

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 12/11/2024
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>37648</p> <p>Based on record review and interview, the facility failed to ensure that a medical provider and the resident's representative were notified timely of a significant change and/or incident for 1 of 3 residents reviewed for falls (Resident #1).</p> <p>Findings:</p> <p>Resident #1 has a history of lumbar vertebra fracture and a bone density disorder with a most recent Brief Interview for Mental Status score of 6 out of 15 indicating severe cognitive impairment.</p> <p>Review of the facilities incident report stated Resident #1 had fallen on 2/2/25 at 5:00 p.m. and the medical provider was notified of the fall on 2/3/25 at 1 p.m. (20 hours after the fall), the incident report lacked any further description, resident assessment or resident representative notification after the fall.</p> <p>Review of the nursing documentation shows a Post Fall Observation completed on 2/3/25 at 4:06 p.m., stating the resident obtained a fall in the dining room while ambulating using a walker and there were no abnormalities in his/her neurological status. The report lacked resident representative notification of the fall. In addition, the post fall nursing documentation lacked evidence of the resident representative being notified of the fall.</p> <p>On 2/5/25 at 2:28 p.m., during an interview, the Director of Nursing stated, she notified the family on Monday, the day after the fall.</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
---	-------	-----------

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 12/11/2024
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37440</p> <p>Based on observations and interviews, the facility failed to adequately maintain maintenance and housekeeping services necessary to maintain the facility in good repair and sanitary conditions for 3 of 3 units (Northern Spy, Cortland and [NAME]) and the laundry room for 1 of 1 environmental tour (12/11/24).</p> <p>Findings:</p> <p>1. On 11/19/24, from 10:05 a.m. to 10:30 a.m., an environmental tour was conducted with the Administrator, the Maintenance Director and the Housekeeping Account Manager, in which the following findings were observed:</p> <p>(continued on next page)</p>		

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 12/11/2024
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- The shower room across her nursing station had a missing ceiling tile and a broken shelf which was missing laminate on the edge exposing bare wood. - -The whirlpool room had ripped/torn flooring at the corners of the sink cabinet and had a large split-apart seam in the middle of the floor which was full of dirt. The bottom edge of the sink cabinet was broke and missing laminate. The walls had chipped/missing paint and holes in them. - Resident room [ROOM NUMBER] - On 12/09/24 at 9:54 a.m., a surveyor tested the hot water and found it to be cool to the touch and at 86 degrees Fahrenheit (F). The surveyor let the water run until 10:00 a.m. and the water was still cool to the touch On 12/9/24 at 10:49 a.m., in an interview, the Maintenance Director stated that the furnace was acting up after being looked at a while ago. He stated that the water temperature fluctuates hot to cold. It never goes above 120 (F). - Resident room [ROOM NUMBER]- The baseboard heater had chipped/missing paint, was broken apart lying on the floor and in disrepair. The bathroom floor was soiled with dirt and the caulking around the base of the toilet was dirty. - Resident room [ROOM NUMBER] - The baseboard heater had chipped/missing paint and was rusting. The bathroom floor dirty around the edges. The caulking around the base of the toilet was dirty. The cold water faucet was broken and ran all the time. The toilet fill water line escutcheon was rusty. - Resident room [ROOM NUMBER] - The room walls were marked/marred with black marks. The baseboard heater was broken apart and rusty. - Resident room [ROOM NUMBER] - On 12/09/24 at 9:52 a.m., a surveyor tested the hot water. After running for 5 minutes the water was not over 100 (F). The baseboard heater in room had chipped/missing paint and was rusty. - Resident room [ROOM NUMBER] - Resident #16 Broda chair was dirty with dried foods. The baseboard heater was broken apart and had chipped/missing paint. The bathroom door had chipped/missing laminate on the bottom left corner creating an uncleanable surface. - Resident room [ROOM NUMBER] - The room walls were marked/marred with black marks and had chipped/missing paint exposing sheetrock and a metal corner. The paint was missing from above the baseboard heater exposing sheetrock and the heater was broken exposing fins and pipes. The bathroom had a dusty/dirty fan on the floor. - There was a broken hallway ceiling tile outside of resident room [ROOM NUMBER]. - Resident room [ROOM NUMBER] - The room walls were marked/marred with black marks and there was unpainted spackle behind and around the book shelf. There was missing paint above baseboard heater exposing sheetrock. - Resident room [ROOM NUMBER]- The bathroom baseboard heater had chipped/missing paint and was rusty. The room baseboard heater was broken, lying on the floor and in disrepair. - Therapy/Rehab Room - The floor is heavily soiled with dirt. - The Northern Spy Unit hallway floor had 35 cracked/broken floor tiles. - The laundry room wall air conditioning unit was dusty/dirty. 2 of the 3 dryers were not operational. #1 has been inoperable for 2 years and #3 broke down a week ago with no timeframe on getting it fixed. On 12/10/24 at 1:19 p.m., observation of laundry rooms with the Housekeeping Account Manager. Dryer #3 has sign do not use and the Housekeeping Account Manager stated laundry sometimes needs to be prioritized due to having one dryer. She stated Dryer #3 has been out of order since about last Friday. On 12/10/24 at 1:28 p.m., in an interview with the Maintenance Director, he stated Dryer #1 has been out of order for over 2 years. Dryer #3 drum is slightly off balance due to a bearing. He had a company come out for a quote but is now having [NAME] equipment come to take a look for a second opinion. A surveyor requested the initial quote and no quote was made available the surveyor.</p> <p>On 11/19/24 at 10:30 a.m., in an interview, the Administrator, the Maintenance Director and the Housekeeping Account Manager confirmed the findings.</p> <p>51331</p> <p>2. On 12/9/24 at 9:54 a.m. and on 12/10/24 at 10:12 a.m., observation of a strong smelling urine odor coming from Resident #21's room.</p> <p>(continued on next page)</p>		

