/17/26, 5/18/26, 5/19/26, 5/21/26, 5/22/26, 5/25/26, 5/26/26, 5/28/26, or 5/29/26. During the night shift 4/18/26, 4/21/26, 4/26/26, 5/10/26, 5/11/26, 5/12/26, 5/13/26, 5/25/25, and 5/26/26.During an interview on 6/25/26 at 9:06 a.m., Certified Nursing Assistant (CNA#1) stated that they are expected to document on each resident in their assignment every day before the end of shift and if a resident refused, it should also be documented in the Electronic Medical Record (EMR).During an interview on 6/25/26 at 12:31 p.m., the Director of Nursing stated CNA staff should be documenting ADL care before the end of their shift. |