STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205006	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montello Manor	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)
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** Based on observations and interview, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable environment on 2 of 2 wings (North and East), a common area, a dining/sitting room and the Laundry room for 1 of 1 facility tour.Findings:On 5/6/26 from 8:15 a.m. to 9:00 a.m., a surveyor completed an Environmental Tour with the Director of Environmental Services in which the following findings were discussed and observed:Common area:- The common area double doors to the nursing units had chipped/missing paint creating an uncleanable surface. - There were 26 broken floor tiles in the common area hallway between the nurse's station and the entrance to the North wing. North Wing:- Resident room [ROOM NUMBER]- The floor fan was dusty/dirty. The sitting room had 25 cracked/broken floor tiles, a baseboard heater that had rust on it, and the sliding door sill was dirty and missing sealant, all creating uncleanable surfaces. - There were broken floor tiles, in the hallway around a clean out, by resident room [ROOM NUMBER].- Resident room [ROOM NUMBER] - The privacy curtain was missing hooks, hanging down and in disrepair. The sitting room had 25 broken floor tiles in back room and the sliding door sill was dirty and missing sealant, all creating uncleanable surfaces. - The hallway ceiling vent, by resident room [ROOM NUMBER], was dusty/dirty.- Resident room [ROOM NUMBER] - The privacy curtain by bed 1 had missing hooks, hanging down, was ripped and was in disrepair.- Resident room [ROOM NUMBER] - The wooden room entrance door and bathroom door were gouged/chipped. The closet door was marred/marked with black marks. There were 5 cracked/broken floor tiles in sitting area entrance.- Resident room [ROOM NUMBER] - The caulking around the base of the toilet was dirty. There was a cracked/broken ceiling tile just inside the room entrance door. The wheelchair was dirty with dust and food.East Wing:- The white patient lift, stored by resident room [ROOM NUMBER] had chipped/missing paint on the legs and base. Additionally, the some of the non-skid surface was torn/missing on the foot plate.-room [ROOM NUMBER] - Wheelchair in corner had a black cushion with the front side covered with black duct tape creating an uncleanable surface. - Resident room [ROOM NUMBER]- Resident #1's wheelchair had left and right armrests that were ripped/torn. - Resident room [ROOM NUMBER]- The bathroom doors had chipped/gouged wood. The bathroom floor was dirty all over and around edges. The high back chair in the room had chipped/missing sealant on the legs. - Resident room [ROOM NUMBER] - The shared bathroom had 2 dirty graduated cylinders on top of toilet that were unlabeled. Dining/sitting room:- A dining/sitting room, across from the nurse's station, had a dirty floor, the ceiling grid was dirty/stained, and a tan high back rocker was dirty and had bolts that were loose and coming out. Laundry Room: - The floor had chipped/missing paint creating an uncleanable surface. On 5/6/26 at 9:00 a.m., in an interview with a surveyor, the Director of Environmental Services confirmed the discussed and observed findings.

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
	205006	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montello Manor	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)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview, the facility failed to review and revise the care plan by an interdisciplinary team (IDT), that included, to the extent possible, participation of the resident and/or his/her representative after each Minimum Data Set (MDS) assessment for 5 of 16 sampled residents reviewed for care planning (Residents #1, #3, #14, #21, #27).Findings: 1. Review of Resident #3's clinical record revealed an MDS Quarterly Assessment was completed on 4/14/26. Further review of Resident #3's clinical record lacked evidence that an IDT meeting was held within 7 days following the assessment. 2. Review of Resident #27's clinical record revealed an MDS Significant Change Assessment was completed on 10/16/25. Further review of Resident #27's clinical record indicated that an IDT meeting was held 10/29/25 (13 days after assessment) and lacked evidence that an IDT meeting was held within 7 days following the assessment. On 5/6/26 at 12:11 p.m. during an interview with 2 surveyors, the MDS Coordinator stated that the facility schedules IDT meetings 14 days from the Assessment Reference Date (ARD) and that IDT meetings are only held on Wednesdays. The surveyors discussed the above findings, and at this time, the MDS Coordinator confirmed that the above IDT meetings were not held within 7 days after the completion of the MDS assessment. 3. Review of Resident #1's clinical record revealed an MDS Annual Assessment was completed on 3/20/26. Further review of Resident #1's clinical record lacked evidence that an IDT meeting, which was held on 4/1/26, was held within 7 days following the completed assessment.Review of Resident #1's clinical record revealed an MDS Quarterly Assessment was completed on 12/19/25. Further review of Resident #1's clinical record lacked evidence that an IDT meeting, which was held on 12/31/25, was held within 7 days following the completed assessment. 4. Review of Resident #21's clinical record revealed an MDS Annual Assessment was completed on 9/16/25. Further review of Resident #21's clinical record indicated that an IDT meeting was held 9/11/25 (5 days before assessment) and lacked evidence that an IDT meeting was held within 7 days following the completed assessment. On 5/6/26 at 12:35 p.m., during an interview with 2 surveyors, the MDS Coordinator stated that the facility schedules IDT meetings 14 days from the Assessment Reference Date (ARD) and that IDT meetings are only held on Wednesdays. The surveyors discussed the above findings, and at this time, the MDS Coordinator confirmed that the above IDT meetings were not held within 7 days after the completion of the MDS assessments. 5.Review of Resident #14's clinical record revealed an MDS Annual Assessment was completed on 11/13/25. Further review of Resident #14's clinical record lacked evidence that an IDT meeting, which was held on 11/25/25, was held within 7 days following the completed assessment. During an interview on 6/6/26 at 12:01 p.m. MDS Coordinator reviewed the MDS and IDT meeting dates and confirmed the IDT meeting was not held within 7 days of the MDS completion.