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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17282 Based on observations and interviews, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in good repair and in a sanitary condition for 3 of 3 environmental tours. On 7/22/24 at 8:01 a.m. through to 8:35 a.m., environmental tours were completed with the Administrator and surveyors with the following findings at the time of the observations. 1. room [ROOM NUMBER]a - the veneer/stain on the bedside table and dresser drawer was chipped and missing creating an uncleanable surface. room [ROOM NUMBER]a - the Lansko fan was soiled with dust. room [ROOM NUMBER]a - the veneer/stain on the bedside table and dresser drawer was chipped and missing creating an uncleanable surface. room [ROOM NUMBER]a - the covers on the fall safety floor mats are soiled and cracked creating an uncleanable surface. The cove base on the floor, left of the bathroom door was pulled away from the wall. The room divider curtain was soiled. room [ROOM NUMBER]a - the veneer/stain on the bedside table and dresser drawer was chipped and missing creating an uncleanable surface. 33242 2. In the locked unit, there were multiple torn cloth chairs that were placed around the tables and in the hallway. In the locked unit, there were multiple cloth living room chairs that had wet spots or dried soiled areas on them. room [ROOM NUMBER]b - there were two fans at the entrance of the room that were soiled with dust. (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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room [ROOM NUMBER]a - there were small holes in the wall behind the headboard of the bed, the headboard of the bed was chipped around the edges creating an uncleanable surface, and there was torn white stuff on the floor between the bed and chair that was first observed on 7/8/24 at 12:00 p.m. and still there at the time of the tour. room [ROOM NUMBER]b - a quarter rail on the bed was soiled with a brown substance. This was first observed on 7/8/24 at 12:00 p.m. and still there at the time of the tour. room [ROOM NUMBER] - the front covers of the baseboard register were not secured to the brackets and there was a broken tile in the bathroom. room [ROOM NUMBER] - the bathroom smelled like urine (first observed on 7/8/24 at 11:46 a.m. and present at the time of the tour) and the drywall to the right of the toilet was bulged. room [ROOM NUMBER]a - the chair cover was soiled. room [ROOM NUMBER]b - the arm of the blue chair was soiled. 35904 3. room [ROOM NUMBER]a - there was one fan in the room that was soiled with dust, and there was a screen on the window that was bent on the bottom. room [ROOM NUMBER]b - the veneer/stain on the dresser was worn creating an uncleanable surface. room [ROOM NUMBER]b - the veneer/stain on the top of the dresser was worn creating an uncleanable surface, and the top dresser drawer was missing.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33242 Based on record review and interview, the facility failed to ensure that the Minimum Data Set (MDS) 3.0 was coded accurately on an admission and annual MDS assessment to indicate that a resident had a state Level II Preadmission Screening and Resident Review (PASRR) and Post Traumatic Stress Disorder (PTSD) for 1 of 1 sampled residents reviewed for PASRR (Resident #61 [R61]). Finding: On 7/9/24, R61's clinical record was reviewed and included a PASSR, dated 5/2/23, that indicated that R61 qualified for Level II services. Review of R61's admission MDS, dated [DATE], and annual MDS, dated [DATE], Section: A1500 were coded to indicate that R61 did not have a Level II PASRR. During review of R61's clinical record, the PASSR Level II, dated 5/2/23, indicated that the resident had a diagnosis of PTSD and physician progress notes repeatedly included documentation that PTSD was well managed considering his/her diagnosis. Review of R61's admission MDS, dated [DATE], and annual MDS, dated [DATE], Section: I6100 were coded to indicate that R61 did not have PTSD. On 7/9/24 at 1:44 p.m., during an interview with a surveyor, the MDS Coordinator reviewed R61's clinical record. R61's original admission MDS, dated [DATE], was coded to include both the PTSD and PASRR Level II. R61 was discharged on [DATE] and returned to the facility on [DATE]. This information was inaccurately entered into R61's clinical record and therefore R61's admission MDS, dated [DATE] and annual MDS, dated [DATE], were both inaccurately coded for PASSR and PTSD. The surveyor confirmed these findings during this interview.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 33242 Based on record review and interview, the facility failed to ensure that a care plan was developed for a resident with the diagnosis of Post Traumatic Stress Disorder (PTSD) for 1 of 1 sampled residents reviewed for PASRR (Resident #61 [R61]). Finding: On 7/9/24, Resident #61's clinical record was reviewed which included documentation on the Level II PASRR and physician progress notes that R61 had a diagnosis of PTSD and a trauma assessment, dated 7/9/23, had been completed that indicated R61 had an traumatic experience in the past. On 7/10/24 at 10:00 a.m., during an interview with a surveyor, the Long Term Care (LTC) Manager reviewed R61's care plan and was unable to find a care plan that addressed R61's possible triggers of PTSD and no evidence of interventions of what staff should do if R61 displayed signs of re-traumatization or should not do that may cause re-traumatization to the resident. The surveyor confirmed this finding during this interview.