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 12/11/2024
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 12/10/24 at 10:20 a.m., during an interview, the above information was confirmed with the Director of Nursing (DON). The DON states that Resident #21's foley bag is frequently not screwed on all the way causing it leaks on the floor. The DON believes that the urine has absorbed into the flooring. When follow up question about what they are doing to counteract the odor, the DON states that housekeeping is cleaning the room daily but it is not helping.</p> <p>3. On 12/9/24 at 9:45 a.m. and on 12/10/24 at 10:12 a.m., observation of 2 wash basins on the bathroom floor, under the sink.</p> <p>On 12/10/24 at 10:27 a.m., the above information was confirmed with the DON.</p>		

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 12/11/2024
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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531</p> <p>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 4 of 4 residents reviewed for baseline care plans. (Resident's #23, #27, #80 & #181).</p> <p>Findings:</p> <p>Review of policy 48 Hour Baseline Care Plan dated 10/18 states .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).</p> <p>1. Resident #180 was admitted on [DATE] with diagnoses to include chronic obstructive pulmonary disease (COPD), Respiratory failure, anxiety, and shortness of breath.</p> <p>Review of Resident 180's clinical record revealed active order dated 11/20/24 for 'Trelegy Ellipta 200 mcg-62.5 mcg-25 mcg powder for inhalation 1 Time Daily for COPD, and order dated 12/2/24 for Oxygen - see notes Continuous: Oxygen (O2) at 3 L/min per nasal cannula Continuous.</p> <p>Review of Resident #180's care plan initiated 11/20/24 lacked evidence that goals and interventions were put into place for his/her respiratory needs.</p> <p>During an interview in presence of 4 surveyors on 12/9/24 at 2:21 p.m., with the Infection Preventionist (IP) indicated that she does care plans on date of admission, and she includes necessary documentation, states that the Minimum Data Set Coordinator (MDS) will let her know if she forgot something. At this time IP confirmed above findings.</p> <p>37440</p> <p>2. Resident #80 was admitted on [DATE] with diagnoses to include sleep apnea.</p> <p>Review of Resident #80's clinical record revealed active order dated 11/30/24 for CPAP (Continuous Positive Airway Pressure) 2 Times Daily 11/30/2024. If refuses CPAP, may use PRN order for oxygen at 2 LPM (Liters Per Minute) via nasal cannula. Oxygen - see notes PRN. If refuses CPAP use 2 LPM oxygen via nasal cannula during night time sleep hours.</p> <p>Review of Resident #80's baseline care plan, initiated 11/22/24, lacked evidence that goals and interventions were put into place for his/her respiratory needs.</p> <p>On 12/10/24 at 10:12 a.m., in an interview, the Quality Improvement Specialist confirmed that the baseline care plan lacked evidence that goals and interventions were put into place for his/her respiratory needs.</p> <p>(continued on next page)</p>		

