Genesis

August 4, 2023

Ms. Celine Donohue, RN Long term Care Supervisor

Maine Department of Health and Human Services

Division of Licensing and Certification

11 State House Station

Augusta, Maine 04333-0011

Dear Ms. Donohue:

In follow up to the recent complaint survey at Sandy River Center conducted on July 10, July 11 and July 20, 2023, please accept the attached Plan of Correction. All deficiencies will be corrected by August 25, 2023. Please do not hesitate to contact me with any follow up questions at 207-779-6591 x2205.

Sincerely,

Joanne M. Shaw, MSM, LNHA

Administrator, Sandy River Center

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205069	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY RIVER CENTER	**119 LIVERMORE FALLS RD FARMINGTON, ME 04938**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 7/10/23, 7/11/23, and 7/20/23, unannounced visits were conducted at Sandy River Center for the purpose of completing the investigation for complaints #ME00044087 and #ME00044270. It was determined that Sandy River Center was not in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000	Sandy River provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed as evidence of the facility's continued compliance with state and federal regulations	08/25/2023
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to administer physician ordered medications to 1 of 2 sampled residents (Resident #2). Finding: On 7/10/23 and 7/11/23, Resident #2's clinical record was reviewed which included Medication/Treatment Administration Records and Nursing Progress notes for May and June 2023. The following were observed: On 5/3/23 at 08:21 a.m., it was documented that an anti-depressant medication, Duloxetine HCl	F 684	Resident #2 was discharged on 06/20/2023. An audit of resident medication records and medication carts was completed to validate those medications ordered by the MD are available for administration. The facility ensures that residents receive treatment and care in accordance with professional standards inclusive of following MD orders. The facility has emergency medications available for those residents who's medications are awaiting delivery from the pharmacy. The facility staff do notify MD of those medications not available for further instruction. Facility licensed staff will be re-educated to these processes. DNS/Designee will complete M-F audits x 4 weeks then weekly x 4 weeks, and then monthly x 3 months to validate medication are given as ordered and/or process followed for notification to MD for further instruction for those medications not available. The results of these audits will be brought to the monthly QAPI Committee for further	

			review and recommendations.	

Joanne Shaw administrator 8/4/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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.

PRINTED: 08/01/2023 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205069	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY RIVER CENTER	119 LIVERMORE FALLS RD FARMINGTON, ME 04938

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 684	Continued From page 1 Oral Capsule Delayed Release Particles 40 milligrams (MG) was not given because the medication was on order. On 5/4/23 at 5:31 p.m., it was documented that an anti-depressant medication, Duloxetine HCl Oral Capsule Delayed Release Particles 40 MG was not given because the medication was not available. On 5/6/23 at 10:40 a.m., it was documented that an anti-depressant medication, Duloxetine HCl Oral Capsule Delayed Release Particles 40 MG was not given because the medication was on order from pharmacy. On 5/8/23 at 8:59 a.m., it was documented that an anti-depressant medication, Duloxetine HCl Oral Capsule Delayed Release Particles 40 MG was not given because the medication was on order. On 5/26/23 at 3:56 p.m., it was documented that a anticoagulant medication used to prevent strokes or blood clots, Apixaban (Eliquis) 5 MG was not given because it was on order. On 5/26/23 at 3:58 p.m., it was documented that a medication used to treat high cholesterol, Atorvastatin 80 MG was not given because it was on order. On 6/11/23 at 3:28 p.m., it was documented that an anti-psychotic medication, Seroquel (Quetiapine Fumarate) 25 MG was not given because it was on order. On 6/15/23 at 8:50 a.m., it was documented that an anti-depressant medication, Duloxetine HCl	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205069	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY RIVER CENTER	119 LIVERMORE FALLS RD FARMINGTON, ME 04938

