

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2026
NAME OF PROVIDER OR SUPPLIER High View Rehabilitation and Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Based on interviews and personnel file reviews, the facility failed to ensure the Dietary Supervisors met the qualifications required to be a Food Service Director or Supervisor. This has the potential to affect all the residents. Finding: On 6/15/26 at 10:05 a.m., during an interview with the acting Dietary Supervisor, she stated that she has been in this role for approximately two weeks. She stated she does not currently have a Serve Safe Certificate from the State of Maine. She is not enrolled in a dietetic technician program and is not certified as a dietary manager. She was hired on 6/1/26 as the Dietary Supervisor. On 6/16/26 at approximately 3:00 p.m. during an interview with the Administrator, the surveyor confirmed that the facility does not have a qualified Dietary Supervisor. She stated they were given permission last week to enroll in the Serve Safe manager program but had not yet enrolled. On 6/17/26 at approximately 1:00 p.m. during a review of the personnel files with the office staff for the current and previous Dietary Supervisors the following was confirmed the last qualified Dietary Supervisor left employment on 6/6/25. The facility does not have a full-time dietician they use a consultant dietician who is not a full-time employee.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. Based on interviews, the facility failed to employ a qualified Activity Director (AD) to manage resident centered activities for all residents (33 residents). On 6/17/26 at 12:30 p.m., during an interview with a surveyor, the Administrator stated that the initial Activities Director's last day was 3/6/26. The Administrator confirmed with the surveyor that the staff member that filled the role on 3/8/26 was not qualified for the position and was terminated on 6/8/26. At this time the surveyor confirmed the facility does not currently have a qualified Activities Director, and that the previous staff member had not completed the State-approved program and was not qualified to be the AD.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on record review and interviews, the facility failed to inform a Resident in advance, of treatment risks and benefits, options, and alternatives related to the use of psychotropic medications (prescription drugs that alter brain chemistry, affecting mood, perception, thoughts, or behavior) for 1 of 5 sampled residents reviewed (Resident #23 [R23]). Finding: On 6/17/26, R23's clinical record was reviewed and indicated that R23 had orders for the following psychotropic medications to treat anxiety and major depression: -Amitriptyline (antidepressant that works by increasing the levels of the neurotransmitters serotonin and norepinephrine in the brain, which helps regulate mood, reduce pain signals, and promote sleep). -Diazepam (anxiolytic that works by calming the central nervous system). -Duloxetine (used to treat depression, anxiety, fibromyalgia, and chronic nerve or muscle pain. It works by increasing serotonin and norepinephrine in the brain to help elevate mood and block pain signals). - Mirtazapine (antidepressant used to treat major depressive disorder and is frequently prescribed off-label for insomnia and to stimulate appetite). The clinical record lacked evidence that the resident was informed in advance of treatment risks and benefits, options, and alternatives prior to the use of psychotropic medications. On 6/17/26 at 1:51 p.m., during an interview with a surveyor and the Director of Nursing (DON), R23's clinical record was reviewed. At this time, a surveyor confirmed the clinical record lacked evidence that R23 was informed in advance of treatment the risks and benefits, options, and alternatives prior to the use of psychotropic medications.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observations and interviews, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in a sanitary, orderly, comfortable, and homelike environment for 3 of 3 days of survey (6/15/26, 6/16/26, and 6/17/26). Finding: 1. On 6/15/26 at 1:49 p.m., during an interview with a surveyor, Resident #6 (R6) stated that when he/she used the bathroom, he/she had urine run down their leg because of the gap between the raised seat and the toilet. At this time the surveyor observed R6's private bathroom. The toilet was observed to be installed facing a wall. A commode seat without a bucket was positioned perpendicular to the toilet creating a large gap between the toilet and seat. Excrement splatter was observed around the rim of the toilet. On 6/17/26 at 10:07 a.m., during an interview with a surveyor and the Maintenance Director, R6's bathroom was observed with the toilet facing the wall and the raised toilet seat / commode seat positioned perpendicular to the toilet. At this time, the surveyor confirmed the toilet is not homelike and does not allow the resident to use the toilet in a dignified and sanitary manner.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure that the Resident Representative (RR) received a written copy of the bed hold and transfer notice for 2 of 2 transfers and admissions to the hospital (3/23/26 and 4/20/26) for Resident #17 (R17), Findings: On 6/16/25, R17's clinical record was reviewed and noted the following: 1, R17 was admitted to the hospital on [DATE] and returned to the facility on 3/25/26.2. R17 was admitted to the hospital on [DATE] and returned to the facility on 4/24/26. The clinical record included a Social Services note, dated 2/3/26, that indicated that R17 had a family member that decided to be the Resident Representative (person to make decisions on R17's behalf) after an Adult Protective Services case was opened. Review of the clinical record indicated R17 received a bed hold and transfer notice for both of these discharge/transfers but there was no evidence that the RR received a written copy of the written bed hold and transfer notice for either of these admissions to the hospital. On 6/17/26 at 11:25 a.m., during an interview with a surveyor, the Administrator stated that the RR was not provided a written copy of the notices.		

