STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205114	A. Building B. Wing	12/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
High View Rehabilitation and Living Center	517 Riverview St Madawaska, ME 04756

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 33242 Based on record reviews and interview, the facility failed to ensure the physician was notified of a resident's change of condition prior to transfer to the hospital for 1 of 2 sampled residents (Resident #1 [R1]}. Findings: On 12/23/24, R1's clinical record was reviewed. 1. On 12/1/24, a staff member reported to Registered Nurse #1 (RN1) that R1 was not looking like [themselves]. Upon assessment by RN1, R1 was experiencing increased confusion with vital signs within normal limits. R1 was later found by a staff member attempting to eat a tea bag At 6:06 p.m., RN1 called 911 and prepared R1 for a hospital transfer, notifying R1's family member and giving report to the hospital. The clinical record lacked evidence of notifying the Medical Provider prior to this acute care facility transfer. 2. On 12/9/24 at 11:30 a.m., a stall remember reported to RN1 that R1 was not looking well and had slurred speech. Upon assessment by RN1, R1 was alert but unable to answer orientation questions with slurred words and was unable to understand what R1 was saying. Vital signs were within normal limits except the resident was experiencing respirations at 28 breathes per minute. According to the Emergency Medical Services (EMS) report, with EMS dispatched to the facility at 1:13 p.m. The clinical record lacked evidence of notifying the Medical Provider prior to this acute care facility transfer. On 12/23/24 11:55 a.m., during an interview with RN1 with the Director of Nursing present, the surveyor asked about documentation about notifying the Medical Provider prior to transferring R1 to the hospital. RN1 stated that she was unaware that she needed to call the provider prior to transferring R1 to the hospital.

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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(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 - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 33242 Based on record reviews, facility reported incident and written statements review, and interviews, the facility failed to transfer a resident to the hospital timely, after a change in condition for 1 of 2 residents reviewed (Resident #1 [R1]). Finding: On 12/11/24, the facility sent a Reportable Incident Report to the State Agency alleging that there may have been a delay in treatment for R1 on 12/9/24. On 12/23/24, R1's clinical record was reviewed. Documentation in the clinical record on 12/9/24 and written statements obtained during the facility's investigation indicated that on 12/9/24, a Certified Nursing Assistant reported to RN1 and Nurse Manager (NM) that R1 was not looking well and had slurred speech, reported between 11:22 a.m. and 11:30 a.m. NM's written statement indicated that she was the one that said that R1 would be sent to the emergency room (ER); RN1 told NM that she needed to finish giving one insulin and then she would be sending R1 out. NM's statement indicated that she started to prepare the paperwork for transfer around 11:50 a.m. and spoke with the Power of Attorney (POA). NM clocked out for lunch at 12:13 p.m., thinking that RN1 would call Emergency Medical Services (EMS) as she informed RN1 that she had completed the paperwork for the ER and EMS. NM returned from lunch at 12:41 p.m. and upon return, RN1 and NM double signed the paperwork that they had gotten verbal permission from the POA to send the resident. NM asked RN1 if EMS had been called and RN1 stated no so NM called the 911 operator. The surveyor reviewed the EMS Care Report for R1's transfer to the hospital on 12/9/24. Per this report, the unit was dispatched at 1:13 p.m. and enroute at 1:14 p.m., EMS is located 0.5 miles from the facility and arrived on scene at 1:16 p.m. On 12/23/24 at 11:55 a.m., during an interview with a surveyor, RN1 stated that she assessed R1 before 12:00 p.m. as she documented vitals in the clinical record at that time. She stated that the resident's vitals were normal except she was tachypneic (respirations were 28). RN1 stated that she checked for stroke and signs were negative other than the slurred speech. The surveyor asked why was there a delay in transferring R1 to the hospital and RN1 stated, there was a lot of paperwork that needs to be completed. I was being pulled in so many directions which is why there was a delay. On 12/23/24 at 12:51 p.m., during an interview with the Administrator and Director of Nursing, the surveyor reviewed the EMS Care Report noting that it was almost 1 3/4 hours after it was reported that R1 had slurred speech to when 911 was called. As a result of this isolated incident, the following actions were initiated: - RN1 received a written warning on 12/13/24 for not following policies and procedures related to resident change in condition. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- RN1 worked on 12/9/24 (incident date) and next scheduled day to work was 12/13/24. RN1 was removed from the Charge Nurse role for the weekend shifts and placed on the Medication Cart with direction to report any concerns to a more experienced nurse. - RN1 has returned to the Charge Nurse role but is to follow up with a more experience nurse for any questions. She also has the Director of Nursing's telephone number. The DON stated on 12/23/24 at 12:51 p. m., RN1 is to report any concerns at all to a senior nurse or call me with any questions. I have my phone on me 24/7 and receive calls at all times of the day or night. - On 12/13/24, additional training, Clinical Assessment/Critical Thinking was completed with RN1 and discussed with the Director of Nursing. - On 12/13/24, the training document, Clinical Assessment/Critical Thinking was provided and reviewed by other nursing staff, including NM; this document will be reviewed with the four remaining nursing staff that are out on leave or are per diem when they return. The facility also provided education to the CNAs, Stop and Watch - Early Warning Tool which helps direct when to report a resident change in condition to a nurse.