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET ION DATE
F 684	Continued From page 2 Oral Capsule Delayed Release Particles 40 MG was not given because it was on order. On 6/16/23 at 9:42 a.m., it was documented that an anti-depressant medication, Duloxetine HCl Oral Capsule Delayed Release Particles 40 MG was not given because it was on order. On 6/16//23 at 5:02 p.m., it was documented that a medication used to treat high cholesterol, Atorvastatin 80 MG was not given because it was on order. On 6/19/23 at 8:12 p.m., it was documented that a medication used to treat diabetes, Basaglar KwickPen Solution insulin (Lantus) was not given because it was on order. On 7/11/23 between 11:30 a.m. - 12:00 p.m., during an interview with a surveyor, the Director of Nursing stated that some of those medications are included in the Emergency Stock (OMNIcell) Inventory and should have been gotten from there. A list was provided to the surveyor and upon review the following medications listed above were included in the Emergency stock: Lantus insulin, Eliquis 5 MG, Quetiapine Fumarate 25 MG and Atorvastatin 80 MG. The Consultant Pharmacist was also present and information was provided that indicated that a delivery of Duloxetine 20 MG was received on 4/24/23. The surveyor confirmed that	F 684		
F 689 SS=D	medications were not administered as ordered by the physician. Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205069	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY RIVER CENTER	**119 LIVERMORE FALLS RD FARMINGTON, ME 04938**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 3 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to re-evaluate a resident for an elopement risk and removed a physician ordered wander guard bracelet for 1 of 1 residents reviewed that attempted elopement (Resident #2). Finding: On 7/10/23, a surveyor reviewed Resident #2's clinical record. The electronic record included a progress note, dated 5/14/23 at 10:54 a.m. written by Licensed Practical Nurse (LPN) #1 that indicated, "at around 7:30 a.m., pt (resident) attempted to elope from facility stating he/she was going home. Per previous shift nurse, Resident has not been taking medications in the evenings for a few days. Wander guard placed for safety." LPN #1 left notification for the Medical Provider. Included in the paper chart was a "Provider Notification" for Resident #2 with a message "attempting to elope.....please eval." It was also written by LPN #1 that a "wander guard" was placed and family was notified. This was signed by the Family Nurse Practitioner (FNP) on 5/15/23, with the response "OK".	F 689	Resident #2 was discharged on 06/20/2023. An audit of resident records was completed to validate those identified as an elopement risk have appropriate interventions to reduce risk and minimize injury. Patients/Residents (hereinafter "patient") will be evaluated for elopement risk upon admission, re-admission, quarterly, and with a change in condition as part of the clinical assessment process. Those determined to be at risk will receive appropriate interventions to reduce risk and minimize injury. The facility also completes security systems checks routinely to ensure the function of wander systems, trigger bracelets, and door alarms. Facility licensed staff and IDT will be re-educated to this process. DNS/Designee will complete random weekly audits x 4 weeks, then biweekly x 1 month, then monthly times 3 months of resident records to validate those identified as an elopement risk have appropriate interventions to reduce risk and minimize injury. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	08/25/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205069	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY RIVER CENTER	119 LIVERMORE FALLS RD FARMINGTON, ME 04938

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 4 On 7/11/23 at 7:30 a.m., during an interview with a surveyor regarding Resident #2's attempted elopement May 14th (Sunday), the Family Nurse Practitioner (FNP) stated that the window was open in the common area and Resident #2 was at it. Staff redirected Resident #2 and then the resident kept rolling up to the front door. A wander guard was placed on him/her at that time and notified the family regarding his/her behaviors. The FNP stated that she did some medication adjustments also. On 7/11/23 at approximately 8:00 a.m., the surveyor asked the Director of Nursing (DON) about an elopement care plan or an elopement assessment after this incident, neither of which the surveyor could find. The surveyor showed the DON the "Provider Notification" that indicated that the wander guard had been placed after Resident #2 attempted to leave. The DON stated that there was a wander (guard) bracelet placed on Resident but she talked about it with others on (5/15/23) Monday and removed it because she felt she wasn't an elopement risk. The surveyor explained to the DON that there were no notes/assessment completed that indicated that Resident #2 was not an elopement risk after this incident and no order to discontinue the wander guard order that the FNP just signed on that day. The DON stated she didn't write any notes about the removal of the wander guard and she didn't realize that there was an order for the wander guard signed by the FNP. On 7/11/23 at approximately 1:30 p.m., the surveyor reviewed the Skilled Nursing Facility (SNF)/Nursing Facility (NF) to Hospital Transfer Form and the eINTERACT Transfer Form V5 for a hospital transfer for Resident #2 on 6/20/23.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205069	A. BUILDING _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY RIVER CENTER	**119 LIVERMORE FALLS RD FARMINGTON, ME 04938**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 5 These forms were completed by LPN #2. The following was noted: SNF/NF to Hospital Transfer Form - Risk Alerts: "May attempt to exit" was checked and on the eINTERACT Transfer Form V5 section 5-13: Are there any additional risks present? It was noted that the box for e. was checked for "May attempt exit". On 7/11/23 at 1:35 p.m., surveyor confirmed with the DON that in addition to the physician order for the use of the wander guard that was signed on 5/15/23, that on 6/20/23, staff documented on the transfer forms that Resident #2 was an elopement risk when they indicated that the resident "may attempt to exit."	F 689		

