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	08/27/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 33242 Based on record review, facility policies review, and interviews, the facility failed to ensure a clinical record contained complete and accurate information for 1 of 1 residents reviewed for a skin tear incident (Resident #1 [R1]). Finding: The facility's policy, Accidents & Incidents - Investigation and Reporting, revised 2/2022, indicated that all accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator. The Nurse Supervisor/ Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. The following data, as applicable, shall be included on the Report of Incident/Accident Form: - the date and time the accident or incident took place; - the nature of the injury/illness (bruise, fall, nausea, etc.); - the circumstances surrounding the accident or incident; - where the accident or incident took place; - the name(s) of witnesses and their accounts of the accident or incident; - the injured person's account of the accident or incident; - the time the injured persons attending physician was notified, as well as the time the physician responded and his or her instructions; - the condition of the injured person including his/her vital signs; - the disposition of the injured (transfer to hospital, put to , sent home, returned to work, etc.) (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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	08/27/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- any corrective action taken; - follow up information; - other pertinent data as necessary or required; what's going on now and - the signature and title of the person completing the report. The Nurse Supervisor/Charge Nurse and or the department director or supervisor shall complete a report of Incident/Accident form and submit the original to the Director of Nursing services within 24 hours of the accident or incident. The Director of Nursing shall ensure that the administrator receives a copy of the report of Incident/Accident form for each occurrence. Incident/Accident reports will be reviewed by the safety committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities The facility's policy, Wound Care, last reviewed on 2/2022, stated that the following information should be recorded in the resident's medical record to include: The type of wound care given, the date and time the wound care was given, All assessment data (wound bed color,size, drainage, etc.) obtained when inspecting the wound. On 8/26/24, R1's clinical record was reviewed and included a nurses note completed by Registered Nurse #1 (RN1) that indicated on 8/2/24 at 7:48 a.m., R1's Resident Representative was notified of a skin tear. The clinical record lacked evidence of an Accident/Incident report being completed. There was also a fax sent to the provider on 8/1/24 at 8:48 p.m., letting the provider know, Skin tear to right lower leg. Got caught on leg rest while transferring to bed with Certified Nursing Assistant (CNA1) and that a dressing was applied per standing order. On 8/26/24 at 12:45 p.m., during an interview with a surveyor, the Long Term Care (LTC) Unit Manager stated that the nurse would have wrote something in the computer under incidents and that information would transfer to the Incident Report; LTC Unit Manager was unable to find any documentation of the incident in the computer or information that described the skin tear wound. The surveyor confirmed there is no documentation of an Incident Report or wound that a dressing was applied to, at the time the incident occurred. On 8/26/24 at 1:05 p.m., during an interview with a surveyor, LTC Unit Manager stated she believed that a foot rest was on (the wheelchair) when the skin tear occurred and R1 tried to get up before staff could remove it. On 8/27/24 at 10:15 a.m., R1's clinical record was reviewed and included a (late) entry incident charting, dated 8/26/24 at 8:57 p.m., completed by RN1, regarding the skin tear incident that occurred on 8/2/24. (continued on next page)

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	08/27/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/27/24 at 9:23 p.m., during a telephone interview with a surveyor, RN1 stated that she documented last night how she thought the incident occurred. CNA1 was present during this telephone conversation and demonstrated for RN1 how the incident occurred. CNA1 stated that R1 attempted to stand up from the wheelchair and grabbed onto the bed rail and when he/she did, R1 hit his/her leg on the wheelchair frame which caused the skin tear; there was not a leg/foot rest on that side. The surveyor confirmed at this time with RN1 that the Incident/Accident was not documented timely or correctly when it was finally documented.

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	08/27/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 33242 Based on observations and interviews, the facility failed to maintain a safe, sanitary environment to help prevent the development and transmission of communicable diseases and infections in 3 of 16 residents diagnosed with Coronavirus (COVID-19). Findings: According to the Centers for Disease Control (CDC) website, About COVID-19 | COVID-19 | CDC, revised June 13, 2024, Coronavirus (COVID 19) spreads when an infected person breathes out droplets and very small particles that contain the virus. Other people can breathe in these droplets and particles, or these droplets and particles can land on others' eyes, nose, or mouth. In some circumstances, these droplets may contaminate the surfaces they touch. On 8/26/24 at 10:50 a.m., a list was provided to a surveyor by the Administrator that identified resident's that currently tested positive for COVID-19. Further review indicated that R2 tested positive on 8/25/24, R3 tested positive on 8/23/24, R4 tested positive on 8/21/24 and 8/25/24. On 8/26/24 between 2:40 p.m. - 2:50 p.m., a tour of the facility was completed with the Administrator with the following observed and confirmed: 1. R2's room door was closed but there was an air conditioner in the window on R2's side of the room, blowing towards the roommate who was currently negative for COVID-19; 2. R3's room door was closed but there was a fan in the room on R3's side of the room, blowing towards the roommate who was currently negative for COVID-19; and 3. R4's room door was closed but there was a fan in the room on R4's side of the room and one in the center of room oscillating from side to side , blowing towards the roommate who was currently negative for COVID-19. During these observations/interviews, the Administrator spoke with staff present who were able to identify that the doors should be closed and that the fans should not be blowing towards the hallway, but did not think about the fan location in the room and the direction it was blowing towards.