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	05/01/2024

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. 49635 Based on observation, record review and interview, the facility failed to notify the physician of a change in status for 1 of 1 sampled residents reviewed for a choking event, (Resident [R]1). Finding: On 4/29/24 at 11:36 a.m., a surveyor observed from the hallway a Certified Nursing Assistant Medication Aide (CNA-M) checking on R1 who was choking. The surveyor heard coughing sounds, almost vomiting, choking sounds, then more repetitive coughing. CNA-M left to get the Registered Nurse (RN3). On 4/29/24 at 11:39 a.m., RN3 entered the room to aid R1. R1's coughing cleared. RN3 stated to the surveyor that the gravy must have gone down the wrong pipe. On 04/29/24 11:41 a.m., RN3 stated that CNA-M is supervising him to eat now. On 04/29/24 at 12:24 p.m., RN3 documented the choking incident in a nurse note as Category: Change of Condition. The note indicates initiating a nursing measure of aspirations precaution monitoring opened [for] 72 hours. There was no evidence to indicate the provider was notified of the incident. On 5/1/24 at 10:30 a.m., in an interview the interim Director of Nursing (DON), she stated that when residents are placed on aspiration precautions for 72 hours following aspiration, this is done following the facility's practice. There is not a policy. The facility's practice includes checking lung sounds, temperature, oxygen saturation, respiratory rate, and making any necessary adjustments like having them out of bed to eat their meals. At this time, the DON called the provider to notify her of the aspiration event and received orders. On 5/1/24 at 10:37 a.m., in an interview with a surveyor, the DON stated, staff should notify the provider after each incident. The provider should have been told while in house yesterday. At this time, the surveyor confirmed the provider had not been notified of a change in status.

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33242 Based on record review and interview, the facility failed to identify the reason for a transfer on the transfer notice and failed notify the resident and/or the resident's representative in writing of the transfer/discharge to an acute care hospital for 1 of 1 residents sampled for hospitalization s (Resident [R]34). Finding: R34 was admitted to the facility on [DATE] and transferred to the hospital on 2/27/24. A review of R34's clinical record lacked evidence of the reason for the transfer identified on the transfer form. This form was signed by the resident on 2/27/24 and also had an area that was to be completed that indicated who received this written notice, that was blank. On 4/29/24 at 2:30 p.m., during an interview with a surveyor, the Social Worker-Conditional stated that the nurses complete the form when they fill out the paperwork for the transfer. On 04/30/24 at 9:34 a.m., during an interview with a surveyor, Registered Nurse (RN) 2 stated that she called the Resident Representative, but she did not mail a written copy of the notice nor did she give a written copy to the resident after the notice was signed. The surveyor also reviewed the form noting that the reason for the transfer was not indicated.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33242 Based on record review and interview, the facility failed to notify the resident and/or the resident's representative in writing of a bed hold notice after a transfer/admission to an acute care hospital for 1 of 1 residents sampled for hospitalization s (Resident [R]34). Finding: R34 was admitted to the facility on [DATE] and transferred to the hospital and was admitted on [DATE]. The Bed Hold Notification form was signed by the resident on 2/27/24 and also had an area that was to be completed that indicated who received this written notice, that was blank. On 4/29/24 at 2:30 p.m., during an interview with a surveyor, the Social Worker-Conditional stated that the nurses complete the form when they fill out the paperwork for the transfer. On 04/30/24 at 9:34 a.m., during an interview with a surveyor, Registered Nurse (RN) 2 stated that she called the Resident Representative but she did not mail a written copy of the notice, nor did she give a written copy to the resident after the notice was signed.