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 17282 Based on record reviews and interviews, the facility failed to ensure that physician orders for medications and treatments were followed for 6 of 8 Residents reviewed for unnecessary medications and/or treatments (Resident #39 [R39]), R22, R77, R55, R49, and R50). Findings: 1. On 7/10/24, R39's clinical record/medication orders were reviewed. R39 had a medication order for Prazosin Hydrochloric acid (HCL) 1 milligram (mg) by mouth every day for Post Traumatic Stress Disorder (PTSD). Prazosin is an antihypertensive drug also used to manage nightmares and sleep disturbances associated with PTSD. R39's May and June 2024 Medication Administration Record (MAR) and medication exception report indicated that from 6/13/24 through to 7/6/24 (25 days), R39's Prazosin was held (not administered to the resident). On 7/10/24 at 2:22 p.m., in an interview with the surveyor, the Long Term Care Manager (LTC) stated the medication was held because the facility was unable to get the correct dose from the pharmacy. She stated she made several calls to the pharmacy but was told the medication was not available at that time. 33242 2. On 7/10/24, R22's clinical record/medication orders were reviewed. A review of the clinical record from April thru July indicated the following: R22 had a medication order for Cranberry capsules, 450 mg to be given twice a day. on 4/11/24, this medication was not given at 9:00 a.m. and 8:00 p.m. because the medication was not available and on 4/12/24, this this medication was not given at 9:00 a.m. because the medication was not available. R22 had a medication order for Mirabegron Extended Release (ER) 25 mg tablet (used to treat overactive bladder) to be given once a day at 9:00 a.m. On 4/23/24, 4/28/24, and 4/29/24 this medication was not given because the medication was not available. R22 had a medication order for Calcium with Vitamin D3 to be given once daily at 8:00 p,. On 5/9/24, this medication was not given because the medication was not availabe. R22 had a medication order for Memantine HCL 10 mg tablet (used to treat moderate to severe dementia) to be given once a day. This medication was not given on 5/14/24, 6/19/24, 6/20/24, 6/22/24, 6/23/24, and 6/24/24 because the medication was not available. R22 had a medication order for Tramadol 50 mg tablet (pain medication) to given at 3:00 a.m. It was was given on 6/3/24 because the prescription needed to be renewed and tehy were waiting for the prescription to be renewed because they could get a code to remove it from the emergency stock. 3. On 7/10/24, R77's clinical record/medication orders were reviewed. A review of the clinical record from April thru July indicated the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R77 had a medication order for Trazodone HCl 50 mg table, give 1/2 tablet (used for depression or sleep) to given at 8:00 p.m This medication was not given on 6/20/24 because the medication was not available. On 7/10/24 at 10:00 a.m., during an interview with a surveyor, the LTC Manager stated that this has been ongoing issue with medications not coming in and she has been trying to monitor it but it seems to still be happening. The surveyor confirmed that R22 and R77 missed medications because they were not available. 35904 4. On 7/10/24, R55's clinical record/medication orders were reviewed. R55 had a physician medication order to hold one dose of Eliquis (a blood thinner) prior to a surgical procedure on 6/25/24. The medication dose was held on the evening of 6/24/24 and on the morning of 6/25/24, two doses prior to a surgical procedure, one dose too early. On 7/10/24, R55's discharge instructions from a medical facility were reviewed. R55 had a medical facility discharge instructions to restart Eliquis on the evening of 6/27/24. The discharge instructions state, no Eliquis until PM (evening) dose on 6/27/24. The medication was held on the PM evening dose on 6/27/24, and not given until the morning dose on 6/28/24, one dose too late. 5. On 7/10/24, R49's clinical record/medication orders were reviewed. R49 had a physician medication order for Humalog Lispro 100 unit/ml (milliliter) solution that states to hold sliding scale insulin if blood sugar level is below 151. On 7/7/24 the 11:30 a.m. blood sugar was 146, and Humalog Lispro 100 unit/ml solution 2 units was given subcutaneously (injection). R29 was administered 2 units of insulin when there was no additional coverage needed per order. On 7/10/24 at 10:45 a.m., in an interview with the Skilled Nursing Facility (SNF) Manager, a surveyor confirmed that physician orders were not followed for R55's medication, Eliquis, to be held and restarted, and for R49 receiving insulin when not needed. 49635 6. On 7/10/24 at 10:50 a.m., R50's clinical record was reviewed and included a physician's order to, Check weight daily every morning using the same scale at the same time of day with the same amount of clothes, dated to start 1/26/24. R50's clinical record lacks evidence that the weights were done as ordered on 7/7/24, 7/6/24, 7/5/24, 7/2/24, and 6/26/24, and lacked evidence indicating the resident refused these treatments. On 7/10/24 at 10:55 a.m., in an interview with the Administrator and SNF Manager, a surveyor confirmed daily weights were not completed as ordered for R50.