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 12/11/2024
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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>37648</p> <p>3. Resident #23 was admitted on [DATE] with diagnosis of dementia with behavioral disturbance. Physician History and physical states resident has diagnosis of dementia with behavioral disturbances.</p> <p>Review of Residents #23's care plan initiated on 10/10/24 lacked evidence of goals and interventions were put into place for his/her dementia needs.</p> <p>On 12/9/24 at 2:01 p.m., the above was discussed with the [NAME] President of Clinical Operations.</p> <p>51331</p> <p>4. Resident #27 was admitted to the facility on [DATE] with the diagnosis' of Chronic heart failure, Chronic respiratory failure, hypertension, and Chronic obstructive pulmonary disease. Review of his/her clinical record lacked evidence of a baseline care plan being initiated.</p> <p>On 12/11/24 at 9:26 a.m., during an interview, the above information was confirmed with the Quality Improvement Specialist.</p>

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 12/11/2024
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531</p> <p>Based on observation, interview and family interview, the facility failed to provide dental care and dress a resident in clean clothes for 2 of 2 residents sampled for activities of daily living (ADL) (Resident's #7 & # 10).</p> <p>Findings:</p> <p>1. Resident 10 was admitted on [DATE] and has diagnoses to include dementia.</p> <p>Review of Minimum Data Set (MDS) dated revealed Resident #10 had a Brief Interview for Mental Status (BIMS) of 0 of 10 indicating he/she is not cognitively intact.</p> <p>During an initial tour of facility on 12/9/24 at 10:15 a.m., Resident #10 was observed walking down the hall with a family member, passing 4 other residents with an excessive amount of what appeared to be food/tartar build up on his/her teeth. At this time the family member indicated that he was bringing his mother/father to the dentist to have his/her teeth cleaned because they were really bad. Resident #10 returned to facility at approximately 12:25 p.m.</p> <p>Review of Resident 10 care plan updated 8/23/24 states: Problem: [Resident 10] requires extensive assistance with self-care secondary to dementia .</p> <p>Review of Resident 10's Activities of Daily Living (ADL) documentation from 12/1/24 through 12/10/24 on 12/10/24 at 2:55 p.m., Quality Improvement Specialist (QIP) confirmed Resident 10 was not receiving mouth care at least twice a day.</p> <p>During an interview on 12/10/24 at 1:11 p.m., Certified Nursing Assistant (CNA)2 indicated staff were supposed to do mouth care twice a day and document it in the Electronic Medical Record (EMR) CNA 2 further indicated Resident #10 never refuses care but is confused.</p> <p>During an observation on 12/11/24 at 8:30 a.m., Resident 10 was observed sitting in a chair across from the nursing station, with obvious food build up visible on the right side of his/her teeth.</p> <p>During an interview on 12/11/24 at 8:43 a.m., CNA3 indicated she was responsible for Resident 10 today and mouthcare is part of daily care, and it would be done when they get up and before they go to bed. At this time CNA 3 indicated that she did not brush Resident 10's teeth this morning, but did rinse his/her mouth out.</p> <p>During an observation on 12/11/24 at 8:54 a.m., a surveyor and QIS observed Resident 10's teeth and confirmed they were not brushed. At this time QIS assisted Resident 10 to his/her room to assist him/her with mouth care. During a follow-up interview at 9:09 a.m., QIS indicated that all she had to do was set up the toothbrush and toothpaste and Resident 10 was able to brush his/her teeth independently.</p> <p>2. Resident #7 was admitted on [DATE] and has diagnoses to include dementia.</p> <p>(continued on next page)</p>		