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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 review, facility protocol, and interviews, the facility failed to complete neurological (neuro) assessments for 1 of 1 residents reviewed who fell and hit their head (Resident [R]136) and the facility failed to ensure Physician orders were followed for 1 of 1 resident observed for Activities of Daily Living (ADL) care (the acts of bathing, dressing, and personal hygiene care), (Resident [R]16). Findings: A review of the facility's protocol, High View Rehab and Nursing Center Fall Protocol, revised 9/1/23, indicated that If resident hits his/her head or are suspected of hitting their head, initiate neuro checks every shift for 72 hours. 1. A review of R136's clinical record included a nursing note written by Registered Nurse (RN)4 that indicated R136 was on the floor, the nose was bruised and tender to touch and slightly abraded (scraped). R136 was sent to the hospital for evaluation for a possible concussion. A review of the hospital records indicated that on 4/5/24, R136 was sent to the hospital after R136 rolled out of bed, hit his/her nose, landed on the floor, striking face and head. The surveyor was unable to find any evidence of neurological assessments in the clinical record. On 4/30/24 at 9:45 a.m., during a joint interview with Interim Director of Nursing (DON) and Registered Nurse (RN)2, the surveyor asked when would you do neurological assessments on a resident? RN2 stated that nursing would enter (special circumstances) in the computer that would direct nursing to complete neuro assessments when a resident hits their head or has an unwitnessed fall. The DON stated that RN4 should have entered a task to complete the neuro assessments in the computer, but did not. The surveyor confirmed that neuro assessments were not completed for R136 during this interview. 49635 2. On 5/1/24 at 10:24 a.m., during observation of ADL care for R16, a surveyor observed RN3 enter the room with a medicine cup containing a white ointment. RN3 identified the ointment as Lantiseptic and applied it to open skin areas on R16's buttocks. RN3 assessed the skin under the breasts and stated she would get some powder for R16. Certified Nursing Assistant (CNA1) dressed R16 while waiting for the powder. On 5/1/24 at 10:27 a.m., a surveyor observed RN3 return to R16's room holding a medicine cup with white powder in it. RN3 handed the cup to CNA1, then left the room. CNA1 lifted R16's shirt to apply the powder under the breasts, then restored R16's clothing. On 5/1/24 review of the clinical record revealed a physician order written on 3/9/24 for Caldesene Powder - apply topically under breasts, armpits, abdominal fold [and] to left/right [abdominal] fold above hips twice daily preventative for preventative measure for redness [and] BID (twice per day) PRN (as needed), and a physician order written on 3/18/24 for Lantiseptic apply small amount barrier to right inner thigh [and] groin for redness/irritation to skin BID [and] BID PRN. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/24 at 12:15 p.m., review of the electronic -Treatment Administration Record (e-TAR) indicated: Lantiseptic apply small amount barrier to right inner thigh and groin for redness and irritation to skin twice a day and twice daily prn, Caldesene Powder Apply topically under breasts, armpits, abdominal fold and to left and right side of abdominal fold above hips twice a day for preventative measures for redness. (and BID PRN), and Calmoseptine with stoma powder to buttocks twice a day, were marked with a checkmark indicating they were administered. On 5/1/24 at 12:28 p.m., in an interview with a surveyor, RN3 stated the documented administrations reflected the applications of ointment and powder during ADL care. RN3 also stated CNA1 was supposed to apply Calmoseptine with stoma powder, it is in a jar in the resident's room. At this time the surveyor confirmed the Lantiseptic, Caldesene, and Calmoseptine were not administered as ordered.