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205006	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montello Manor	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)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, facility policy, and interviews, the facility failed to provided care in accordance with professional standards of practice, based on the comprehensive person-centered care plan, and the residents' choices for 1 of 2 resident reviewed for activities of daily living (Resident #4). Additionally, the facility failed to follow physician orders for 2 of 17 resident's reviewed (Resident #7 and #14) and failed to notify a resident representative of a fall for 1 of 1 resident reviewed for falls. (Resident #7)Findings: 1.Resident #4 has diagnoses to include dementia and is receiving hospice services for end of life care. During observation of Resident #4 the following was observed: -5/4/26 at 8:34 a.m. Resident #4 was observed sitting in a wheelchair in the far corner of the dining room at a table. The Television (T.V.) in the opposite corner is on but is not in view and is not loud enough for Resident #4 to hear. There is another resident sitting directly in front of the T.V. -5/4/26 at 12:35 p.m., Resident #4 was observed sitting in a wheelchair in the far corner of the dining room at a table. The Television (T.V.) in the opposite corner is on but is not in view and is not loud enough for Resident #4 to hear. There is another resident sitting directly in front of the T.V. At this time a surveyor asked Director of Nursing (DON) why Resident #4 was still in the dining room, with nothing to do. DON stated that his/her family doesn't like him/her to be in bed all day, so they leave him/her in the dining room. When asked why she hadn't gotten checked on or received brief assistance, DON stated she didn't know but she'd have someone take care of [him/her]. - 5/5/26 at 9:50 a.m., Resident #4 was observed sitting in a wheelchair in the far corner of the dining room at a table. The Television (T.V.) in the opposite corner is on but is not in view and is not loud enough for Resident #4 to hear. There is another resident sitting directly in front of the T.V . -5/5/26 at 1:35 p.m., Resident #4 was observed being wheeled out of the dining room and into his/her room by nursing staff. -5/6/26 at 7:15 a.m., 11:30 a.m., and 1:00 p.m., Resident #4 was observed sitting in a wheelchair in the far corner of the dining room at a table. The Television (T.V.) in the opposite corner is on but is not in view and is not loud enough for Resident #4 to hear. There is another resident sitting directly in front of the T.V . Review of Minimum Data Set (MDS) dated [DATE] revealed Resident 4 had a Brief Interview for Mental Status (BIMS) score of 3 of 15 indicating he/she is not cognitively intact and is dependent on staff for all activities of daily living. Review of annual MDS dated [DATE] states Resident #4 is always incontinent of bladder and bowel, Further review of Resident #4's MDS revealed it is very important for him/her to do things with groups of people, do his/her favorite activities and go outside to get fresh air when the weather is good. Review of Resident #4's care plan states: Needs assistance/escort to actives and rest breaks; prefers to listen to 50's and 60's music; preferred activities are watching cards and bingo, BBQs (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205006	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montello Manor	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	musical programs/entertainment, pet visits and ringing win wheelchair outside; when [Resident #4] chooses not to participate in organized activities [he/she] prefers to watch TV and play with activity blanket for social and sensory stimulation. Invite [Resident #4] to activities. Review of May 2026 Activity Calendar states Activities were held daily at 10:00 a.m. and 1:30 p.m., 7 days a week. There was no evidence that Resident #4 was asked/attended these activities, and individual activities were not asked/offered. Review of Individual Activities and Room Visit Program dated 3/25 states Individual activities will be provided for those resident's whose situation or condition prevents participation in other types of activities, and for those residents who do not wish to attend group activities. Residents who are able to maintain an independent program will have supplies available to them . Individualized activities offered are reflective of the resident's activity interest, as identified in the activity assessment, progress notes and the resident's comprehensive care plan. It is recommended that residents with in-room activity programs receive, at a minimum, three in-room visits per week. Responsibility of the facility and the activity staff to make regular contact with residents who choose to pursue independent activities, maintain appropriate records and offer supplies as needed. Further review of Resident 4's care plan updated 5/3/26 states [Resident #4] has bladder and bowel incontinence r/t dementia.check and change every 2 hours and as required for incontinence. wash, rinse and dry perineum. Change clothing PRN after incontinence episodes; Review of Bladder Elimination task states Resident #4 received brief assistance on 4/30/26 at 8:08 a.m., and 20:14, on 5/2/26 at 10:46 a.m. and 19:58, on 5/4/26 at 13:42, 20:13, and 23:42, on 5/5/26 at 10:21 a.m., 20:01, and 22:52. As of 11:16 a.m. on 5/6/26 there is no documented evidence resident #4 received brief assistance. During interview with 4 surveyors present on 5/6/26 at 12:45 p.m. the Director of Nursing stated that it is her expectation that residents are toileted for checked at least every 2 hours. At the time a surveyor reviewed the above findings with the Director of Nursing. During interview on 5/6/26 at 1:50 p.m., Certified Nursing Assistant (CNA) stated that most of the time [Resident #4] is a no void, but she still doesn't get checked. They do not normally bring [him/her] to activities, nor do they ask. During interview on 5/6/26 [time] Anonymous #1 stated that Resident #4 is left in the dining room a lot and hasn't seen anyone check her or bring him/her to room to change. Has never seen anyone ask if he/she wanted to attend and has never seen him/her attend an activity and isn't really provided any activity [he/she] can do independently. Has seen him/her with a lap activity blanket before but doesn't know where it is. During interview with 2 surveyors on 5/6/25 at approximately 3:45 p.m., the above concerns were confirmed with DON. Review of Resident #4's Activity Progress notes dated 2/13-25 states Baseline Care plan and Initial assessment are complete. [Resident #4] to participate in independent (tv, visitors) and group activities that [he/she] enjoys. During an interview on 5/6/26 at 1:15 p.m., CNA #3 was asked how often Resident #4 received brief (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205006	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montello Manor	