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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. Based on clinical record reviews and interview, the facility failed to follow physician orders for 1 of 2 residents reviewed for constipation (Resident #6 [R6]). Findings: 1. On 6/17/26, R6's clinical record was reviewed and indicated the following: - Review of R6's Bowel Elimination Record indicated R6 did not have a bowel movement from 5/22/26 through 5/26/26 (5 days total). Additionally, R6 did not have a bowel movement from 6/2/26 through 6/5/26 (4 days total). - Review of R6's standing orders stated, Constipation (Acute): 1. Two days without a bowel movement: a. If resident has an as needed laxative ordered, use that order as directed b. Milk of Magnesia 30 [milliliters (cc)] by mouth [one dose (x1 dose)] 2. Three days without a bowel movement: a. Dulcolax 5 [milligram (mg)] tab-Give 2 tabs = 10mg by mouth x1 dose OR Dulcolax 10mg suppository insert 1 suppository rectally x1 dose. b. If Dulcolax tab or suppository not effective within 8 hours, repeat dose x13. Four days without a bowel movement: a. Contact [the doctor (MD) or Family Nurse Practitioner (FNP)] - Review of the Medication Administration Record for the month of May indicated that on 5/24/26 (day 3 without a bowel movement) R6 received a 15-milliliter dose of Milk of Magnesia for constipation (1 day late and only 1/2 the dose indicated on the standing order). - Review of the Medication Administration Record for the month of June indicated that on 6/4/26 (day 3 without a bowel movement), R6 received a 30-milliliter dose of Milk of Magnesia (1 day late). On 6/5/26 (day 4 without a bowel movement), R6 received a 10-milligram dose of Dulcolax (1 day late). The clinical record lacked evidence that standing order interventions were provided as ordered. Additionally, the clinical record lacked evidence that the provider was notified when R6 went 4 or more days, without a bowel movement, as ordered. On 6/17/26 at 1:51 p.m., during an interview, a surveyor and the Director of Nursing (DON) R6's clinical record was reviewed for bowel elimination. At this time the surveyor confirmed the clinical record lacked evidence that the provider was not notified of 4 or more days without a bowel movement and that interventions were not provided per the provider's standing orders.		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. Based on interviews, observation, and record review, the facility failed to ensure transportation was provided timely for a wound care clinic appointment for 1 of 1 resident reviewed for leg and foot wound care (Resident #2 [R2]). Findings: On 6/16/26 at 10:56 a.m. in an interview and observation with a surveyor, R2 stated that he/she goes to a wound clinic for wound care for his/her lower legs and feet every week and is not sure if there is transportation available to go tomorrow (6/17/26) and is concerned about this. The surveyor observed R2's left and right lower legs and feet wrapped with cling wrap/bandages. Review of R1's clinical record, hospital discharge instructions on 4/3/26 states, you were hospitalized for an infection of the left lower extremity. More than likely, one of the chronic ulcers that you have become infected. Review of R1's Wound Outpatient note on 6/10/26 15:41(3:41 p.m.) states, Wound Outpatient Note: wound location - Bilateral lower legs/feet (multiple sites), left outer midfoot, right inner heel, right outer ankle. Follow up appointment scheduled for: Wednesday June 17, 2026, 10:30 a.m. Writer gave Highview driver the follow up appointment card and MD order sheet. R1 has been seen weekly for wound care since April, 2026. Review of Physician Order dated 5/12/26 states, Right lower leg ulcer: (1) Cleanse with wound wash (2) Dry well (3) Apply mupirocin ointment to scab (4) Cover with dry dressing two times a day, discontinue 5/12/26 9:38 a.m. Discontinue Date/Reason Resident having wound clinic dressing changes weekly., and Left lower leg - Cleanse area, hydrofera blue (cut to fit), ABD pads, wrap with cling- change daily and as needed. Every day shift. Discontinue 5/12/26 9:36 a.m. discontinue date/reason: resident having wound clinic dressing changes weekly. On 6/16/26 at 1:45 p.m. in an interview with the Director of Nursing [DON], a surveyor confirmed that the facility could not provide transportation to R1's wound clinic appointment on 6/17/26 and could not provide transportation to R1's wound clinic appointment rescheduled for 6/16/26. The DON contacted the wound clinic today, and a new appointment was scheduled 6/22/26, 5 days past the weekly scheduled wound care appointment.