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 32540 Based on record review and interview, the facility failed to ensure the pharmacist identified an irregularity for a psychotropic medication for 1 of 4 residents reviewed for the use of Psychotropic medications (Resident [R]28) Finding: On 5/1/24 at 10:00 a.m., R28's clinical record was reviewed, it revealed that the R28 was on an anti-psychotic medication, Olanzapine. R28's current physician order dated 4/16/24 contained a treatment to complete Abnormal Involuntary Movement Scale (AIMS) testing every 6 months. The last AIMS test completed for R28 was done on 5/27/23. On 05/01/24 at 10:55 a.m. During a clinical record review with the Minimum Data Set (MDS) nurse. The surveyor confirmed at this time the Pharmacist did not identify in their monthly medication reviews that the AIMS test for R28 was not completed in November and that the AIMS test is supposed to be done every 6 months.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 32540 Based on record review and interview, the facility failed to ensure an Abnormal Involuntary Movement Scale (AIMS), used to monitor for potentially irreversible side effects of anti-psychotic medications, was completed every 6 months for 1 of 4 sampled residents reviewed for the use of Psychotropic medications (Resident [R] 28). Finding: On 5/1/24 at 10:00 a.m., R28's clinical record was reviewed, and revealed that the R28 was on an anti-psychotic medication, Olanzapine. R28's current physician order dated 4/16/24 contained a treatment to complete Abnormal Involuntary Movement Scale (AIMS) testing every 6 months. In the electronic record under the other assessments tab, documentation shows the last AIMS test was completed on 5/27/23. Review of the electronic treatment administration record (e-tar) shows that the AIMS test was due to be completed on 11/26/23, the AIMS test was not completed. On 5/1/24 at 10:55 a.m., during an interview with the Minimum Data Set (MDS) Nurse the surveyor confirmed that the AIMS test was not completed for R28 in November.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 49635 Based on interviews, the facility failed to ensure they had a qualified Food Service Director for 3 of 3 days of survey (4/29/24, 4/30/24, and 5/1/24). This has the potential to affect all the residents. Findings: On 4/29/24 at 10:10 a.m., Dietary Aide [DA]2 stated, we do not have a Food Service Director, the Administrator is filling the role until one is hired. We are working on it, but they are hard to find in Northern Maine. On 04/30/24 at 7:55 a.m., in an interview with the Cook, DA1, and DA2; they stated they do not have serve safe certifications. On 04/30/24 at 2:24 p.m., In an interview with a surveyor, the Administrator stated, no, I do not have a serve safe manager certificate. On 05/01/24 at 11:58 a.m., in an interview with the Administrator, a surveyor confirmed the facility did not have a qualified Food Service Director.

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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. 49635 Based on observations, and interviews, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety by not storing dishes in a sanitary manner for 1 of 3 days of survey (4/30/24), not storing food in a sanitary manner, not wearing hair nets or beard restraints while preparing food, and not maintaining the kitchen in a clean and sanitary manner for wall around oven for 2 of 3 days of survey (4/29/24 and 4/30/24), and not maintaining a clean kitchen floor for 3 of 3 days of survey (4/29/24, 4/30/24, and 5/1/24) . Findings: On 4/29/24 at 10:10 a.m., during initial tour of the kitchen a surveyor observed that portions of the floor were uncleanable, including a circular patch of concrete near the oven, circular slices in the linoleum where tables were relocated within the kitchen, and broken tiles around a drain in front of the walk in freezer. In the dry storage area on the shelf and available for use the following items: 2 cans labeled 28.2oz Mushroom Pieces and Stems, both cans had dented in bottom seals 1 can labeled 7 pounds (lb) 4oz [NAME] Creek Cherry Pie Filling Ready to Use, with a dented in bottom seal 1 package 12oz Pork Flavored Gravy mix, undated and open to the environment On 4/29/24 at 10:31 a.m., a surveyor observed and confirmed the above findings with Cook. On 4/29/24 at 10:45 a.m., a surveyor observed in back storage on the shelf and available for use 2 package of cereal, open, and undated 1 bottle of Glucerna original shake Rich Chocolate flavor with an expiration date of 12/1/2023 23 bottles of Glucerna Homemade Vanilla flavor, with an expiration date of 4/1/24 A surveyor observed and confirmed these findings with DA1 at the time of the observations. On 4/29/24 at 11:10 a.m., Observation of the walk-in freezer