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 12/11/2024
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Minimum Data Set (MDS) dated revealed Resident #7 had a Brief Interview for Mental Status (BIMS) of 3 of 10 indicating severe cognitive impairment.</p> <p>Review of Resident #7's current care plan states: Problem: [Resident 7] requires extensive assistance with self-care secondary to dementia .</p> <p>On 12/9/24 at 9:56 a.m., a surveyor observed Resident #7 sitting in his/her wheelchair in her room. Resident #7 had black pants on and a red full sleeve sweater on which had dried food particles on the residence shirt and pants.</p> <p>On 12/9/24 at 11:48 a.m., a surveyor and CNA #1 observed Resident #7 lying in bed and CNA #1 stated Resident #7 refused to go to the dining room for lunch. A surveyor and CNA #1 observed dried food particles and on Resident #7's shirt and pants. When asked about the dirty clothes on Resident #7, CNA #1 confirmed at this time that it was a dignity issue and her clothes should have been changed in the morning after breakfast before she was laid down.</p> <p>On 12/10/24 at 10:20 a.m., the surveyor discussed the finding with the Quality Improvement Specialist who confirmed this was a dignity issue and Resident #7 shouldn't have been left in dirty clothes and put in bed.</p>

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 12/11/2024
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37648</p> <p>Based on facility policy, record review and interviews, the facility failed to adequately monitor a resident after an unwitnessed fall for 1 of 2 residents reviewed for falls (#5).</p> <p>Findings:</p> <p>The facilities Fall Management Policy, last revised 7/19 subsection D states, A fall incident report will be completed after a resident has had a fall, whether it is a witnessed or not, subsection E states, Complete Post Fall Observation tool, following a fall, to help identify if the cause of the fall is related to mental status changes, physical limitations or environmental factors and subsection F states, Documentation must be completed in the nurse's note on each shift X3 following the fall.</p> <p>The 'Neurological Assessment Policy, last revised 1/2019 states, Residents with suspected neurological compromise will have a neurological sign monitored and recorded for a minimum of 12 hours. Subsection III Procedures states A neurological assessment following resident head injury will be completed for all residents sustaining head trauma or suspected head trauma. In EMR: Neuro Checks will be conducted-every 15 minutes x4, every 30 minutes x4, every 1 hr. x4, every 4 hr. x2, and every 8 hr. x1. Frequency of neuro checks after 24 hours is determined by resident's observed signs and symptoms of neurological compromise.</p> <p>Resident #5 was admitted on [DATE] with a diagnosis of Dementia and has a Brief Interview of Mental Status (BIMS) score of 4, indicating severe cognitive impairment. Nurse documentation on 9/25/24 at 3:18 a. m., states, At approximately 2130 resident came to the nurses station in [his/her] wheelchair to self-report I fell in my bathroom, when asked how [he/she] got up resident states 'I pulled myself up with the bar', reported incident was unwitnessed and it's unknown if resident actually fell or not, resident is often confused at baseline related to dementia . resident states [he/she] has mild pain in her left knee . Further review of Resident #5's medical record lacked evidence of the facility completing a fall incident report, a post fall observation tool or continued monitoring of him/her for further injuries and/or neurological changes after the unwitnessed fall.</p> <p>On 12/10/24 at 10:08 a.m., during an interview, the Quality improvement Specialists confirmed the facility failed to complete the required documentation and further monitoring of Resident #5's unwitnessed fall.</p>		