Department of Health and Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205069	A. BUILDING: _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY RIVER CENTER	119 LIVERMORE FALLS RD FARMINGTON, ME 04938

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE

T 001	Initial Comments On 7/10/23, 7/11/23, and 7/20/23, unannounced visits were conducted at Sandy River Center for the purpose of completing the investigation for complaints #ME00044087 and #ME00044270. It was determined Sandy River Center was not in substantial compliance with 10-144 Chapter 110 - Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities.			08/25/2023
T 222	9.A.4. Minimum Staffing Rules The nursing staff-to-resident ratio is the number of nursing staff to the number of occupied beds. Nursing assistants in training shall not be counted in the ratios. The minimum nursing staff-to-resident ratio shall not be less than the following: a. On the day shift, one direct-care provider for every 5 residents; b. On the evening shift, one direct-care provider for every 10 residents; and c. On the night shift, one direct-care provider for every 15 residents The definition of direct care providers and direct care is found in Chapter 1 of these Regulations. This Regulation is not met as evidenced by: Based on review of staffing schedules, daily census, and interviews, the facility failed to		The facility will continue to schedule direct care staff to meet the care needs of the residents. This includes meeting the State of Maine staffing ratio minimums (Day Shift 1staff:5 residents, Evening Shift 1staff:10 residents. Night Shift 1 staff: 15 residents). The days that staff call out sick, on-call nursing management staff will be available to cover direct care staff shifts to meet the needs of the facility while meeting the staff-to-resident ratios outlined for State of Maine minimum staffing requirements. The facility will also utilize non nursing managerial staff to assist in tasks, that are within their scope of practice, to adjunct the needs of residents. The facility secures sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population. The minimum nursing staff-to-resident ratio shall not be less than the following:	

Joanne M Shaw administrator 8/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____	(X3) DATE SURVEY COMPLETED C

	205069	B. WING _____	07/20/2023

NAME OF PROVIDER OR SUPPLIER

SANDY RIVER CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

119 LIVERMORE FALLS RD

FARMINGTON, ME 04938

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 222	Continued From page 1 ensure staffing minimums were met in accordance to the "State of Maine Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities," Chapter 9.A.4.A., for 5 of 5 day shifts reviewed between 6/16/23 - 6/20/23, 17 of 20 day shifts reviewed between 7/1/23 - 7/20/23. Findings: The "State of Maine Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities," Chapter 9.A.4.A., indicates the minimum nursing staff-to-resident ratio shall not be less than one direct care provider for every 5 residents on the day shift; not be less than one direct care provider for every 10 residents on the evening shift, and not be less than one direct care provider for every 15 residents on the night shift. "Direct Care" means hands-on care provided to residents, including, but not limited to feeding, bathing, toileting, dressing, lifting, moving residents, treatments, and medication administration per the definition in Chapter 1 of the regulations. On 5/1/23, the facility census was 75, which would require 15 direct care staff on duty during the day shift. The facility had 15 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 5/2/23, the facility census was 75, which would require 15 direct care staff on duty during the day shift. The facility had 13 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 5/3/23, the facility census was 75, which	T 222	On the day shift, one direct-care provider for every 5 residents, on the evening shift, one direct-care provider for every 10 residents, and on the night shift, one direct-care provider for every 15 residents. Facility staff responsible for the scheduling of direct care staff will be re-educated to this process. The CNE/Designee will audit staffing sheets daily to validate sufficient direct care staff are scheduled to meet the needs of the residents and the State of Maine minimum nursing staff -to-resident ratios. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	08/25 /23