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assistance/repositioning or was checked during the day. CNA #3 stated Resident #4 is normally in the dining room from breakfast until 1:00 p.m., and it depends on the day. If it's Hospice Day, they might change/check [him/her], but they [facility staff] don't normally do it. When asked why Resident #4 is left in the dining room and doesn't go to an activity or have something to do. CNA#3 responded that she doesn't know. When asked what days Hospice comes in, CNA #3 stated she didn't know. Review of Hospice documentation revealed Resident #4 receives Hospice services 3 times a week. During an interview with 4 surveyors present on 5/6/26 at 3:42 p.m., the DON was asked why Resident #4 didn't attend activities, even if he/she couldn't participate, [he/she] could listen. DON stated that she was told that if a resident fell asleep during an activity, they had to be removed from the room but shed look into it. 2. Resident #14 was admitted 2/24 and has diagnoses to include COPD, vascular dementia with agitation, depression, morbid severe obesity, was admitted to Hospice for end of life care on 4/26/26. Review of Resident #14's pertinent orders revealed: -Order with start date of 5/15/25 for daily weights one time a day. Review of Resident clinical record lacks evidence that weights were obtained or refused on 5/1/26, 5/3/26, 5/4/26, 5/5/26 or 5/6/26. April 4/2/26, 4/3/26, 4/4/26, 4/5/26, 4/12/26, 4/15/26 through 4/30/26. -Order with start date of 5/21/25 for Intake monitoring: encourage Fluid Restriction 2 Liters in 24 hours every shift: Intake amount: Review of Resident 14's Treatment Administration Record dated May 2026 lacked evidence of intake documentation on 5/1/26 day shift and 5/5/26 evening shift. Review of APRIL 2026 TAR lacked evidence intakes were documented during the day shift on 4/5/26, 4/10/26, 4/18/26 or 4/24/26. Evening shifts on 4/20/26 and 4/21/26. During an interview on 5/6/26 at 9:02 a.m. the above was discussed with Director of Nursing (DON), who stated, the daily weights should have been discontinued because Resident #14 is on hospice, so the orders will have to be updated. DON further stated she will talk to staff about documenting appropriately. 3. Facility policy titled Assessing Falls and Their Causes states Notify the following individuals when a resident falls: a resident's family. Resident #7 sustained an unwitnessed fall on 4/28/26. Review of his/her progress notes revealed a progress note dated 4/28/26 at 1831 which stated; Resident had a unwitnessed fall in {his/her} room. has a bruise to left elbow. Orders: . Neuro checks with VS (vital signs) s/p (status post) fall as follows: Q15 x1 hour, Q30 x1 hour, hourly x 4 hours, Q4 hours x24 hours. Further review of Resident #7's entire clinical record lacked evidence of any neurological checks being completed. Additionally, the clinical record lacked evidence of family notification. On 5/5/26 at 3:01 p.m., in an interview with the Director of Nursing, she states no neurological checks were completed after the fall on 4/28/26 and family was not notified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205006	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montello Manor	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, facility policy, record review, and interviews, the facility failed to ensure that the resident's environment was free of accident hazards relating to a commode for 3 of 3 observations for 2 of 3 days of survey (5/5/26 and 5/6/26). Furthermore, the facility failed to ensure that a resident's smoking assessment was adequately completed for 1 of 1 resident reviewed for smoking. (Resident #18)Findings: 1.On 5/5/26 at 11:56 a.m., Resident #5 wheeled up to a surveyor stating he/she have something to show the surveyor. A surveyor observed Resident #5's commode in his/her room next to the door. The bilateral arms were very loose and would not stay in place and posed an accident hazard. Resident #5 stated he/she can't get into the bathroom so he/she had to have it. Resident #5 stated that he/she had been asking for a new one for quite a while. 2. On 5/5/26 at 3:25 p.m., in an observation and interview with a surveyor, the Director of Environmental Services confirmed that commode arms were very loose, wouldn't stay in place and wouldn't stay tightened. On 5/6/26 at 3:30 p.m., two surveyors observed the same commode arms to still be very loose. On 5/6/26 at 3:38 p.m., in an interview with two surveyors present, confirmed the loose commode arms being an accident hazard with the Director of Nursing. 3. A review of the facility policy titled Smoking Policy states If a smoker, the evaluation includes. ability to smoke safely with or without supervision (per completed safe smoking evaluation. Any resident with smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, [NAME] or volunteer worker at times while smoking. Resident's who have independent smoking privileges are permitted to keep cigarettes, electronic cigarettes, pipes, tobacco, and other smoking items in their possession. On 5/5/26 a review of Resident #18's smoking evaluation done on 2/25/26 lacks evidence if they are independent or need supervision with smoking. On 5/5/26 at 11:28 a.m., in an interview with the Director of Nursing the above information was confirmed and discussed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205006	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montello Manor	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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record reviews and interviews, the facility failed to ensure that two people who are authorized to administer medications signed the Shift Count page indicating that they counted all controlled substances at the change of shift for 2 of 2 units reviewed for medication storage (East and North Units).Findings:1. Review of East Wing Med Cart Controlled Substance Log on 5/5/26 revealed the following:- No outgoing signature on 12/13/25 at 2200, 1/20/26 at 0600, 1/20/26 at 1400, 1/31/26 at 2200, 2/1/26 at 2200, 2/3/26 at 2200, 2/23/26 at 1400, 4/8/26 at 2200, and 4/22/26 at 2200.- No incoming signature on 12/13/25 at 1400, 1/19/26 at 2200, 1/20/26 at 0600, 2/3/26 at 1400, 2/23/26 at 0600, 2/24/26 at 1400, 4/8/26 at 2000, and 4/22/26 at 2000.2. Review of North Wing Med Cart Controlled Substance Log on 5/5/26 revealed the following:- No outgoing signature on 3/20/26 at 2200, 3/29/26 at 2200, 4/11/26 at 1400, 4/12/26 at 1400, 4/14/26 at 2200, and 4/15/26 at 2000.