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 12/11/2024
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>37440</p> <p>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 2 of 3 days of survey (12/9/24 and 12/11/24).</p> <p>Findings:</p> <p>The Safety Data Sheet for Rapid Multi Surface Disinfectant Cleaner noted the following: 4. First Aid Measures In case of eye contact: Rinse immediately with plenty of water, also under the eyelids, for at least 15 minutes. Remove contact lenses, if present and easy to do. Continue rinsing. Get medical attention immediately. In case of skin contact: Wash off immediately with plenty of water for at least 15 minutes. Wash clothing before reuse. Thoroughly clean shoes before reuse. Get medical attention immediately. If swallowed: Rinse mouth with water. Do not induce vomiting. Never give anything by mouth to an unconscious person. Get medical attention immediately. If inhaled: Remove to fresh air. Treat symptomatically. Get medical attention.</p> <p>The Safety Data Sheet for Enzymatic Foul Odor Digester noted the following: 4. First Aid Measures Eyes: Rinse with water for a few minutes. Consult physician if symptoms occur. Skin: Rinse with water. Consult physician if symptoms occur. Ingestion: Get medical attention if symptoms occur. Inhalation: Treat symptomatically.</p> <p>The Safety Data Sheet for Germs Be Gone Hand Sanitizer Gel noted the following: 4. First Aid Measures Danger. Flammable. May be harmful if swallowed. Causes serious eye irritation. Eyes: rinse cautiously with water for several minutes. Remove contact lenses if present and easy to do. Continue rinsing. If irritation persists, get medical attention. Skin: rinse with water. Ingestion: may be harmful if swallowed. Seek medical attention immediately. Inhalation: remove person to fresh air and keep comfortable for breathing. Call a poison center or a doctor if you feel unwell</p> <p>The Safety Data Sheet for GelRite Instant Hand Sanitizer (with vitamin E) noted the following: 4. First Aid Measures Skin contact: If skin irritation develops, stop use and consult a physician. Skin absorption: If exposed to large quantities as in a spill, removed clothing and wash skin with soap and water. Eye Contact: Flush eyes with clear running water for 15 minutes. If irritation persists, seek medical attention. Inhalation: If exposed to large amounts of vapor as in large spills, watch for signs of intoxication and move to fresh air. Ingestion: If swallowed, rinse mouth with water, get medical attention.</p> <p>On 12/9/24 at 10:00 a.m., a surveyor observed in the unlocked soiled utility room a 12 fluid ounce bottle of Rapid Multi Surface Disinfectant Cleaner, a 12 fluid ounce bottle of Enzymatic Foul Odor Digester, a 16 fluid ounce bottle of Germs Be Gone Hand Sanitizer Gel and two 16 fluid ounce bottles of GelRite Instant Hand Sanitizer with vitamin E.</p> <p>(continued on next page)</p>		

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 12/11/2024
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 12/9/24 at 10:14 a.m., in an interview with the Acting Director of Nursing and Infection Preventionist confirmed the chemicals were not stored safely behind a locked door. When asked if the facility had confused, compromised and vulnerable residents that can move around the facility, she answered yes.</p> <p>On 12/11/24 at 10:00 a.m., a surveyor observed in the unlocked soiled utility room a 12 fluid ounce bottle of Rapid Multi Surface Disinfectant Cleaner.</p> <p>On 12/11/24 at 10:05 a.m., in an interview, the Quality Improvement Specialist confirmed the finding.</p>		

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 12/11/2024
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531</p> <p>Based on observations, record reviews, and interviews, policy review, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to respiratory care for 2 of 3 residents reviewed for respiratory care (Resident's #14, and #180). In addition, the facility failed to follow provider orders for 2 of 3 residents reviewed for respiratory care. (Resident 's #80 & #180)</p> <p>Findings:</p> <p>Review of facility policy CPAP/BIPAP/AVAP Management dated 8/6/24 states .keep out of direct sunlight. Store in clean zip lock or string-tie plastic bag. The storage bag should be changed weekly .</p> <p>1. Resident 180 was admitted on [DATE] with diagnoses to include chronic obstructive pulmonary disease (COPD), respiratory failure, anxiety, and shortness of breath.</p> <p>Observations of Resident #180 on 12/9/24 at 10:20 a.m., and 2:28 p.m., and 12/10/24 at 10:25 a.m., a nebulizer was observed on bedside table with tubing connected to mask lying on top of table not bagged. Resident #180 states he/she has not used it in a couple of days.</p> <p>Review of Resident 180's clinical record revealed active order dated 11/20/24 for Trelegy Ellipta 200 mcg-62.5 mcg-25 mcg powder for inhalation 1 Time Daily for COPD.</p> <p>On 12/9/24 10:40 a.m., During an observation of Resident #180 with Acting Director of Nursing/Infection Preventionist (DON/IP) confirmed nebulizer tubing should be bagged when not in use. At this time IP retrieved a bag and was observed placing nebulizer tubing in bag. At this time DON/IP indicated the facility follows the same policy for all respiratory equipment.</p> <p>During an observation with 2 surveyors on 12/10/24 at 10:27 a.m., Quality Improvement Specialist (QIP) confirmed Resident #180's nebulizer was not bagged.</p> <p>On 12/9/24 at 10:20 a.m., and 2:28 p.m., and 12/10/24 at 10:25 a.m., Resident #180 was observed in a wheelchair with oxygen concentrator running continuous at 1.5 liters per minute (lpm) via nasal cannula.</p> <p>Review of Resident #180's clinical record revealed order dated 12/2/24 for Oxygen - see notes Continuous: Oxygen (O2) at 3 L/min per nasal cannula Continuous.</p> <p>During an observation with 2 surveyors on 12/10/24 at 10:27 a.m., Quality Improvement Specialist (QIP) confirmed Resident #180's oxygen was set at 1.5 liters per minute.</p> <p>51669</p> <p>2. Resident #14 was admitted has diagnoses to include chronic obstructive pulmonary disease (COPD), asthma, heart failure, chest pain, hypoxemia, obstructive sleep apnea, and wheezing.</p> <p>(continued on next page)</p>