PRINTED: 08/01/2023
FORM APPROVED

Department of Health and Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205069	A. BUILDING: _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY RIVER CENTER	119 LIVERMORE FALLS RD FARMINGTON, ME 04938

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE

T 222	Continued From page 2 would require 15 direct care staff on duty during the day shift. The facility had 13 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 5/4/23, the facility census was 77, which would require 16 direct care staff on duty during the day shift. The facility had 12 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 5/6/23, the facility census was 74, which would require 15 direct care staff on duty during the day shift. The facility had 14 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 5/7/23, the facility census was 74, which would require 15 direct care staff on duty during the day shift. The facility had 13 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 5/8/23, the facility census was 75, which would require 15 direct care staff on duty during the day shift. The facility had 11 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 5/9/23, the facility census was 72, which would require 15 direct care staff on duty during the day shift. The facility had 11 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 5/10/23, the facility census was 72, which would require 15 direct care staff on duty during the day shift. The facility had 11 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m.	T 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205069	A. BUILDING: _____ B. WING _____	C 07/20/2023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 222	Continued From page 3 On 5/11/23, the facility census was 70, which would require 14 direct care staff on duty during the day shift. The facility had 11 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 5/12/23, the facility census was 70, which would require 14 direct care staff on duty during the day shift. The facility had 12 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 5/14/23, the facility census was 69, which would require 14 direct care staff on duty during the day shift. The facility had 11 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 5/15/23, the facility census was 69, which would require 14 direct care staff on duty during the day shift. The facility had 11 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 5/16/23, the facility census was 69, which would require 14 direct care staff on duty during the day shift. The facility had 10 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 5/17/23, the facility census was 69, which would require 14 direct care staff on duty during the day shift. The facility had 10 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 5/18/23, the facility census was 68, which would require 14 direct care staff on duty during the day shift. The facility had 11 direct care staff	T 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205069	A. BUILDING: _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY RIVER CENTER	119 LIVERMORE FALLS RD FARMINGTON, ME 04938

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 222	Continued From page 4 on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 5/19/23, the facility census was 66, which would require 14 direct care staff on duty during the day shift. The facility had 10 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 5/20/23, the facility census was 66, which would require 14 direct care staff on duty during the day shift. The facility had 12 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 5/21/23, the facility census was 64, which would require 13 direct care staff on duty during the day shift. The facility had 11 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 5/22/23, the facility census was 62, which would require 13 direct care staff on duty during the day shift. The facility had 11 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 5/23/23, the facility census was 64, which would require 13 direct care staff on duty during the day shift. The facility had 8 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 5/24/23, the facility census was 64, which would require 13 direct care staff on duty during the day shift. The facility had 9 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m.	T 222		

	On 5/25/23, the facility census was 64, which			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205069	A. BUILDING: _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY RIVER CENTER	119 LIVERMORE FALLS RD FARMINGTON, ME 04938