- No incoming signature on 4/8/26 at 1400, 4/14/26 at 2200, 4/15/26 at 2200, and 4/28/26 at 1400.On 5/5/2026 at 10:08 a.m., the above findings were reviewed and confirmed with the Director of Nursing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205006	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montello Manor	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)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record reviews and interviews, the facility failed to respond to the consultant pharmacist's recommendations in a timely manner for 2 of 5 sampled residents reviewed for unnecessary medications (Resident's #14 and #26).Findings: 1.Resident #14 has diagnosis dementia and chronic pain and is receiving Hospice services for end of life care. Review of Pharmacy Recommendation dated 2/4/26 states: The resident has an order for Diclofenac 1%. Apply topically to hands for pain. [Note: Maximum total body dose of 1% gel should not exceed 32 g (gram) per day,} Please clarify the amount for nursing to apply. The clinical record lacks evidence that the provider responded to this recommendation. During an interview on 5/5/26 at 1:56 p.m., with 4 surveyors present Director of Nursing confirmed there is no evidence that a provider reviewed pharmacy recommendations. 2. A review of Resident #26's medical record revealed an active physician order dated 4/15/26 for Lorazepam oral concentrate 2MG/ML (milligram/milliliter) with instructions to Give 0.25 ml by mouth two times a day for anxiety/agitation for 30 days AND Give 0.25 ml by mouth every 1 hours as needed for anxiety/agitation. Review of Resident #26's Recommendation Summary for Medical Director dates 4/18/26 states: This resident is currently on PRN (as needed) Lorazepam with the following diagnosis: anxiety. Please evaluate current diagnosis, behaviors, and use patterns and evaluate continued need. PRN psychotropic orders can not exceed 14 days with the exception that the prescriber documents their rationale int eh residents medical record and indicate the duration for the PRN order. On 5/5/26 at 10:15 a.m., in an interview with the Director of Nursing, she confirmed that the provider did not respond to the recommendation made by the pharmacist on 4/18/26.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205006	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montello Manor	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)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on record review, observation, interviews, and guidance from Centers for Disease Control and Prevention (CDC), the facility failed to ensure medications were stored properly in medication storage refrigerator for 1 of 1 medication refrigerator observed. Additionally, the facility failed to monitor temperature controls for 1 of 1 medication refrigerator observed for 2 of 2 months reviewed. Findings: Review of the CDC document titled CDC Vaccination Storage Best Practice states Don't use dormitory-style refrigerator. A dormitory style refrigerator is a small combination freezer/refrigerator with an external door and an evaporator plate (cooling coil), which is usually located in the icemaker compartment (freezer). The accumulation of excess ice on the coils in the freezer compartment can affect the temperature of the refrigerator. The temperature change can cause a change in the potency by comprising the integrity of insulin.Review of Manufacturer instructions reveled Lantus Solostar Step by Step Guide dated 2022 states Store unopened Lantus in refrigerator between 36-46 (F) Fahrenheit.During an observation of Medication Storage room with Director of Nursing (DON) on 5/5/26 at 9:10 a.m., a dormitory-style refrigerator was observed with ice buildup. The refrigerator contained medications Insulin Lantus, Ativan, and tuberculin purified protein (PPD). During an interview with the DON, she states that this refrigerator currently does not contain vaccinations, but this is where they would be stored.Review of the medication refrigerator temperature logs from April 1,2026 through April 28, 2026 showed missing temperatures for 1 out of the 28 days and temperatures being out of range for 25 out of 28 days. Review of the temperature logs from May 1, 2026 through May 5, 2026 showed missing temperatures for 4 out of the 5 days. On 5/5/26 at 9:10 a.m., the above findings were confirmed and reviewed with the Director of Nursing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205006	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montello Manor	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interview, and the facility's Food Storage and Protection policy, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for the hood systems, the floor, a wall mounted air conditioning unit, and a food slicer; failed to ensure foods in the kitchen, the dry storage room, the walk-in refrigerator and the walk-in freezer were dated and/or labeled; and failed to ensure that kitchen staff with facial hair wore facial hair protection for 2 of 2 tours on 1 of 3 days of survey.(5/4/26) Findings:The Facility's Food Storage and Protection policy and procedure noted: - Food shall be stored, prepared, served, transported with protection at all times from potential contamination including dust, insects, rodents, uncleaned equipment and utensils, unnecessarily handling, coughs and sneezes, flooding, drainage, leakage and condensation. - Food, weather raw or prepared, if removed from the container or package in which it was obtained, shall be sorted in a clean and sanitized container, be labeled and dated. - All leftovers must be securely covered, labeled, and dated. - Staff shall wear clean outer clothing and aprons. Head and facial hairs shall effectively be restrained through the use of Nets or other clean hair covering.1. On 5/4/26 from 8:10 a.m. to 8:45 a.m., a surveyor conducted an initial kitchen tour with the Food Service Director in which the following findings were discussed and observed: - The cook stove hood was heavily soiled with dust/dirt.- The kitchen floor had food and debris under the equipment and shelving.- The wall mounted air conditioning unit was heavily soiled with dust/dirt. - The food slicer had food particles on the base. - A shelf in the kitchen had two large bags of rice that were not labeled. - A hood, over a food preparation area, had chipped/missing paint, creating an uncleanable surface. - The dry storage room had four large bags of cereal that were not labeled. - The walk-in refrigerator had two, 12-ounce bags of whipped topping with no thaw date on them. The manufacturer's directions note that the product is only good for two weeks after thaw date. - The walk-in freezer had a large bag of what looked like meat that was not labeled. On 5/4/26 at 8:45 a.m.- in an interview with a surveyor, the Director of Food and Nutrition confirmed the findings. 2. On 5/4/26 at 12:04 p.m., a surveyor and the Director of Food and Nutrition observed kitchen staff member with facial hair working in the kitchen and not wearing facial hair protection. At this time, Director of Food and Nutrition confirmed the finding.