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 12/11/2024
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident #14's clinical record revealed an active order, dated 5/31/24, for Oxygen (O2) at 3L/min per nasal cannula continuous.</p> <p>A review of Resident #14's care plan, updated 9/19/24, revealed, Problems: HOSPICE/PAIN/RESPIRATORY DISTRESS: .Dx end stage COPD w/ oxygen dependence .Interventions: Oxygen will be delivered via nasal cannula .Oxygen per MD orders .</p> <p>On 12/9/24 at 9:43 a.m. and on 12/10/24 at 10:32 a.m., Resident #14 was observed lying in bed receiving continuous oxygen via a nasal cannula that was connected to an oxygen concentrator, with the oxygen flow rate set to 2.5 liters (L) per minute.</p> <p>During an observation with a surveyor on 12/10/24 at 10:39 a.m., the Quality Improvement Specialist (QIS) confirmed that Resident #14's oxygen concentrator was set at 2.5 liters per minute.</p> <p>37440</p> <p>3. Resident #80 was admitted on [DATE] with diagnoses to include sleep apnea.</p> <p>Review of Resident #80's clinical record revealed active order dated 11/30/24 for CPAP (Continuous Positive Airway Pressure) 2 Times Daily 11/30/2024. If refuses CPAP, may use PRN order for oxygen at 2 LPM (Liters Per Minute) via nasal cannula. Oxygen - see notes PRN. If refuses CPAP use 2 LPM oxygen via nasal cannula during night time sleep hours.</p> <p>On 12/9/24 at 10:28 a.m., a surveyor observed Resident #80's CPAP machine stored on the nightstand and the face mask was stored in the open top drawer of the nightstand and was not bagged.</p> <p>On 12/9/24 at 10:40 a.m., in an observation with a surveyor and interview, the Acting Director of Nursing/Infection Preventionist (DON/IP) confirmed that Resident #80's CPAP face mask was stored inappropriately and should be bagged when not in use.</p>		

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 12/11/2024
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 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>37648</p> <p>Based on medical record review and interview the facility failed to ensure that a resident's drug regimen was free from unnecessary drugs by administering doses of Insulin outside of the physician order parameters and failed to follow the care plan in the area of nutrition for 1 of 5 reviewed for unnecessary medications (#5).</p> <p>Finding:</p> <p>Resident #5's current Physician orders contained an order, dated 9/7/23 for Novolog Insulin 100 unit/mL (milliliter) give 6 units subcutaneous three times daily for type 2 Diabetes Mellitus with Diabetic Polyneuropathy with Instructions to Hold for Blood sugar less than 110.</p> <p>Review of the Electronic Medication Administration Record (EMAR) for October 2024 states, nursing administered Novolog insulin, 6 units on 10/13/24 with a documented blood sugar of 100 and on 10/16/24 with a blood sugar of 98. The EMAR for November 2024 states, nursing administered Novolog insulin, 6 units on 11/9/24 with documented blood sugar of 109. In December 2024, nursing administered Novolog insulin, 6 units on 12/1/24 with a blood sugar of 108 and on 12/7/24 with a blood sugar of 96.</p> <p>Resident #5's nutrition care plan initiated on 7/1/24 with a goal of [resident] will not experience any complications related to Diabetes over the next 90 days, with an intervention instructing nursing to Medications and treatments per physician orders</p> <p>On 12/10/24 at 10:52 a.m., during an interview, the Quality Improvement Specialists reviewed the EMAR for October, November and December and confirmed nursing failed to follow physician orders and the care plan by administering excessive doses of NovoLog insulin outside of parameters.</p>