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE

T 222	Continued From page 5 would require 13 direct care staff on duty during the day shift. The facility had 10 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 5/26/23, the facility census was 64, which would require 13 direct care staff on duty during the day shift. The facility had 8 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 5/28/23, the facility census was 64, which would require 13 direct care staff on duty during the day shift. The facility had 11 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 5/29/23, the facility census was 65, which would require 13 direct care staff on duty during the day shift. The facility had 11 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 5/30/23, the facility census was 66, which would require 14 direct care staff on duty during the day shift. The facility had 9 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 5/30/23, the facility census was 69, which would require 14 direct care staff on duty during the day shift. The facility had 10 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 7/11/23 at 2:00 p.m., in an interview with the Director of Nursing (DON), she confirmed that the facility did not meet the State minimum staff to resident ratio.	T 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205069	A. BUILDING: _____ B. WING _____	C 07/20/2023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 222	Continued From page 6 On 7/10/23 at 2:21 p.m. - a surveyor asked the Upper Level Unit Manager (NUM2) if she worked the floor. NUM2 stated that she does not typically work the floor. On 7/10/23 at 2:30 p.m., a surveyor asked the MDS Nurse (CCR1) if she worked the floor. She responded that she does not work the floor. On 7/10/23 at 2:37 p.m., a surveyor asked the Lower Level Unit Manager NUMD if she worked the floor. She stated she does not typically work the floor but will help when needed. If she is scheduled to work the floor she is listed on schedule as licensed staff. On 7/10/23 at 2:40 p.m., a surveyor asked the Wound Nurse (TLSH) if she worked the floor. She responded that this was a new per diem role and she is still learning. She does work the floor doing wound care and documentation and education. Certain residents have wound care on certain days. Surveyor asked what education was, and she stated for herself. On 7/11/23 at 9:20 a.m., during an interview with a surveyor, the Scheduler stated that the facility's day shift is 6 a.m. to 2 p.m. During this interview, the facility's staffing schedules and daily census were reviewed and the following was confirmed during this review: On 6/16/23, the facility census was 77, which would require 16 direct care staff on duty during the day shift. The facility had 10 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 6/17/23, the facility census was 77, which would require 16 direct care staff on duty during the day shift. The facility had 9 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m.	T 222		

Department of Health and Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205069	A. BUILDING: _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY RIVER CENTER	119 LIVERMORE FALLS RD FARMINGTON, ME 04938

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE

T 222	Continued From page 7 On 6/18/23, the facility census was 76, which would require 16 direct care staff on duty during the day shift. The facility had 10 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 6/19/23, the facility census was 74, which would require 15 direct care staff on duty during the day shift. The facility had 8 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 6/20/23, the facility census was 76, which would require 16 direct care staff on duty during the day shift. The facility had 10 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 7/1/23, the facility census was 74, which would require 15 direct care staff on duty during the day shift. The facility had 10 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 7/2/23, the facility census was 73, which would require 15 direct care staff on duty during the day shift. The facility had 11 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 7/3/23, the facility census was 74, which would require 15 direct care staff on duty during the day shift. The facility had 9 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 7/4/23, the facility census was 73, which would require 15 direct care staff on duty during the day shift. The facility had 10 direct care staff	T 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205069	A. BUILDING: _____ B. WING _____	C 07/20/2023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 222	Continued From page 8 on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 7/5/23, the facility census was 73, which would require 15 direct care staff on duty during the day shift. The facility had 11 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 7/6/23, the facility census was 72, which would require 15 direct care staff on duty during the day shift. The facility had 10 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 7/7/23, the facility census was 73, which would require 15 direct care staff on duty during the day shift. The facility had 11 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 7/8/23, the facility census was 72, which would require 15 direct care staff on duty during the day shift. The facility had 12 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 7/9/23, the facility census was 72, which would require 15 direct care staff on duty during the day shift. The facility had 10 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 7/10/23, the facility census was 72, which would require 15 direct care staff on duty during the day shift. The facility had 10 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 7/13/23, the facility census was 72, which would require 14 direct care staff on duty during	T 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205069	A. BUILDING: _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY RIVER CENTER	119 LIVERMORE FALLS RD FARMINGTON, ME 04938

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 222	Continued From page 9 the day shift. The facility had 12 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 7/15/23, the facility census was 73, which would require 15 direct care staff on duty during the day shift. The facility had 11.5 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 7/16/23, the facility census was 73, which would require 15 direct care staff on duty during the day shift. The facility had 11.5 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 7/17/23, the facility census was 75, which would require 15 direct care staff on duty during the day shift. The facility had 13 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 7/18/23, the facility census was 76, which would require 15 direct care staff on duty during the day shift. The facility had 12 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 7/19/23, the facility census was 80, which would require 16 direct care staff on duty during the day shift. The facility had 13 direct care staff on the floor for the entire shift between 6:00 a.m. and 2:00 p.m. On 7/20/23, the facility census was 81, which would require 16 direct care staff on duty during the day shift. The facility had 12 direct care staff on the floor for the entire shift	T 222		

	between 6:00 a.m. and 2:00 p.m.			