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205006	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montello Manor	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interviews, the facility failed to ensure that clinical records were complete and contained accurate information for multiple dates for 2 of 2 residents reviewed for Activities of Daily Living (ADLs) (Residents #19, #27).Findings:1. On 3/9/26, the Department of Licensing and Certification (DLC) received a complaint alleging that Resident #19 is normally not incontinent and that on this date, he/she was found by oncoming staff lying in bed saturated in urine.Review of Resident #19's care plan states, .has an ADL self-care performance deficit r/t [related to] debility. requires extensive assistance by 1 staff for toileting. has episodes of Bowel and Bladder incontinence.Review of Resident #19's ADL task documentation for March 2026 revealed the following toileting-related interventions:Bladder Elimination Q (every) shiftToilet transfer Q shiftToileting hygiene Q shiftResident #19's ADL task documentation lacked any documentation that the above interventions were/were not completed or that Resident #19 refused or was not available for the following dates:Night shift: 3/2/26, 3/8/26, 3/21/26, and 3/30/26Evening shift: 3/26/262. On 3/9/26, the DLC received a complaint alleging that Resident #27 was not receiving adequate care at the facility, and that on this date he/she was found by oncoming staff saturated in urine.Review of Resident #27's care plan states, .has an ADL self-care performance deficit r/t immobility. requires extensive assistance by 1-2 staff for toileting, occasionally incontinent of bowel and Bladder; Toilet or offer bedpan every 2 hours and PRN [as needed]. uses briefs/pull-ups for incontinence . Per [Resident #27's] request offer Bedpan at 0400 [4:00 a.m.] daily if [he/she] does not ring prior .Review of Resident #27's ADL task documentation for March 2026 revealed the following toileting-related interventions:Bladder Elimination Q shiftBowel Elimination Q shiftToilet transfer Q shiftToileting hygiene Q shiftThe ADL task documentation lacked any documentation that the above interventions were/were not completed or that Resident #27 refused or was not available for the following dates:Night shift: 3/2/26, 3/8/26, and 3/21/26Evening shift: 3/26/26Further review of Resident #27's task documentation revealed an intervention for Toilet Resident every 2 hours and lacked documentation for the scheduled intervention on 3/30/26 at 10:00 p.m. and 3/31/26 at midnight, 2:00 a.m., and 4:00 a.m.Additional review of Resident #27's task documentation revealed an intervention for Resident's request to be awakened to use the bedpan by 0400 if he/she does not ring prior and lacked documentation for the intervention on 3/2/26, 3/8/26, and 3/21/26. Furthermore, on 3/1/26, 3/6/26, 3/7/26, 3/10/26, 3/11/26, 3/12/26, 3/13/26, 3/14/26, 3/15/26, 3/17/26, 3/18/26, 3/20/26, 3/22/26, 3/24/26, 3/25/26, 3/27/26, 3/28/26, and 3/31/26, the intervention was documented as completed during the 10:00 p.m. and 11:00 p.m. hours, at the beginning of the night shift, not in the overnight hours.On 5/6/26 at 10:18 a.m. a surveyor discussed the above findings with the Director of Nursing (DON). During an interview at this time, the DON stated that Resident #27 had recent increased episodes of incontinence overnight as the result of a urinary tract infection, and that during that time, Resident #27 was often sleeping through night and was upset if he/she was incontinent of urine overnight. The DON then stated that the bedpan intervention was implemented so that if Resident #27 did not awaken to toilet on his/her own by 4:00 a.m., staff were to awaken him/her to toilet to prevent an incontinence episode. The DON then stated that she expects staff to document the bedpan intervention in the overnight hours, around 4:00 a.m., and not at the beginning of the shift, prior to completing the intervention. The surveyor then discussed Resident #19's and Resident #27's missing ADL documentation, and the DON confirmed that the clinical records were not complete and accurate for the above dates.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205006	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montello Manor	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, interviews, record review, and facility policy, the facility failed to maintain an Infection Control Program designed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to hand hygiene during a dining service observation on 1 of 3 days of survey (5/5/26). Additionally, the facility failed to conduct an annual review of its Infection Prevention and Control Program (IPCP). Findings: 1. On 5/5/26 at 11:44 a.m., during the lunch meal service in the dining room, a surveyor observed Resident #17 with clear nasal drainage running from his/her nostrils. At 11:48 a.m., CNA #1 approached Resident #17 and told him/her that she needed to clean his/her nose. CNA #1 then donned (put on) a pair of gloves, removed a tissue from a tissue box located in front of Resident #17 and proceeded to wipe his/her nose. CNA #1 then discarded the tissue in a trash can and doffed (took off) her gloves and discarded them in the trash can. Without sanitizing her hands, CNA #1 then donned a clean pair of gloves, told Resident #17 that she was going to feed him/her now, and proceeded to lift the cover on Resident #17's meal plate. At this time, the surveyor intervened, and during an interview at this time, CNA #1 stated that sometimes she just forgets to wash her hands and that she will do it now. On 5/5/26 at 11:52 a.m. the surveyor discussed the above finding during an interview with the Director of Nursing (DON). At this time, the DON stated that she had just educated CNA #1 about hand hygiene after another surveyor's observation but that she will provide reinforced education. Facility policy, Handwashing/Hand Hygiene revised 2/26 states, .Hand hygiene is indicated . before preparing or handling food . after exposure to blood, body fluids, excretions, or contaminated surfaces . after glove removal . The use of gloves does not substitute for hand hygiene. Always perform hand hygiene after gloves are removed . Perform hand hygiene before applying non-sterile gloves . 2. On 5/5/26, initial review of the facility's infection control policies included the following: Facility policy, Infection Prevention and Control, effective 6/2016, last reviewed 3/2025 Facility policy, Vaccination of Residents, effective 10/2019, last reviewed 03/2025 Facility policy, Influenza Vaccine, effective 3/2022, last reviewed 3/2025 Facility policy, Pneumococcal Vaccine, effective 10/2023, last reviewed 3/2025. Facility policy, Isolation-Notices of Transmission-Based Precautions, effective 11/2017, last reviewed 3/2025 Facility policy, Isolation-Initiating Transmission-Based Precautions, effective 11/2017, last reviewed 3/2025 Facility policy, Infection Prevention and Control, revised 3/2025 states, .Policies and procedures are reviewed and revised as necessary . and at least annually. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205006	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montello Manor	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/6/26 at 1:02 p.m., during an interview with the DON, the surveyor discussed the above finding and that some of the facility's infection control policies had been reviewed 2/2026. The surveyor requested evidence of annual review of the above policies. At this time, the DON confirmed that the above policies included in the facility's IPCP are the most current and that she was unaware that they needed annual review.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205006	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montello Manor	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)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to maintain an effective pest control program so that the facility is free of pests for 2 of 2 units(North and East), the sitting area near the front door, and the conference room. Findings:1. On 5/4/26 at 9:10 a.m., in an interview with a surveyor, Resident #15 (room [ROOM NUMBER]) stated that there's fruit flies that come in the room with the food all the time. 2. On 5/4/26 at 9:11 a.m., in an interview with a surveyor, Certified Nursing Assistant(CNA #2) stated that there are fruit flies and they are worse in the bathroom of resident room [ROOM NUMBER]. A surveyor observation of resident room [ROOM NUMBER] bathroom, with CNA #2, revealed many fruit flies that were flying around the sink.3.On 5/4/26 at 9:30 a.m., during an interview with Resident #2 in resident room [ROOM NUMBER], a surveyor observed fruit flies flying around the resident. Resident #2 stated they have been in the room for weeks.4.On 5/4/26 at 9:49 a.m., during an interview with Resident #14(room [ROOM NUMBER]), a surveyor observed fruit flies flying around Resident #14 and surveyor.5. On 5/4/26 at 10:50 a.m., a surveyor observed fruit flies in resident room [ROOM NUMBER] buzzing around the room during an interview with the Resident #35. On 5/4/26 at 11:45 a.m., a surveyor discussed the finding with the Director of Environmental Services. 6. On 5/4/26 at 11:48 a.m., a surveyor observed the arrival of the lunch meal cart to the East Wing. At 11:54 a.m., a surveyor observed a fruit fly on surface of the meal cart. There were 14 resident meal trays on cart. The plates were covered, however there were vent openings on the top of the covers, large enough to allow flies in to the food. The surveyor then observed multiple flies swarming in hall. At this time, the surveyor discussed the observation with CNA #5, who stated that the flies have been present for a couple weeks now.7. On 5/4/26 at 12:03 p.m., a surveyor observed fruit flies on wall outside resident room [ROOM NUMBER], in the doorway of resident room [ROOM NUMBER] and fruit flies flying around the resident in resident room [ROOM NUMBER]. 8. On 5/5/25 at 11:35 a.m., in an observation and interview with a surveyor, CNA#2 observed and confirmed fruit flies in resident room [ROOM NUMBER] bathroom.9. On 5/5/25 at 11:35 a.m., two surveyors observed fruit flies in resident room [ROOM NUMBER] bathroom. 10. On 5/6/26 at 8:53 a.m., in an interview and observation in resident room [ROOM NUMBER] bathroom, the Director of Environmental Services confirmed the observation of fruit flies.11. On 5/6/26 at 12:06 p.m., three surveyors observed fruit flies in conference room where the survey team was set up for survey. 12. On 5/6/26 at 12:35 p.m., while 2 surveyors were present at an interview with the Minimum Data Set (MDS) Coordinator in her office on the North Unit, all three observed a fruit fly flying around the office. The MDS Coordinator stated that she doesn't know why she has them in her office but they have been there for days. 13. On 5/6/26 at 1:25 p.m., while a surveyor was interviewing a family member of a resident in the sitting area near the front door, both the surveyor and the family member observed a fruit fly buzzing around them. On 5/6/26 at 1:45 p.m., in an interview with four surveyors present, a surveyor discussed the multiple observations and findings of fruit flies with the Administrator. At this time, the Administrator confirmed that the facility's pest management program was not effective.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205006	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montello Manor	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)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record reviews and interview, the facility failed to ensure the Notice of Medicare Provider Non-Coverage (NOMNC) form was provided at least two days prior to end of Skilled services for 1 of 3 residents whose Medicare Part A Skilled services were discontinued (Residents #40). In addition, the facility failed to ensure the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) form 10055, which included appeal rights and liability of payment was provided at least two days prior to a resident's last covered day for 2 of 2 residents whose Medicare Part A services were discontinued and remained in the facility (#40 and #41).Findings:1. Resident #40's NOMNC indicated that the resident's Medicare Part A services would end on 12/11/25 and was signed by the resident on 12/10/25, one day prior to end of skilled services. Furthermore, the medical record lacked evidence that the resident was provided a SNFABN when the Medicare A coverage for skilled services was discontinued. The resident remained living in the facility.2. Resident #41's clinical record lacked evidence that he/she was provided a SNFABN when the Medicare A coverage for skilled services ended on 2/18/26. The resident remained living in the facility.On 5/6/26 at 10:15 a.m., during an interview with the Director of Nursing, she stated that they have not been giving ABN to residents. At this time, the above information was discussed and confirmed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205006	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montello Manor	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)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, record review, and interviews, the facility failed to investigate a complaint/grievance for 1 of 1 resident reviewed for personal property (Resident #6).Findings:Facility policy titled Grievances/Complaints, Recording and Investigating states: Upon receiving a grievance and complaint report, the grievance officer will begin an investigation into the allegations.Review of Resident #6's annual Minimum Data Set (MDS) dated [DATE] revealed Resident had a Brief Interview for Mental Status (BIMS) of 15 of 15, indicating he/she is cognitively intact.On 5/4/26 at 9:01 a.m., in an interview with Resident #6, he/she stated that about 4-5 months ago he/she had 4 vintage cameras go missing.On 5/5/26 at 2:24 p.m., in an interview with the Administrator, she states about a month or two ago she remembers Resident #6 telling her that he/she had 4 missing cameras. At this time, the Administrator stated she never investigated or filed a complaint/grievance for his/her missing cameras.On 5/6/26 at 10:31 a.m., in an interview with the Director of Nursing, she discussed speaking with Resident #6's POA (Power of Attorney) today. At that time, the POA confirmed that they brought in 4 cameras to leave with the resident about 4 months ago.