revealed a box labelled 5lb Fully Cooked Ground Italian Sausage, within the box was an opened, undated and unlabeled bag. The surveyor confirmed this with DA2 at the time of the observation. On 04/30/24 at 7:47 a.m., review of the walk-in refrigerator revealed the following: 1 unopened box containing 48 cups, 4oz each, Yoplait Light strawberry/ banana yogurt, with a use by date of 4/29/24 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1 open box containing 40 cups, 4oz each, Yoplait Light strawberry/ banana yogurt, with a use by date of 4/29/24 At this time the surveyor confirmed with the Cook that 88 cups were available for use and the yogurt was used during breakfast service that morning. No residents were effected. On 04/30/24 at 12:50 p.m., a surveyor observed and confirmed with the Cook that the serving pans were stored in an unsanitary manner, face up, and exposed to the environment with debris visibly accumulated on pans. The surveyor also confirmed wet stacking of serving pans on kitchen racks with the Cook. On 04/30/24 at 01:10 p.m., Two surveyors observed and confirmed with Cook that portions of the floor were uncleanable, including a circular patch of concrete near the oven, circular slices in the linoleum where tables were relocated within the kitchen, and broken tiles around a drain in front of the walk in freezer. Two surveyors also confirmed at that time food splashings dried to the wall around and behind the stove top, and preparation of food by Cook without a hairnet or beard restraint on 4/29/24 and 4/30/24. On 5/1/24 at 4:45 p.m., a surveyor observed that portions of the floor remained uncleanable, including a circular patch of concrete near the oven, circular slices in the linoleum where tables were relocated within the kitchen, and broken tiles around a drain in front of the walk in freezer.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 35904 Based on Infection Prevention Control Program (IPCP) review and interview, the facility failed to implement the elements of the Legionella Water Management Program for 1 of 1 Water Management Program reviewed. Finding: On 5/1/24, the facility's Legionella Water Management Program policy was reviewed. In Policy Interpretation and Implementation: Under #5: the water management program includes the following elements: 5c - The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria, including: 1) storage tanks; 2) Water heaters; 3) Filters; 4) Aerators; 5) Showerheads and hoses; 6) Misters, atomizers, air washers and humidifiers; 7) Whirlpool tubs; 8) Fountains; and 9) Medical devices such as CPAP machines, hydrotherapy equipment; etc. 5d - The identification of situations that can lead to Legionella growth, such as: 1) Construction; 2) Water main breaks; 3) Changes in municipal water quality; 4) The presence of biofilm, scale or sediment; 5) Water temperature fluctuations; 6) Water pressure changes; 7) Water stagnation and; 8) Inadequate disinfection. On 5/1/24 at 1:55 p.m., in an interview with the Administrator, a surveyor confirmed that the facility does not have measures in place to assess and monitor areas where Legionella and opportunist waterborne pathogen can grow and spread.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33242 Based on facility policy reviews, record reviews, Centers for Disease Control and Prevention (CDC) recommendations, and interview, the facility failed to offer the influenza vaccination to 4 of 5 residents reviewed (Resident [R]9, R15, R24, and R30) and failed to offer the updated Pneumococcal vaccination to 5 of 5 residents (R9, R15, R17, R24, and R30). Findings: The facility's policy, Influenza Vaccine, revised 9/2022, indicated that between October 1st and March 31st each year, the influenza vaccine shall be offered to residents. The facility's policy, Pneumococcal Vaccine, revised 10/2023, indicated prior to or upon admission, residents will be assessed for eligibility to receive the Pneumococcal vaccine series and when indicated, will be offered the vaccine series within thirty days of admission to the facility unless medically contraindicated or the resident has already been vaccination. Assessments of Pneumococcal vaccination status will be conducted within five working days of the resident's admission if not conducted prior to admission. Administration of the Pneumococcal vaccines or revaccinations will be made in accordance with current CDC recommendations at the