STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205004	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hibbard Skilled Nursing & Rehabilitation Center	1037 West Main Street Dover Foxcroft, ME 04426

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 17282 Based on record review and interview, the facility failed to inform a resident representative that two new Stage II pressure ulcers were observed (Resident # 39 [R39]). Finding: On 7/9/24, R39's clinical record was reviewed. On 10/18/23, a nurses note indicated that there were two new open skin areas (Stage II pressure ulcers): one on R39's right buttocks/leg crease and one on the upper back side of the right leg. There was no evidence in the clinical record that R39's representative (son) was notified of the new pressure ulcer areas. On 07/10/24 at 7:42 a.m., in an interview with the surveyor, the Administrator confirmed that the son was never notified of the new two pressure ulcer.

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