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205006	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montello Manor	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure resident received timely Activities of Daily Living (ADL) care for a resident who is dependent for ADL care for 1 of 1 resident reviewed for toileting (Resident #4).Findings:1.During an initial observation on 5/4/26 at 8:34 a.m., Resident #4 was observed sitting in a wheelchair located in the back corner of the dining room with no activity. The television (TV) is on in the opposite corner, not in Resident #4's line of vision and the volume is not high enough for him/her to hear. Another resident is observed sitting at a small table directly in front of the T.V. During a follow up observation at 12:35 p.m., Resident #4 was observed in the same spot with no activity, TV is on, not in line of vision, volume is not high enough for him/her to hear. Another resident is observed sitting at a small table directly in front of the TV. At this time a surveyor asked the Director of Nursing (DON) why Resident #4 was still in the corner of the dining room with no activity, and there's no evidence that the staff had checked on him/her or given brief assistance during this time. DON stated Resident #4's is on hospice and family doesn't want him/her to stay in bed all day because all he/she wants to do is sleep, and she will have staff attend to him/her.Review of Minimum Data Set (MDS) dated [DATE] revealed Resident 4 had a Brief Interview for Mental Status (BIMS) score of 3 of 15 indicating he/she is not cognitively intact and is dependent on staff for all needs.Review of Resident 4's care plan updated 3/5/26 states Toileting.totally dependent on 2 staff for toileting; check and change every 2 hours and as required for incontinence. Activities: needs 1:1 bedside/in room visits and activities if unable to attend out of room events. Needs assistance t/escort to activity functions.prefers to listen to 50s and 60's music, watch westerns on his/her roommates TV or east dining room, preferred activities are watching cards and bingo, musical programs, entertainment, pet visits and riding in wheelchair outside. When choosing not to participate in organized activities prefers to watch TV and play with activity blanket for social and sensory stimulation.Further observations of Resident#4 on 5/5/26 at 9:50 a.m., and 1:35 p.m., 5/6/26 at 7:15 a.m., 11:30 a.m., 11:30 a.m., and 1:00 p.m., Resident #4 was observed sitting in a wheelchair located in the back corner of the dining room with no activity. The television (TV) is on in the opposite corner, not in Resident #4's line of vision and the volume is not high enough for him/her to hear. Another resident is observed sitting at a small table directly in front of the T.V. During an interview on 5/6/26 at 1:50 pm. CNA#6 stated that most of the time Resident #4 is a no void, but he/she should still get checked but doesn't. During an interview Anonymous #1 Resident #4 is left in the dining room a lot and hasn't seen anyone check him/her or bring him/her to room to change and has never seen him/her with an activity in the dining room.During an interview on 5/6/26 at 1:15 p.m., CNA #3 was asked how often Resident #4 received brief assistance/repositioning or was checked during the day. CNA#3 stated Resident #4 is normally in the dining room from breakfast until 1:00 p.m., and it depends on the day. If it's a hospice day, they may change her or check on her, but they don't normally do it. When asked why he/she isn't going to/or have an activity CNA#3 responded that she doesn't know.During an interview with 4 surveyors present on 5/6/26 at 12:45 p.m. the Director of Nursing stated that it is her expectation that residents are toileted at least every 2 hours. At the time a surveyor reviewed the above findings with the Director of Nursing. During a follow up interview at 3:42 p.m., with 4 surveyors present, the Director of Nursing stated that she was told that if a resident fell asleep during an activity, they had to be removed from the room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205006	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montello Manor	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)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview, the facility failed to provide evidence of documentation to justify the continued use of psychotropic medication and failed to ensure an as needed (PRN) psychotropic medication met the required 14-day limit for 1 of 5 residents reviewed for unnecessary medications. (#26)Findings:Review of Resident #26's clinical record shows an active physician order dated 4/15/26 for Lorazepam oral concentrate 2MG/ML (milligram/milliliter) with instructions to Give 0.25 ml by mouth every 1 hours as needed for anxiety/agitation with no stop date. Further review of the clinical record lacked evidence of clinical rational to continue the medication for longer than 14 days.On 5/6/26 at 11:30 a.m., the above information was discussed and confirmed with the Director of Nursing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205006	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montello Manor	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)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interviews, the facility failed to ensure that a discharge summary, including a recapitulation of stay and medication reconciliation, was provided to 1 of 1 resident reviewed for discharge planning (Resident #39).Finding:A review of Resident #39's clinical record indicated that he/she was admitted to the facility in March 2026.Review of Resident #39's care plan states, . admission discharge goal. wants to return to Apartment at. independent living, with referral to [home health agency] for PT [Physical Therapy], OT [Occupational Therapy], HHA [Home Health Aide] also signed on for services. for med [medication] set up/mgt [management] and PSS [Personal Support Specialist] to assist with care.Further review of Resident #39's clinical record revealed that on 