Department of Health and Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205069	A. BUILDING: _____ B. WING _____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY RIVER CENTER	119 LIVERMORE FALLS RD FARMINGTON, ME 04938

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE

T 222 T 400	Continued From page 10 On 7/20/23 at 3:15 p.m., the surveyor discussed with the Administrator and the Director of Nursing, that from 7/11/23 through 7/20/23, minimum staffing ratios had not been met on the day shift, even when management staff were included. 16.A.5. Physician Services The physician must visit the resident and review the resident's total program of care including medications and treatments as needed, at least once every thirty (30) days for the first ninety (90) days and every sixty (60) days thereafter. A grace period of ten (10) days may be allowed for the resident whose condition during this period of time did not require medical attention. This Regulation is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure the physician reviewed the resident's total program of care, which included signing orders for medications and treatments listed on the Order Summary Report (Physician block orders) in a timely manner for 3 of 5 sampled residents (Resident #1, #2, and #3). Findings: 1. On 7/10/23, Resident #1's clinical record was reviewed. Documentation in Resident #1's clinical record indicated that the Physician signed the Physician Block Orders Sheet on 1/13/23. These orders were good for 60 days with the next Physician Order Sheet to be signed due by 3/26/23 (including 10 day grace period), now 51 days overdue including the grace period. There were no newer block orders signed in the clinical	T 222 T 400	Resident#1 discharged on 05/27/2023. Resident #2 discharged on 06/20/2023. Resident #3 discharged on 07/21/2023. An audit of resident records was completed to validate the physician had visited the resident and reviewed the resident's total program of care including medications and treatments as needed, at least once every thirty (30) days for the first ninety (90) days and every sixty (60) days thereafter. The facility ensures that the MD/APP visit the resident and review the resident's total program of care including medications and treatments as needed, at least once every thirty (30) days for the first ninety (90) days and every sixty (60) days thereafter.Administrative staff including attending providers will be re-educated to this process. DNS/Designee will complete random checks of resident records to ensure the provider visited the resident and completed a review of the resident's total program. This includes review and signing of medication and treatments on the "order summary report" . These audits will be weekly x 4 weeks, biweekly x one month, and monthly times 3 months. Results of these audits will be brought to the Monthly QAPI Committee for further review and recommendations.	08/25/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C

NAME OF PROVIDER OR SUPPLIER

SANDY RIVER CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

119 LIVERMORE FALLS RD

FARMINGTON, ME 04938

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 400	Continued From page 11 record. On 7/10/23 at 2:00 p.m., in an interview with the surveyor, the Director of Nursing confirmed the MD Block orders had not been signed timely. 2. On 7/10/23, Resident #2's clinical record was reviewed. Documentation in Resident #2's clinical record indicated that the Physician signed the "Order Summary Report" (block orders) on 1/12/23. These orders were good for 60 days with the next "Order Summary Report" to be signed due by 3/25/23 (including 10 day grace period), now 52 days overdue including the grace period. There were no newer block orders signed in the clinical record. On 7/11/23 at 10:05 a.m., during an interview with a surveyor, the Director of Nursing confirmed she could not find any newer signed block orders and they had not been signed timely. 3. On 7/20/23, Resident #3's clinical record was reviewed. Documentation in Resident #3's clinical record indicated Resident #3 was admitted to the facility from the hospital on 7/5/23. The clinical record indicated the physician examined Resident #3 on 7/7/23. A review of physician orders noted the physician failed to review and sign the hospital discharge summary and admission orders. In addition, there were no block orders found that had been signed in ink or electronically by the physician. On 7/20/23 at 3:15 p.m., in an interview with the Administrator and the Director of Nursing, the surveyor discussed that as of 7/20/23, none of Resident #3's physician orders had	T 400		

	been signed since admission on 7/5/23.			