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 49635 Based on interviews and observations, the facility failed to follow physician orders for use a equipment (wedge pillow) to maintain and/or improve residents' highest level of bed mobility for 1 of 1 resident reviewed for positioning and mobility. (Resident #50 [R50]) Finding: On 7/09/24 at 10:55 a.m., a surveyor observed R50's position to be slouched in bed on R50's right side. In an interview with the surveyor, R50 stated the need for a wedge pillow to maintain positioning, without the wedge pillow he/she often ends up lying on their right side. R50 stated it also is hard to reach items at meal times without extra support, and the wedge pillow has been missing for a while. No wedge pillow or other support pillows were observed in use at the time of the interview. On 7/10/24 at 7:29 a.m., a surveyor observed R50 lying in bed waiting for breakfast. No wedge pillow or other support pillows were observed in use at the time of the observation. On 7/10/24 at 10:00 a.m., clinical record review for R50 included a doctor's order dated 6/17/24 to use wedge daily, the Plan of Care Summary indicated use pillows to position [R50] comfortably and [R50] should not be laying on the right side due to shoulder going in and out of placement. On 7/10/24 at 10:11 a.m., in an interview with the Skilled Nursing Facility Manager, a surveyor observed and confirmed R50 was not supported by a wedge pillow as ordered by the doctor to assist with positioning.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 33242 Based on observations, manufacturer's manual review, and interview, the facility failed to ensure that an oxygen concentrator was operated and maintained per manufacturer's directions for 1 of 1 residents reviewed with oxygen (Resident #22 [R22]). Finding: On 7/8/24, a review of R22's physician order's indicated that R22 used oxygen at night and there was a weekly treatment to clean the filter and change the tubing on Sunday nights (7/7/24). On 7/8/24 at 12:17 p.m., a surveyor observed the oxygen concentrator in R22's room noting that it was missing the cabinet filter compartment which snaps on the back of the concentrator. Review of the manufacturer's manual for the Invacare Perfecto2 reads on page 24, do not operate the concentrator without the filter installed. On 7/9/24 at 10:35 a.m., a surveyor observed the oxygen concentrator again without the cabinet filter compartment attached to the concentrator. On 7/10/24 at 10:08 a.m., a surveyor showed the Long Term Care (LTC) Manager the diagram that outlined the oxygen concentrator parts in the manufacturer's manual and then went to R22's room to observe the oxygen concentrator. During this observation, the surveyor confirmed that the cabin filter compartment was missing and had been missing at least since Monday (7/8/24). The LTC Manager removed the concentrator from the room.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33242 Based on record review and interview, the facility failed to ensure a Physician ordered lab was completed for a urine test for 1 of 2 urinalysis ordered for Resident #35 (R35). Finding: On 7/9/24, R35's clinical record was reviewed and included a physician order, dated 6/17/24, for a urinalysis as the physician thought that symptoms R35 was having was being caused by an infection. The order was entered into the computer to be completed on 6/18/24. The clinical record lacked evidence that a urine was collected for testing until another order was received and collected on July 7th. On 7/11/24 at 11:25 a.m., during an interview with a surveyor, the Long Term Care Manager stated she was unable to find evidence that a urine as collected and tested on [DATE].

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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. 17282 Based on record reviews and interviews, the facility failed to accurately document resident weights for 2 of 3 resident reviewed for weight loss concerns (Resident #39 [R39] and R14). Findings: 1. On 7/10/24, R39's clinical record was reviewed. A Registered Dietician's (RD) note, dated 6/18/24, indicated a follow up was done due to a weight loss of 51% over the past 30 days. The RD indicated from 4/9/24 to 6/13/24, weights ranged from 148.4 pounds (#) to 216# making it difficult to fully access trends. The following weights were documented: 4/9/24 - 216#, 4/18/24 - 167.3#, 5/7/24 - 156.4#, 6/4/24 - 190.6#, 6/13/24 - 148#. On 7/10/24 at 9:33 a.m., in an interview with the surveyor, the Long Term Care Manager (LTC Manager) confirmed that several of the weights were inaccurate and a re-weigh should have been done. 33242 2. On 7/8/24, R14's clinical record was reviewed and included a RD note, dated 5/19/24, that indicated this was a follow up due to significant weight loss in April of 13.7% over 30 days and 14.8% over 90 days. RD does question this weight as it is 17.2 lbs less than prior weight and R14 consumed 75-100% meal on average and resident has eaten 79% of meals on average over the past two weeks per Certified Nursing Assistant (CNA) charting. RD will follow upcoming weights as there was no May weight yet to review. The following weights were documented: 2/26/24-117.6#, 3/26/24-125.4#, 4/24/24-108.2#, 5/19/24-108.2# from 4/24/24, 5/23/24-116#, and 6/21/24-127.6#. On 7/10/24 at 12:04 p.m., during an interview with the surveyor, the LTC Manager stated the weights wed not seem correct (noting mainly 4/24/24 weight) and that R14 probably did not have that much weight loss. The LTC Manager immediatley contacted the Staff Development Coordinator about arranging education to staff on how to properly weigh residents.