

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  205006	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/21/2026
NAME OF PROVIDER OR SUPPLIER  Montello Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  540 College St Lewiston, ME 04240	

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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on record review and interview, the facility failed to ensure that clinical records were complete and contained accurate information for 1 of 3 residents reviewed for Medication Administration Record (MAR) and Treatment Administration Record (TAR) (Resident #1) and 1 of 3 residents reviewed for wound care (Resident #2). Findings: 1. Review of Resident #1's MAR and TAR for the month of April lacked evidence of completed documentation for the following physician orders: Lavage left ear with warm water. One time a day to irrigate, Triad cream to open area on left stage 2 (presently) buttocks crease daily in the afternoon for open area stage 2, Monitor for signs and symptoms of respiratory infection/COVID: fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, SOB (shortness of breath), cough, and new loss of taste of smell every day and night, Air mattress on bed every shift for skin care, Document if resident has shortness of breath, Encourage off loading of right hip, HOB (head of bed) to be elevated &gt;30 degrees at all times for every shift, If resident has any difficulty with swallowing food, or medication., Keep HOB upright x1 hours after meals, May have right side 1/2 bedrail as enabler for bed mobility, Nurse to educate resident about medically recommended to have supervision with meals., and OOB in wheelchair for all meals. On 4/21/26 at 1:00 p.m., the above information was confirmed with the Director of Nursing. 2. Review of Resident #2's clinical record revealed a physician progress note on 4/3/26 stating that he/she has a stage 2 upper medical posterior thigh pressure ulcer with interval improvement per nursing. No weeping, induration, fluctuance, or tenderness. Continue with calcium alginate and island dressing changes and continue with foley for moisture management. A review of Resident #2's entire clinical record shows a physician order dated 2/2/26 that states wound care: left posterior thigh-cleanse with wound wash, pat dry, apply calcium alginate to wound bed f/b (followed by) boarder foam and cover with Tegaderm; change every 2 days and PRN (as needed) for soiling or dislodgment. The record revealed that this order was discontinued on 3/6/26 and a new order was placed on 3/11/26 for triad hydrophilic wound dress external paste to be applied to wound. Further review of the clinical record showed that he/she had his/her foley removed during his/her most recent hospitalization from 3/17/26 to 3/21/26. On 4/21/26 at 1:00 p.m., in an interview with the DON, she confirmed that Resident #2's provider note did not contain accurate information related to his/her wound care orders.</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
---	-------	-----------