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record reviews and interviews, the facility failed to ensure that a Resident Profile (Facesheet) contained accurate and complete information regarding a responsible party for 1 of 5 residents reviewed for Advance Directives (Resident #17 [R17]). Finding: On 6/16/26, a surveyor reviewed R17's clinical record and was unable to locate an Advance Directives. On 6/17/26 at 9:20 a.m., during an interview with a surveyor, the Administrator stated that R17 was not capable of completing an Advance Directive and provided a Social Service note, dated 2/3/26, that Adult Protective Services had been involved in a case concerning R17 but closed it because R17 had a family member that agreed to be the person that would make decisions on R17's behalf. On 6/18/26 at approximately 2:45 p.m., during an interview with the Administrator, the surveyor confirmed that R17's resident profile indicated that R17 was responsible for self and had not been updated to reflect that R17 has a responsible party.		

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. Based on record review and interview, the facility failed to complete and transmit a discharge Minimum Data Set 3.0 (MDS) electronically to the State MDS database for 1 of 1 sampled resident transferred to another long-term care facility. As of 6/16/26, this MDS was due to be completed and transmitted by 5/14/26, now 33 days late. On 6/15/26, R7's clinical record was reviewed and indicated that on 4/21/26, R7 was discharged to another long-term care facility, and a recapitulation of stay was in the clinical record. There was no evidence in the clinical record that the discharge MDS had been completed within 14 days from discharge and transmitted to the State MDS database within 14 days after completion. On 6/16/26 at 2:56 p.m., during an interview with the Minimum Data Set (MDS) Coordinator, a surveyor confirmed this finding.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observations and interview, the facility failed to post the daily nurse staffing information in a prominent place, readily accessible and visible to all residents for 2 of 3 days of survey (6/15/26 and 6/16/26). Findings:1. On 6/15/26 at 12:32 p.m., a surveyor observed the daily staff report attached to a magazine rack that was partially shielded by the weekly menu which was also attached to the magazine rack; both of these documents were hanging sideways from the rack. In order to read this report, a person would need to turn the page upright which would move the menu during this process. 2. On 6/16/2026 at 2:33 p.m., the Nurse Manager (NM) and surveyor a surveyor observed the daily staff report (dated for yesterday) attached to a magazine rack that was partially shielded by the weekly menu which was also attached to the magazine rack; both of these documents were hanging sideways from the rack. In order to read this report, a person would need to turn the page upright which would move the menu during this process. This observation of placement and report date was confirmed at this time with the NM who stated that she forgot to post the report for today.		

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F 0944 Level of Harm - Potential for minimal harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. Based on personnel file reviews and interview, the facility failed to ensure staff received mandatory training on its Quality Assurance and Performance Improvement Program (QAPI), which included the staff's role and communication with the program, for 3 of 3 personnel files reviewed that had been employed greater than 1 year (Certified Nursing Assistant #1 (CNA1, CNA2, and CNA3). Findings: On 6/16/26, a surveyor reviewed the following Certified Nursing Assistant (CNA) personnel files and was unable to find evidence QAPI training had been provided: 1. CNA1 was hired on 5/8/24, the employee training record lacked evidence of QAPI training. 2. CNA2 was hired on 8/1/23, the employee training record lacked evidence of QAPI training. 3. CNA3 was hired on 1/11/23, the employee training record lacked evidence of QAPI training. On 6/17/26 at 11:25 a.m., during an interview with a surveyor, the Administrator stated that QAPI training had only been provided to new hire employees during orientation that were hired after 3/18/26 and had not been provided to employees hired prior to that date.		