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 12/11/2024
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>42531</p> <p>Based on observation and interview the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for the hood system, 2 wall air conditioning units, a floor fan, a grease trap cover and the ceiling grid hangers for 1 of 1 tour.</p> <p>On 12/9/24 from 9:05 a.m. to 9:35 a.m., an initial kitchen tour was completed with the Food Service Director in which the following findings were observed:</p> <ul style="list-style-type: none"> - The hood system filers was dusty/dirty. - The wall air conditioning unit and the wall above it, by the 3-bay pot sink, were dusty/dirty. Also, the wall below the air conditioning unit was soiled with dried liquid residue. - The wall air conditioning unit and the wall above it, in the dish room, was dusty/dirty. - The ceiling grid hangers were rusty and stained a yellowish color throughout the kitchen. - The floor fan was dusty/dirty. -The grease trap lid had chipped/missing paint creating an uncleanable surface. <p>On 12/9/24 at 9:35 a.m., in an interview, the Food Service Director confirmed the findings.</p>

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 12/11/2024
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 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>37648</p> <p>Based on record review and interviews, the facility's Quality Assurance Committee failed to ensure that the Plan of Correction for identified deficiencies from the Annual Long Term Care Survey Process for Federal Recertification dated 12/11/24, were effective. The Federal citations F684, and F757 were cited again during the re-visit to the annual Long Term Care Recertification Survey, dated 2/5/25.</p> <p>Finding:</p> <p>1. During the follow-up survey on 2/5/25, it was determined that F684 and F757 would be recited for the same reasons: F684 for failure to document and adequately monitor a resident after an unwitnessed fall and F757 for failure to ensure that a resident's drug regimen was free from unnecessary medications (see F684 and F747).</p> <p>On 2/5/25 at 3:20 p.m., during and interview, the above was confirmed with the [NAME] President of Quality Improvement and Nursing Services and the Director of Nursing.</p>

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 12/11/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531</p> <p>Based on observation and interview the facility failed to ensure food was served under sanitary conditions during 1 of 3 units observed during lunch meal (Cortland Unit).</p> <p>Findings:</p> <p>Review of Infection Control: Standard Transmission Based Precautions Policy dated 9/18 states: Hand washing is the single most important seep in infection control. Hands must be washed before and after all resident contact .</p> <p>On 12/9/24 at 12:00 p.m., Licensed Practical Nurse (LPN) was observed coming out of room [ROOM NUMBER] holding a lunch tray. LPN was observed walking down the hall to kitchen utility cart located outside of room [ROOM NUMBER]. LPN then removed trash from the top of the lunch tray with bare hands and placed it in trash can. LPN then placed the lunch tray on the kitchen utility cart, walked past hand sanitizer located outside room [ROOM NUMBER], and proceeded to walk across the hall and into room [ROOM NUMBER] where she was observed to place her right bare hand on a resident's shoulder, and her left bare hand on the side table located over the bed. LPN then walked out of the room and directly to the lunch cart located outside of the room, opened it with her left hand and reached in to obtain another lunch tray. At this time a surveyor intervened, and LPN confirmed she did not sanitize her hands in between resident contact.</p> <p>During an interview on 12/9/24 at 12:05 p.m., Acting Director of Nursing/Infection Preventionist (DON/IP) stated it was her expectation that staff sanitize their hands before and after resident contact. At this time the above was discussed with DON/IP.</p>