time of the vaccination. On 4/30/24, between 12:30 p.m. - 1:00 p.m. during an interview with the Interim Director of Nursing/Infection Preventionist (DON), resident's vaccination records were reviewed for influenza and Pneumococcal vaccinations. During this interview, the DON used the PneumoRecs VaxAdvisor: Vaccine Provider App | CDC tool to determine Pneumococcal vaccination recommendations for the 5 residents. During this interview, the DON confirmed that the Pneumococcal assessments were not conducted within 5 days of admission nor were the Pneumococcal vaccines offered within 30 days of admission to the facility and confirmed that influenza had not been offered/administered either. The following were confirmed during this interview: 1. R9 was admitted to the facility on [DATE]. The clinical record lacked evidence of offering the influenza vaccination and the CDC recommendation was to administer one dose of Prevnar 20 which had not been offered. 2. R15 was admitted to the facility on [DATE]. The clinical record lacked evidence of offering the influenza vaccination and the CDC recommendation was to administer one dose of Prevnar 20 which had not been offered. 3. R17 was admitted to the facility on [DATE]. The CDC recommendation was to administer one dose of Prevnar 20 which had not been offered. 4. R24 was admitted to the facility on [DATE] and is currently [AGE] years old. The clinical record lacked evidence of offering the influenza vaccination and the CDC recommendation was to administer one dose of Prevnar 20 which had not been offered. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. R30 was admitted to the facility on [DATE]. The clinical record lacked evidence of offering the influenza vaccination and the CDC recommendation was to administer one dose of Prevnar 20 which had not been offered.

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33242 Based on clinical records review, facility policy review, Centers for Disease Control and Prevention (CDC) recommendations, and interview, the facility failed to follow the CDC guidelines and offer the updated 2023-2024 Coronavirus (COVID-19) vaccine doses for 4 of 5 residents reviewed (Resident [R]15, R17, R24, and R30). Findings: The facility's policy, COVID-19 Vaccination of Residents, revised 6/2023, indicated that vaccine recommendations and schedules are consistent with the Centers for Disease Control Interim Clinical Considerations for the Use of COVID-19 Vaccines in the United States. Booster vaccine doses are provided in accordance with current CDC guidance. The CDC website, Stay Up to Date with COVID-19 Vaccines | CDC, indicated that CDC recommends the 2023-2024 updated COVID-19 vaccines: Pfizer-BioNTech, Moderna, or Novavax, to protect against serious illness from COVID-19 and that people aged [AGE] years and older who received 1 dose of any updated 2023-2024 COVID-19 vaccine (Pfizer-BioNTech, Moderna or Novavax) should receive 1 additional dose of an updated COVID-19 vaccine at least 4 months after the previous updated dose, and that you are up to date when you have received 2 updated 2023-2024 COVID-19 vaccine doses. On 4/30/24, between 2:00 p.m. - 2:15 p.m. during an interview with the Interim Director of Nursing/Infection Preventionist, the following resident's vaccination records were reviewed and confirmed that the updated 2023-2024 COVID-19 vaccinations were not offered: 1. R15 was admitted to the facility on [DATE] and is currently [AGE] years old. R15's last documented COVID-19 vaccination was 10/10/22. The clinical record lacked evidence of offering the updated COVID-19 vaccination. 2. R17 was admitted to the facility on [DATE] and is currently [AGE] years old. R17's last documented COVID-19 vaccination was 10/25/23. The clinical record lacked evidence of offering the additional dose of the updated COVID-19 vaccination. 3. R24 was admitted to the facility on [DATE] and is currently [AGE] years old. R24's last documented COVID-19 vaccination was 12/23/21. The clinical record lacked evidence of offering the updated COVID-19 vaccination. 4. R30 was admitted to the facility on [DATE] and is currently [AGE] years old. R30's last documented COVID-19 vaccination was not found in the clinical record. The DON called the Medical Providers office and was given documentation that the last documented COVID-19 vaccination was 6/4/21. The clinical record lacked evidence of offering the updated COVID-19 vaccination.