

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  205176	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/23/2024
NAME OF PROVIDER OR SUPPLIER  Forest Hill Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 25 Bolduc Ave Fort Kent, ME 04743	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>35904</p> <p>Based on interview and record review, the facility failed to follow physician orders to obtain a urine sample for 1 of 2 residents reviewed for resident to resident abuse (Resident #24 [R24]).</p> <p>Findings:</p> <p>Review of Resident #24's medical record contained a provider order dated 4/18/24 to obtain an u/a (urinalysis, or urine sample to rule out urinary tract infection), due to change in mental status.</p> <p>On 4/23/24 at 11:46 a.m. in an interview with the Administrator, a surveyor confirmed that a urine sample was not obtained, as ordered, 5 days after the provider's order, and there is no record of attempt or completion of urine sample.</p>

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

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