4/3/26, he/she had a planned discharge from the facility to independent living. The clinical record lacked evidence of a discharge summary, including a recapitulation of stay and medication reconciliation. On 5/6/26 at 2:00 p.m. a surveyor discussed the above finding during an interview with the Director of Nursing (DON).On 5/6/26 at 2:30 p.m. during an interview in the presence of 4 surveyors, the DON confirmed that she could not find any evidence of a discharge summary that provided the necessary information to Resident #39's continuing care providers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205006	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montello Manor	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)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, record review, and interview's, the facility failed to ensure that a care plan was adequately developed/followed in the areas of bowel and bladder care for 1 of 1 resident's reviewed for ADL (activities of daily living) care (Resident #4) and smoking for 1 of 1 resident reviewed for smoking (Resident #18). 1.Resident #4 has diagnosis to include senile dementia and is receiving hospice services for end of life care. Review of Minimum Data Set (MDS) dated [DATE] revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 3 of 15 indicating he/she is not cognitively intact. He/she is dependent on staff for all toileting needs. Review of Resident #4's care plan updated 3/5/26 states [Resident #4] has bladder and bowel incontinence r/t dementia.Incontinent: check and change every 2 hours and as required for incontinence. wash, rinse and dry perineum. Review of Bladder Elimination task states Resident #4 received brief assistance on 4/30/26 at 8:08 a.m., and 20:14, on 5/2/26 at 10:46 a.m. and 19:58, on 5/4/26 at 13:42, 20:13, and 23:42, on 5/5/26 at 10:21 a.m., 20:01, and 22:52. As of 11:16 a.m. on 5/6/26 there is no documented evidence Resident #4 received brief assistance. During an interview with 4 surveyors present on 5/6/26 at 12:45 p.m. the Director of Nursing stated that it is her expectation that residents are toileted at least every 2 hours. At the time a surveyor reviewed the above findings with the Director of Nursing. 2. A review of the facility policy titled Smoking Policy states Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) are noted in the care plan, and all personal caring for the resident shall be alerted to these issues. A review of Resident #18's clinical record revealed a smoking care plan that lacked evidence of appropriate goals and interventions for how he/she smokes and how he/she will smoke safely. On 5/5/26 at 11:15 a.m., Resident #18's care plan was reviewed with the Director of Nursing, at this time she confirmed that the care plan lacks appropriate goals and interventions related to smoking.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205006	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montello Manor	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)
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. Based on observation and interviews, the facility failed to maintain respiratory equipment for 1 of 3 residents reviewed for respiratory (Resident #15).Findings:Observation of Resident #15's oxygen concentrator located next to bed, revealed visible debris build up on the filter on 5/4/26 at 9:18 a.m., on 5/5/26 at 11:15 a.m., and 5/6/26 at 10:00 a.m., and 3:14 p.m. Review of Resident #15's care plan updated 3/2026 states . has the potential for altered respiratory status/difficulty r/t Sleep Apnea, . Care/cleaning of equipment and supplies per facility protocol. The facility did not provide respiratory protocol by the end of survey.Review of Resident #15's active orders revealed order with start date of 3/30/26 to change 02 tubing weekly on Tuesday; date and initial new tubing and store in bag when not in use, and clean concentrator filter every day shift every Tuesday for change; and date new tubing. Review of Resident #15's Treatment Administrator Record (TAR) states it was completed 5/5/26 during the day shift.During an interview on 5/4/26 at 9:19 a.m., Resident #15 stated that he/she has sleep apnea and requires Oxygen while he/she is sleeping and uses the oxygen every night.During an interview on 5/6/25 at 3:14 pm a surveyor and Licensed Practical Nurse (LPN)1 stated she's never been shown how to clean the filter, so she just marks that she doesn't know how to do it.During an interview on 5/6/26 at 3:25 p.m., 2 surveyors discussed above findings with Director of Nursing who stated LPN1 was new and she has not gotten around to showing her how to clean the oxygen concentrator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205006	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montello Manor	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)
F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation and interview, the facility failed to maintain a garbage storage area in a sanitary condition to prevent the harborage and feeding of pests for 1 of 2 trash dumpsters for 1 of 3 days of survey (5/6/26).Findings:On 5/6/26 at 8:00 a.m., a surveyor observed 1 of 2 dumpsters with the top front right lid open exposing trash. On 05/6/26 at 8:02 a.m., in an interview with a surveyor, the Director of Food and Nutrition confirmed the finding.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205006	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montello Manor	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)
F 0730 Level of Harm - Potential for minimal harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on record reviews and interviews, the facility failed to complete performance reviews at least once every twelve months for 3 of 5 Certified Nursing Assistants selected for review (Certified Nursing Assistant's (CNA) (CNA's #, #8 and #9).Findings:1.CNA #4 was hired on 11/26/18. Review of CNA #4's personnel file revealed her last annual review completed 3/11/25. Further review of personnel file lacked evidence that an annual review was completed for 3/2026. During an interview on 3/5/26 at 1:15 p.m., CNA #4 stated that they had always gotten annual reviews in March. Confirmed she had an annual review in March of 2025 and should have had another in March 2026, but she has not had one yet.2. CNA #6 was hired 9/5/91. Review of CNA6's personnel file revealed annual review dated 3/11/25. The personnel file lacked evidence that an annual review was completed for 3/2026.3. CNA #8 was hired 8/28/18. Review of CNA #7 personnel file revealed annual review dated 3/17/25. The personnel file lacked evidence that an annual review was completed for 3/2026.During an interview on 5/6/26 at 2:14 p.m., the Administrator confirmed the annual reviews are done in March but have not been completed as the Director of Nursing hasn't had the time yet.