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 12/11/2024
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 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement a program that monitors antibiotic use.</p> <p>37648</p> <p>Based on facility policy, record reviews, and interviews, the facility failed to implement its Antibiotic Stewardship Program (ASP) that includes antibiotic use protocols and a system to monitor antibiotic use. This has the potential to affect all residents receiving an antibiotic.</p> <p>Findings:</p> <p>Review of the facility policy Antibiotic Stewardship Program last revised on 8/24 states .To improve antibiotic use are expected to reduce adverse events, prevent emergence of resistance and lead to better outcomes for residents . Infection Preventionist: Monitors and supports antibiotic activities through rounds, review of providers orders, documentation, and available reports. Tracks antibiotic therapy through use of line listings and pharmacy report. Reviews antibiotic resistance patterns: Monitors HAI (Heath care Acquired Infections) and MDRO's (multi-drug resistant organisms) on Monthly Line listings and Infection Control Report looking for increased rates or trends and under Tracking/Reporting: Monitoring measures of antibiotics use by auditing available reports and resident medical records, monitoring if cultures are obtained before antibiotics are initiated . and monitor rates of new antibiotic starts/1,000 resident days through use of line list or [pharmacy report.</p> <p>1. Review of the facility provided Safety Meeting, Infection Control Report revealed the following:</p> <p>-During the month of 9/12/2024, there were 5 documented facility acquired infections that were prescribed antibiotics.</p> <p>-During the month of 10/10/2024, there were 6 documented facility acquired infections that were prescribed antibiotics.</p> <p>-During the month of 11/21/2024, there were 4 documented facility acquired infections that were prescribed antibiotics.</p> <p>2. Review of the facility provided Quality Assurance & Performance Improvement Pharmacy quarterly reports for Quarter #4 dated 12/23, Quarter #1 dated 3/24, and Quarter #2 dated 6/24, and Quarter #3 dated 9/24, section VIII is the Antibiotic/Antimicrobial Stewardship Discussion. Further review showed the quarterly reports lacked a section VIII failing to provide evidence that the pharmacist/facility reviewed antibiotic use and/or Antibiotic Stewardship program during these meetings.</p> <p>On 12/10/24 at 2:38 p.m., during an interview, the Infection Preventionist, Acting Director of Nursing confirmed the facility does have a lot of frequent urinary track infection's which required antibiotics and that for the most part the physician would review culture results to ensure the correct antibiotic was being prescribed but she has not implemented any tracking systems to identify trends and antibiotic use. In addition, she stated she does not review the monthly pharmacy antibiotic report.</p>		

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 12/11/2024
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 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>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.</p> <p>37648</p> <p>Based on review of the facility's Infection Control Immunizations - Influenza, Pneumococcal, COVID and Employee Immunization/Vaccination Requirements policy and procedures and interviews the facility failed to develop and implement policy and procedure to ensure all staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine or information on obtaining COVID-19 vaccine. This has the potential to effect all employees.</p> <p>Findings:</p> <p>Review of the Infection Control Immunizations - Influenza, Pneumococcal, COVID policy, last revised on 12/24, and the Employee Immunization/Vaccination Requirements policy, last revised on 9/5/23 failed to include procedures relating to staff education regarding the benefits and potential risks associated with COVID-19 vaccine or information on obtaining COVID-19 vaccine.</p> <p>1. On 12/10/24 at 2:38 p.m., during an interview, the Infection Preventionist confirmed that staff are not provided education regarding the benefits and potential risks associated with COVID-19 vaccine, stating, No, I haven't since last year, In addition, she confirmed that there is no information relating to COVID-19 in the new employee packet.</p> <p>51331</p> <p>2. On 12/11/24 at 7:50 a.m., during an interview with the Maintenance Director, he states that he has not recieved education on the COVID Spikevax within the past year.</p> <p>3. On 12/11/24 at 7:55 a.m., during an interview with the Licensed Pratical Nurse, who states she has not received education on the COVID spikevax within the past year.</p> <p>4. On 12/11/24 at 8:00 a.m., during an interview with the facilities [NAME] Clerk, she discussd that she has never received education on the COVID spikevax.</p>		